



RACIAL, ETHNIC, LANGUAGE DISPARITIES WORK GROUP

UPDATE REPORT
TO

Delegate Nathan-Pulliam, Chair

**Minority Health Disparities Subcommittee
Health and Government Operations Committee**

December 2010

RACIAL, ETHNIC, LANGUAGE DISPARITIES WORK GROUP

Bruce Kozlowski (Chair)
Director, Center for Health Care
Financing and Health Policy
Maryland Health Care Commission

Aisha Pittman, MPH (Co-Chair)
Chief, Health Plan Quality &
Performance
Maryland Health Care Commission

Julie Deppe, Executive Assistant
Center for Health Care Financing
and Health Policy
Maryland Health Care Commission

Health Insurance Representatives:

Aetna

Richard Fornadel, MD, MBA
Medical Director

Wayne S. Rawlins, MD, MBA
National Medical Director
Racial and Ethnic Equality Initiatives

Michele Toscano
Head, Business Management,
Planning and Reporting
The Office of the Chief Medical
Officer

CareFirst BlueCross BlueShield

Malcolm Joseph, MD
Medical Director

Sandra Purcell
Lead Business Analyst

Inca Shultz
Quality Improvement Manager

CIGNA Health Care Mid-Atlantic Region

Ruth-Elizabeth Downer
Compliance Officer, State
Government and Regulatory Affairs

Peggy Payne, MA, CDE
Director, Cultural and Linguistic Unit

Coventry Health Care of Delaware, Inc.

Dave Reynolds
President and CEO

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Monica Villalta, MPH
Director, Diversity Programs

United Healthcare

Nancy Selig Amsden
Regulatory Affairs Analyst
Legal and Regulatory Affairs

Elizabeth Tripp
Compliance Reporting Manager

Susan Wojciechowski
Compliance Consultant

Academic Representatives:

Darrell Gaskin, PhD
Deputy Director, Hopkins Center for
Health Disparities
Johns Hopkins Bloomberg School of
Public Health

M. Chris Gibbons, MD, MPH
Associate Director, Johns Hopkins
Urban Health Institute
Assistant Professor, Johns Hopkins
Medical Institutions

Thomas LaVeist, PhD
William and Nancy Richardson
Professor in Health Policy
Director, Hopkins Center for Health
Disparities
Johns Hopkins Bloomberg School
of Public Health

Association and Society Representatives:

Marcos Pesquera
Executive Director, Center on Health
Disparities
Adventist Healthcare
*representing Maryland Hospital
Association*

Ron Wineholt
Vice President of Government
Affairs
Maryland Chamber of Commerce

Larry Gourdine
Executive Director
Monumental City Medical Society

Cynthia Reeves Tuttle, PhD, MPH
Vice President, Center for
Prevention and Health Services
National Business Group on Health

Wendy Frisby
Account Manager
Pfizer, Inc

Pamela S. Smith, PharmD
Director, Medical Outcomes
Specialist
Southeast Region
Global Medical Division, Pfizer, Inc.

Public Policy Organizations:

Kalahn Taylor-Clark, PhD, MPH
Research Director, Economic Studies
Engelberg Center for Health Care
Reform
The Brookings Institution

State/County Representatives:

Carlessia A. Hussein, RN, DrPH
Director, Office of Minority Health
and Health Disparities
Department of Health and Mental
Hygiene

David Mann, MD, PhD
Epidemiologist, Office of Minority
Health and Health Disparities
Maryland Department of Health and
Mental Hygiene

Sonia E. Mora, MPH
Manager, Latino Health Initiative
Administrator, Suburban Maryland
Welcome Back Center
Montgomery County Department of
Health and Human Services

Tinna Damaso Quigley, Esq.
Director of Government Relations
Maryland Insurance Administration

INTRODUCTION

In 2010 the Racial, Ethnic, Language Disparities Work Group (“Work Group”) focused on opportunities for education and training regarding the accurate collection of race, ethnicity and language choice data. This effort resulted in a draft “blueprint” for outreach and education which engages health plans, employers, health care professionals, individual consumers and state government. This report provides the draft blueprint for action and a detailed background and history of the efforts of the Work Group.

With the passage of the Patient Protection and Affordable Care Act, the Governor created the Maryland Health Care Reform Coordinating Council (“Council”) charged with providing recommendations to the 2011 General Assembly related to addressing the challenges of federal health reform. The Council is comprised of six work groups including the Education and Outreach Workgroup, whose charge included education to support the collection and reporting of race, ethnicity and language. So as not to duplicate the work of the Council, the Maryland Health Care Commission (“Commission”) Work Group suspended its meetings in September 2010 awaiting the full report of the Council, but provided input to the Council’s Education and Outreach Workgroup including oral presentations and written materials developed to date.

