ASTP | Health IT Advisory Committee

Health Equity by Design (HEBD) Task Force 2024

Hannah Galvin, Co-Chair

Hung Luu, Co-Chair

October 29, 2024

Call to Order/Roll Call and Task Force Member Introductions

Seth Pazinski, Designated Federal Officer, ASTP

Health Equity by Design Task Force 2024 Roster

Name	Organization	Name	Organization
Hannah Galvin* (Co-Chair)	**Cambridge Health Alliance**	Susan M. Jenkins	HHS Assistant Secretary for Planning and Evaluation (ASPE)
Hung S. Luu* (Co-Chair)	**Children's Health**	Meagan Khau	Centers for Medicare & Medicaid Services (CMS)
Shila Blend*	North Dakota Health Information Network	Kikelomo Oshunkentan*	Pegasystems
Medell Briggs-Malonson*	UCLA Health	Rochelle Prosser*	Orchid Healthcare Solutions
Kristie Clarke	Centers for Disease Control and Prevention (CDC)	Belinda Seto	National Institutes of Health (NIH)
Sooner Davenport	Southern Plains Tribal Health Board	Fillipe Southerland*	Yardi Systems, Inc.
Derek De Young*	Epic	Christopher St. Clair	U.S. Food and Drug Administration (FDA)
Sarah DeSilvey*	Gravity Project	Janice Tufte	Hassanah Consulting
Steven Eichner*	Texas Department of State Health Services	Janée Tyus	IMPaCT Care Inc, University of Michigan-Flint and Michigan Health Information Network (MiHIN)
Cynthia Gonzalez	RAND Corporation		

Opening Remarks

Hannah Galvin, Task Force Co-Chair

Hung Luu, Task Force Co-Chair

Agenda

10:00 AM **Call to Order/Roll Call and Task Force Member Introductions**

- Seth Pazinski, Designated Federal Officer, ASTP

10:20 AM **Opening Remarks**

- Hannah Galvin, Task Force Co-Chair
- Hung Luu, Force Co-Chair

10:25 AM **Task Force Charge, Draft Framework, and Draft Workplan**

- Mark Savage, ASTP Program Staff Lead

10:40 AM **Discussion**

- Hannah Galvin, Task Force Co-Chair
- Hung Luu, Task Force Co-Chair

11:10 AM **Overview of Public Feedback on ASTP Health Equity by Design Concept Paper**

- Mark Savage, ASTP Program Staff Lead

11:20 AM **Public Comment**

- Seth Pazinski, Designated Federal Officer, ASTP

11:25 AM **Next Steps**

- Hannah Galvin, Task Force Co-Chair
- Hung Luu, Task Force Co-Chair

11:30 AM **Adjourn**

Task Force Charge, Draft Framework, and Workplan

Mark Savage, ASTP Program Staff Lead

HEBD Task Force Charge

Incorporating HEBD Principles in Health IT

Provide ASTP with recommendations on promising practices, challenges, and resources to support health and human services organizations to incorporate HEBD principles into the design, build, implementation, use, and monitoring of health IT

- The recommendations should include:
  - Considerations that health and human services organizations can use to include HEBD in health IT
  - Recommendations for ASTP on potential next steps to advance the implementation of HEBD principles in the design, build, implementation, use and monitoring of health IT

- **Recommendations Due:** May 2025

Health Equity by Design Task Force 2024: Public Participation

- All Task Force meetings are open to the public
- Public comment is welcome in the chat throughout the meeting, and public comment time is included on all Task Force meeting agendas
- Calendar of HITAC meetings, meeting materials, and information on how the public can participate are available at: https://www.healthit.gov/topic/federal-advisory-committees/hitac-calendar

