

Maryland Health Disparities Collaborative

Research and Evaluation (Data) Workgroup

Report on Secretary's Request for Assistance

August 10, 2012

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Secretary Sharfstein's Request to the Workgroup:

- By August 1, recommend to the Maryland Health Care Commission a standard set of measures for health plans regarding racial and ethnic variations in quality and outcomes.
- By August 1, recommend to the Health Services Cost Review Commission how the Commission should utilize racial and ethnic data in evaluating hospital performance and outcomes.

Contents of the Workgroup Response:

- 1. Background, Recommendations and References on the categories of Race, Ethnicity, Nationality, and Language for Healthcare to be collected and analyzed in HSCRC and MHCC data.**

References

- 2. Background, Recommendations and References on the health care quality, health system process, and patient health status outcomes to be analyzed in terms of the Race, Ethnicity, Nationality, and Language variables in HSCRC and MHCC data, and on the methods for such analysis.**

References

- 3. Names and Titles of Workgroup Participants**

Background and Recommendations on the categories of Race, Ethnicity, Nationality, and Language for Healthcare to be collected and analyzed in HSCRC and MHCC data.

Background: Hispanic ethnicity, as well as basic categories of Race (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander) are generally collected according to the standards set in the Federal Office of Management and Budget Directive 15 (as revised 1997). Various additional recommendations and/or data collection systems refer to collection of subcategories of race (most often identified by nationality, but sometimes by current or historical tribal affiliations), of the preferred language for healthcare (with or without a self-assessment of English proficiency), and of disability status. For the question of evaluating racial and ethnic variations in health care quality, process and outcomes, a standard approach to data collection regarding race, ethnicity (including racial subcategories), and language for healthcare is necessary.

The National Stakeholder Strategy (NSS) for Achieving Health Equity (found at <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>), published by the National Partnership for Action to End Health Disparities (NPA), includes a goal titled *Data, Research, and Evaluation*. In this goal, the NSS seeks to “ensure the availability of health data on all racial, ethnic, and underserved populations”. The recommendations below are designed to help in the achievement of this goal.

Recommendation 1: Adopt the approach of OMB Directive 15 as the overarching shell for Race, Ethnic and Language data collection. This means collect Hispanic ethnicity (yes or no response) and Race in categories of White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander (pick all that apply).

Rationale:

The seminal Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002) (Brian Smedley, Ph.D, e.d.), documented the widespread existence of racial and ethnic disparities in the health care system. In addition, the Agency for Healthcare Research and Quality (AHRQ) annually documents the progress on healthcare disparities reduction in the *National Healthcare Disparities Report*, which also provides state snapshots of performance. Similarly, the Maryland Department of Health and Mental (DHMH) Office of Minority Health and Health Disparities and the State Health Improvement Process (SHIP) document health and healthcare disparities at the state-wide level.

The American Recovery and Reinvestment Act of 2009 (ARRA) established the meaningful use of electronic health records (EHRs). According to the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Programs Electronic Health Record Incentive Program, eligible professionals, eligible hospitals and critical access hospitals participating in Medicare and Medicaid are eligible for incentive payments for the adopting and demonstrating the meaningful use of EHRs. In stage 1, these providers are required to collect

Maryland DHMH Office of Minority Health and Health Disparities • Director: Carlessia A. Hussein, R.N., Dr. P.H. 3
201 W. Preston Street • Room 500 • Baltimore, Maryland 21201 • Phone: 410-767-7117 • Fax: 410-333-5100

<http://www.dhmh.maryland.gov/mhhd>

patient demographic data, including race, ethnicity, and preferred language. (See: <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>, p. 44340). The rule notes that the race and ethnicity codes should follow those of the Office of Management and Budget (http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_app-a-update.pdf)

Recommendation 2: In addition to race and ethnicity, collect data on English proficiency and preferred language for healthcare. Use the questions in the HHS new data collection guidelines.

Rationale:

Studies indicate that patients with limited English proficiency (LEP), meaning those who speak, read, and write English “less than very well” and who are the most likely to require the services of qualified medical interpreters, are at increased risk for poorer outcomes, medical errors, and increased diagnostic tests due to ineffective communication. Although many healthcare organizations can identify language requests, they are less able to adequately identify the language needs of the patient population. Furthermore, several mandates and regulatory standards require the provision of language services for limited English proficient patients, such as Title VI of the Civil Rights Act of 1964, the U.S. Department of Health and Human Services, Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS Standards) (2001), the enhanced version of which is scheduled for release in September 2012, and The Joint Commission Standards on “Effective Communication, Cultural Competence, and Patient-Centered Care” for the Hospital accreditation program.

