ASTP | Health IT Advisory Committee

Health Information Technology Advisory Committee

Health Equity by Design (HEBD) Task Force 2024 Virtual Meeting

Transcript | October 29, 2024, 10 – 11:30 AM ET

Attendance

Members

Hannah Galvin, Cambridge Health Alliance, co-chair
Hung S. Luu, Children's Health, co-chair
Shila Blend, North Dakota Health Information Network
Medell Briggs-Malonson, UCLA Health
Kristie Clarke, Centers for Disease Control and Prevention (CDC)
Derek De Young, Epic
Sarah DeSilvey, Gravity Project
Steven (Ike) Eichner, Texas Department of State Health Services
Cynthia Gonzalez, RAND Corporation
Susan M. Jenkins, HHS Assistant Secretary for Planning and Evaluation (ASPE)
Rochelle Prosser, Orchid Healthcare Solutions
Belinda Seto, National Institutes of Health (NIH)
Christopher St. Clair, U.S. Food and Drug Administration (FDA)
Janice Tufte, Hassanah Consulting
Janée Tyus, IMPaCTCare Inc, University of Michigan-Flint and Michigan Health Information Network (MiHIN)

Members Not in Attendance

Sooner Davenport, Southern Plains Tribal Health Board
Meagan Khau, Centers for Medicare & Medicaid Services (CMS)
Kikelomo Oshunkentan, Pegasystems

ASTP Staff

Seth Pazinski, Designated Federal Officer
Whitney Weber, Support Team
Maggie Zeng, Support Team
Mark Savage, Task Force Program Lead

Call to Order/Roll Call and Task Force Member Introductions (00:00:00)

Seth Pazinski
Hello and welcome to the Health IT Advisory Committee's Health Equity by Design Task Force (HEBD TF). I am Seth Pazinski with the United States Department of Health and Human Services (HHS) Assistant Secretary for Technology Policy (ASTP), and I will be serving as your designated federal officer for today's call. As a reminder, this meeting is open to the public, and public feedback is welcome throughout the meeting. You can use the Zoom chat feature. There will also be time for verbal public comment scheduled at the end of today's agenda. I am going to start with a roll call and introduction. Since this is our first Health Equity by Design Task Force meeting, when I call your name, please just give your name and provide a brief introduction. If you could try to keep it to about 45 seconds or less, it would be much appreciated. If there is any additional information you want to share about yourself, feel free to share that in the chat as well. I am going to start with our co-chairs. Hannah Galvin?

Hannah Galvin
Here, present. My name is Hannah Galvin. I am a pediatrician by training and a practicing pediatrician. I am the chief medical information officer for Cambridge Health Alliance, an assistant professor at Harvard Medical School and Tufts University School of Medicine, and I am the board chair of Shift, the independent healthcare Task Force for equitable interoperability, working on health IT standards for granular segmentation, implementation guidance, and terminology to promote consent and granular segmentation of sensitive data in order to increase equity as we scale the interoperability ecosystem. It is great to be here and to be helping to lead this very important work.

Seth Pazinski
All right, thank you, Hannah. Hung Luu?

Hung S. Luu
Good morning. My name is Hung Luu, and I am a hematopathologist and professor of pathology at the University of Texas (UT) Southwestern Medical Center here in Dallas, and I am also the director of clinical pathology at Children's Health, which is a pediatric healthcare system here in north Texas, and I am really glad to be helping to lead this effort because, obviously, health equity is close to my heart, being at a pediatric healthcare center. We are the safety net for a lot of the underserved population, so I appreciate this opportunity.

Seth Pazinski
Thank you, Hung. Medell Briggs-Malonson?

Medell Briggs-Malonson
Good morning, everyone. It is such a pleasure to be here, and I, am very excited that this Task Force is kicking off. As Seth mentioned, my name is Medell Briggs-Malonson. I am a practicing emergency physician as well as an associate professor of emergency medicine at the David Geffen School of Medicine, but what I really do in my day-to-day job is that I am the chief for health equity, diversity, and inclusion for the University of California, Los Angeles (UCLA) Health System as well as the lead health equity officer for the entire University of California Health System. In addition to that, my love and my focus is always on technology, so my overall expertise is directly with the intersectionality between how we design and implement health technologies in order to improve the health outcomes of all populations, especially populations that have been historically divested in and marginalized, and I am also very proud to serve as the cochair of HITAC, so it is always great to be on this Task Force and bring all this information all the way back up to HITAC as well as to ASTP and the rest of our federal agencies in order to implement it. It is great to be here with all of you today.

Seth Pazinski
Thank you, Medell. Shila Blend?

Shila Blend
Good morning, everyone. Pardon me, my internet did not want to come off mute. I am Shila Blend, and I am happy to be here with everybody. My current role is as health IT director here in North Dakota, and I oversee North Dakota Health Information Network (NDHIN), which is our statewide health information exchange, and I find this Health Equity by Design Task Force especially important. Living in a rural state, having access to a lot of this information is so important for the rural area, so, thank you.

Seth Pazinski
Thank you, Shila. Kristie Clarke?

Kristie Clarke
My apologies, I pressed my mute button. Hello, everyone. My name is Kristie Clarke. I am also a pediatrician, so it is nice to hear that I have a lot of pediatric colleagues on the line as well today, and I have also been a medical epidemiologist for the past 13 years at the Center for Disease Control and Prevention, and for the last 10 of those years, my focus has really been on the intersection of public health and health information technology, both abroad and in the States. I currently serve as the senior advisor on data for health equity in the Office of Public Health, Data Surveillance, and Technology at CDC.

Seth Pazinski
All right, thank you, Kristie. Derek De Young?

Derek De Young
Good morning, everyone. My name is Derek De Young. I work in research and development at Epic. I work in the interoperability space, specifically focused on all the work that we are doing around parent-provider collaboration, which is a lot. It is a very broad space, but there are a lot of opportunities for social determinants of health (SDOH) and equity work, even in that space. For example, just last year, we had the first payers start to share their SDOH assessments and care management programs back with providers, and we are starting to see some good success with that, so I am happy to be here.

Seth Pazinski
Thank you, Derek. Sarah DeSilvey?

Sarah DeSilvey
Good morning, everybody. My name is Sarah DeSilvey. I work in clinical practice as a rural family practice nurse practitioner at Federally Qualified Health Center (FQHC) in rural Vermont. I am also here as the founder and director of the Gravity Project, which is a data standards consensus collaborative that has the charter to develop data standards to address the social determinants of health. The purpose of this Task Force is so deeply critical, both from my daily practice in underserved, remote, rural primary care and also in my leadership of Gravity. In addition to my work at Gravity, I also assist CMS with some social risk sensitive quality measure development, and I have the honor of cochairing HITAC with Medell. It is so good to be here with you all, and I look forward to our critical work.

