OeHI
Office of eHealth Innovation

EHEALTH COMMISSION MEETING

WEB-CONFERENCE ONLY

October 12, 2022

OeHI
Office of eHealth Innovation

NOTE:

NEW ZOOM WEBINAR LINK

PASSCODE: ehealth

DIAL IN BY PHONE:

US: +1 346 248 7799

OR: +1 669 900 6833

WEBINAR ID: 843 6179 7953

IF YOU ARE EXPERIENCING AUDIO OR PRESENTATION DIFFICULTIES DURING THIS MEETING, PLEASE TEXT ISSUES TO

Cierra Childs at 970-216-6817

October Agenda

OeHI
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Title	Start	Duration
Call to Order • Roll Call and Introductions • Approval of August and September Minutes • October Agenda and Objectives *Kaakpema "KP" Yelpaala, Chair*	12:00	5 mins
Announcements • OeHI Updates-eHealth Commission Updates • Decision Items & Action Items *Stephanie Pugliese, Director, Office of eHealth Innovation (OeHI)* *eHealth Commission Members*	12:05	15 mins
New Business **Data Equity: Collecting, Interpreting, and Presenting Race and Ethnicity Data** *Fernando De Maio, PhD* *Vice President, Health Equity Research and Data Use* *Center for Health Equity, American Medical Association*	12:20	1 hour
Debrief and Tie to Colorado Ecosystem *Stephanie Pugliese, Director, OeHI* *All Commissioners*	1:20	15 mins
Public Comment Period	1:35	5 mins
eHealth Commission Meeting Closing Remarks • Open Discussion • Recap Action Items • Future Agenda Items • Adjourn Public Meeting *Kaakpema "KP" Yelpaala, Chair*	1:40	10 mins

Announcements

OeHI and eHealth Commission Updates

- Colorado Provider Telehealth Survey-
  - Closes 10/25, please share with your networks!
- Dollars to Digitize grant opportunity is open!
  - Intent to Apply form due 11/18
- Colorado Health Innovation Resource Platform (CHIRP)

Note: If you are experiencing audio or presentation difficulties during this meeting, please text 970-216-6817

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Data Equity: Collecting, Interpreting, and Presenting Race and Ethnicity Data

Fernando De Maio, PhD
Vice President, Health Equity Research and Data Use
Center for Health Equity, American Medical Association

Data Equity & Health Justice

Fernando De Maio, PhD
Vice President, Health Equity Research and Data Use Center for Health Equity

Professor, Department of Sociology
DePaul University

Colorado eHealth Commission
10/12/2022

Land and labor acknowledgement

We acknowledge that we are all living off the stolen ancestral lands of Indigenous peoples for thousands of years. We acknowledge the extraction of brilliance, energy and life for labor forced upon people of African descent for more than 400 years. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us, and we are continually called to be better as we lead this work.

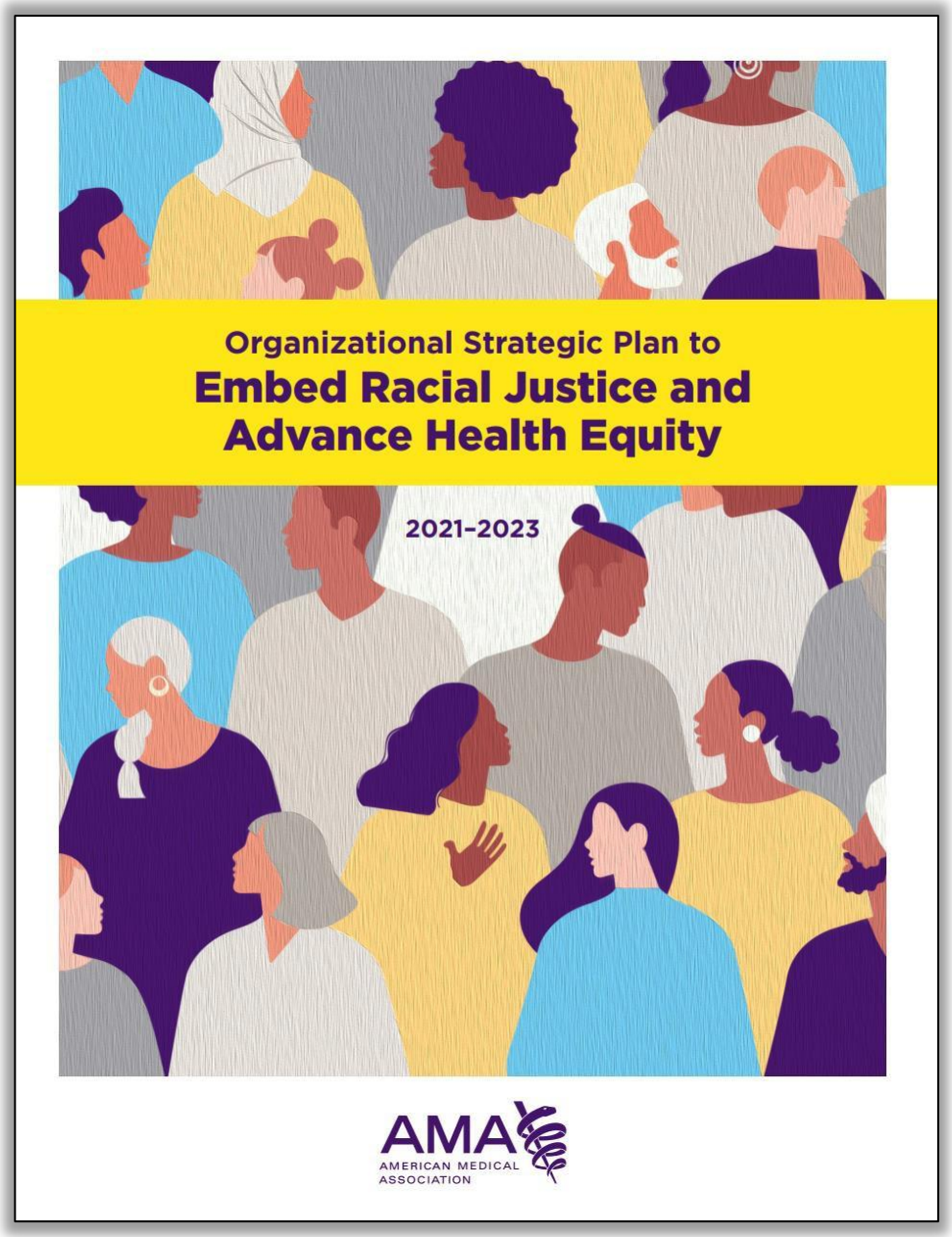
Image Details:
Top Image: Oregon Health & Science University's Native American Center of Excellence aims to increase American Indian and Alaska Native representation in the healthcare workforce. This image is of the Spring 2021 cohort of scholars celebrating their completion of the OHSU Wy'East Post-Baccalaureate Pathway at a blanket ceremony .Photo Credit: OHSU/Michael Schmitt
Bottom Photo: Washington B. New Orleans; 2019. https://www.the15whitecoats.org/media. Accessed December 10, 2021.

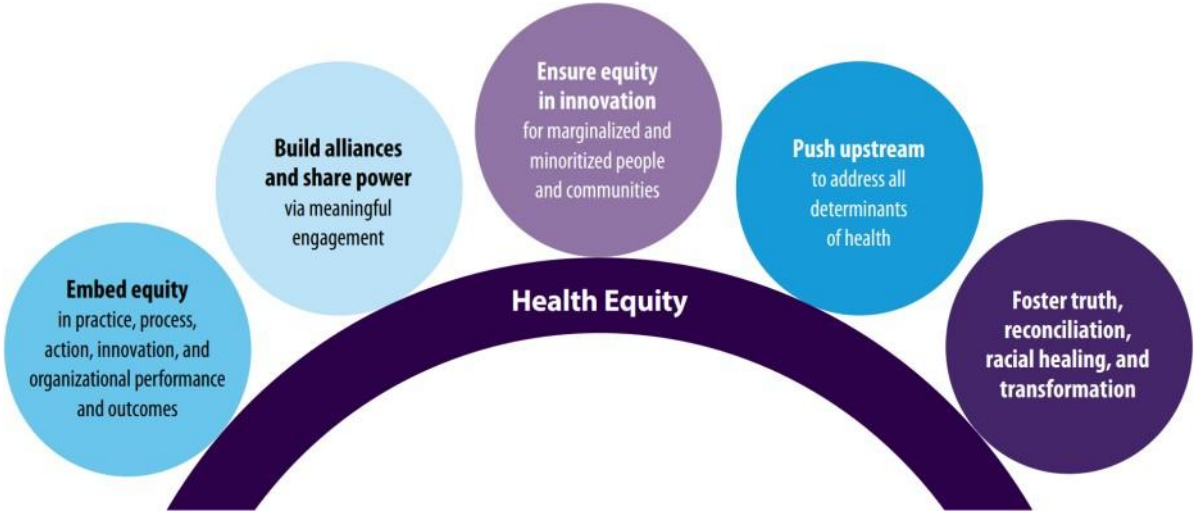
Three Main Points

1. **Consensus:** it would be unethical to continue to merely describe health inequities
    - Without devaluing the need for rigorous descriptive data to quantify gaps and monitor trends

