

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADVISORY COMMITTEE ON MINORITY HEALTH**

**Hubert H. Humphrey Building
Washington, D.C., 20201**

February 12- 13, 2015

Committee Attendees

Roderick K. King, MD, MPH, FAAP (Chair)
Arthur Chen, MD
B. Ashleigh Guadagnolo, MD, MPH
Paul Juarez, PhD
Beverly L. Malone, PhD, RN, FAAN
Sela V. Panapasa, PhD
Rea Pañares, MHS
Roland J. Thorpe, Jr., PhD

Federal Staff

J. Nadine Gracia, MD, MSCE, Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services
Rashida Dorsey, PhD, MPH, Director, Division of Policy and Data, Office of Minority Health, U.S. Department of Health and Human Services (Designated Federal Officer, ACMH)
Minh Wendt, PhD, Public Health Advisor, Division of Policy and Data, Office of Minority Health, U.S. Department of Health and Human Services (Alternate Designated Federal Officer, ACMH)

Invited Presenters

Lisa Clemans-Cope, PhD, Senior Research Associate, Health Economist, Urban Institute
Karen B. DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health, U. S. Department of Health and Human Services
Sandra Lynne Fryhofer, Director of Delivery System Reform, Office of Health Reform, U. S. Department of Health and Human Services
Paul E. Jarris, MD, MBA, Executive Director, Association of State and Territorial Health Officials
Monica Valdes Lupi, JD, MPH, Chief Program Officer, Health System Transformation, Association of State and Territorial Health Officials
Hyon B. Shin, MA, Chief, Racial Statistics Branch, U.S. Census Bureau

Day One – Thursday February 12, 2015

My Brother’s Keeper Community Challenge White House National Convening

(via live streaming)

- Valerie Jarrett, Senior Advisor to the President
- Eric Holder, U.S. Attorney General

Committee members watched the opening remarks of the My Brother’s Keeper (MBK) Community Challenge White House National Convening. Dr. Gracia represented the Department of Health and Human Services (HHS) in her capacity as the HHS designee on the MBK Task Force.

Call to Order, Welcome, and Introductions

- Roderick K. King, MD, MPH, Chair

Dr. King welcomed committee members and staff, outlined the key topics for the meeting, and invited committee members to introduce themselves.

Dr. King reviewed the agenda for the meeting and described how it was developed.

Health Care Delivery System Reform

- Karen B. DeSalvo, MD, MPH, MSc, Acting Assistant Secretary for Health, U. S. Department of Health and Human Services
- Sandra Lynne Fryhofer, Director of Delivery System Reform, Office of Health Reform, U. S. Department of Health and Human Services

Dr. DeSalvo described the HHS vision for improving health delivery (better care, smarter spending, and healthier people) and presented the framework to achieve that vision:

- Incentives
 - Promote value-based payment systems
 - Test new alternative payment models
 - Increase linkage of Medicaid, Medicare Fee-for-Service (FFS), and other payments to value.
 - Bring proven payment models to scale
- Care delivery
 - Encourage the integration and coordination of clinical care services
 - Improve population health
 - Promote patient engagement through shared decision-making
- Information
 - Create transparency on cost and quality information
 - Bring electronic health information to the point of care for meaningful use
 - Interoperability of health information technology systems
 - Electronic decision support tools for patients

This framework enables HHS to set clear goals and expectations and a well-defined roadmap to achieve them, including collaboration with the private sector.

Ms. Fryhofer described how HHS would implement delivery system reform. She noted that Secretary Burwell charged Dr. DeSalvo, the Director of the Center for Medicare and Medicaid Innovation (CMMI), and the Director of the Office of Health Reform with coordinating this effort across the Department and obtaining feedback from experts and stakeholders.