Seth Pazinski
Thank you, Sarah. Steve Eichner?

Steven Eichner
Good morning. My name is Steve Eichner. I am the health IT lead for the Texas Department of State Health Services, where I have responsibility for a wide range of health IT-related activities, including supporting providers

in interoperability as well as supporting our public disease reporting unit, which works with providers across the state to receive data for things like electronic case reporting, electronic laboratory reporting, and other activities related to public health surveillance. Public health has had a long interest in health equity and ensuring that we are getting and receiving high-quality health equity information so that we can help design public health interventions to improve health across the population. I am also heavily engaged in the rare disease community. I have one of the rarer diseases that are out there, and rare disease is also significantly impacted by health equity issues. I am very happy to be here. Thank you.

Seth Pazinski
Thanks, Steve. Cynthia Gonzalez?

Cynthia Gonzalez
Hi, everyone. I am happy to be here. My name is Cynthia Gonzalez. I am the director of community-related special projects at RAND. My focus is really bringing community perspectives into our research portfolio and really thinking about ensuring that those with lived experience are valued and integrated into the ways in which we understand health outcomes and the ways in which we understand inequity in health disparities. I am also an assistant professor at Charles Drew University and focus on teaching integrating social justice and advocacy into public health curricula. I am an anthropologist by training, and my interest and my background are really looking at neighborhood assessments and how to develop collaboratives and coalitions to really identify local solutions to local problems by the people that are experiencing it. I am happy to be here.

Seth Pazinski
Thank you, Cynthia. Susan Jenkins?

Susan M. Jenkins
Hi, good morning. I am Susan Jenkins, the HHS evaluation officer, as well as the director of the Division of Evidence Evaluation and Data Policy in the HHS Office of Science and Data Policy. My division facilitates or runs the HHS Data Council as well as the HHS Evidence and Evaluation Policy Council, and we co-lead the National Committee for Vital and Health Statistics. I am also the cochair of the federal standing committee helping to implement Statistical Policy Directive 15, which was recently revised and offers the standards for how the federal government collects data on race and ethnicity. Thank you.

Seth Pazinski
All right, thank you. Meagan Khau messaged that, unfortunately, she will not be able to join today. Kikelomo Oshunkentan? Rochelle Prosser?

Rochelle Prosser
Hi, good morning. My name is Rochelle Prosser, and I am the chief nurse executive officer for Orchid Healthcare Solutions. I am a 30-year neurotrauma intensive care unit (ICU) nurse, and I also serve as a member on the HITAC committee. For conflict of interest, I just wanted to inform you that I have been appointed as a patient ambassador to the Foundation for the National Institute of Health to promote precision medicine, and I am under their Project ULTRA for rare diseases and cancers in the United States. I am a founding member of the CancerX Moonshot as well as Digital Medicine Society. I sit on the board of St. Jude Children's Research Hospital here in Miami for their Miami committee, and I am a member of ASCO and of various other boards and organizations in the cancer space. Thank you for having me here. It is a pleasure to be here.

Seth Pazinski
Thank you, Rochelle. Belinda Seto?

Belinda Seto
Good morning, everyone. I am the deputy director of the Office of Data Science Strategy in the Office of the Director of the National Institutes of Health. In this office, we currently support a $50 million initiative to use artificial intelligence/machine learning to address health disparities. Prior to this office, I had had many years as a research program officer overseeing infant mortality research and minority youth behavioral research programs. I am happy to be here. It is good to meet all of you.

Seth Pazinski
Thank you, Belinda. Fil Southerland? Christopher St. Clair?

Christopher St. Clair
Good morning. I am Chris St. Clair. I am a scientist in FDA's Office of Minority Health and Health Equity. My background includes patient-reported outcome development as well as clinical review for gastroenterology drugs here at FDA, and my current focus is on advancing diversity in clinical trial enrollment. I also lead initiatives focused on analysis of unstructured narrative data, and our methods include the use of artificial intelligence.

Seth Pazinski
Thank you, Chris. Janice Tufte? Janée Tyus?

Janée Tyus
Wow, I am impressed that you got that correct. Thank you. Good morning, everyone. I am Janée. I am currently the head of community mobilization at Impact Care. I bring you greetings from Michigan, where I serve as a health information technology commission of our Department of Health and Human Services, and I am also the appointed board member for our Michigan Health Information Network. I have done a lot of work in community-based settings and also trying to get them to understand there is a social side to the clinical space, so I am happy to be here in this space and have led a couple different Task Forces in Michigan regarding community information exchange, and that has a strong link to what we will discuss here, so I appreciate the invitation.

Seth Pazinski
Thank you, Janée. Is there anyone I missed or who recently joined us that would like to announce themselves? Okay. Well, we are running about three minutes early, so I am going to take a chance and give Mark Savage an opportunity to introduce himself and the role he will be playing in supporting the Task Force.

Mark Savage
Good morning. Thanks, Seth. I am Mark Savage, and I am pleased and honored to serve as your ASTP program staff lead. I will be providing a couple of presentations today. I am here as a resource for all of you. In between meetings, I will be a resource to the co-chairs, just as you are all resources to ASTP, and thank you so very much. I am a civil rights litigator by training. Equity and poverty issues have been at the core of my work since the very beginning, and I have been working primarily on equity and digital health since the Health Information Technology for Economic and Clinical Health (HITECH) Act was passed in 2009. This is such a great Task Force to be coming together and such important work, and I am honored to be serving with you. Thank you.

Seth Pazinski
Thank you, Mark. Just for your awareness, we also have a few ASTP staff who are available to chime in if you have questions on ASTP's perspective on things. I see that we have David Hunt, Sam Meklir, and Carmela Couderc available for questions as well or to participate in the discussion as needed. So, I have one administrative note just before I hand it over to the co-chairs to get into our agenda. I know that some of you have reached out to note some potential conflicts you have with some of the Task Force meetings that are scheduled, so I just wanted to make everyone aware that all of our Task Force meetings are audio recorded and transcribed, and we will also

be sending out homework with instructions in between the Task Force meetings. So, certainly, attendance is critical so we can have an engaging discussion and benefit from your expertise in those deliberations, but if you do have a conflict and are unable to attend, I just wanted to note those opportunities to get caught up on the Task Force's discussions and deliberations. With that, I am going to turn it over to Hannah Galvin and Hung Luu to get us started on our agenda.