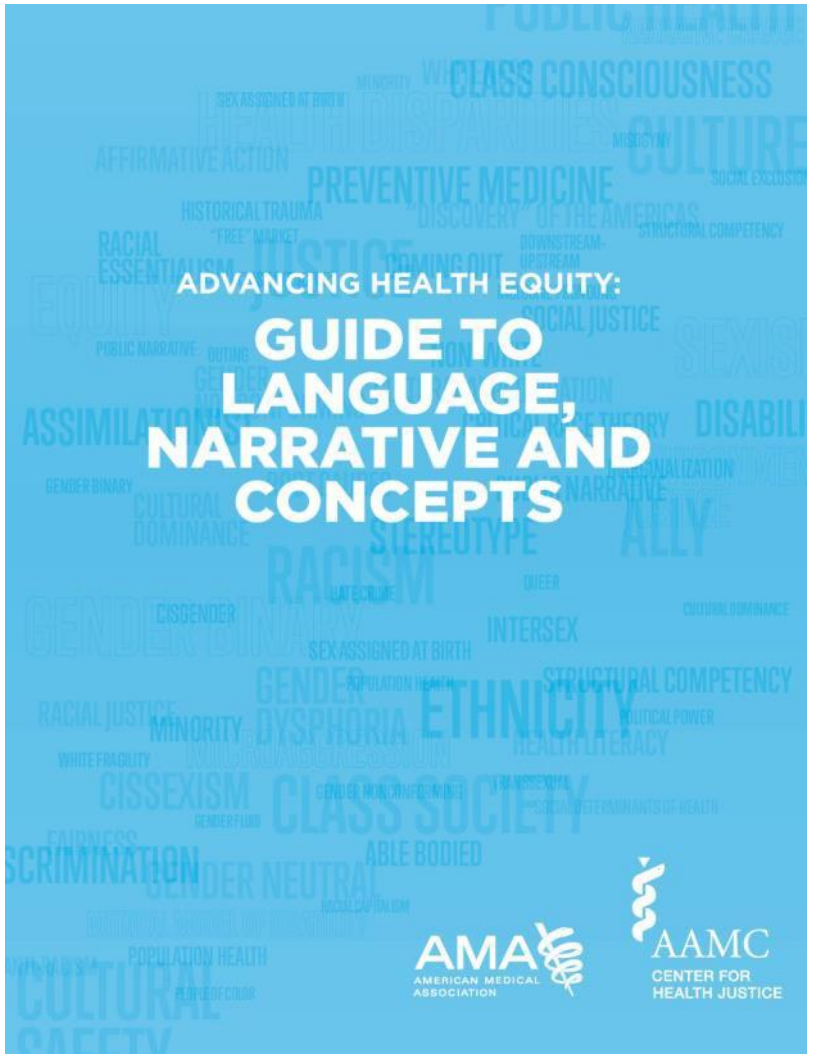
2. **Continued problem, in all areas of health care:** Prioritization of explanations and interventions focused on “beliefs, behaviors, and biology” of individuals

3. **A need for a “historically deep and geographically broad” understanding of structural violence and the root causes of health inequities**
    - Requiring greater clarity on language and narratives, including narratives around race





"We envision a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources and opportunities to achieve optimal health; and all physicians are equipped with the consciousness, tools and resources to confront inequities and dismantle white supremacy, racism, and other forms of exclusion and structured oppression, as well as embed racial justice and advance equity within and across all aspects of health systems."



It is critical to address all areas of marginalization and inequity due to sexism, class oppression, homophobia, xenophobia and ableism. Yet conversations about race and racism tend to be some of the most difficult for people in this country to participate in for numerous reasons, including a lack of knowledge or shared analysis of its historical and current underpinnings, as well as outright resistance and denial that racism exists. Given the deep divides that exist between groups in the United States, understanding and empathy can be extremely challenging for many because of an inability to really "walk a mile in another's shoes" in a racialized sense. Collectively, we have an opportunity and obligation to overcome these fissures and create spaces for understanding and healing.

AMA Center for Health Equity
Research & Data Use: Principles & Actions

Principles

1. We conduct research to not just describe inequities but to overcome them
2. We conduct research to support physicians and health systems work towards health equity
3. We value collaboration in all aspects of the research process, recognizing expertise of partners (particularly from groups often marginalized in traditional research infrastructure)
4. We recognize that data are not “neutral,” but reflect underlying systems of power (shaping how data are collected, shared, analyzed, and interpreted)
5. Informed by social epidemiology and critical race theory, we recognize that health inequities are the products of deep-rooted structural and social drivers
6. History and narrative (often neglected in statistical modelling) are critical in our work
7. While we need national-level analyses, we also recognize that health inequities manifest in small areas. It is in small areas where research can be particularly valuable, presenting locally disaggregated data. This requires both quantitative and qualitative approaches.
8. We recognize that the research process holds both empowering and potentially damaging features and seek to mitigate unintended harms in all aspects of our work

Actions

CHE Research / Data Use will work to:

- **Serve** as a reliable producer and curator of health equity data. This includes both **social epidemiologic data** (looking at places) as well as **health services research** (looking at health systems)
- **Develop** new metrics and ways of understanding the drivers of health inequities at structural, community, and institutional levels (from social epidemiology to quality/safety/equity at the point of health care system delivery)
- **Leverage** our strengths in research and data to contribute to place-based efforts with health equity missions (e.g., West Side United)
- **Embed** health equity research in medical education, integrating empirical findings into “upstreamist” training materials as well as throughout the AMA enterprise (with health equity data training and collaboration with other BUs)
- **Evaluate** our work by developing frameworks and tools to systematically track progress on CHE projects and the AMA strategic plan for racial justice and health equity

Collaborative work for equity in data

The AAMC, ACGME, and AMA are working together to establish best practices for data sharing and standards **for sociodemographic data, including race and ethnicity, sexual orientation, gender identity, language proficiency, disability, and more.** These efforts will enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum.

PRESS RELEASES

AMA adopts new policy to increase diversity in physician workforce

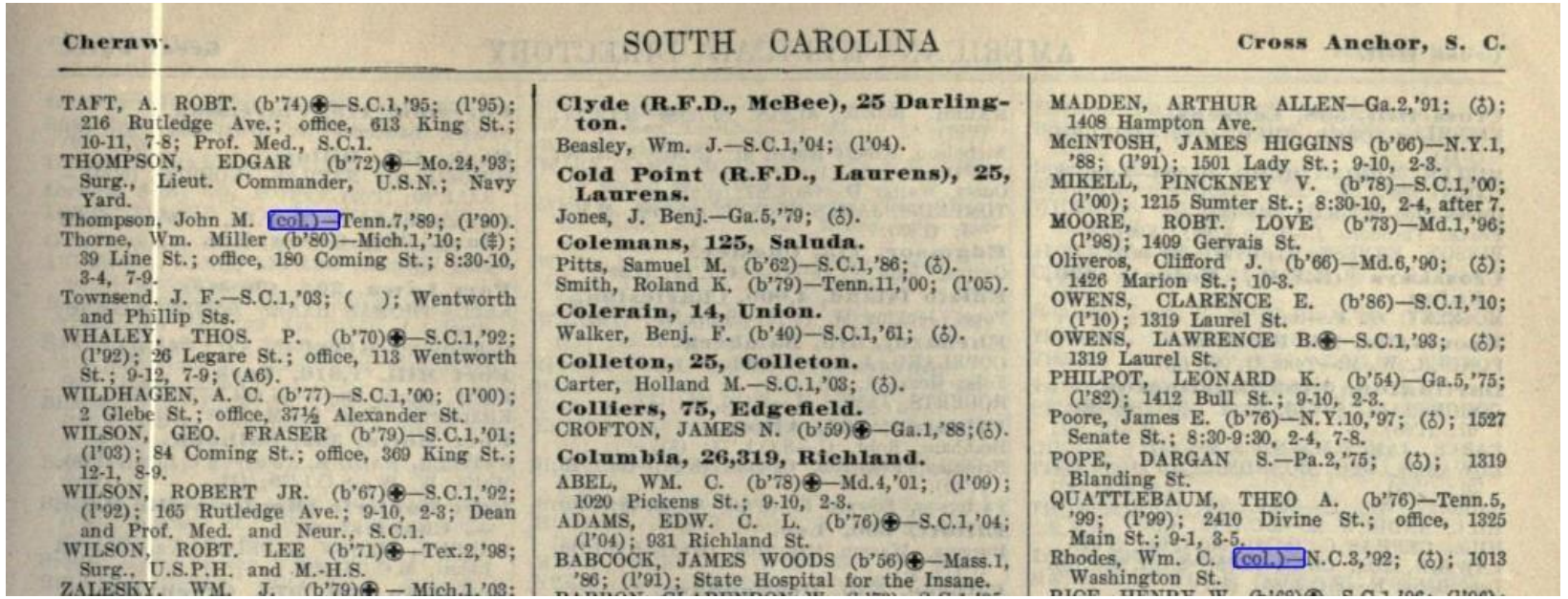
JUN 17, 2021

"Studies show that racial, ethnic and gender diversity among health professionals promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population. Yet, **our physician workforce does not adequately reflect the actual racial, ethnic or gender makeup of the patients in the communities we serve**,"

"A critical step in moving forward, we must call out the lasting negative impact that the Flexner Report, and other harmful past actions by the medical profession, has had on today's physician workforce. We must address and reconcile these lasting harms to ensure that future physicians are aware of structural factors that are impeding their
patient's health outcomes, and continue efforts to ensure a diverse physician workforce
that meets the needs of our patients."