Recommendation 3: In the future, add to the OMB approach collection of relevant subcategories of the primary racial and Hispanic ethnic groups. Appropriate lists of subcategories for Maryland should be determined by consultation with appropriate minority populations and by reference to subgroup population sizes from the 2010 census. Maryland should develop a process for obtaining input from the various minority populations and their advocacy groups, including the Governor’s Ethnic Commissions.

Rationale:

While data collection using the broad OMB racial and ethnic categories is a start, disparities affecting granular ethnicities may be subsumed to the overall racial group. For example, a study in Massachusetts of breastfeeding among Asian ethnicity women indicated that Asian women breastfed at a rate higher than the general Massachusetts population. However, after reviewing the data by granular ethnicity, it was revealed that Cambodian women had breastfeeding rates far lower than the rest of the Asian women and even lower than the Massachusetts population.

In 2006, the Massachusetts Department of Public Health developed a race, ethnicity, and language preference data collection instrument to be used by all healthcare organizations in Massachusetts. The list followed the OMB racial and ethnic categories, but added a list of

ethnicities and languages most commonly found in Massachusetts. This list was crucial in that each healthcare organization did not have to try to identify such a list themselves.

References

Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report (2011) <http://www.ahrq.gov/qual/qrd11.htm>

Agency for Healthcare Research and Quality (AHRQ). State snapshots (2010) <http://statesnapshots.ahrq.gov/snaps10/index.jsp>

Divi, C. et al. (2007) "Language Proficiency and Adverse Events in U.S. Hospitals: A Pilot Study" *International Journal for Quality in Health Care* 19.2: 60-67.

Flores, G. et al. (2003) "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters" *Pediatrics* 111: 6-14.

Flores, G. (2005) "The Impact of Medical Interpretation Services on the Quality of Health Care: A Systematic Review." *Medical Care Research and Review* 62: 255-299.

Flores, G. et al. (2000) "The Importance of Language and Culture in Pediatric Care: Case Studies from the Latino Community." *Journal of Pediatrics* 137:842-848.

The Joint Commission. Hospitals, Language, and Culture: A Snapshot of the Nation. Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings, 2007. http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4DC4ACD4BF8BD3/0/hlc_paper.pdf

The Joint Commission. One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations, 2008. http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm

Maryland Department of Health and Mental Hygiene (DHMH), Office of Minority Health and Health Disparities, Health Equity Data, <http://dhmh.maryland.gov/mhhd/SitePages/Health%20Equity%20Data.aspx>

Maryland Department of Health and Mental Hygiene (DHMH), Office of Minority Health and Health Disparities, Maryland Chartbook of Minority Health and Minority Health Disparities Data (December 2009) http://dhmh.maryland.gov/mhhd/Documents/Chartbook_2nd_Ed_Final_2010_04_28.pdf

Maryland Department of Health and Mental Hygiene (DHMH), Maryland State Health Improvement Process, Racial and Ethnic Health Disparities,
<http://dhmh.maryland.gov/ship/SitePages/RacialandEthnicHealthDisparities.aspx>

Massachusetts Department of Public Health, “Implementing New Race, Ethnicity, and Language Data Collection Standards,” 2006. <http://www.mass.gov/eohhs/docs/dph/health-equity/race-ethnicity-language-data.pdf>

National Standards on Culturally and Linguistically Appropriate Services (CLAS)
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

Nerenz, David et al. (eds.) Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: Institute of Medicine, 2009.

Jacobs, E.A. et al. 2004 “Overcoming language barriers in health care: costs and benefits of interpreter services.” American Journal of Public Health 94.5: 866-869.

Smedley, Brian et al (ed.). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: Institute of Medicine, 2002.

State of Massachusetts. Asian Births in Massachusetts, 1996-1999; Hispanic Births in Massachusetts, 1996-1999; and Black Births in Massachusetts, 1997-2000.

U.S. Department of Health and Human Services, Office for Civil Rights. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons. 69 Fed. Reg. At 47311-47323.