Opening Remarks (00:16:28)

Hannah Galvin
Thanks, Seth. Good morning, everyone, and welcome. I am delighted to be cochairing this Task Force with Hung. This is critical work to everything that ASTP and our other federal agency partners are doing to advance standards, policies, implementation specifications, and certification relating to the health IT infrastructure and electronic access, exchange, use, and interoperability of health IT across the country. We are really excited to have such a diverse and experienced group here to collaborate around these recommendations, and we really look forward to kicking this off today. Welcome, and I will turn it over to Hung.

Hung S. Luu
Thank you, Hannah. I would like to echo Hannah's comments, and for those who know me, interoperability is my purpose in life, and from that vantage point, what I have seen is huge advancements in big data and an incoming revolution in terms of artificial intelligence (AI) and machine learning. What I hope to help guide this group for is to ensure that when that wave comes, it lifts all the boats, and no one is left behind. Thank you.

Seth Pazinski
Great. Can we go to our next slide, please? Just to quickly review the agenda for today, Mark Savage is going to go over the Task Force charge, a draft framework that was put together by ASTP for consideration to kickstart the conversations with the Task Force, as well as a draft workplan on how to progress through our immediate agenda to complete the work by May to deliver the final recommendations for HITAC's consideration. And then, we will spend about half an hour on questions and discussions to make sure we are all on the same page as we kick off this Task Force, and then we will go back to Mark, who is going to give an overview of the public feedback that we have received from the ASTP Health Equity by Design concept paper, so we wanted to share that background with you all as information as you begin your work, and then we will go to public comment and adjourn the meeting. Go to the next slide. I will turn it over to Mark to give us an overview of the charge, the framework, and the workplan.

Task Force Charge, Draft Framework, and Draft Workplan (00:19:13)

Mark Savage
Thank you. Next slide, please. So, this is the charge. Those of you who have been listening in on the HITAC meetings will be familiar with this already, but it is to provide ASTP with recommendations on promising practices, challenges, and resources to support both health and human services organizations, which is a broad ecosystem, to incorporate health equity by design principles into the design, build, implementation, use, and monitoring of health IT. It is a broad charge, but health equity is a broad issue. The charge asks you to think about this in two phases: What the ecosystem can do to include health equity by design in health IT, but also, in particular, what ASTP can do as potential next steps to help to facilitate to convene in advancing the implementation of health equity by design principles. So, as you are going through the broad charge, think both about health and human services organizations and what is needed there, but also, how ASTP can help in framing your recommendations. Next slide, please.

As Seth mentioned at the beginning, public participation is very important to us. I would just like to add to what is on the slide. We encourage members from diverse communities across the nation to be listening to these Task

Force meetings to add comment and their own lived experience in the chat, and even provide verbal comment at the end, if they wish. These are public meetings, and we welcome a diversity of public comment across the nation. Next slide, please. These are the three ASTP core aims around health equity. They were laid out in ASTP's concept paper, released in April, so these have been front and center for a while. Next slide, please.

This is a definition of health equity, just to ground things. It is by no means complete, as you can certainly attest from your own experience as you deal with the details of health equity. The first definition comes from CMS, and it is organized more around data elements. The second definition comes from CDC, and it is defined more around systemwide factors such as social determinants of health, social and community context, and so forth. The third is a reminder that individual entities and communities may have their own respective definitions of health equity, and it would be good to hear those and to integrate those into the work of this Task Force. Next slide, please.

These are the five principles from the ASTP concept paper in April. Captured in the graphic on the right is incorporating health equity by design from the beginning, throughout design, build, and implementation, designing and building for the diversity of users and uses, not just a single use or single user. Consult, design, and build workflows with the diversity of users, not without them. You cannot build everything perfectly all at once, which is usually not possible. At least think through and do not build in barriers to health equity down the line. Lastly, identify and monitor gaps and inequities that could be addressed by changes, meaning measure, improve, iterate, measure, improve, and iterate. So, these are the five draft principles from the concept paper. Next slide, please.

In the draft framework that ASTP is presenting to discuss with the co-chairs in advance, for your consideration, we built five pillars around those five principles, design, build, implement and use, monitor, and improve. Those are the ones that you see at the top. We have a series of considerations, or sort of a checklist, maybe, that it struck us as good to run through as you think about each of the five principles and what recommendations you might provide for ASTP and for the ecosystem in building in health equity by design. Those are listed underneath. They are some fairly well-known things, like involving all of the interested parties, governance and leadership, infrastructure and workflow, and so forth, so it is just there as a single checklist to run through as you go through each of the five principles. You may come up with others to add as well. That is fine. This is not meant to be a limitation, just a set of considerations that occurred to us at the beginning.

And then, the discussion questions are there on the left, the kinds of questions that seem to be well served to go through each of the pillars. What is the current status in each of those five pillars? What is working, what are the best practices, what is not working, and what needs improvement? What resources and tools exist? What resources are needed? Are there any gaps that need to be addressed? The third overall question is around structural drivers. What are the health equity by design practices that could be done upstream to improve health outcomes, reduce disparities, and reduce the burden and health inequities that we find downstream in clinical settings? Those are not the only questions that you may come up with, but this is a draft framework that we have put together to get the discussion started and present that to you today for your consideration, and the co-chairs will be leading you through a discussion of that over this meeting and the next couple of meetings as well. Next slide, please.

This is just a word about what ASTP would like to do with some of your recommendations. Your recommendations may cover the gamut, and ASTP will consider all of them, but one of the things ASTP does want to do is try to create and provide informational resources back to the entire ecosystem. So, to the extent that your recommendations might be framed around providing informational resources, we encourage you to think about it and frame your recommendations that way. Here are some examples of information resources that ASTP has put together just to illustrate how that can be helpful. So, the one in the middle, for example, is the SDOH information exchange toolkit. Informational resources usually help best when they are concise and presented in pockets of

information, so this is just a thought on type and format of some of your recommendations. They might be tailored towards informational resources. Next slide, please.

These are some of the considerations that you will probably be going through as you are developing your recommendations. They are fairly commonsense, lifting up promoting the involvement of all users, communities, patients, and underserved populations. The fourth one there is incorporating accountability into health IT health equity by design efforts, and the last one, for example, includes public feedback and comment on the ASTP's concept paper that was released in April, and I will give you a very short presentation on that later on in this meeting. These are considerations throughout your work on each of the pillars across the board. Next slide, please.