Dr. DeSalvo and Ms. Fryhofer reviewed key developments and announcements:

- Incentives
 - On January 26, 2015 Secretary Burwell announced measurable goals and a timeline for the Medicare program and the health care system to implement alternative payment models and value-based payments.
 - Alternative Payment Models: 30 percent of Medicaid payments are tied to quality or value by alternative payment models by 2016, and 50 percent by the end of 2018 (the current rate is 20 percent)
 - Linking FFS Payments to Quality/Value: 85 percent of all Medicare FFS payments are tied to quality or value by 2016, and 90 percent by the end of 2018
 - Categories of payment types:
 - Category 1: FFS, no link to quality
 - Category 2: FFS, link to quality
 - Category 3: Alternative payment models build on FFS architecture
 - Category 4: Population-based payment
 - HHS created a national Health Care Payment Learning and Action Network to foster collaboration between providers, private payors, and others to develop a methodology to achieve the goals and to clarify quality measures.
 - Testing of the Pioneer Accountable Care Organization (ACO) model has shown promising results, including significant improvements against national benchmarks for 15 quality and patient experience measures.
 - HHS used its rule-making authority to require health insurance plans to identify their quality improvement plans in order to participate in the marketplace and will soon require them to share their reimbursement models.
 - CMMI recently announced new State Innovation Model (SIM) grantees. More than half of the states are now involved, representing 60 percent of the population.
- Care Delivery
 - The Transforming Clinical Practice Initiative announced in October 2014 provides more than \$800 million to support the development of Practice Transformation Networks and Support and Alignment Networks (<http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/>). Awards will be announced in the near future.
 - Hospital-acquired infections were reduced by 17 percent from 2010 to 2013. This decrease aligned with the creation of the Partnership for Patients program and the Hospital Engagement Networks, which provided opportunities for hospitals to share best practices on how to reduce patient harm and improve care transition.
- Information
 - The Office of the National Coordinator for Health IT announced a draft Interoperability Roadmap that addresses technical requirements, engagement and

governance, regulatory environments, and privacy and security protections for health information. Public comments were accepted through April 3, 2015 (<http://www.healthit.gov/policy-researchers-implementers/interoperability>).

Dr. DeSalvo noted that delivery system reform involves all agencies of HHS. It does not require new legislation or new funds. Secretary Burwell is committed to achieving this vision, and HHS is counting on feedback from the committee as they roll out the framework.

Questions and Answers

1. *Dr. Guadagnolo asked what mechanism was available to facilitate integration of best practices for payment into the Indian Health Services (IHS).*
 - Dr. DeSalvo replied that the IHS has developed many of its own payment systems and care models, including effective models for diabetes care. These models could inform the rules for the ACO model and Medicaid. She noted that the Medicaid Innovation Accelerator uses examples from various states to help states develop their own care models and payment systems.
2. *Dr. Guadagnolo asked whether there were any efforts to standardize Medicaid data, which are currently very difficult for researchers to use.*
 - Dr. DeSalvo acknowledged the importance of standardizing data in order to understand how decisions are impacting populations. She stated that the Medicaid Innovation Accelerator encourages states to move toward the standards developed for the Interoperability Roadmap.
3. *Dr. Juarez noted that significant progress had been made in health care, with limited progress in population health or health disparities. He asked if the National Healthcare Quality Report and the National Healthcare Disparities Report were helping to guide the discussion and whether community health workers (CHWs) were included in payment models.*
 - Dr. DeSalvo replied that some of the successful models would pay for population care instead of outcomes. Most of those models include some form of peer support or outreach, such as CHWs. The primary care demonstrations have used community networking. HHS would prefer to focus on outcomes, without being prescriptive regarding what a health care delivery team should include. The workforce issues are critical, including certification and licensure and the ability to work across state lines, where appropriate. States must be involved in these discussions. The Health Resources and Services Administration (HRSA) is doing important work in this area.
 - Ms. Fryhofer added that CMMI funded some demonstration projects that were looking at the role of CHWs. The results from those investments will help to inform the development of other models.
4. *Dr. Chen asked whether HHS accounts for the fact that interventions are ongoing when they use cost data to determine whether a population is at risk.*
 - Ms. Fryhofer noted that stakeholders expressed similar concerns, and a law passed in 2014 charged HHS with looking at this issue. The Assistant Secretary for Planning and Evaluation was looking at how to use Medicaid data from existing programs and payment models to determine how care models could take that into account. The work was just beginning, and they would welcome recommendations.

- Dr. DeSalvo added that HHS was taking that issue into consideration when renewing ACO contracts. She offered to provide more information regarding that effort.