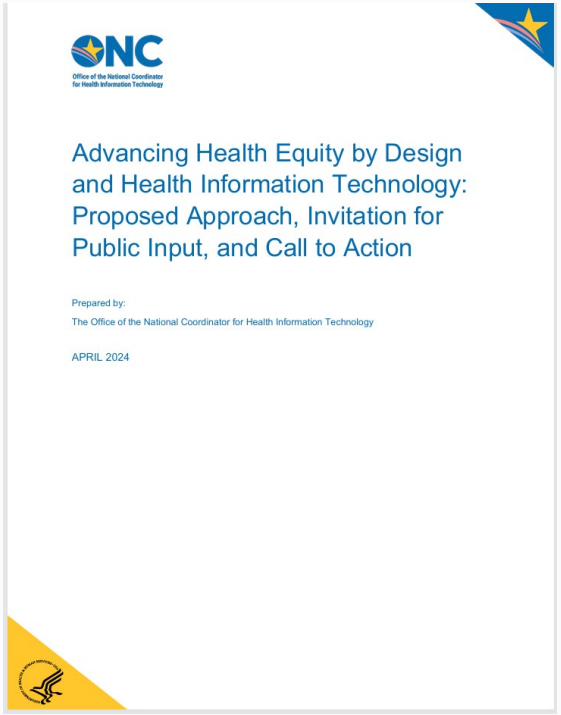
ASTP Concept Paper:
Advancing Health Equity by Design and Health Information Technology: Proposed Approach, Invitation for Public Input, and Call to Action

(April 2024)

1. Health IT, its workflows, and accompanying policies are focused on helping eliminate disparities in health and care access and contribute to equitable health outcomes

2. Health IT systems are designed to identify and quantify disparities and can be utilized to target “upstream” causes to prevent avoidable “downstream” healthcare conditions such as an advanced disease state or episodic health crisis

3. Federal authorities related to interoperability, healthcare data standards, certification requirements for health IT, and health IT coordination improve health equity consistent with this approach



https://www.healthit.gov/sites/default/files/2024-04/ONC-HEBD-Concept-Paper_508.pdf

Health Equity

- Means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.[1]

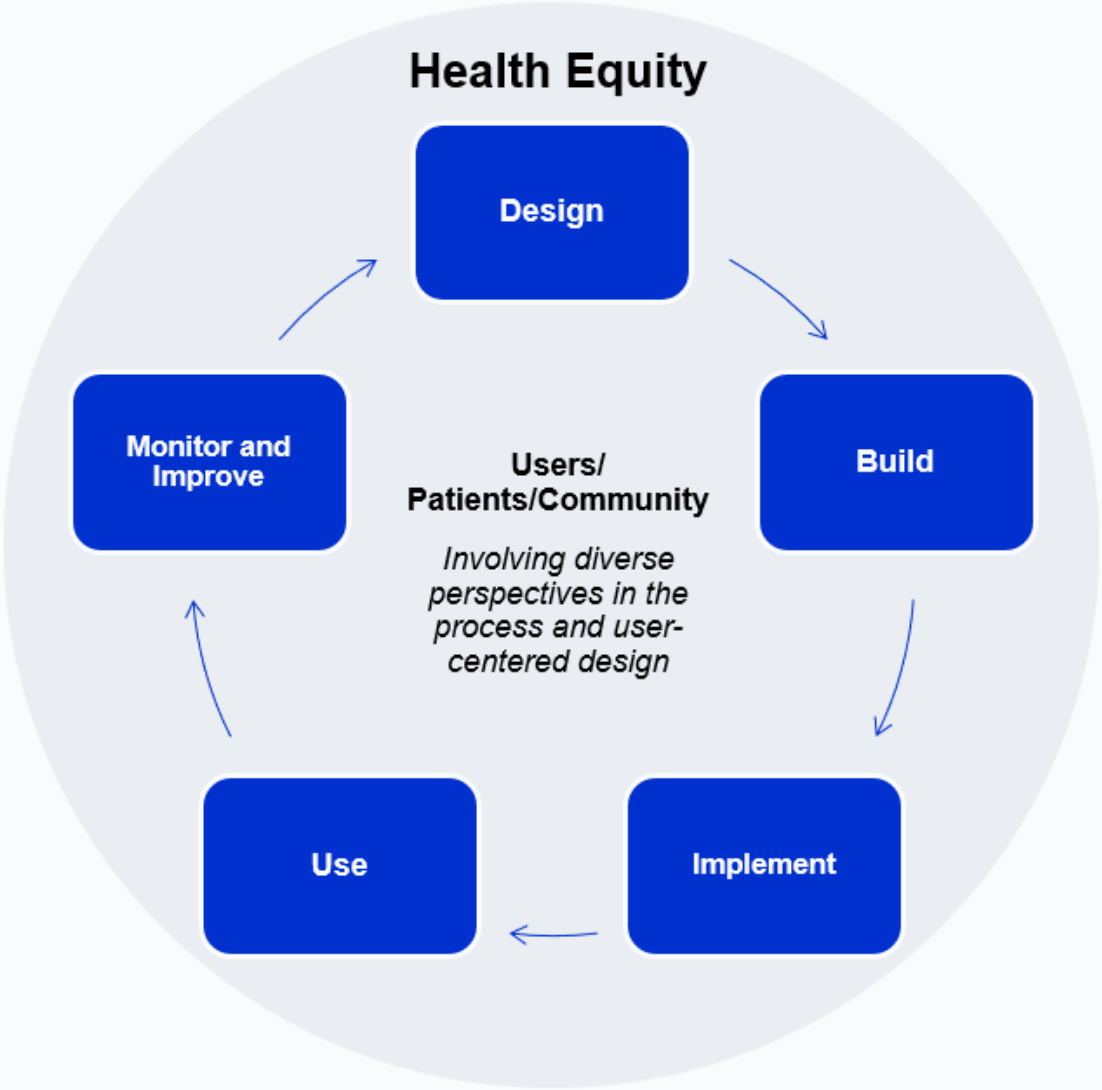
- Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Factors affecting health equity include social determinants of health, social and community context, healthcare access and use, neighborhood and physical environment, workplace conditions, education, and income and wealth gaps.[2]