Jesse M. Ehrenfeld, M.D., M.P.H.

Equity Considerations



Cheraw. SOUTH CAROLINA Cross Anchor, S. C.

TAFT, A. ROBT. (b'74)⊕—S.C.1,'95; (l'95); 216 Rutledge Ave.; office, 613 King St.; 10-11, 7-8; Prof. Med., S.C.1.
THOMPSON, EDGAR (b'72)⊕—Mo.24,'93; Surg., Lieut. Commander, U.S.N.; Navy Yard.
Thompson, John M. (col.)—Tenn.7,'89; (l'90).
Thorne, Wm. Miller (b'80)—Mich.1,'10; (‡); 39 Line St.; office, 180 Coming St.; 8:30-10, 3-4, 7-9.
Townsend, J. F.—S.C.1,'03; ( ); Wentworth and Phillip Sts.
WHALEY, THOS. P. (b'70)⊕—S.C.1,'92; (l'92); 26 Legare St.; office, 113 Wentworth St.; 9-12, 7-9; (A6).
WILDHAGEN, A. C. (b'77)—S.C.1,'00; (l'00); 2 Glebe St.; office, 37½ Alexander St.
WILSON, GEO. FRASER (b'79)—S.C.1,'01; (l'03); 84 Coming St.; office, 369 King St.; 12-1, 8-9.
WILSON, ROBERT JR. (b'67)⊕—S.C.1,'92; (l'92); 165 Rutledge Ave.; 9-10, 2-3; Dean and Prof. Med. and Neur., S.C.1.
WILSON, ROBT. LEE (b'71)⊕—Tex.2,'98; Surg., U.S.P.H. and M.-H.S.
ZALESKY, WM. J. (b'79)⊕—Mich.1,'03;

Clyde (R.F.D., McBee), 25 Darlington.
Beasley, Wm. J.—S.C.1,'04; (l'04).

Cold Point (R.F.D., Laurens), 25, Laurens.
Jones, J. Benj.—Ga.5,'79; (♁).

Colemans, 125, Saluda.
Pitts, Samuel M. (b'62)—S.C.1,'86; (♁).
Smith, Roland K. (b'79)—Tenn.11,'00; (l'05).

Colerain, 14, Union.
Walker, Benj. F. (b'40)—S.C.1,'61; (♁).

Colleton, 25, Colleton.
Carter, Holland M.—S.C.1,'03; (♁).

Colliers, 75, Edgefield.
CROFTON, JAMES N. (b'59)⊕—Ga.1,'88;(♁).

Columbia, 26,319, Richland.
ABEL, WM. C. (b'78)⊕—Md.4,'01; (l'09); 1020 Pickens St.; 9-10, 2-3.
ADAMS, EDW. C. L. (b'76)⊕—S.C.1,'04; (l'04); 931 Richland St.
BABCOCK, JAMES WOODS (b'56)⊕—Mass.1, '86; (l'91); State Hospital for the Insane.

MADDEN, ARTHUR ALLEN—Ga.2,'91; (♁); 1408 Hampton Ave.
McINTOSH, JAMES HIGGINS (b'66)—N.Y.1, '88; (l'91); 1501 Lady St.; 9-10, 2-3.
MIKELL, PINCKNEY V. (b'78)—S.C.1,'00; (l'00); 1215 Sumter St.; 8:30-10, 2-4, after 7.
MOORE, ROBT. LOVE (b'73)—Md.1,'96; (l'98); 1409 Gervais St.
Oliveros, Clifford J. (b'66)—Md.6,'90; (♁); 1426 Marion St.; 10-3.
OWENS, CLARENCE E. (b'86)—S.C.1,'10; (l'10); 1319 Laurel St.
OWENS, LAWRENCE B.⊕—S.C.1,'93; (♁); 1319 Laurel St.
PHILPOT, LEONARD K. (b'54)—Ga.5,'75; (l'82); 1412 Bull St.; 9-10, 2-3.
Poore, James E. (b'76)—N.Y.10,'97; (♁); 1527 Senate St.; 8:30-9:30, 2-4, 7-8.
POPE, DARGAN S.—Pa.2,'75; (♁); 1319 Blanding St.
QUATTLEBAUM, THEO A. (b'76)—Tenn.5, '99; (l'99); 2410 Divine St.; office, 1325 Main St.; 9-1, 3-5.
Rhodes, Wm. C. (col.)—N.C.3,'92; (♁); 1013 Washington St.

American Medical Directory, 1912

Beginning in 1906, our AMA's American Medical Directory, which lists all U.S. physicians, officially marked African American doctors with the "col." notation for "colored."

The AMA discontinued its policy of listing Black physicians as "col." in its American Medical Directory in 1939, after years of protest from the National Medical Association.

Source: AMA Archives; deShazo, R. *The Racial Divide in American Medicine*. Jackson: University of Mississippi Press.

Opportunities

- To ensure physician networks are appropriately diverse and align with patient population
- Establish a benchmark to measure improvement in diversity of physician networks
- Help regulators hold insurers accountable for creating diverse networks that meet the needs for their enrollees

Concerns

- Historically, designation of a physician's race has been used as a tool to discriminate and exclude physicians
- Displaying this information in provider directories could expose minoritized physicians to discrimination from patients

Suggestions

- Standardize race and ethnicity categories
- Evaluate benefits and unintended harms for both physicians and patients over time; share evaluation findings
- Be ready to adjust the program in real-time if necessary
- Support diversification and health equity in other ways

“Data” is never a “given”… data instead are always produced by people, out of what they observe, fail to see, or suppress in the world in which they live.

- Nancy Krieger, 2021

Source: Krieger N. (2021) *Frontiers in Public Health*

https://healthequitytracker.org

Health Equity Tracker

What is Health Equity? Explore the Data Downloads & Methodology About

Advancing Health Equity

We know that the data we collect can be flawed and at times even worsen health inequities many people face if not reported or analyzed correctly.

We work to change that narrative by identifying, understanding, and responding to health inequities in our communities in a way that will allow every person to live well and long from generation to generation.

Join us in powering transformational action!

Explore the Health Equity Tracker

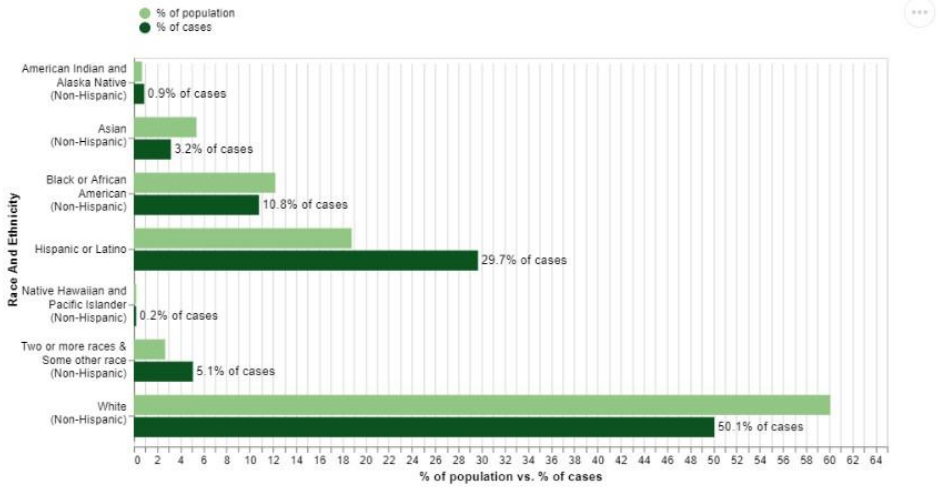
Investigate rates of COVID-19 in United States

Major gaps in the data

Structural racism and oppression create health inequities, and lead to missing data. The maps and tables below reflect the best data we have, but there are major known gaps in the data. We're working to close these gaps which, in turn, will help us create more effective health policies in the United States. Read more about missing and misidentified people.

Share Of Total COVID-19 Cases vs. Population By Race And Ethnicity In United States

38.3% of cases reported unknown race and ethnicity. The chart below only displays data for cases where race and ethnicity was known.