OMH Welcome and Updates

- J. Nadine Gracia, MD, MSCE, Deputy Assistant Secretary for Minority Health, U. S. Department of Health and Human Services

Dr. Gracia welcomed committee members and provided an update on Office of Minority Health (OMH) activities:

- OMH staff: The OMH leadership team has two new members: Deputy Director, Carol Jimenez, and Senior Advisor to the Deputy Assistant Secretary for Minority Health, Alexis Bakos.
- Affordable Care Act: The OMH Communications Director is actively engaged in outreach to minority media and communities of color, and OMH is supporting the Centers for Medicare & Medicaid Services (CMS) on the Coverage to Care initiative.
- My Brother's Keeper: The MBK Community Challenge was launched in September 2014. Local elected officials and tribal leaders around the country have formally accepted the challenge and have convened local action summits to identify issues and develop action plans. The implementation phase has three anchors: policy, place, and private sector. MBK has received significant commitments from the private sector and foundations. Committee members can get involved in local efforts through the "Allies" link at www.mbkchallenge.org. The MBK Task Force will present its first-year progress report to the president in the near future.
- Minority Youth Violence Prevention: OMH launched a new grant program in partnership with Department of Justice (DOJ) Office of Community-Oriented Policing Services. The program is funding nine demonstration sites across the country that are developing innovative strategies to reduce youth violence through collaboration between law enforcement and public health.
- National Partnership for Action to End Health Disparities: The Regional Health Equity Councils are supporting Affordable Care Act outreach and enrollment. The Federal Interagency Health Equity Team (FIHET) is conducting a series of webinars highlighting innovative models to advance equity in all policies and all sectors.
- 30th Anniversary of the Report of the Secretary's Task Force on Black and Minority Health (Heckler Report): OMH will host a national event during Minority Health Month (April) to commemorate this anniversary. The event will highlight the progress that has been made and the work that remains to be done.
- ACMH deliverables: The committee's reports on foster care and the safety net are still under review.

Discussion

1. *Dr. Thorpe asked if events to commemorate the anniversary of the Heckler Report would occur throughout the year.*
 - Dr. Gracia replied that OMH will host a key event in April and will support additional events throughout the year. OMH will provide updates to the committee regarding the schedule of events.

2. *Dr. Juarez noted that the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (CDC) had been funding research on youth violence prevention for many years and asked if OMH was working with them.*

- Dr. Gracia stated that CDC has been involving with technical assistance for the grantees.

Health Care Delivery System Reform (continued)

- Paul E. Jarris, MD, MBA, Executive Director, Association of State and Territorial Health Officials (ASTHO)
- Monica Valdes Lupi, JD, MPH, Chief Program Officer, Health System Transformation, ASTHO

Dr. Jarris and Ms. Lupi provided an overview of ASTHO's activities and positions related to delivery system reform. Key points were as follows:

- ASTHO is moving toward a focus on health equity. Access to health insurance is an important first step, but it is important to look at enrollment data disaggregated by income, race, and ethnicity. The greatest decline in uninsured rates during the first open enrollment period was among young adults, low-income adults, and Latinos. The decline in uninsured rates among African Americans was minimal.
- The U.S. spends more per person on health care than other developed nations, yet it has a lower life expectancy. ASTHO is working with HRSA to address significant geographic disparities in life expectancy and infant mortality in the U.S.
- Social and economic factors represent 40 percent of the determinants of health, with high school education the biggest marker of health outcomes.
- National Prevention Strategy: ASTHO convenes cross-sector meetings on a regular basis and hopes the new Surgeon General will embrace this approach.
- Electronic health records: ASTHO advocates for the need to create registries and improve the transparency of data and for the use of geo-coding to identify areas of risk.
- Community Health Needs Assessments (CHNAs): Final rules issued by the Internal Revenue Service require non-profit hospitals to work with state offices of public health in conducting CHNAs, but they do not require community engagement in priority setting, planning, or implementation. ASTHO sees the lack of community engagement as a major equity issue. Some organizations are working on including those requirements through the state rule-making process.
- Aligning resources for assessments: Hospitals, health departments, community agencies, and financial institutions conduct numerous types of needs assessments. ASTHO is engaged in efforts identify opportunities for partnerships and resource alignment.
- Public health accreditation: Seven state health departments have obtained public health accreditation, 22 are in the pipeline, and two tribal health authorities are going through the process.
- CHWs: Several states have introduced certification standards for CHWs. OMH participates in an interagency task force on CHWs, and new CMS rules support reimbursement for CHWs.
- The ASTHO website has resources on health equity, health in all policies, and CHNAs (<http://www.astho.org>) plus a wiki on SIMs (<http://www.astho-sim.wikispaces.com/>).