- Different entities and communities may have their own respective definitions of health equity

[1] Centers for Medicare & Medicaid Services, CMS Strategic Plan: Health Equity, p. 1 (May 22, 2023). See generally U.S. Department of Health and Human Services, Health Equity and Health Disparities Environmental Scan (Mar. 2022). https://www.cms.gov/about-cms/what-we-do/cms-strategic-plan
[2] Centers for Disease Control and Prevention. https://www.cdc.gov/health-equity/what-is/index.html#:~:text=Health%20equity%20is%20the%20state,their%20highest%20level%20of%20health.

Draft HEBD Framework for Task Force Consideration

- Incorporate health equity by design from the beginning, throughout the design, build, and implementation of health IT systems, policies, programs, and workflows.
- Design and build for the diversity of users and uses.
- Consult, design, and build workflows with the diversity of users, not without them.
- Even if you cannot design and build for everything at the beginning, do not build in barriers to health equity.
- Identify and monitor existing gaps and inequities that could be redressed by changes to technologies, workflows, and uses, so that they anticipate, avoid, and reduce health disparities, not exacerbate them.



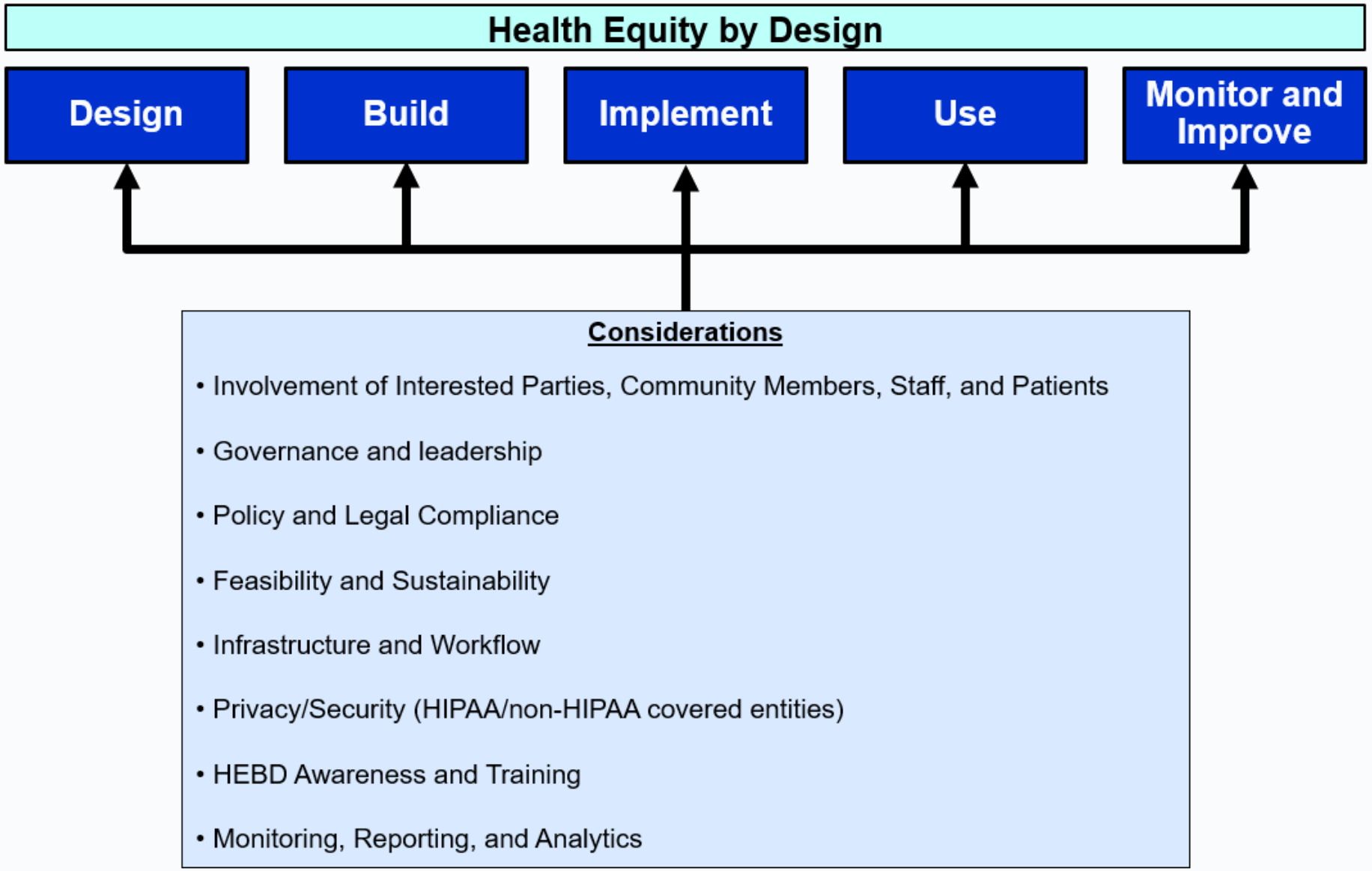
Draft HEBD Framework for Task Force Consideration (continued)

Discussion Questions

Current Status
- What is working (best practices)?
- What is not working?
- What needs improving?

Resources
- What resources and tools exist?
- What resources are needed?
- What gaps are there in awareness?

Structural Drivers
- What HEBD practices should be done "upstream" to improve health outcomes, reduce disparities, and reduce the burden that health inequities drive "downstream"?