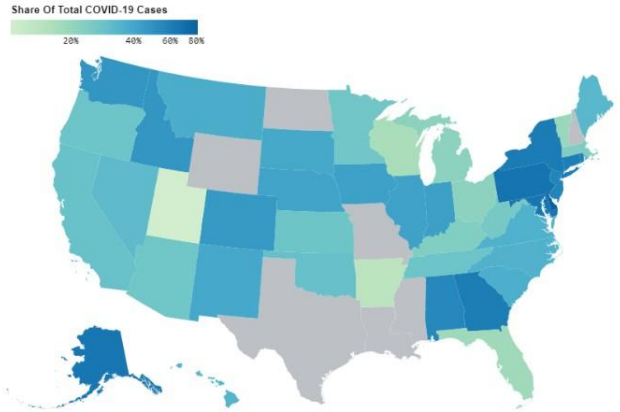


Sources: CDC Case Surveillance Restricted Access Detailed Data (updated May 2021) American Community Survey 5-year estimates (updated 2019)

Share Of Total COVID-19 Cases With Unknown Race And Ethnicity

United States

38.3% of cases reported unknown race and ethnicity. The map below displays data for cases where race and ethnicity was unknown.

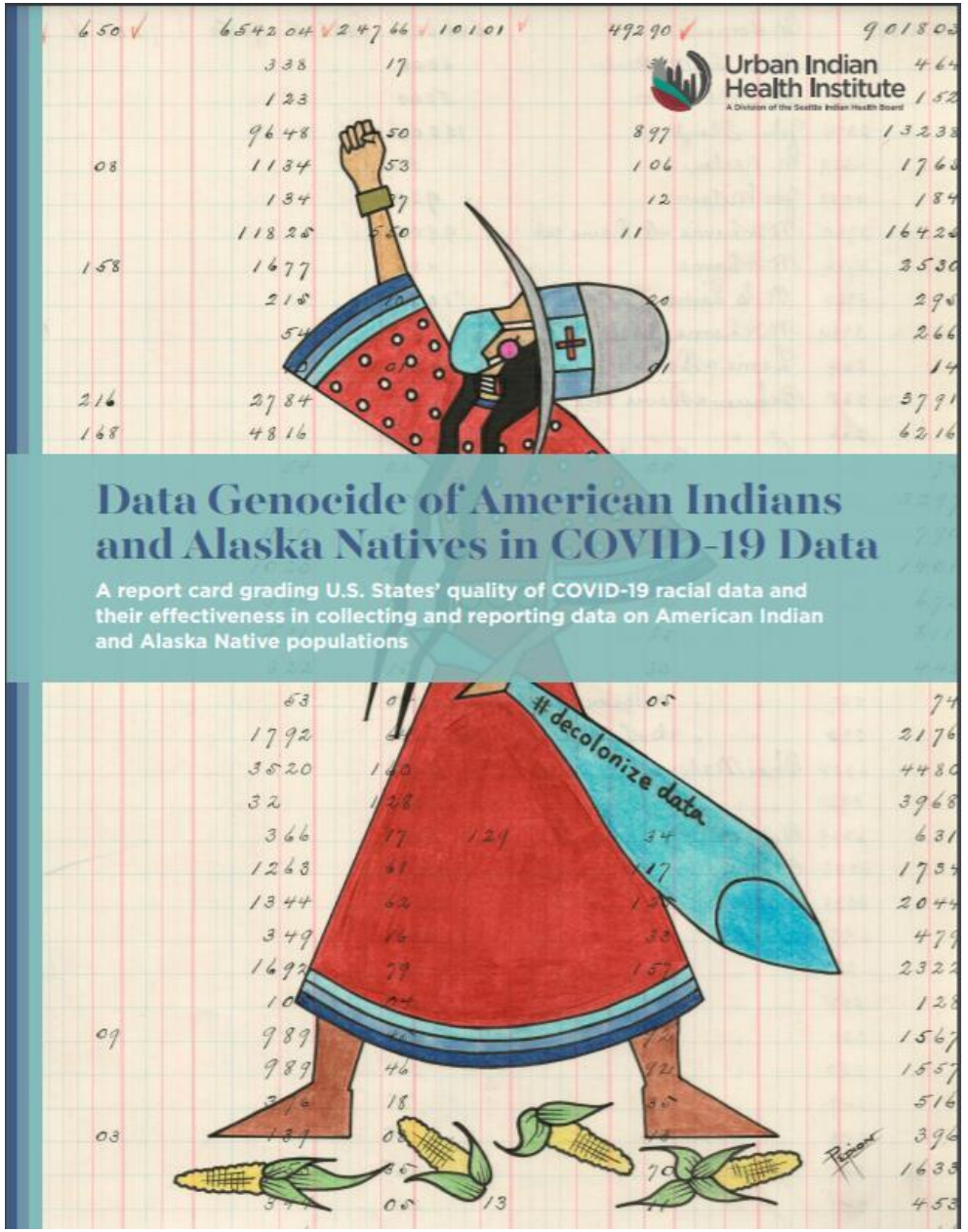


Sources: CDC Case Surveillance Restricted Access Detailed Data (updated May 2021) American Community Survey 5-year estimates (updated 2019)

Why Are Data Missing?

"This information is meant to address the data genocide happening to Indigenous people. We must urge state and federal policy actions to respond to the parallel crisis we are facing in our public health data systems."

– ABIGAIL ECHO-HAWK (PAWNEE), DIRECTOR OF URBAN INDIAN HEALTH INSTITUTE



AS FOR CLIMATE, THIS IS WORLD'S HEALTHIEST CITY

Chicago is the healthiest large city in the civilized world, according to official statistics from the governments of four continents, Europe, Asia, and the Americas.

For the second consecutive year, the city's clear supremacy as a safe place in which to live and rear a family was proved yesterday when comparative death rate figures for 1925 were revealed by the department of health.

The ranking of world cities showing the number of deaths per thousand population, is as follows:

Chicago	11.5	Buenos Aires	13.7
Berlin	11.7	Paris	14.7
New York City	12.2	Bombay	25.4
Vienna	12.9	Calcutta	32.7
Philadelphia	13.2		

In order to verify the accuracy of the death rates, Dr. Herman N. Bundesen, health commissioner, who compiled the report, wrote directly to the chief health officers of the various countries.

The British commissioner of health was unable to furnish statistics on the London death rate, but Dr. Bundesen pointed out that Chicago led the great English city in 1924.

Figures Show Chicago's Rise.

Although last year was the first time the tabulation was made in this manner, unofficial figures for previous years show the steady rise of Chicago to its present health leadership. A decade ago the city ranked far down the list.

The showing made in the last two years Dr. Bundesen attributes to the following principal factors:

1. General health education and cooperation by the mayor, civic bodies, and the general public.
2. Strict regulations on quarantines and other preventive measures to check disease.
3. Abatement of the smoke evil.
4. Reduction of infant mortality through pre-natal clinics and other baby welfare work.
5. Correction of defects in school children.
6. Safe water, food, and milk supplies, good climate, adequate sewage disposal, and improved housing conditions.

In a report supplementing the health comparisons the commissioner asserted that probably the greatest single factor that keeps up Chicago's record is its steady reduction in baby deaths.

"Chicago is proud of its 1925 infant mortality rate, 74.7 deaths per thousand births, the lowest the city has ever had," he said.

"Chicago rapidly is becoming the medical center of the western hemisphere," Dr. Bundesen added. "Its physicians stand preëminent in their field and are invaluable in conserving health. The Chicago Medical society, with its 4,000 members, deserves special commendation for its coöperation with the health department.

"Our weather at all seasons has a deserved reputation for healthfulness. We have just the right mean temperature and moisture to stimulate active outdoor life. This means building up resistance to sickness, preventing colds and especially, less pneumonia. The lake is a permanent source of fresh air at all seasons.