Questions and Answers

1. *Dr. Guadagnolo requested more information on CMS rules on CHWs and clarification regarding the distinction between CHWs and patient navigators.*
 - Ms. Lupi stated the new CMS rule allows reimbursement for non-clinical prevention services. To date, this mechanism has not been incorporated in any state plan amendments. Parallel processes have emerged, such as certification programs. There is some concern that over-professionalizing the workforce could create barriers.
2. *Ms. Pañares asked to what extent SIM grantees were addressing upstream factors, what gaps existed, and which states were more innovative.*
 - Ms. Lupi replied that one state created an Office of Health Transformation. The second round of grants required states to develop a population health plan. Some of those plans focus on chronic disease prevention, some are tied to state health improvement plans, and some include tobacco cessation or maternal and child health. Iowa is a testing state and specifically identified the social determinants of health as one of their strategies. Tennessee will co-host a public health conclave with CDC. Washington, Oregon, and Minnesota are looking at accountable communities of care and accountable communities of health. ASTHO is creating an online resource library with information on SIM grants that includes six case studies across multiple themes. Colorado is using that resource to identify behavioral health examples for its SIM grant.
3. *Dr. Panapasa appreciated the recognition of data limitations associated with Electronic Health Records (EHRs), and she stated that emerging efforts related to “big data” were a potential avenue to address existing data limitations and link biological health measures with social and health measures. She asked about the extent to which CHNAs are able to provide meaningful data on their populations. She also asked where the territories would fall in the discussion of equity, in the absence of baseline data, and she noted that there was some discussion of bringing the National Health Information Survey to the territories.*
 - Dr. Jarris stated that there are many issues related to data. Public health agencies collect survey data, while clinical medicine collects individual patient data. National level data are not available at the Zip code level. Initiatives that use data to drive action, such as the Million Hearts campaign, are willing to make do with currently available data. ASTHO wants to move toward more real-time data, even if it is not ideal, rather than waiting for historic data. Other issues include the availability of identifiable versus de-identified data and the challenge of sharing data across states that have different standards.
4. *Dr. Juarez stated that health data should incorporate a lifespan approach in addition to clinical data and noted the need for guidance on how to implement population health. He asked about the status of a systematic nomenclature for EHR.*
 - Dr. Jarris stated that it was difficult to get population health measures incorporated into meaningful use. Many EHR systems were developed to improve billing, and the market does not currently support incorporating public health aspects.
5. *Dr. Chen asked Dr. Jarris to share his impression of the efforts of the Association for Community Health Improvement to support innovative approaches.*
 - Dr. Jarris replied that it is important for associations to find innovators among their membership and make them champions.
 - Ms. Lupi stated CDC would be rolling out a community health improvement navigator. National associations were involved in a demonstration project. ASTHO pushed for the tool to go beyond disparities and include health equity.

Census Bureau Minority Health Data

- Hyon B. Shin, MA, Chief, Racial Statistics Branch, U.S. Census Bureau
- Lisa Clemans-Cope, PhD, Senior Research Associate, Health Economist, Urban Institute

Dr. Shin described the 2010 Census Alternative Questionnaire Experiment (AQE) that compared two questionnaire strategies: separate questions for race and ethnicity, which is the existing format, and a combined question. Data were obtained through forms mailed to about 500,000 households; telephone re-interviews with about 20 percent of those households; and 67 focus groups across the country.

The goals of the AQE were to increase reporting of race and ethnicity, as defined by the Office of Management and Budget (OMB); decrease non-response; increase the accuracy and reliability of results; and elicit detailed responses for all categories.

Major findings for the combined question were as follows:

- Combining race and Hispanic origin into one question did not change the proportion of Hispanics, Blacks, American Indians and Alaska Natives (AI/AN), Asians, or Native Hawaiians or other Pacific Islanders;
- Fewer respondents selected “Some Other Race”;
- “White” responses dropped to levels that reflect the white, non-Hispanic population;
- Lowered item non-response rates;
- Increased detailed reporting for most groups, but decreased reporting for other groups;
- Re-interview respondents felt the questions better reflected their self-identity; and
- Focus group respondents felt the combined question offered fair, equitable treatment for all groups.