Deliverable Type and Format

To the extent relevant, the Task Force should draft its recommendations to HITAC in ways that ASTP could use and incorporate into one or more informational resources.

Examples of ASTP informational resources:

- ASTP Neonatal Abstinence Syndrome Informational Resource
- ASTP SAFER Guides
- ASTP SDOH Info Exchange Toolkit
- Get It, Check IT, Use IT
- Security Risk Assessment Tool

The anticipated format for the ASTP informational resource(s):

- Concise format
- Pockets of information; individual components useful on their own and as fully compiled

Considerations for Development of HITAC Recommendations

- Succinct and clear format focused on meaningful impact
- Promote the involvement of users, communities, patients, and underserved populations
- Consider framing of information to incorporate intersectionality, person-centeredness, whole-person care, and historical inequities
- Deliberate on how to incorporate accountability into health IT HEBD efforts
- Focus on implementation across a variety of health and human services organizations (e.g., health systems, community-based organizations, human services, payers, pharmacies, laboratories, public health, health IT developers, and others)
- Consider application across various use cases, and how use cases interrelate (e.g., shared care planning and coordination, public health, social determinants of health, artificial intelligence)
- Acknowledge that organizations have different resource levels and are at different stages of implementation
- Include considerations from *Advancing Health Equity by Design and Health Information Technology: Proposed Approach, Invitation for Public Input, and Call to Action* and public feedback received