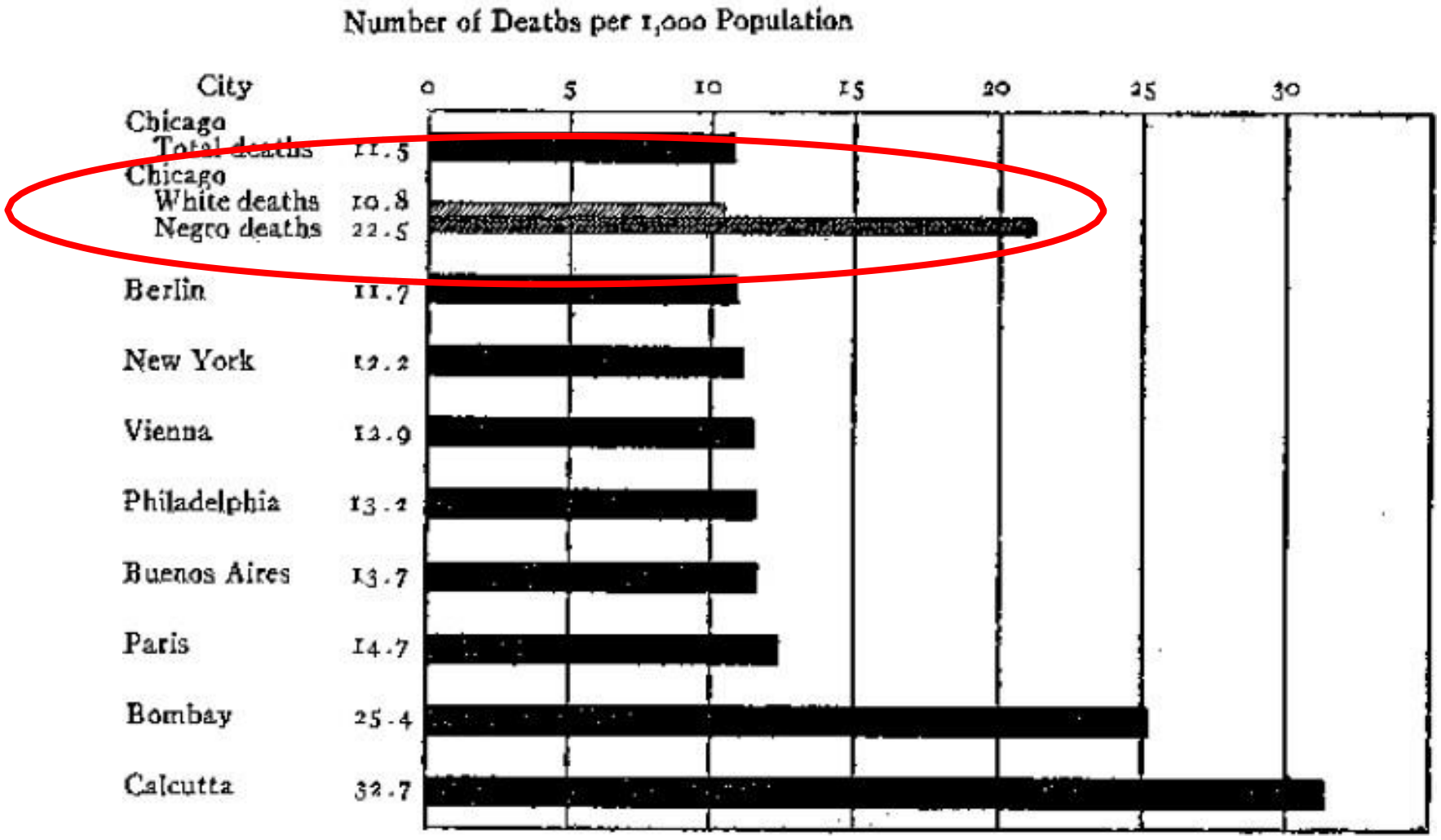
"To live in Chicago is a safeguard. It is a form of life insurance. But it has certain advantages over insurance since it costs nothing extra and every one benefits during his own life time."

FINED FOR FIRE FAG STARTED.

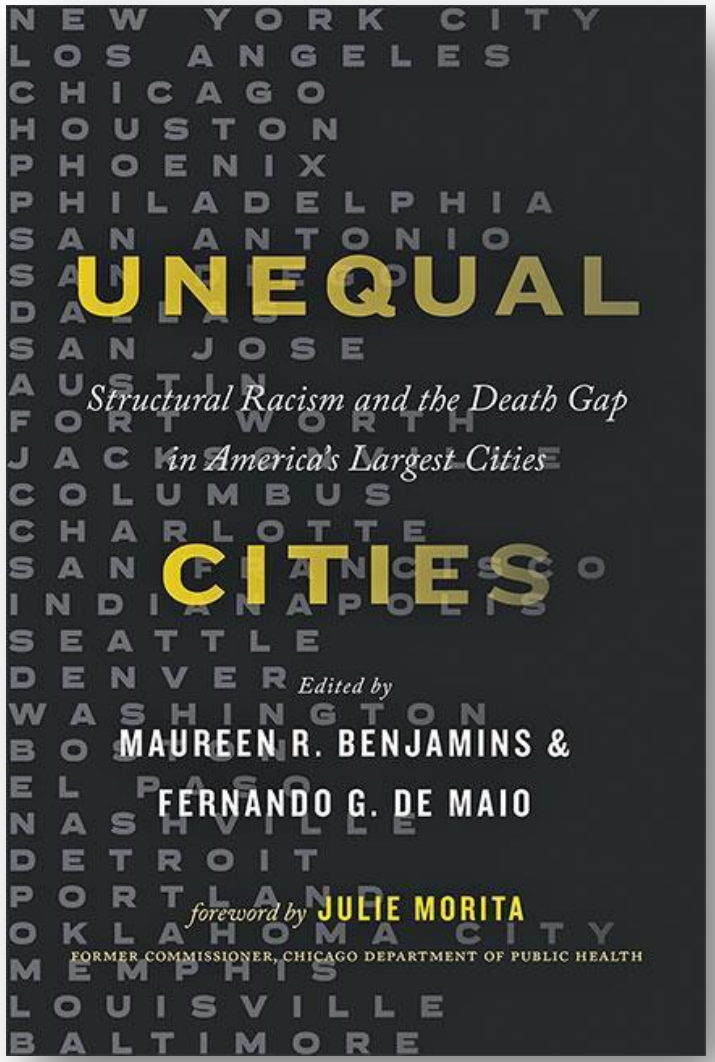
Paul Jerkusky fell asleep with a lighted cigaret in his mouth and set fire to his employer's junk shop at 1034 West Lake street. Yesterday he was fined $3 for his carelessness.

Chicago Tribune, 1926

Death-Rates in Cities of over 1,000,000 Population for Which Data Are Available, 1925