BLUEPRINT FOR OUTREACH AND EDUCATION

The purpose of the Work Group's outreach and education campaign is to increase consumer, medical provider and employer awareness about the importance of health plans' efforts to collect race, ethnicity and language preference with the purpose of reporting, measuring and reducing health disparities so all Marylanders can have improved access, patient centered services and improved treatment outcomes. Despite new laws requiring health plans to report information on race, ethnicity and language preference, patient self-reporting and accurate reporting remain as significant challenges often due to fear of unintended consequences related to their employment or insurability. In addition, employers have been reluctant to share collected information with health plans due to lack of understanding of the business costs incurred due to disparities in health care access and treatment of their employees, and/or because they fear that their insurability or premiums may be adversely affected.

In order to address these challenges, the blueprint includes a multi-touch approach where the core message of "knowing your race, ethnicity and language choice helps provide better services for everyone" is disseminated by multiple stakeholders in multiple culturally sensitive settings. Outlined below are the core audiences and the goals for outreach.

Core Audiences

Employers

Employers are able to collect race and ethnicity information; however, their methods are not always ideal. Employers collect race and ethnicity information through voluntary self-identification forms during the hiring process. This information is de-identified and typically collected on all applicants so it does not provide accurate race and ethnicity data for current employees. For very large employers, this does provide an estimation of aggregate race and ethnicity data but geo-coding methods may be more accurate. Additionally employers may have the opportunity to collect race and ethnicity data through health risk appraisals; transferring this information to health plans does provide an opportunity for the plan to receive accurate self-reported data. However, health risk appraisals may not be available to all employers due to the cost. Primarily, it will be important to leverage employers providing health coverage as they serve as a key educational resource for their employees. Goals for outreach to the employer community include:

- Increase understanding of the importance of collecting accurate racial, ethnic and language (REL) data; including how utilizing REL data can help improve health care and increase health care value (quality, effectiveness and efficiency) and reduce the employers costs

- Gain support in helping educate employees/members about the importance of accurate REL data reporting

Medical Providers/Clinical Staff

Collection of REL information at the point of service can serve as an educational resource for patients. Additionally, state efforts including electronic medical records (EMR), health information exchange (HIE) and patient centered medical home (PCMH) provide a direct communication line with practitioners. Goals for outreach to medical practitioners and clinical staff include:

- Increase medical provider and health system understanding of why it's important to gather the information
- Increase medical provider and clinical staff willingness to ask for the information
- Prepare medical providers for addressing patient fears about how REL information will be used
- Dispel practitioners' fears that collection or failure to collect may create a potential treatment legal liability
- Gain support in spreading the message to consumers in general

Patients and the Greater Community

This population serves as the primary audience for the outreach and educational campaign. The earlier audiences provide opportunities to filter information to patients and the community so that the message is coming from multiple sources. Goals for outreach to patients and the community include:

- Assure patients, community members and providers that by sharing REL data everyone will benefit, disparities can be addressed, prevention efforts can be more targeted and health outcomes for all Marylanders can be enhanced
- Increase consumers (patients, parents and caretakers of patients) understanding about why the information is being asked and why it is in their best interest to share the information with their medical providers
- Increase Marylanders awareness about the importance of self-identified REL data in order to accurately identify, measure and address health disparities that may affect them and their community
- Dispel fear among community members and patients that the information might be used for insurance decisions that might adversely affect coverage or premiums
- Encourage accurate reporting of self-identified REL data

- Increase Marylanders understanding about the role of health plans and government as it relates to collecting, safeguarding and using the data exclusively for the enhancement of services (preventive interventions and development of materials that will help the organizations be culturally and linguistically appropriate)

Additional Audiences and Venues

Using our partners in this effort— other state agencies that provide health information to the public (i.e., Maryland Insurance Administration, county health offices), advocacy groups, health plans and provider associations to filter information to patients and the community at-large.

Outreach Strategy

The key points in the outreach strategy are:

- Maintain a consistent message. While the message can be slightly tailored according to method of delivery and sub-audience, the message must be consistent in order to gain and maintain consumer trust.
- Utilize trusted community resources that are culturally appropriate to convey the message.
- Highlight the value proposition. The message must clearly tell each audience their value to collecting or providing REL data. This can be done by highlighting best practices and engaging community leaders to be an example.

BACKGROUND & HISTORY

Maryland was one of only four states that prohibited insurance carriers from collecting racial and ethnic data at the time of application. The logic was well founded when the law was passed: the law was intended to minimize the insurance industry's ability to "redline" based on an individual's or a group's race and ethnicity. Much has changed over the years, and the need for such a restriction has diminished. Concurrently, the existence of and the need to address health and health care disparities have gained a significantly higher profile for state policymakers. At a time when there is much interest in analyzing data to identify disparities, especially by region or locality, there is an absence of Maryland specific information. There is some ability to extrapolate from national census or other data sources, but the information that is derived is anemic at best, especially when trying to identify and address dominant race and ethnic maladies by geographic prevalence.