Here is the draft workplan for you. It is organized around the five principles to help flesh out and operationalize each of them. We had this initial kickoff meeting and a couple of meetings to socialize and discuss the proposed framework and adjust it if you think it needs adjusting. And then, you will see two meetings organized around each of the five pillars suggested there, and another two meetings organized around the structural drivers and how to incorporate those upstream and downstream. Next slide, please.

And then, there is fine-tuning and honing to prepare for a set of draft recommendations to review with HITAC, and then a set of final recommendations to review with HITAC for a vote in May of 2025. It is a somewhat malleable schedule, so, yes, there are two meetings per pillar, but you may find that you need less for one pillar and more for another. The co-chairs will work to identify how to actually set that up, but for the purposes of this draft workplan, there are just two meetings each, and you will see that the proposed schedule skips meetings the weeks of Thanksgiving, ASTP's annual meeting, and the winter holiday. Next slide, please. With that, I am happy to answer any questions and turn it back to Hannah and Hung.

Discussion (00:29:36)

Hannah Galvin
Thanks, Mark. So, this time is for discussion around the framework and the proposed framework itself. Does anyone have any thoughts around what has been proposed in terms of the charge, the framework, and the draft workplan? Any questions or thoughts? Medell?

Medell Briggs-Malonson
Good morning, and thank you, Mark, for that wonderful overview of what the charge is, as well as some of the framework. I think that for us as a Task Force and as the HITAC, moving towards proposing recommendations that can truly be implemented nationwide is going to be key because a lot of people want to do this work and understand this work, but they do not have the tools to do so. As part of that, especially before we get into some of the next pieces of our discussion, I do think that this Task Force would be incredibly impactful, especially when it comes to language, and I think we need to look at the language that we are incorporating into our discussions and our recommendations and make sure that they are forward-facing and actually moving us. This is health equity by design. Truly, the ultimate goal is health justice, so we have to make sure we are using the right language.

As a perfect example, I think we as a Task Force need to determine if we are addressing health disparities or health inequities. There is a difference between those two, and it is really important for us to make sure that we as a Task Force are aligning and developing the true language in order to move this work forward. It is the same thing as we refer to our various different communities. Many of us have stepped away from terms like "underserved" toward "under-resourced" or other types of terminology. I just want to highlight that this is going to be such an incredibly influential and impactful Task Force with all of these experts in part of this Task Force just thinking about exactly what language and terminology we are going to use in order to push us forward, and I would highly

recommend we focus on inequities because inequities are rooted in injustice. I highly recommend we use terms like "social drivers," which is where ASTP has also started to move towards as well, so I am just bringing that into play as we think about some of the next steps, but this is fantastic. I love all of the work that you all have already preplanned, and thank you so much, Mark, for that overview.

Hannah Galvin
Thank you, Medell. I could not agree more. Perhaps we should even have a terminology section at the beginning where we define and describe why we are using those terminologies. If others have thoughts on specific terminologies that we should call out, like talking about inequities as opposed to disparities or social drivers as opposed to social determinants, those are a couple of really good points that we should call out. There is one more, Medell, that you called out, and perhaps you could put it in the chat. We want to make sure we call it out, and if there are others that people have, we want to make sure we capture those. Any other thoughts? Natasha, you wrote in the chat in the same spirit, getting agreement or alignment on the term "healthcare provider" as we move forward on this. Are we going to use the term "healthcare provider" or "clinician," and what does "healthcare provider" mean in relation to this? Any other thoughts on the charge or the draft workplan?

Hung S. Luu
Well, it looks like we can move into the overview of the public feedback, perhaps.

Hannah Galvin
Sounds good.

Overview of Public Feedback on ASTP Health Equity by Design Concept Paper (00:34:27)

Mark Savage
Thanks very much again. Next slide, please. So, in April of 2024, ASTP released a concept paper, "Advancing Health Equity by Design and Health Information Technology." It included a proposed approach invitation for public comment and a call to action. It did lay out the five guiding principles that I covered earlier. There were nine questions for public comment. There was an overview of ASTP's tools and efforts to provide resources to the community, but it was also an invitation to the ecosystem to let ASTP know what everybody is doing with their lived experiences with trying to address health equity by design. Comments were submitted by July 11th, 2024, and there were 36 public comments received. Next slide, please.

This is one of the graphics that was within the paper, and I pull it out and lift it up here just to illustrate the depth and breadth of the work that we all face when we are thinking about health equity by design. It is not a single stakeholder group or use case. There is actually just a range of healthcare providers, and to the comment in the chat, yes, providers are in clinical settings, but there have been health and healthcare providers, so to speak, in communities, families, and faith-based organizations for centuries, so the idea of having this long list, both on the left and the major national use cases on the right, is just to help us all keep in mind the breadth of users and the breadth of use cases that we will be thinking about as we do our work over the next months. Next slide, please.

These are the nine questions that ASTP laid out. Because it was a draft concept paper, one of the questions was did the public submitter have any changes that they would recommend based on their own experience with health inequities and health equity by design? It asked if there were any activities that had been described that the submitter thought might have unintended or adverse effects on health equity. How do the different members of the public design and integrate health equity into their work? What are the exemplars and the lessons that they would lift up to ONC to consider? What are their immediate priorities and long-term priorities? What do they think the leading barriers are to health equity and health equity by design? What are additional activities that they might recommend ONC undertake to implement health equity by design?

Lastly, since it was a call to action, many people are doing things, many can do more, some are just getting started, so there is a general call to action that we must carry this work forward on and where we must be working towards health justice. As you might imagine, from those nine questions, there was a rich amount of comment that came back to ASTP, and we are grateful for that. Next slide, please.

This is a quick breakdown of the 36 public submissions that we received by the type that they selected in the dropdown menu that they selected for public comment and the organizations. Next slide, please. There are some perspectives that people did not select when they submitted. There may be people who submitted comments that see themselves as being academic, research, or individual providers, but they did not select that category, so that is the first bucket that you see up there as perspectives that were not listed. Developers were not a part of the group, communities and community SMEs, and some of the healthcare sectors, laboratories, and registries. It is great to see who did submit comments, but also flag who might not have been as active in submitting comments. Next slide.

So, these are some of the initial key takeaways. Look at the mix of comments. Does this capture the range of issues and perspectives across the national landscape, or do we need to augment it in some way? It is a little bit subjective on my part, but I did sense a tone of genuine appreciation and support for ASTP's leadership. In the various comments, there were a lot of thank-yous for having released the paper and appreciation for having done that. Most everyone agreed that the draft identified the core issues and headed in the right direction. Thirty-one of 36 respondents replied yes, and there were three nos. Most everyone explicitly or implicitly committed to implementing a health equity by design approach. There was no stated disagreement with the five guiding principles.

