Race, Ethnicity, Language and Disability (REALD) Data, Health Equity and CCO 2.0

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Oregon Health Authority

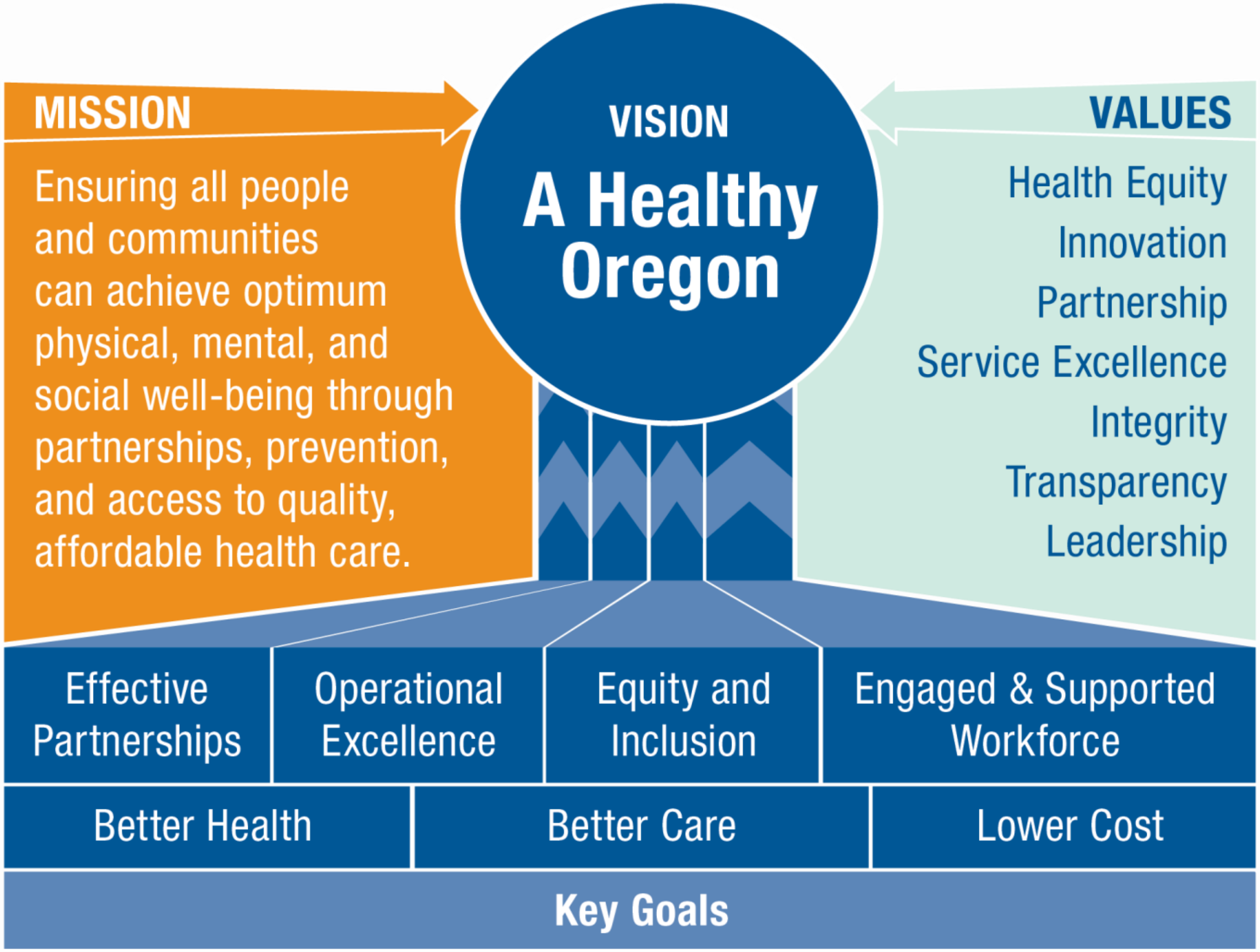
Presentation Overview

- Health Equity Is the Goal
- Collecting REALD Data – Current Systems and Challenges
- Strategies to Address REALD Data Collection Challenges
- Measuring Performance in the Medicaid Program
  - Health Equity Measurement workgroup

The Triple Aim Vision for Oregon

1. Better health
2. Better care
3. Lower costs

OHA Performance System



MISSION

Ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

VISION

A Healthy Oregon

VALUES

Health Equity
Innovation
Partnership
Service Excellence
Integrity
Transparency
Leadership

Effective Partnerships
Operational Excellence
Equity and Inclusion
Engaged & Supported Workforce

Better Health
Better Care
Lower Cost

Key Goals

Oregon Health Authority

Health Equity is the Goal

OHA's Mission is to ensure **all people and communities** can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality affordable health care.

- Addressing social determinants of health and health equity is a cornerstone of CCO 2.0.
- Culturally and linguistically appropriate services are key elements in the work of eliminating health disparities and advancing health equity.
- Data collection and analysis are key tools for improving the health and well-being of a population and should be considered with other strategies.