Source: Harris, 1927



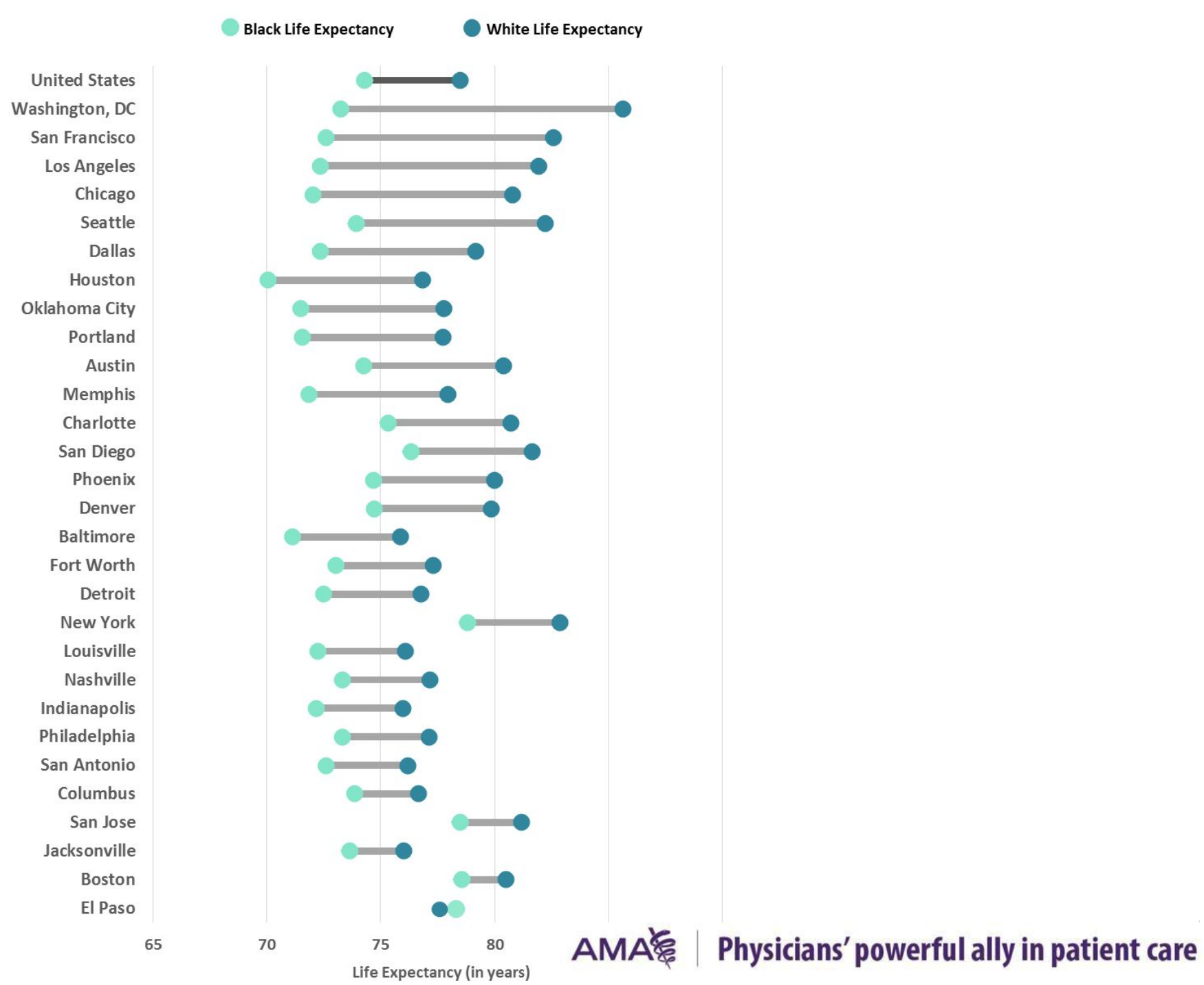
Life Expectancy

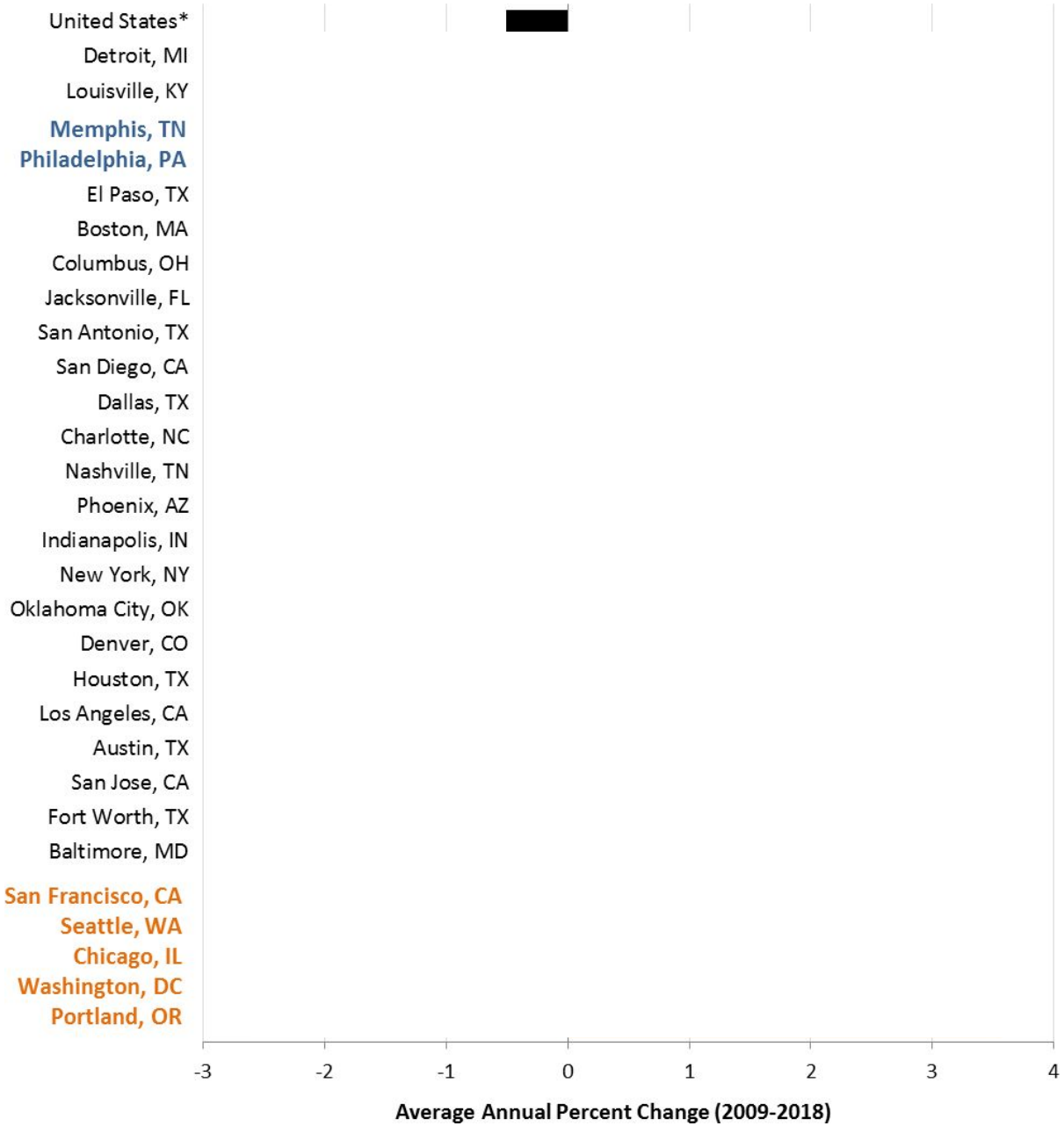
(2013-2017)

10 Years

Life Expectancy by Race

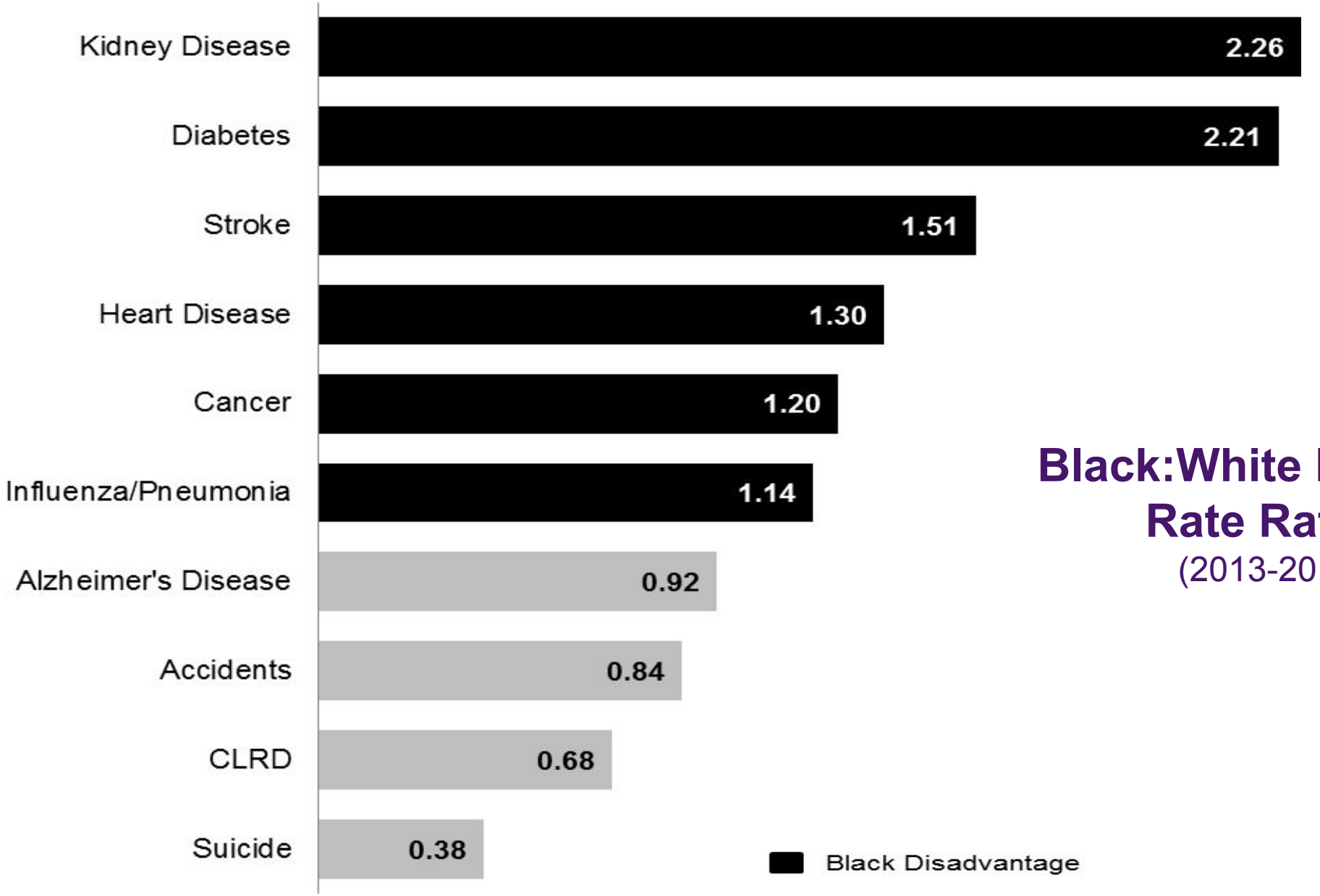
(2013-2017)





Changes in All-Cause Mortality Black:White Rate Ratios (2009-2018)