There were some crosscutting themes, tensions, and balances on the next slide, which I will just cover briefly. My apologies for the small print. Again, this is my teasing out and pulling out themes from the different comments, so this is not something that an individual commenter said, but my trying to assess some of the cross-cutting themes. So, I would say that a lot of the themes and tensions were grounded in the differences between the clinical health settings and the human services settings. There are regulatory, technical, workflow, economic, social, and other differences, and yet, health equity usually depends on the interconnection of those different settings. An example is data. Depending on the setting, some people were saying we need to minimize the amount of data that is collected or that we do not have the resources to collect all the data, whereas others were saying we need to collect a lot of data, so there is data minimization and data maximization, or granular data and more aggregated data. So, you see a lot of different comments there, and they tended to vary with what the setting was from which they were coming.

Another difference is who is working with a certified health IT system and who is working with a noncertified health IT system. Again, there are different approaches. Meeting needs locally might depend on where they were on that spectrum. Another key issue is the Health Insurance Portability and Accountability Act (HIPAA) framework, HIPAA-covered entities versus non-HIPAA-covered entities. What are the requirements for exchange and the guidance for exchange? That is a big issue across many of the comments. The fourth bullet point there is incentives. There is a group of people within the ecosystem that have received some support for purchasing certified health IT and certified electronic health records (EHR), but there is a whole range in the ecosystem and nonclinical settings that have not had that similar level of support, so it puts the sustainability in the financial model for those people and helping them be at the same level. There was little mention and discussion within those public comments of the upstream social drivers of health inequities and disparities in clinical care and outcomes, so I am just lifting that up.

With few exceptions, most of the comments focused on social determinants or social drivers of health alone, which are an important part of health equity, but are not the whole of health equity, so I am just lifting that up as a theme

and something I noticed as well. Interestingly, a lot of people made the point that strategies in other areas end up being strategies that support health equity. So, a privacy strategy including data segmentation and data tagging is also a health equity strategy. A patient-matching strategy so that you improve matching the patient and can aggregate data and use it for measurement is a health equity strategy. A data quality strategy is a health equity strategy. These are just a few of the crosscutting themes, tensions, and balances that I have picked out. I lift this up as sort of a tease for what is to come. Next slide, please.

This is another list of some of the issues that we have found across all of the different comments. So, I have mentioned some of them: Interoperability, real-world testing, including health equity components, artificial intelligence. All of these issues were mentioned, and as we get to the public comment itself and a deeper dive, you will see all of these issues. Next slide, please.

What I have done is provide the briefest of overviews because this is such a packed first meeting, and my understanding is that the co-chairs will circulate a presentation that we have put together that will include a lot of the detail that I have alluded to here, but not really covered or mentioned in detail, so that you can review that over the week and come back, and if you have questions, we can address the questions, but for a rich discussion at the next meeting. Consider this a brief peek, look forward to the homework that the co-chairs will be providing to you, and we can go into much more detail next week. With that, I will turn it back to the co-chairs. Thank you.

Hannah Galvin
Thank you, Mark, for that great presentation. I know we are going to be diving into this into considerably more detail as we go forward. I think that we now go into public comment, if I am not mistaken. Is that right, Seth?

Seth Pazinski
I think we have time for some discussion.

Hannah Galvin
Some discussion? Okay great.

Seth Pazinski
We are running ahead on time, so, at this point, we can start discussion on our preliminary thoughts on the public comment and how to incorporate that into the final document. Thank you so much, Mark, for your exhaustive work. I am sure it was not easy.

Mark Savage
It was a labor of love.

Seth Pazinski
All those comments…

Hannah Galvin
Any initial thoughts? Steve?

Steven Eichner
Sorry, I was on mute. Thank you so much for sharing all this wonderful information. I think one other piece that may fit in this puzzle, as I was discussing with a few folks yesterday, is thinking about access to AI, not only for the benefit of folks who may have otherwise been disadvantaged or left behind in terms of ensuring that their data is included in AI models, large learning models, and the like in that space, but also looking at access to AI services by patients in that space so that you are looking at patient-accessible health forecasts or other tools where AI

comes into play. I think that is also part of the puzzle, and figuring out how we address that may be something we might want to consider.

Hung S. Luu
We have some hands raised. Belinda?

Belinda Seto
Thank you. That was a great summary. I would like to propose that we also include environmental determinants of health because oftentimes, the under-resourced communities and some of the communities that receive Superfund have very different environmental conditions. Thank you.

Hung S. Luu
Thank you. Medell?

Medell Briggs-Malonson
This is great, and thank you, Mark, for bringing out the themes because that allows us to synthesize some of the various different comments on the original paper. Since we are adding in various different items, when we think about health equity or healthcare equity, I know we are going to get to defining both of those and how we want to approach it because the approaches for both are different, and it is important that we as a Task Force think about how we are moving forward in terms of addressing and bringing in the technologies, policies, and standards, and if they are focused on healthcare equity, health equity, or both. But even along the same lines that my colleagues just mentioned, we know for sure that we have significant inequities based off of geography, and the comments have not come up here, but I think we should make sure we are addressing all the various different geographical areas where we know there are differences, but also think how we can propose this work that will fit all clinical settings, public health settings, and LTPAC settings because we know that the resources that are available in a large academic health center versus, potentially, a rural FQHC, versus a public health department…

All of those entities are incredibly important as we really do march forward with achieving equitable outcomes and provision of services. And so, I just want to put it out there that as we are thinking about these important key areas, or at least some of the themes that came up with the comments, all of which I agree with, we are also incorporating some of those other aspects across diverse clinical settings, public health settings, and geography.

Mark Savage
Medell, I will just chime in from my own recollections on the public comment. There was some discussion about rural communities as a category, but your comment about geography is deeper than that. Not all rural communities are the same, and geography can also be about not what region of the country one lives in, but if one is on a desert, a mountain, or that kind of thing. I did not see that level of detail in the comments, and it will be great to surface that here.

Medell Briggs-Malonson
To your point, Mark, you are exactly right. Even if we take two different communities, we may have a rural community that has limited resources, and we may have a community that sits in a huge metropolitan area that also has limited resources, so while the geography is very different, the limited resources and the type of resources are different. We cannot boil the ocean, but I think we have the right people within this Task Force to think comprehensively about how we can truly advance this work and give guidance to the rest of the country, who is really trying to figure this out.