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>

U.S. Department of Health and Human Services, Office of Minority Health, Data Collection Standards for Race, Ethnicity, and Primary Language

<http://minorityhealth.hhs.gov/templates/content.aspx?ID=9227&lvl=2&lvlID=208>

U.S. Department of Health and Human Services, Office of Minority Health, National Partnership to Eliminate Minority Health Disparities. The National Stakeholder Strategy for Eliminating Health Disparities. Rockville, MD, April 2011.

U.S. Department of Health and Human Services, Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services (CLAS).

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

Background and Recommendations on the health care quality, health system process, and patient health status outcomes to be analyzed in terms of the Race, Ethnicity, Nationality, and Language variables in HSCRC and MHCC data, and on the methods for such analysis.

Background: HSCRC and MHCC currently assemble health care utilization data that includes a variety of outcome and process measures. MHCC currently analyzes certain outcome, process, and patient experience (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures for its legislatively mandated annual quality reports on health benefit plans, nursing facilities, and hospitals and ambulatory surgery facilities. HSCRC currently has quality-based reimbursement programs that examine performance on the following outcome measures: preventable hospital complications, hospital re-admissions, and a set of hospital quality of care measures. The MHCC Patient Centered Medical Home pilot has an incentive system to providers (a shared savings incentive model) based on providers receiving a share of savings that result from reductions in preventable utilization (emergency department visits and hospital admissions). In addition, the Maryland Hospital Association provides links to various hospital quality and performance measures. Each of these systems currently analyzes relevant health care outcome, process, and patient experience measures. Each of those systems currently operates in a race/ethnicity neutral or blind fashion. However, a large body of research demonstrates that disparities exist on the basis of race, ethnicity, and primary language, and that these disparities exist even when socioeconomic factors are held constant. Further, research demonstrates that an array of social determinants of health, such as income, occupation, and neighborhood poverty concentration (among many other social, economic, and environmental factors) shape both health status as well as access to and outcomes of health care. Therefore, HSCRC and MHCC data should be 1) analyzed by race, ethnicity, and primary language; 2) these analyses should include measures of social determinants of health, both to examine how they may modify the effect of race as well as to assess their independent association with healthcare and health indicators; and 3) these analyses should be publicly reported, to raise awareness and inform general audiences, as well as to measure and ensure public accountability toward the elimination of health and healthcare disparities.

Recommendation 4: The current set of health outcome, healthcare process, and patient experience measures in the HSCRC and MHCC data systems are reasonable for an initial analysis of these outcomes by race, ethnicity and eventually, language.

For the future, additional outcome measures to be analyzed by race, ethnicity and language could include measures from the Robert Wood Johnson Foundation (RWJF) Speaking Together language services performance measures, which have been endorsed by the AHRQ National Quality Measures Clearinghouse; additional HEDIS measures; and additional measures from the NHQR and NHDR reports.

Recommendation 5: Compare the results of this analysis within and across groups of race, Hispanic ethnicity, and language to identify disparities in these outcome, process, and patient experience measures.

Recommendation 6: Where possible, analyses of quality, process, and outcome variables disaggregated by race, ethnicity, and primary language should include variables that reflect social determinants of health such as patient education level, occupation, and/or zip code of residence (or discharge destination).

Recommendation 7: The current outcome, process, and patient experience measures are publicly reported on the MHCC, HSCRC, and Maryland Hospital Association websites. These same measures when analyzed by race, ethnicity, and language should also be publicly reported on the same websites.

Recommendation 8: The current outcome, process, and patient experience measures are benchmarked on a national and state-level. The same measures when analyzed by race, ethnicity, and language should also be benchmarked on a national and state-level through such reports as the AHRQ National HealthCare Quality and National Healthcare Disparities Reports, the Maryland DHMH Office of Minority Health and Health Disparities, and Maryland DHMH SHIP data.

References

Agency for Healthcare Quality and Research (AHRQ), State snapshots (2010)
<http://statesnapshots.ahrq.gov/snaps10/index.jsp>

Agency for Healthcare Research and Quality (AHRQ). National Healthcare Disparities Report (2011) <http://www.ahrq.gov/qual/qrd11.htm>

Institute of Medicine. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press.

