

# Health Equity ACTION BRIEF

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### **>>>>**

## Race, Ethnicity, and Language

Health disparities, due to differences in race, ethnicity, or language (REL), can lead to preventable hospital readmissions, reduced quality of care, and higher costs. Understanding medication use and health outcomes by REL can help managed care advise internal leadership and develop interventions that address REL inequities among health plan members.

## CALL TO ACTION

- Develop comprehensive standards for REL data collection specific for subpopulations and ethnicity.
- Include REL in the standard member file to enable operational integration across pharmacy claims, member relations, and other data centers.
- Augment REL data with algorithms to provide a more complete view of REL data.
- Build trust with plan members by explaining why the plan collects REL data and how the health plan will use this information.
- □ Enable members to opt-out of information collection rather than opt-in.
- Stratify medication use and quality measures by race, ethnicity, and language to identify gaps in care.

## WHY THIS MATTERS

Inconsistent and incomplete REL data can lead to missed opportunities to provide appropriate care. Improving REL data collection and assessment can help plans understand their members' unique needs, develop targeted initiatives, and customize interventions.

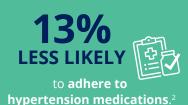
Compared to whites, Blacks/African Americans were



to be **prescribed opioids** for pain.<sup>1</sup>



Compared to non-Hispanic whites, Mexican Americans were



Compared to English-speaking Latinos, **limited English proficiency Latino patients** were

> 16% LESS LIKELY

to adhere to oral diabetes medication.<sup>3</sup>

### **Existing Standards**

The US Department of Health and Human Services (HHS) does not mandate the collection of REL data. Two standards are used widely, the US Office of Management and Budget (OMB) and the HHS standards. The OMB standards have five classifications of race and one option for ethnicity.<sup>8, 9</sup> In contrast, the 2011 HHS standards include 14 race options, three options for ethnicity, and a question to measure English proficiency. Some states and organizations have additional guidance on racial subcategories, such as Oregon.<sup>10</sup>



### What is the member's ethnicity or racial identity? Check all that apply.

American Indian or Alaska Native	<ul> <li>American Indian</li> <li>Alaska Native</li> <li>Canadian Inuit, Metis,</li> <li>Indigenous Mexican,</li> <li>First Nation</li> <li>Central American, South American</li> </ul>
Asian	□ Chinese □ Vietnamese □ Korean □ Hmong □ Laotian □ Filipino/a □ Japanese □ South Asian □ Asian Indian □ Other Asian
Black or African American	🗆 African American 🗆 African (black) 🗆 Caribbean 🗆 Other Black
Hispanic or Latino/a	Mexican     Central American     South American     Other Hispanic/Latino
Native Hawaiian or Pacific Islander	□ Native Hawaiian  □ Guamanian or Chamorro  □ Samoan □ Micronesian  □ Tongan  □ Other Pacific Islander
White	□ Western European □ Eastern European □ Slavic Middle Eastern □ Northern African □ Other White
Other	Unknown Decline to Answer

If more than one ethnic or racial identity is chosen, please CIRCLE the one that best represents this person's primary identity.

### **REL Data Sources Used by Health Plans**

- REL data is commonly collected through claims data or plan enrollment forms. It may be collected in case
  management programs, health risk assessments, patient experience surveys, electronic medical records, or transfer
  of clinical information. This data is not always easily transferable between health plans and health systems.<sup>4, 5, 7, 9, 11, 12</sup>
- REL data can be augmented with geocoding software based on US-Census data, surname recognition software, and private data collection organizations.<sup>4, 5, 7, 9, 11, 12</sup>

# Challenges and Opportunities to Improve the Collection, Analysis, and Use of REL Data



### CHALLENGE

Plan members can be reluctant to provide REL data due to mistrust related to the historical use of REL data or unclear reasons to collect this data.<sup>5, 6, 7, 11</sup>



### **OPPORTUNITIES**

- Include standard language regarding why REL data are collected and how it will be used.
   Information should be available in multiple languages and publicly.
- Facilitate member trust by using community navigators and other health care advocates to assist members with health plan enrollment.

## CHALLENGE

Federal guidance on the collection of REL data varies widely. OMB REL standards are not comprehensive and do not include guidance on collecting language data.<sup>5, 6, 7, 11</sup>

### OPPORTUNITIES

- Utilize HHS standards to collect REL data, at minimum.
- Partner with other organizations to develop more inclusive national, universal data standards for REL.

# Challenges and Opportunities to Improve the Collection, Analysis, and Use of REL Data



### CHALLENGE

REL data are not often comprehensive or complete. Demographic data are most frequently self-reported and optional.<sup>5, 6, 7, 11</sup>

Data collected may not be easily accessible throughout the health care system (e.g., enroll-

health record data) due to a lack of interoperability of the platforms.<sup>5, 6, 7, 11</sup>

ment, claims, prior authorization, or electronic

### CHALLENGE



### **OPPORTUNITIES**

 Allow REL data collection are an "opt-out" rather than an "opt-in" feature to increase data completeness.

### OPPORTUNITIES

 Integrate REL data and the provenance of this data into health plan databases and systems.

### How Managed Care Pharmacy Organizations are Addressing REL Inequities



Blue Cross Blue Shield of Massachusetts: To identify racial disparities among plan members, 48 quality measures were stratified by race and ethnicity and shared publicly. In 2023, equity measures will be incorporated into clinician contracts and payment programs.<sup>13</sup>



# Michigan Department of Health and Human Services:

To track equity outcomes, Michigan publishes an annual Healthcare Effectiveness Data and Information Set (HEDIS) health equity report where measures are stratified by race and ethnicity. Managed care contracts include a **performance bonus for improving rates for five measures among specific race/ethnicity categories**.<sup>14</sup>



New York State of Health: New York made changes to the 2022 Marketplace enrollment application and **reduced missing** race and ethnicity data by 45%. Changes included an explanation of how the collected information will be used, new categories for race, new subcategories for applicants who identify as Hispanic, Latin(o/a/x), or of Spanish origin, mandatory responses with options for "don't know" or "choose not to answer," and education and sample scripts for enrollment assisters and brokers.<sup>15</sup>

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