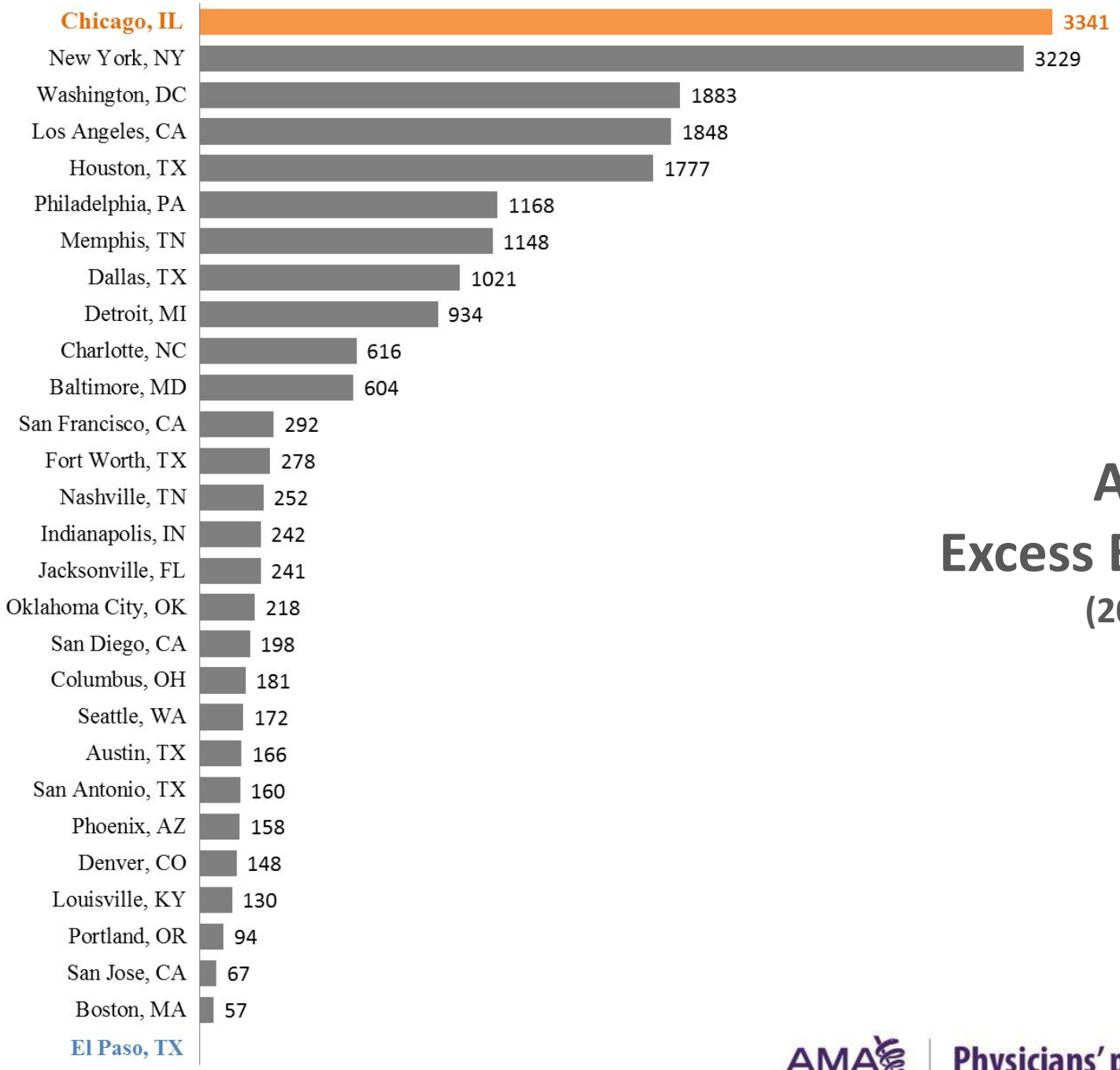
Benjamins, Silva, Saiyed, De Maio. *JAMA Network Open*. 2021.



Black:White Mortality Rate Ratios

(2013-2017)

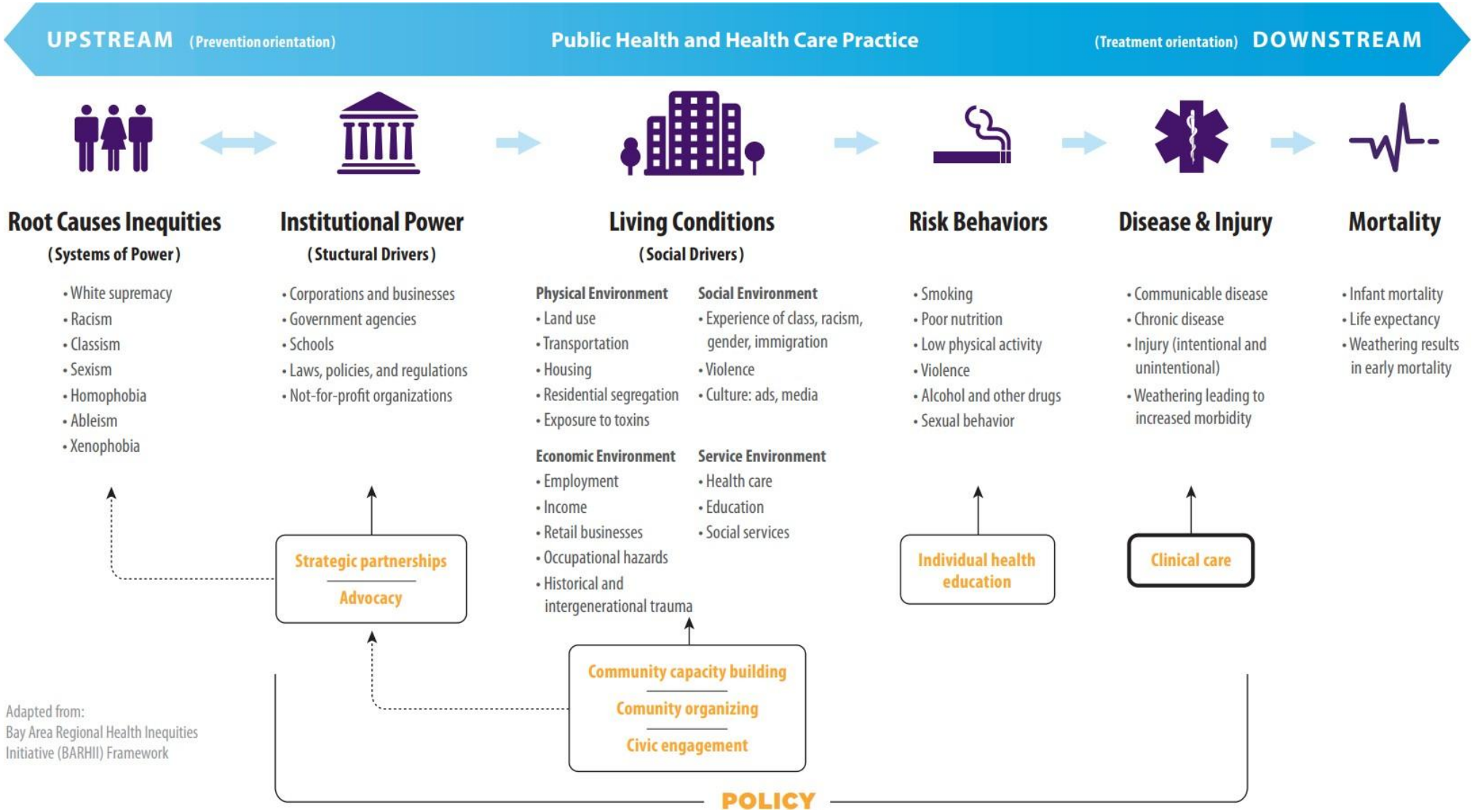
Source: Benjamins and De Maio (eds.) *Unequal Cities.* 2021



Annual Excess Black Deaths

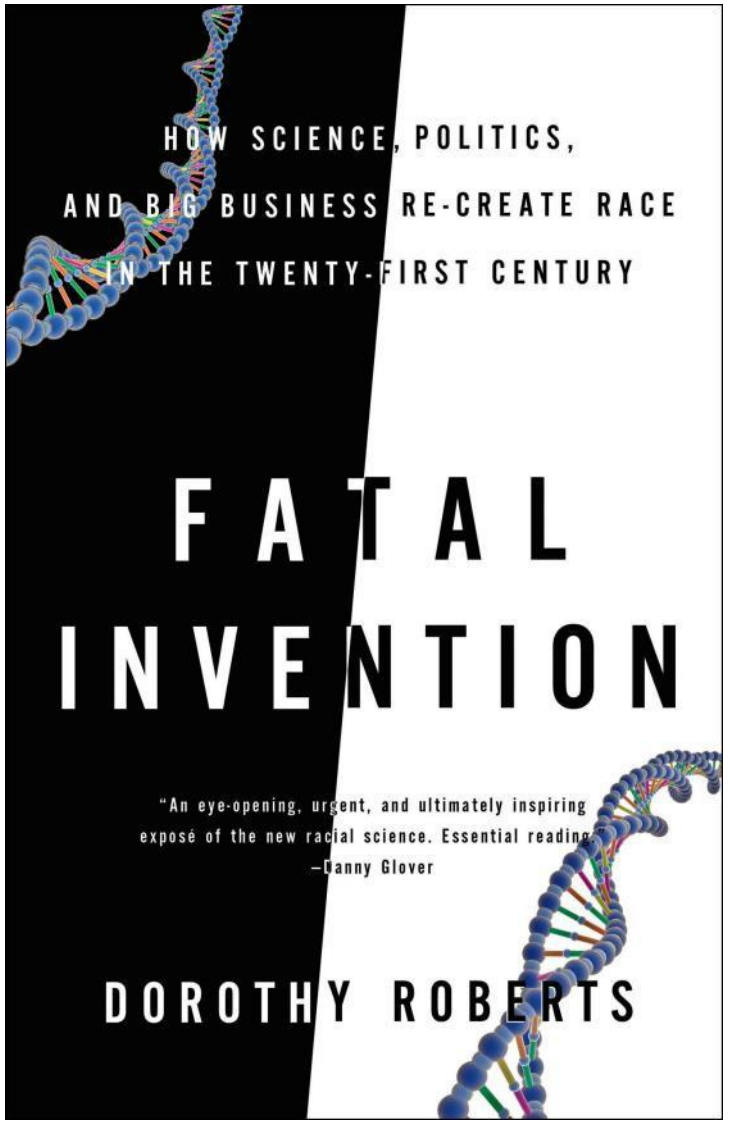
(2013-2017)

What Creates Health Framework



"Race is not a biological category that naturally produces these health disparities because of genetic difference. **Race is a social category that has staggering biological consequences … because of the impact of social inequality on people's health.** ...