Health Equity by Design Task Force – Draft Workplan

Proposed Meeting Weeks		Meeting #	Draft Agenda Topics
Week 1	10/29	Meeting 1	Kickoff Meeting, Overview of Public Feedback on ASTP Health Equity by Design Concept Paper
Weeks 2 & 3	11/06 & 11/13 (11/07 HITAC Meeting)	Meetings 2 & 3	Discuss and get consensus on a recommended HEBD Framework
Weeks 4 & 5	11/20 & 12/11	Meetings 4 & 5	**Design:** Discussion and draft recommendations
Weeks 6 & 7	12/18 & 01/08	Meetings 6 & 7	**Build:** Discussion and draft recommendations
Weeks 8 & 9	01/15 & 01/22 (01/23 HITAC Meeting)	Meetings 8 & 9	**Implement:** Discussion and draft recommendations
Weeks 10 & 11	01/29 & 02/05	Meetings 10 & 11	**Use:** Discussion and draft recommendations
Weeks 12 & 13	02/12 & 02/19 (02/13 HITAC Meeting)	Meetings 12 & 13	**Monitor and Improve:** Discussion and draft recommendations
Weeks 14 & 15	02/26 & 03/05	Meetings 14 & 15	**Structural Drivers (Upstream/Downstream):** Discussion and draft recommendations

Health Equity by Design Task Force – Draft Workplan (continued)

Proposed Meeting Week		Meeting Topic	Draft Agenda Items
Weeks 16 & 17	03/12 & 03/19 (3/20 HITAC Meeting)	Meeting 16 & 17	Discuss steps for ASTP to support HEBD implementation and draft recommendations
Weeks 18 &19	03/26 & 04/02	Meeting 18 & 19	Prepare draft recommendations for HITAC
Week 20	04/10	HITAC Meeting	Present draft recommendations
Weeks 21 & 22	04/16 & 04/23	Meeting 20 & 21	Finalize for HITAC Vote
Week 23	05/08	HITAC Meeting	HITAC Vote