Data Systems: Oregon Eligibility and MMIS

- Data is collected in the Oregon Eligibility (ONE) system
  - Information is collected from individuals through the Applicant Portal, the Worker Portal and referrals from the federal Marketplace
  - This data is then transferred into the Medicaid Management Information System (MMIS) system

- Data from the ONE system flows into the MMIS system
  - MMIS is the system used by providers and plans to confirm an individuals’ information, eligibility and benefit level, for claims submission/reimbursement

REALD Requirements

- In 2013, the Legislature passed HB 2134, directing DHS and OHA to improve how race, ethnicity, language, and disability (REALD) demographics are collected.

- OHA Office of Equity and Inclusion (OEI) developed the REALD data collection standards in collaboration with internal and external stakeholders and researchers.

- REALD includes a set of standardized data categories and questions that OHA and DHS datasets, as well as data collected by contractors of OHA and DHS, are required to collect.

REALD Data Collection Implementation Timeline

Prior to 2014

Race and ethnicity information collected through interview or paper application; Detailed disability and language information was not collected from OHP applicants

2014

Race and ethnicity information was collected through the paper application only

2016

ONE Applicant Portal was launched

2017

ONE system and MMIS was upgraded to collect race, ethnicity and disability information that aligned with REALD requirements

2019

An updated OHP paper application, aligned with REALD, will be released in December

Current Status & Challenges for REALD Data Collection

- Depending on the metric, roughly 40 to 45% of MMIS records are missing information about an individual's race and/or ethnicity

Key Challenges to REALD Data Collection:

- Delay in implementation of collection of REALD data
- Updated (REALD compliant) paper application for OHP has been delayed until December 2019
- Automatic renewals
- ONE system data collection design limitations
- MMIS limitations when REALD data is transferred from ONE

REALD Assessment: Summary of Preliminary Findings

- ONE system data collection design limitations:
  - Respondents were able to skip REALD questions (“Did not answer”)
  - Approx. 33% of new enrollees answered all REALD key questions

- ONE system design and protocols limitations
  - Applicants are able to skip REALD questions
  - Not answering primary race question leads to loss of other responses

- No validation protocols in place to ensure enrollees confirm responses that seem contradictory

- MMIS limitations when REALD data is transferred from ONE

Strategies to Address REALD Data Collection Challenges

- In May 2019, updates to ONE system will make REALD questions mandatory in the Applicant Portal
- Updated OHP paper application that includes all REALD questions will be released in December 2019
- DHS and OHA will identify and prioritize updates to REALD functionality after the implementation of integrated ONE
- Establish a continuous quality improvement team focusing on REALD data quality

Measuring Health Equity Performance in the Medicaid Program

There are three main data sources for Medicaid performance metrics:

- The Medicaid Management Information System (MMIS)
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
- Electronic Health Records

- Other sources include manual collection of information from health records (chart reviews) or reports compiled by the CCOs.

Other Sources for Race & Ethnicity Data

- Many OHA surveys contain self-reported race and ethnicity data, although they are not yet REALD compliant:
  - Oregon Health Insurance Survey (OHIS)
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - Consumer Assessment of Healthcare Providers & Systems (CAHPS)
  - Oregon Healthy Teens (OHT)/Student Wellness Survey (SWS)
- Limitations of survey data:
  - There can be too few respondents in population groups of interest for data to be reportable, even with oversampling.
  - Surveys are not connected with administrative data such as eligibility, claims, electronic health records, etc.

Most metrics used to track Medicaid system performance are from MMIS data

- This includes:
  - Data collected during enrollment: demographics, data used to determine eligibility, and eligibility status, which is not standardized nationally
  - Data collected as a result of services delivered (claims or encounters) is standardized based on national specifications

- REALD data has to be adjusted for HIPAA compliance in MMIS to meet federal requirements

- The main function of MMIS is accurately tracking eligibility and paying claims; it was not designed to track performance

The Health Equity Measurement Workgroup

- The Health Equity Measurement Workgroup (HEMW) began meeting in October 2018 to develop performance metrics to address health equity and disparities.

- Chaired by the Director of OEI and the Director of Health Analytics, its nine members are comprised of representatives from: the Health Equity Committee (a subcommittee to the OHPB), Public Health Advisory Board (PHAB), Metrics & Scoring and OHA.

Health Equity Measurement Workgroup Approach

- After exploring the background and past work, the group decided to take a step back and approach solutions from a new perspective:
  - Develop a measure less reliant upon systems with inherent data collection problems associated with REALD
  - Continue working to develop measures that rely on traditional data sources such as MMIS but would allow for updates to that system

Establishing a Foundational Health Equity Metric: Interpretation Services

This foundational metric focuses on ensuring interpretation services for individuals with limited English proficiency.

- Research has demonstrated that for any organization to take effective action on health equity it must first establish infrastructure to address disparities.
- Quality, accessible and meaningful interpretation services has been identified by OHP members, advocates, and health equity stakeholders as important to advancing equitable care.

Next Steps: Establishing a Health Equity Outcome Metric

- The HEMW's next task will be to explore outcome metrics based on data available through standardized systems such as MMIS, which are appropriate for use as incentive measures.
- On target to be ready for 2020 implementation.

Oregon Health Authority

There is still a lot of work to do.

- While we are taking targeted steps to improve REALD data collection in our systems and working to develop innovative metrics to address health equity CCO 2.0, this works takes time

- Health equity work requires long term solutions and strategies

- This work requires a continued shift in our culture, paradigm and systems