What if doctors joined the forefront of a movement to end the structural inequities caused by racism, not by genetic difference?"



TIME

IDEAS • HEALTH

The World's Leading Medical Journals Don't Write About Racism. That's a Problem

A new study reveals how leading medical journals overlook and ignored racism in publishing research articles. Getty Images © David Sacks

BY RHEA BOYD, NANCY KRIEGER, FERNANDO DE MAIO, AND ALETHA MAYBANK

APRIL 21, 2021 3:36 PM EDT

IDEAS

Rhea Boyd, MD, MPH, is a pediatrician, public health advocate and scholar who writes and teaches on the relationship between structural racism, inequity, and health. Nancy Krieger, PhD, is Professor of Social Epidemiology, American Cancer Society Clinical Research Professor, Department of Social and Behavioral Science, at the Harvard T.H. Chan School of Public Health. Fernando De Maio, PhD, is Director, Health Equity Research and Data Use, at the Center for Health Equity, American Medical Association. Aletha Maybank, MD, MPH, is chief health equity officer and ***senior*** *vice president at the American Medical Association.*

Health Affairs

HEALTH AFFAIRS BLOG | HEALTH EQUITY

RELATED TOPICS:
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Medicine's Privileged Gatekeepers: Producing Harmful Ignorance About Racism And Health

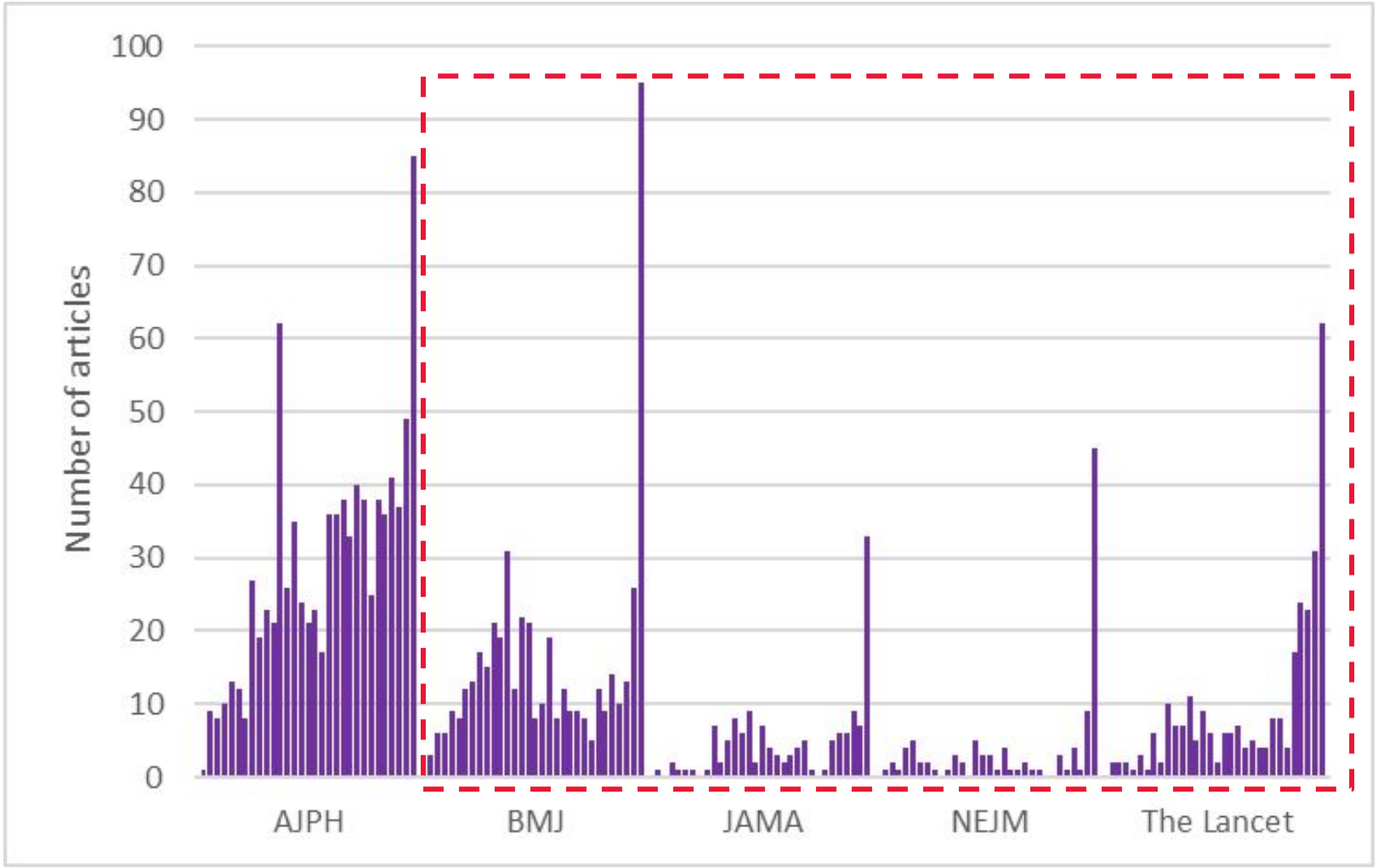
Nancy Krieger, Rhea W. Boyd, Fernando De Maio, Aletha Maybank

APRIL 20, 2021 10.1377/hblog20210415.305480

★ ADD TO FAVORITES SHARE

Ignorance is neither neutral nor benign, especially when it cloaks evidence of harm. And when ignorance is produced and entrenched by gatekeeper medical institutions, as has been the case with obfuscation of at least 200 years of knowledge about racism and health, the damage is compounded. The racialized inequities exposed this past year—involving COVID-19, police brutality, environmental injustice, attacks on democratic governance, and more—have sparked mainstream awareness of structural racism and heightened scrutiny of the roles of scientific institutions in perpetuating ignorance about how racism harms health.

A dramatic increase in number of articles including the word “racism” in 2020…



https://www.healthaffairs.org/do/10.1377/hblog20210415.305480/full/

Yet for the medical journals, the vast majority of articles were commentaries and viewpoints – not empirical studies

	AJPH	BMJ	JAMA	NEJM	The Lancet
Total # of articles (1)	14,192	78,545	40,411	43,378	63,971
Total # of articles that included the word "racism" anywhere in the text (2)	891	644	145	109	315
Total # of articles that included the word "racism" anywhere in the text and available for analysis	891	475	141	109	288
Total # of commentaries / viewpoints / letters (3)	356 (40%)	455 (96%)	130 (92%)	105 (96%)	259 (90%)
Total # of empirical studies (Intro, Methods, Results, Discussion or review with significant data component) (3)	535 (60%)	20 (4%)	11 (8%)	4 (4%)	29 (10%)

Source: Authors' analysis. AJPH = American Journal of Public Health; *BMJ* = British Medical Journal; *JAMA* = Journal of the American Medical Association; *NEJM* = New England Journal of Medicine. *Notes: (1) PubMed results by journal. (2) Obtained from each journal's website, searching for "racism" anywhere in the title, abstract, or text. For BMJ, the actual number of pieces (articles, letters, etc.) containing "racism" may be less than the total reported, since some files contain more than one piece and all pieces in the file may turn up in the search, even if not all the individual pieces in the file contain "racism." (3) Primarily for BMJ, we were unable to obtain copies of some articles due to incomplete library coverage and other issues. (4) Manually coded, except for AJPH, which categorizes and displays articles by type on its website*

…if we, as medical and public health professionals cannot name and confront racism as a root cause of racial health inequities, it profoundly affects what the broader public knows and *doesn't know* about the racial distribution of health and disease and its social causes.

It is past time for the world's leading medical journals to name racism, publish evidence on how racism harms health, and articulate how dismantling racism can prevent racial health inequities.

https://time.com/5956643/medical-journals-health-racism

You know, it’s one thing to talk about data.
But, I think, maybe it’s possible to get lost in the data…

Remember that this is… literally a matter of life and

death.

- Steve Whitman, PhD

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CLOSING REMARKS