In the 2006 legislative session, HB 58 was introduced and passed into law. The legislation required the Maryland Health Care Commission by October 1, 2007 to incorporate to the extent feasible, racial and ethnic variation information into the annual performance reports for health maintenance organizations, hospitals, ambulatory care facilities, and nursing facilities, work collaboratively with the Office of Minority Health and Health Disparities (OMHHD), assist OMHHD in the production of an annual report card, and analyze variations in insurance coverage and composition of practicing physicians and specified diseases. Although the intent of the legislation was laudable, it did not remove the barrier for health insurance carriers' collection of racial and ethnic information at the time of application.

In the 2007 legislative session, HB 788 was introduced and passed into law. The legislation authorizes health insurers to make an inquiry about race and ethnicity at the time of application but prohibits the use of specified racial or ethnic information to deny or otherwise affect a health insurance policy or contract. The legislation also allows the Commission to collect data on race and ethnicity from health insurers and generate reports based on that information.

In January of the 2008 legislative session, Delegate Nathan-Pulliam, Chair, Minority Health Disparities Subcommittee, Health and Government Operations Committee, called together the major health insurers, the Maryland Insurance Administration (MIA), the Commission and the OMHHD to provide a briefing on efforts to date to collect and report on health disparities. Each health insurer reported on their past and current efforts to address disparities. Although there were several very interesting initiatives discussed, and each plan had some disparate effort to respond to this new opportunity, collection and reporting of race and ethnic data was in its infancy, especially as it related to Maryland specific information. It was apparent to the Chair and the attendees that a more coordinated effort would be required in order for a timely and

substantive result to be achieved. To this end, Chair Nathan-Pulliam sent a letter to the Maryland Health Care Commission requesting the Commission to be the catalyst for a more unified approach to data collection and reporting by bringing together the diverse stakeholders who collect, analyze and report on such information.

The Commission identified eleven health insurance carriers that had appreciable market share in Maryland and would be the most likely candidates for collaboration and eventual impact on health and health care disparities. Six of the largest carriers agreed to participate. Invitations were also sent to the OMHHD, universities and the MIA. The response was overwhelming, as reflected by the roster of Work Group members at the front of this report.

In a letter dated March 5, 2008 from Delegate Nathan-Pulliam, Chair, Minority Health Disparities Subcommittee to Dr. Rex Cowdry, Executive Director of the Maryland Health Care Commission, the Delegate requested that the Commission seek consensus in the following five action areas:

- A need for health plans to utilize plan specific data to affect measurable positive change in areas where health and health care disparities are clearly evident
- Agreement on data elements for collection and reporting to the Commission for statewide analysis and reporting
- A project plan that includes a timetable, but recognizes the diversity and implementation challenges
- A collaborative effort by health plans to utilize statewide data to affect measurable changes in areas where health and health care disparities are clearly evident
- A collaborative effort to educate members about the importance of designating their racial or ethnic status at the time of application or post-application

2009 Workgroup Efforts

In 2009, the Work Group focused on recent developments related to collection of race, ethnicity and language at the federal level, in other states, and at the National Business Group on Health on which the Commission is represented. Most importantly the Work Group adopted recommendations from the Institute of Medicine (IOM) Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement and reached consensus in the following areas:

1. The reporting of race and ethnicity categories will be based on Office of Management and Budget (OMB) standards as recommended by the IOM, which include the following questions and categories:
 - Hispanic Ethnicity

- Hispanic or Latino
 - Not Hispanic or Latino
 - Race
 - White
 - Black or African American
 - American Indian or Alaska Native
 - Asian
 - Native Hawaiian or Other Pacific Islander
 - Some Other Race
 - Granular Ethnicity A locally relevant list of categories will be developed from the IOM list.
2. Race will be reported using two fields to capture information from multi-racial individuals.
 3. Following the recommendations of the IOM, a question asking “Preferred Language in Health Care” is added to the data reporting.
 4. Time frame for data collection and reporting is modified to conform to changes in Maryland Medical Care Data Base (MCDB) expansion process.
 5. Consensus that there needs to be a concerted and collaborative effort by employers, health plans, and government to educate our citizens about the safeguards in the law related to personal health information and the benefits of accurate reporting to employers and health plans.

At its November 2009 Commission meeting, the Commission adopted the proposed data collection regulations (COMAR 10.25.06) and the Work Group’s preferred data collection language was incorporated into the regulations as part of the data dictionary.