Meeting Notes

The fourth meeting of the Social Justice & Health Disparities Working Group was held on March 11, 2021 from 3:00-4:30pm.

Dr. Dora Hughes opened the meeting with a brief follow-up presentation to the working group's most recent discussion on Value-Based Insurance Design (V-BID) and addressed the following questions:

- Does V-BID improve health outcomes?
- Does V-BID benefit higher income populations?
- Does V-BID reduce disparities?

Michelle Jester on Racial and Ethnic Data Collection

This week's guest speaker, Michelle Jester, is with America's Health Insurance Plans (AHIP). She gave a presentation titled "Race and Ethnicity Data Collection: Strategies, Challenges, & Opportunities."

She began with an overview of methods and strategies for data collection, including indirect and direct data collection methods. This was followed by a deeper dive on the data collection methods she identified, including methods, challenges and opportunities for each.

- **Indirect Methods:** Geographic assignment, Bayesian Indirect Surname and Geocoding (BISG)
- **Direct Methods:** Collection at enrollment/re-enrollment; obtaining data from EHRs; obtaining data from providers as part of claims; surveying members and other outreach methods; revising health risk assessments; through website interaction/customer contact centers/grievance submissions/etc.; when a member utilizes LEP services; through care managers; and those participating in health education or chronic disease management programs

Michelle noted that indirect data collection methods have limitations, as neighborhoods and families are not homogenous, and subsequently direct data collection methods are "the gold standard."

Sample scripts and forms for collecting race and ethnicity data should make sure to include the following information in order to build trust with the community: why the information is being collected, a statement about how providing this information is voluntary, a description of how it will be used and how it will not be used, and how it will be protected. Michelle also shared an example form to collect more granular race and ethnicity data.

Finally, Michelle reviewed the NCQA proposal on stratifying HEDIS measures by race and ethnicity.

Discussion

Dr. Hughes asked Michelle to talk about some of the different ways plans have used race and ethnicity data to address the care of their members. Michelle responded that at a higher level, plans use this data to identify disparities, and once those disparities are identified it's on the plans to communicate that information with provider networks on the ground. Plans also use this data to help members identify providers they may be more comfortable seeing for care, and the information can guide plans in developing initiatives that meet the needs of the community.

Dr. Hughes also asked if we know which strategies are most effective for data collections. Michelle answered that collecting the data at enrollment appears to be the most effective, and other potential avenues include having it as part of claims or having agreements with providers to share EHR data.

Finally, Dr. Hughes asked Michelle to talk more about interoperability issues. The U.S. Core Data for Interoperability is a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange. It can help facilitate standardized data sharing between providers and plans. Dr. Hughes followed up by asking if it would be useful for all plans to use the same indirect methods (if that's what they are currently using), and what indirect method is best. Michelle answered that in her opinion, geographic assignment is the better data collection method compared to BISG, but there are limitations with both.

Michelle then reviewed a few of AHIPs working groups, including one focused on social determinants of health and another on health equity. In the health equity working group, the current priorities are establishing demographic data standards, promoting diverse provider networks, and implicit bias and antiracism training. They also have a health equity measures for value-based care work group.

Dr. Hughes then asked to hear directly from the plans on racial and ethnic data collection efforts.

Allison Mangiaracino stated that Kaiser collects race, ethnicity, and language data in the care setting. Their data collection rate in the mid-Atlantic is 85%, and she believes that includes all lines of business. They do use indirect methods (the RAND methodology, which is a combination of geographic and surname analysis) for high level, national analysis where they have identified data gaps, but they do not use those methods at the regional level for quality improvement efforts.

Daniel Wilson stated that United Healthcare does not collect race and ethnic data on the commercial side. They have started an enterprise-wide initiative called "Supporting Underserved Communities" that includes a survey to better understand if they are meeting the needs of the community from a racial, ethnic, and language standpoint.

Janice Davis asked Allison Mangiaracino to describe KP's use of collected racial and ethnic data. Allison responded that because the information is in the EMR, they are able to break out HEDIS measures by race and ethnicity and use it for clinical improvement activities.

Dr. Cara James then discussed her experience at CMS and policy in the racial and ethnic data collection space. During her time at CMS in the Office of Minority Health, they specifically focused on data collection analysis and reporting to try and increase and standardize data collection happening across programs, as well as to use the data to look at quality, access, and other outcomes, and share that information with different stakeholders. They made sure that the Affordable Care Act's data standards for race, ethnicity, sex, primary language, and disability were used in surveys as well as administrative data collection efforts. She also discussed data gaps and challenges related to collecting data through the federal marketplace. They had challenges with Medicaid data because every state was collecting it differently, so they were unable to provide a national picture of what is happening with the Medicaid program.

In the Medicare space, they worked to analyze the HEDIS and CAHPS data used in the Star Ratings program. They also began to think about how they could better capture information on social determinants, and an opportunity arose when they were required to standardize the patient assessment tools used in post-acute care settings. They included a screener for health literacy, social isolation, and transportation, and sought comment on other areas stakeholders wanted included. The also tried to increase awareness of Z codes (part of ICD-10 codes) that are specific to social determinants and can be leveraged to create a more complete picture of the patients for whom providers are caring. Dr. James supported efforts to incorporate health equity into quality improvement and value-based purchasing. Her office developed a health equity summary score in collaboration with RAND Corporation that can be applied to the Star Ratings program so that plans would be assessed on how they performed.

Dr. Hughes closed the meeting by saying we are looking forward to our next meeting and learning more about carriers' various initiatives to address disparities.

Attendees

Dora Hughes
Helen Mittmann
Michelle Jester – Guest Speaker
Diane Lewis
Mila Kofman
Purvee Kempf
Janice Davis
Tamara Watkins
Paul Speidell
Chikarlo Leak
Yulondra Barlow
Tonya Vidal Kinlow
Anneta Arno
Allison Mangiaracino
Ciana Creighton
Daniel Wilson
Howard Liebers
Yolette Gray
Pamela Riley
Patricia Quinn
Jacqueline Bell
K. Hathaway