Hannah Galvin

To your point, Medell, the charge is really focused around health and human services, and then ASTP and ASTP's role, and so, figuring out how we provide these recommendations to ASTP and their role in healthcare, health IT certification, and standards development, as well as their coordination role in health and human services, and how we divide up our recommendations for the two pieces of this charge will be critical in terms of where we provide those recommendations specifically in terms of health and healthcare as you define that.

Hung S. Luu
We do have some questions or comments in the chat. Rochelle, did you want to talk about your comment, or would you prefer just to have it in the chat?

Rochelle Prosser
Hi, everyone. Thank you so much. Medell, thank you. You touched quite a bit of what I was wanting to discuss. Another part was where there is no connectivity or where broadband is not able to access those communities, and it does not necessarily mean that we are talking about rural communities. They could be in a valley because they are surrounded by mountains so the satellite does not get there and the cellular infrastructure is not there. They could be in urban centers because it is an FQHC and a community center is providing the care, not the local larger hospital down the street.

These patients can exist in Medicare or Medicaid, where the actual healthcare specialist is just not available. In some areas of the country, I believe they are more than 200 miles away from the next pediatrician, which is a specialty just for children, never mind image and diagnostic data transfer and interoperability, because it just does not exist in the pediatric space. So, how are we including all of these different organizations, including Indian Health Services, into the fold as we design this Health Equity by Design, and did we include nursing as a subcategory, since they are the ones who have the pulse of what is happening with the patients? They are the first reporters, the collectors of the data, etc.

Mark Savage
Rochelle, I will just jump in and say nurses were not excluded, but your point is to see them listed.

Rochelle Prosser
Yes. I truly think that we should have them listed out as an entity. Where physicians and nurse practitioners or other higher-level organization or skilled services are absent, it is the nurses that stand in the gap through telehealth medicine or other means, so we would like to see how health equity is promoted in those spaces. Often, you will have rural nursing coming in through the fold of the city, and then there is a different equitable structure there, and then nursing fails. And so, I just wanted to have that isolated and teased out as a category because it is different whether you are in a desert provider versus in an academic center. Health equity completely changes when you do not understand the communities that you are serving.

Hannah Galvin
I was just going to call out that the tribal space was called out as an area where we wanted to have representation on this committee as well, and I will defer to ASTP on that, but I think we were looking into representation.

Rochelle Prosser
Thank you. If you need names, I am happy to give you a few for Indian Health.

Hung S. Luu
We did have one comment in the chat. I think this might be for you, Mark, or for all of us. "Will codesign opportunities with consumers, community-based organizations, and healthcare stakeholders be part of this work?"

Mark Savage
I would say it is a part of the five principles, designing and building both the technology and the workflows with the diversity of users, not without them. You will recall that phrase. That would include the people within the communities, individuals, patients, family caregivers, etc.

Hung S. Luu
We have another comment. "Communication needs to be its own line. It is not just about broadband access, but also about connectivity to healthcare systems to effectively collaborate on healthcare." I think that might be in reference to "I do not think communications is its own pillar." Is that correct?

Rochelle Prosser
Are they discussing the interoperability, or are they actually talking about communication between providers and systems?

Hung S. Luu
I think they are talking about communication between providers and coordination as well. It is overall connectivity between organizations and providers, not just infrastructure, but also coordination.

Hannah Galvin
Will also just commented, but I think we do have two full meetings dedicated to going through the proposed framework and discussing whether this is good framework or if we want to modify it, so I do see some very good proposals in the chat about whether we want to potentially add integration as a theme, and I know we have some dedicated meetings to looking at the framework and asking if it is the framework we want, if we want to modify it, and what the finalized framework is that we want to use. And so, I think that is what we want the group to start thinking about, and this is just a draft framework for us to then modify and hone. This is really great feedback to start, and we will have several meetings just focused on honing this framework. I also see that Cynthia brought up a question in the chat about intending to integrate our lived experience on trust. Cynthia, is that something you want to speak a little bit more about as well?

Cynthia Gonzalez
Yes, thanks for that. There are going to be a lot of assumptions operating in our conversations, and we have to really begin to think about what that could be. We already started talking about coordination and infrastructure, and in the communities I have been a part of, there is already sort of a barrier in thinking about folks even showing up for care and service. That is often situated and rooted in trust in the system that fosters these health inequities, and really calling that out to be very intentional about the inequity component of our recommendations.

Hung S. Luu
Belinda, you have your hand raised.

Belinda Seto
Yes, thank you, Hung. Under the two top bullets, data and interoperability, when we think about trial nations, we must keep in mind that these are sovereign nations. They own the data. We have to be very respectful of the governance of data and sharing that have very different practices. I wanted to make sure that that we keep those data points, and when we discuss tribal nations, that we do not lose sight of the fact that they are sovereign nations and we respect the sovereignty.

Hannah Galvin
That is a great point, Belinda. Thank you. Mark?

Mark Savage
To that point, Belinda, there were actually comments about data sovereignty within some of the public comments, so I have lifted those up, and you will see them in the homework. There is not a uniform perspective. Some were saying that the practice is not to exchange data as a practice of tribal sovereignty or data sovereignty, and others were will willing to exchange. All of that is worthy.

Belinda Seto
Yes, and because these are nations, kind of like the European Union (EU), they do not all behave the same way. They are component nations, right? The HHS Tribal Advisory Council is where NIH takes all of its planned projects before they are even launched to get consultation to get approval by the tribal nations involved.

Hung S. Luu
Theresa says, "Please do not forget to account for those users that may not use technology. We need to build a front end for those end users and a technology back end for architecting." I actually have a thought. I know the discussion is around what HHS can do, but is there an opportunity to leverage some of the resources that exist already in the community, but in other silos, so to speak? I know we have been talking a lot about rural populations, but I think it is also true that some urban settings are as much of a resource desert as any rural setting you can think of. Telehealth has been raised as an opportunity to be able to provide services to those communities at a distance, but that is only helpful if your patients have access to a laptop or an iPad. I think most urban communities have libraries that do have computer resources. They are not set up, obviously, for consultations and things like that, but is there an opportunity for HHS to partner with these community organizations to set up appropriate areas with appropriate privacy, firewalls, and what have you in place as a resource for populations that do not have access to that kind of technology on their own?

Hannah Galvin
That is a great point, Hung. My health system is a public health system, and we actively work with community-based organizations like libraries and even food pantries and other community-based organizations to try to provide access where there is none. I know that others are doing the same, but there are still too few. We are trying to work with the public housing system as well, but it is still too few and far between. I think there are a lot of opportunities there to work with HUD and others to increase access where there are deserts. I think Medell is next.