Discussion

Hannah Galvin, Task Force Co-Chair

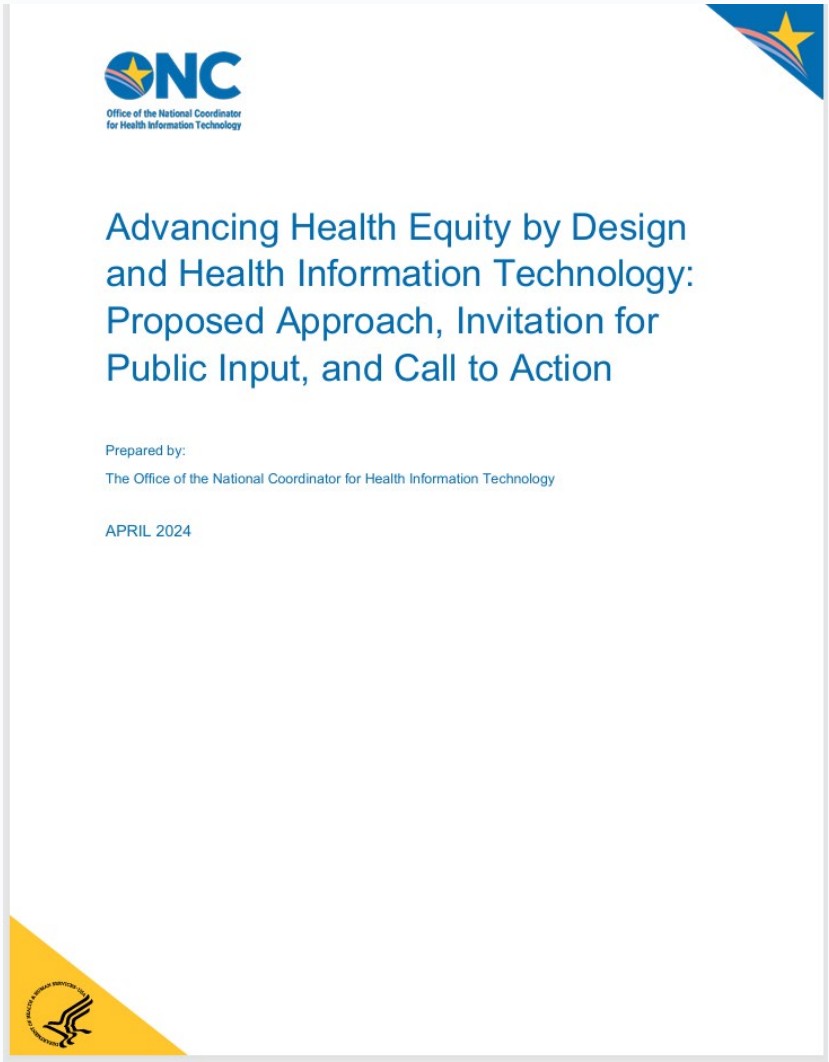
Hung Luu, Task Force Co-Chair

Overview of Public Feedback on ASTP Health Equity by Design Concept Paper

Mark Savage, ASTP Program Staff Lead

Background

- ASTP released “Advancing Health Equity by Design and Health Information Technology: Proposed Approach, Invitation for Public Input, and Call to Action” on April 11, 2024, for public comment
- Five guiding principles for Health Equity by Design
- Nine questions for public comment
- Overview of ASTP tools and efforts
- Comments due by July 11, 2024
- 36 public comments received



HEBD Across the Health Ecosystem

Health Care Stakeholder Groups (not exhaustive)	National Use Cases (not exhaustive)
• Providers (clinical, behavioral, etc.) • Hospitals & health systems, Skilled nursing facilities, Tribal clinics, Community clinics • Individuals/patients/family caregivers, communities • Laboratories, pharmacies • Payers (including CMS) • Health IT/EHR developers, App developers/innovators, Devices • HIEs, Registries • Community-based organizations, Social-service organizations, Faith-based organizations, Referral platforms • Data standards organizations • Public Health • Research • Government (national, state, tribal, territorial, local)	• Value-based & fee-based care delivery • Health equity and disparities • Social determinants of health • Interoperability • Shared care planning and coordination • Remote care, PGHD, device data • Patient access • COVID-19 • Patient safety • Public and population health • Precision medicine and genomics • Research • API/app innovation • Digital quality measures • Artificial intelligence & Machine learning

Public Comment Received on Nine Questions

- Are there changes you recommend based upon your own experiences with health inequities and health equity by design?
- Are there any activities described above that you think are having unintended, adverse effects on health equity by design?
- What ways do you design and integrate health equity in health information technology, exchange, and use across your work in health care and delivery?
- What are the exemplars and lessons you would share with ONC in your comments?
- What are your immediate priorities for health equity by design?
- What are your long-term priorities for health equity by design?
- What are the leading barriers to health equity and health equity by design that you experience in your efforts? How do you think ONC can help?
- What additional activities, if any, do you think ONC should undertake to implement Health Equity by Design fully and effectively?
- How will you heed this call to action? What practical steps will you take, both near term and long term, to use and design technology for health equity improvement purposes?

Breakdown of 36 Submitters

#	Type (self-selected)	Submitter
11	Association or Specialty Body	AdvaMed Imaging American Academy of Pediatrics American College of Physicians American Medical Association American Psychiatric Association American Society of Anesthesiologists Connected Health Initiative Council of State and Territorial Epidemiologists Health IT End-Users Alliance HIMSS National Health Council
6	Government (Federal / State / Tribal / Local)	CDC FDA Federal Electronic Health Record Modernization Office HHS/ASPE/Division of Evidence, Evaluation & Data Policy State of Washington—Department of Health Vermont Truth and Reconciliation Commission
4	Health Care Organization / System	City of Hope M Health Fairview Mayo Clinic UnitedHealth Group
4	Other (non-profit community-based organization, health data non-profit, statewide data sharing coalition	Council for Affordable Quality Healthcare (CAQH) Connecting for Better Health Massachusetts Health Data Consortium Michigan Community Information Exchange Task Force
2	EHR or Other Technology Developer	Consensus Cloud Solutions OCHIN
2	Public Health Department (State / Tribal / Local)	Minnesota Department of Health Pima County [Arizona] Health Department
2	Standards Development Organization	Health Level Seven National Council for Prescription Drug Programs (NCPDP)
1	Accreditation Body	National Committee for Quality Assurance (NCQA)
1	Consultant	Language Equity & Access Partners LLC
1	Individual	Ron Wyatt
1	Payer	CareFirst
1	Pharmacy	Community Pharmacy Enhanced Services Network (CPESN)
36	TOTAL	