Maryland Department of Health and Mental Hygiene (DHMH), Office of Minority Health and Health Disparities, Health Equity Data,
<http://dhmh.maryland.gov/mhhd/SitePages/Health%20Equity%20Data.aspx>

Maryland Department of Health and Mental Hygiene (DHMH), Maryland State Health Improvement Process, Racial and Ethnic Health Disparities,
<http://dhmh.maryland.gov/ship/SitePages/RacialandEthnicHealthDisparities.aspx>

Maryland Health Care Commission, Hospital Guide,
<http://mhcc.maryland.gov/consumerinfo/hospitalguide/index.htm>

Maryland Health Services Cost Review Commission, Quality Improvement,
http://www.hsrc.state.md.us/init_qi.cfm

Maryland Hospital Association. Quality Performance Measures,
<http://www.mhaonline.org/quality/quality-performance-measures>

Robert Wood Johnson Foundation (RWJF) Speaking Together Language Services Performance Measures, <http://www.qualitymeasures.ahrq.gov/browse/by-organization-indiv.aspx?objid=25803>

Research and Evaluation (Data) Workgroup - List of Workgroup Members

Name	Organization
Abraham, Meena	OIDPCS, Infectious Disease & Environmental Health Administration
Addo-Glover, Doris	Delmarva Foundation for Medical Care
Ahmad, Afaq	Maryland Cancer Registry
Alborn, Salliann	
Alexander, Nadine	Johns Hopkins School of Public Health
Butler III, James	University of Maryland Center for Health Equity, School of Public Health, University of Maryland College Park
Childers, Morgan	Maryland Center for Health Equity, University of Maryland School of Public Health
Clark, Roger	Monumental City Medical Society
Cornelius, Llewellyn	University of Maryland
Dinwiddie, Gniesha	University of Maryland
Doxzen, Erica Blue	Baltimore American Indian Center and Department of Behavioral and Community Health, School of Public Health, University of Maryland College Park
Dreyfuss, Moshe	Government
Edwards, Willarda	National Medical Association
Finigan, Nadine	Ruth Young Center - School of Social Work, University of Maryland, Baltimore
Garza, Mary	
Griffith, Melony Ghee	Maryland House of Delegates

Henson, Sonya	
Hiner, Kimberly	Maryland Office of Minority Health and Health Disparities
Hussein, Carlessia	Maryland Office of Minority Health and Health Disparities
Jackson Bowen, Darlene	University of Maryland Eastern Shore
Jacobs, Donna	Government and Regulatory Affairs, University of Maryland Medical System
Kick, Sandy	Maryland Women's Coalition for Health Care Reform
Lee, Candace	
Loubert, Linda	Morgan State University
Mann, David (Staff)	Maryland Office of Minority Health and Health Disparities
Mix, Aisha K.	
Nathan Pulliam, Shirley	Maryland General Assembly
O'Connor, Mary	Governor's Workforce Investment Board
Opoku, Efua	Health Leads
Otto, Natasha	Morgan State University
Pesquera, Marcos	Adventist Health Care, Center for Health Disparities
Powell, Lauren	NIH- National Cancer Institute, Division of Cancer Treatment and Diagnosis, Office of the Director
Rajakannan	Department of PHSR, School of Pharmacy UMB
Robinson, Allison	University of Maryland School of Medicine, Office of Policy and Planning
Ross, Wilhelmina	WESTAT
Sahlu, Ida	
Sam, Tanyka	Johns Hopkins School of Medicine
Santiago, Nitza	Lifebridge Health Inc
Schlimm, Donald	Baltimore County Local Management Board
Scott, Jacqueline R.	National Academy for State Health Policy

Scott, Michael	Equity Matters
Senesie, Jattu	
Sheikhhattari, Payam	Morgan State University
Silver, Gillian	Morgan State University
Smedley, Brian (Vice-Chair)	Health Policy Institute, Joint Center for Political and Economic Studies
Smith, Camille	
Terry, Tequila	Maryland Health Benefit Exchange
Thomas, Stephen (Chair)	Maryland Center for Health Equity, University of Maryland School of Public Health
Tschudy, Megan	Johns Hopkins - Pediatrics, Hamet Lane Clinic
Warren, Nicolette	Society for Public Health Education
Weeks, Kristina	Armstrong Institute
Williams, Ralph	Access to Wholistic and Productive Living Inc.
Wilson, Cheri	Johns Hopkins Bloomberg School of Public Health/Hopkins Center for Health Disparities
Wilson, Patty	Johns Hopkins University School of Nursing working in the Community/Public Health Department
Wright, Jennifer	
Young, Pamela	Sinai Hospital of Baltimore
Zambrana, Ruth	University of Maryland College Park
Zito, Julie	University of Maryland, Baltimore