Medell Briggs-Malonson
Thank you, Hannah. Listening to the conversation, I think there are also two additional components, and I know this is a free-for-all discussion, and then we are really going to dive into the framework in the upcoming meetings, but I also think that this is an opportunity to try to identify the best practices that are already in play throughout the country because there are several institutions, whether larger or smaller, whether federally qualified health centers or networks of such, that are already on this journey, and I think this also provides an opportunity for us to identify at least where some of those practices are in order to help inform some of the additional aspects of the framework of how we can ensure that this is all accessible to everyone. And so, I do not think we have to recreate the wheel at all because I can name from my institution and my partners all the work that we have been doing in this space.

The other thing I wanted to bring up is something that Hung reminded me of when speaking about telehealth services. We know there are a large number of federal regulations that are now here, for instance, especially with telehealth, but also with our decision support tools and others, which have clearly stated that all of our various different health services cannot be discriminatory. And so, I also think as we move through our discussions that we are pulling in some of those final rules and pulling in some of those federal statutes to ensure that our work is aligning and, most importantly, it can scaffold us so that all the work that we are proposing and especially the work that is going on within HHS is building upon all of that work versus being fragmented. And so, that is just one thing, and I know that we have already pulled some of that work already that is going on in HHS that is there to promote

nondiscrimination in health technologies and also promote health equity as well as fair and just artificial intelligence, and when we develop our recommendations, that may be another opportunity for us to build upon some of the other work that is also being done.

Hung S. Luu
Thank you, Medell. Janice? We might have lost her.

Janice Tufte
Sorry, I just want to apologize for being late. I had problems getting on this morning. I am a patient that is a representative on the Health Equity by Design committee, and I am involved with the Gravity Project. I have been deeply involved. I spent a decade around affordable housing, so I am very knowledgeable there, and I have made resource guides for our greater Muslim community for three counties in Washington state, which grew immensely over those two decades in refugees and immigrants from around the world with different needs. And so, I just want to add that there is a lot going on here. The digital divide, of course, is huge. There are organizations that are working on that, but then, there has been some rollback in telehealth, and as far as interoperability goes, we still have the problem with the small FQHCs having different vendors and how to bring them all together.

In the social determinants of health, we are often only collecting the big three, food, housing, and transportation, about which, in reality, very little can be done. Food can usually be addressed in some areas, but not in others, and if it is addressed, it might not be healthy for their diet. As everybody had mentioned, there is the access to having a patient portal or whatever. There is a huge issue I hear about there in the patient community. People can have 10 portals when they have cancer, and they have to address all those. We still have very low rates of people reading their notes, and this is important to know. You might pick up something that a doctor did not call you about.

So, when it comes to health equity, I just want to say I really appreciate that we are tackling this, but it is huge, and I do see an opportunity for artificial augmented intelligence in bringing some of this together, but also, there, it is aspirational more than practical at this point. There is one point I want to bring up regarding equity. I mentioned Pacific Islanders. Over the last four or five years, I have seen where the different communities really want to be noted for their data. Japanese, Chinese, Pacific Islanders, and Hawaiians are all different, but they get lumped together. Another issue we have is very important, that patients can self-identify what they call themselves. Our largest category in our county right now is “other” because they come from multiple backgrounds. How are we going to address that? I just wanted to touch on that point. Thank you.

Hannah Galvin
Great comments. Thanks and welcome, Janice. Ike?

Steven Eichner
I think another health equity by design issue that we may want to consider is looking at discrimination based on new focus on healthcare quality measures. I will pick on myself as an example, as I am wont to do. As I said earlier, I have a rare condition, and it limits my ability to exercise, which limits the ability to control my heart rate because there are lots of things that I cannot physically do. I am really, really concerned, both personally and for folks out there in a broader capacity, about being discriminated against because my data will not reflect very well on my provider if you are looking at a panel of his patients in terms of looking at his ability to help them reduce their heart rates, and I do not want to be persona non grata as a patient because my health outcomes are statistically such that they cannot be improved even though I am getting the absolute highest and best level of medical care that I can. Not just from an emotional standpoint, but medically, probably the best outcome that I can hope for right now is to not decline further.

That may not be where I want to be, but from a technology standpoint, that is about where we are. If we are not careful about this health equity by design perspective and are not doing it well, we are going to look at health quality measures that effectively discriminate against broad classes of patients because their data does not help their provider or their hospital meet whatever numbers are set out to get at our targets. So, part of what we may want to look at is channeling or looking at revisiting how healthcare quality measures are actually developed in the first place and look at it as an aggregate score of individual health performance against the best health outcome measures for that particular individual, as well as incentivizing providers to care for more complex patients or patients that medical technology cannot really help because there are not available drugs. Thanks.

Hannah Galvin
Thanks so much, Ike, for that really thoughtful comment. Since we do not have any other hands raised at this time, I think we will move to public comment. Please move the slides to the public comment slide, and let's see if there is anyone from the public who has a comment for us.

Public Comment (01:15:25)

Seth Pazinski
Thank you, Hannah. We will open up the lines for public comments at this point. If you are on the Zoom and would like to make a comment, please use the raise hand function, which is located on the Zoom toolbar at the bottom of your screen. If you are participating by phone only today, you can press *9 to raise your hand, and then, once called upon, press *6 to mute and unmute your line. As we give folks a few minutes to queue up with any public comments, I just want to give a reminder that our next Health Equity by Design Task Force meeting is scheduled for Wednesday, November 6 from 1:30 to 3:00 p.m. Eastern Time, and all the materials from today's meeting and all of the Task Force meetings will be available on HealthIT.gov. So, checking for public comments, I see we have none on the line and no hands raised at this point, so I will turn it back to you, Hannah and Hung, for next steps.

Next Steps (01:16:33)

Hung S. Luu
All right. I just want to say that I am really heartened by the robust discussion that we have gathered today. It gives me faith that we have assembled the right group of people, and I think we have the opportunity to really make a difference. That said, obviously, we have a series of meetings scheduled, but not all the work can be accomplished during the meetings, so we do have some homework for you, and you knew what you signed up for, I hope. So, between now and the next meeting, there will be an email sent out with some homework assignments, and also, we ask that you review the Task Force charge and framework and think about whether you have any suggestions on any improvements or modifications. Also, take some time to review the overview of the health equity by design. concept paper that is available on the ONC/ASTP website. We will be discussing the comments and integrating them into the document.