Missing Perspectives

- Submitter categories listed in drop-down menu but *not* selected by any submitter
  - Academic / research
  - Individual patients and consumers
  - Media
  - Patient advocates
  - Individual providers
- Developers
  - Health IT developers
  - Health app developers
  - AI developers
- Communities and community SMEs
  - Community clinics
  - Community-based organizations (health and human services delivery)
  - Nonprofit advocacy/policy organizations working for equity and against discrimination
- Some health care sectors
  - Laboratories
  - Registries

Key Takeaways

- Is this mix of 36 comments sufficient to capture and represent the **range of issues and perspectives** across the national landscape?
- Tone of genuine appreciation and support for ASTP's leadership and overall HEBD approach
- Most everyone agreed that the draft **identifies the core issues** and **heads in the right direction**
  - Of 36 respondents, 31 replied yes, 3 replied no, and 2 did not answer
- Most everyone (30 of 36) explicitly or implicitly committed to implementing an HEBD approach
- No disagreement with HEBD draft's **five guiding principles**
- Some cross-cutting themes, tensions, and balances

Synthesis of cross-cutting themes, tensions, and balances from the public comments

- Many cross-cutting themes and tensions are essentially grounded in **differences**—regulatory, technical, workflow, economic, social, and other—**between clinical health settings and human services settings**. Yet health equity usually depends in part upon their interconnection and interoperability.
  - **Data**: Too much data, too little data, not all the right data, more aggregated data, more granular data, data maximization, data minimization. Data quality and integrity for accurate aggregation, comparison, and measurement of disparities. Disparities in organizational capacity to collect and analyze data. Different motives for data maximization (business models, research, etc.).
  - Standardization and relative uniformity of Certified Health IT, versus the various **non-certified health IT systems** in human services, community-based organizations, social service organizations, sometimes tailored to local needs.
  - Established HIPAA framework for covered entities, versus various **non-HIPAA frameworks** for non-covered entities. Some noted that requiring under-resourced human service settings to comply with HIPAA would erect barriers to health equity. Others noted the importance of privacy protection and building trust in historically mistreated communities. TEFCA requires participants to be HIPAA-compliant before they can participate in TEFCA. Community partners, however, operate in contexts which are non-clinical and not regulated by HIPAA.
  - Incentives and other financial and educational resources that have supported Medicare and Medicaid professionals and hospitals since 2009, versus the **lack of similar support** for human services settings and historically marginalized communities.
- Little mention and discussion of the structural, upstream/downstream drivers of health inequities and disparities in clinical care and outcomes. **With a few exceptions, comments focused on social determinants/drivers of health—an important part, but not the whole of health equity and health equity by design.**
- Privacy strategy (including data segmentation and data tagging) is health equity strategy. Patient matching strategy is health equity strategy. Data quality strategy is health equity strategy.

Overview of Synthesis of Cross-Cutting Themes Described in the Comments

- **Data** (availability, standards, data quality, use, capacity to collect, need for flexibility)
- **Interoperability** (local tailoring of standards, different starting points, governance)
- **Digital Divide** (differences in infrastructure, lightweight solutions)
- **Social Determinants of Health** (balance of standardization vs. flexibility, reflecting changes in status)
- **Privacy and Security** (building trust, privacy considerations for non-clinical contexts, tagging standardized data elements)
- **Monitoring and Measurement** (standards in metrics, variables, outcomes, disparities measurement)
- **Real-World Testing** (including health equity components)
- **Funding/Sustainability** (financing for under resourced entities, financing models)
- **Artificial/Augmented Intelligence** (bias, performance, quality, standards)

Public Comment

To make a comment please

Use the Hand Raise Function

If you are on the phone only, press "*9" to raise your hand

*(Once called upon, press **"*6"** to mute/unmute your line)*

All public comments will be limited to three minutes

You may also email your public comment to onc-hitac@accelsolutionsllc.com

Written comments will not be read at this time,
but they will be delivered to members of the Task Force and made part of the public record

Next Steps

Hannah Galvin, Task Force Co-Chair

Hung Luu, Task Force Co-Chair

ASTP | Health IT Advisory Committee

Meeting Adjourned