Hannah Galvin
Thanks, Hung. As you think about these and as you read through the concept paper and the summary of the public comments and that feedback, we would like you to particularly think about some questions like what resonated with you, what you think is important for us to emphasize in the work of this Task Force as we go forward, what perspectives you think are important to bring into the conversation, and what gaps you think may not have been covered in this work and that you think are important for us to bring into the conversation going forward. Those are some things you might want to reflect on and think about, and we are going to be thinking about them as we bring this forward into the coming weeks. On behalf of myself, Hung, Mark, and ASTP, we just want to thank you again for your commitment, your contributions to the Task Force, and your expertise. I just want to echo what

Hung said. I really am heartened by this, and I think we have the right group together to really focus on this incredibly important work, and we look forward to our discussion at the next meeting. Thank you, everyone.

Seth Pazinski
All right, thank you, all. We will adjourn for today. Again, for our Task Force members, please be on the lookout for a homework message that should be coming to you in the next day or so. Thank you, everyone.

Adjourn (01:19:16)

Questions and Comments Received Via Zoom Webinar Chat

Seth Pazinski: Administrative point -- please select "Everyone" when posting a comment to the chat if you would like your comment included as part of the public record. We include "Everyone" chat comments in the meeting transcription. Thank you!

Natacha Fernandez: Good point - distinguish the two (equity and disparities)

Natacha Fernandez: On that same spirit getting agreement/alignment on Healthcare provider

Natacha Fernandez: especially for social care vs clinical care

Rochelle Prosser: Great overview of this charge

Kevin Henderson: I agree but I also think whether health equity or health disparity, from an impactful standpoint

Kevin Henderson: it would be helpful to put these in the context of health outcomes

Medell K. Briggs-Malonson: Inequities (differences rooted in injustice) vs. disparities (differences that may not be rooted in injustice)

Social, environmental, and political drivers of health

Health related social need

Under-resourced vs underserved

Health care equity vs health equity

Health justice

Just a few... there are more.

Rochelle Prosser: Is there a reason Nurses are not a separated-out category?

Rita Torkzadeh: Any comments from health plans? that could be another perspective (along with patients/individuals, clinicians, and other providers)

Rochelle Prosser: Did we include the various community based local organizations closer to undervalues populations? i.e. Indian Health Services, FQHC's from Medicaid

Sandra Ciuffreda: Critical and basic to health equity is availability of high-speed broadband to all, particularly in rural areas. Should recommendations regarding communication infrastructure be addressed as part of this task force? In addition, patient education regarding use of technology is very often not addressed and would lead to inequities.

Ashley Gray: +1 to Sandra Ciuffreda's comment

Rochelle Prosser: For those who do not have Broad Band, how are we including those communities inside of this Model?

Hannah K. Galvin: Agreed, Sandra. Yes, in ASTP's coordination work with the FCC, we can include access and availability to broadband Internet.

Teresa Younkin: +1 to Rachel Prosser's discussion on Broadband

Ashley Gray: I had to join late so apologies in advance if this was covered - will co-design opportunities with consumers, community-based organizations, and healthcare stakeholders be part of this work?

Natacha Fernandez: Agreed with @Sandra. Communications needs to be its own line. It is not just about broadband access, but also about connectivity to healthcare systems and to effectively collaborate on care

Rochelle Prosser: Currently in rural America, there are often no Health care provider in the specialty of Pediatrics, Pediatric Services or just a pediatrician. How do we propose to include the sourcing of and creation and collection of data and AI within these specific circumstances within this document. We have quite a few Pediatric specialists here on this call.

Natacha Fernandez: I would say that communication would have three pillars, infrastructure, P2P communication, provider to health system

Rochelle Prosser: Healthcare and connectivity deserts can exist everywhere and anywhere. Urban, Rural, Mountain, valley, Costal Heartland.

Cynthia Gonzalez: How do we intend to integrate lived experience that centers trust?

Janée Tyus: We know that a lot of health care is being provided in clinical settings where interoperability is likely not even possible for various reasons listed here. Perhaps we add integration as a theme well?

Rochelle Prosser: +1 Janee

Rochelle Prosser: +1 Cythia

Medell K. Briggs-Malonson: +1 for Cynthia and Janee

Rochelle Prosser: That is why IHS should be at the table to ensure we address their needs and not exclude them

Teresa Younkin: Please do not forget to account for those users that may not use technology. We need to build front end for those end users and technology backend for architecting.

Rochelle Prosser: +1 Teresa

Susan M. Jenkins: Underlying issues of interoperability is the quality of the data and the assumptions underlying the data. The data are initially collected and provided by individuals with all of the biases that they may bring with them. I am thinking, for example, of perceptions that members of some racial groups have higher pain tolerance. This assumption, to the extent that it affects diagnosis and prescribing, then biases the data. This then becomes another dimension that affects data quality in addition to completeness and other measures of quality that we typically look for.

Rochelle Prosser: +1 Hung

Rochelle Prosser: Excellent point Susan and Janice

Janée Tyus: I think there also needs to be some sort of accountability in the framework we recommend. Could be a component of governance, but should be called out specifically. Folks tend to have more trust when they know that there are things in place to address when the tech fails individuals or communities. And, +1 to Belinda.

Teresa Younkin: +1 Susan- This is a great point

Rochelle Prosser: BY bring these communities to the table and making room for them and their intricacies, will promote health equity and understanding within these communities. Most importantly inclusion. we can begin to respect their boundaries once we know what they are and how to engage.

Rochelle Prosser: +1 Medell

Hannah K. Galvin: Agreed on data bias. Some populations may be underrepresented. As we expand the interoperable ecosystem, mistrust also increases (especially among certain populations), and data sharing may further decrease, which further affects data quality and increases bias.

Rochelle Prosser: "Cannot be discriminatory"

Natacha Fernandez: @Steven, this has been a huge challenge especially with attributions of lives to a provider, where the ability to effect the patient's outcome is completely out of control, especially when the patient can't even be connected to (which is the initial intervention needed).

Hannah K. Galvin: +1 Medell

Cynthia Gonzalez: Could you please email the homework list? :)

Seth Pazinski: ASTP HEBD concept paper https://www.healthit.gov/sites/default/files/2024-04/ONC-HEBD-Concept-Paper_508.pdf

Hung S. Luu: You will receive an email with the homework before the next meeting.

Rochelle Prosser: +1 Ike, I believe we discussed looking at creating specifically crafted quality metrics and KPI that distinctly focus on the disables community.

Cynthia Gonzalez: Thanks all!

Teresa Younkin: Thank you!

ASTP

Questions and Comments Received Via Email

No comments were received via email.

Resources

Health Equity by Design Task Force 2024
Health Equity by Design Task Force 2024 - October 29, 2024, Meeting Webpage

Transcript approved by Seth Pazinski, HITAC DFO, on 11/13/24.