The Census Bureau is conducting mid-decade research that includes four key dimensions:

- Separate versus combined questions;
- Creation of a new “Middle Eastern or North African” (MENA) category;
- Revision of instructions and terminology to optimize responses; and
- Web-based designs to improve question understanding and optimize reporting of detailed racial and ethnic groups.

Dr. Clemans-Cope described how Census data are used in research, using the example of an analysis of projected changes in uninsured rates under the Affordable Care Act (<http://www.urban.org/publications/2000046.html>). The study merged three years of data from the American Community Survey (ACS) to create 2016 coverage projections for five major racial and ethnic groups under three scenarios (baseline without the Affordable Care Act; Affordable Care Act with current Medicaid expansion decisions; Affordable Care Act with all states expanding Medicaid). The study predicted that uninsured rates will drop for all groups, in all scenarios. An unexpected finding was that a high share of blacks will remain uninsured in states that are not expanding Medicaid.

Nearly 75 percent of the AI/AN population included in the ACS reported either no tribal affiliation or multiple races/ethnicities. The Urban Institute’s projections only included individuals who reported a sole tribal affiliation and no other race or ethnicity. This led to underreporting for individual tribes.

Dr. Clemans-Cope stated that most researchers discard “Other Race” responses. The proposed changes to the Census questions would help to minimize that problem.

Dr. Clemans-Cope noted that determining which hierarchy to use when respondents check multiple categories has a major impact on results. That issue is under researched, and it would be helpful to have strong recommendations in this area. Currently, individual researchers make their own determination regarding the hierarchy of data.

Questions and Answers

1. *Dr. Thorpe asked what federal agencies are responsible for statistics.*
 - Ms. Shin stated that the federal statistical agencies are the National Center for Education Statistics and National Center for Health Statistics
2. *Dr. Chen asked how individuals who check multiple entries would be categorized.*
 - Ms. Shin stated that the comparison would be at the level of detailed reporting. Tabulation includes an “Alone” category for individuals who only select one category.
3. *Dr. Juarez asked Ms. Shin to clarify the underlying goal of developing a new MENA category.*
 - Ms. Shin replied that seven percent of respondents to the 2010 census and the separate question version of the AQE checked “Some Other Race,” which made it the third largest group, after white and black. “Some Other Race” does not provide sufficient nuance for many data users. The combined question reduced the number of respondents who selected that category to less than half a percent.
4. *Dr. Malone supported Dr. Clemans-Cope’s call for direction regarding data hierarchies.*
 - Dr. Clemans-Cope reiterated the importance of developing a gold standard in this area that all researchers would follow.
 - Ms. Shin noted that the Census Bureau’s mission is to provide high quality, timely data. She would not want to develop a policy that might skew the work of external researchers.
5. *Dr. Juarez expressed concern that Hispanic or Latino origin currently falls under the “white” category. He noted that the categories in the combined question include race, ethnicity, and nationality, which could be confusing*
 - Ms. Shin stated that the wording of the separate question format reflects the understanding that Hispanics can be of any race. The wording of the combined question was intended to help people find the categories that most accurately reflect their identity. The Census Bureau is trying to elicit the most detailed and accurate information possible, within the parameters of the current OMB definitions.
6. *Dr. Chen asked if there had been any discussion about quantifying the data, which could have implications for policy decisions.*
 - Ms. Shin replied that the Census Bureau did not currently have a plan to quantify the data. The goal is to increase response and decrease item non-response. The re-interview component of the AQE was designed to determine the accuracy of self-reporting.

7. *Dr. Guadagnolo observed that Medicaid data are difficult to use and are often incomplete. She asked whether Medicaid claim files would be available for researchers.*
 - Dr. Clemans-Cope stated that the Urban Institute uses research-quality Medicaid data, but those files are extremely large. She noted that Medicaid was planning to roll out a more complete file that would include data on encounters and spending in managed care. However, the race and ethnicity data are difficult to benchmark and should be researched.
8. *Dr. Panapasa noted that the Census Bureau does not have a way to verify or quantify self-reported data. It would be helpful to try to standardize data collection in order to obtain comparable data. She noted that the new level of granularity had the potential to inform sampling design.*
 - Ms. Shin agreed that individuals should be able to respond according to how they identify themselves. However, there is a need for guidance for multiple reporting.
 - Dr. Clemans-Cope stated that researchers are looking for an authoritative body to lead the effort to establish a consensus about categorization. That effort should include the Institute of Medicine, the State Health Access Data Assistance Center, and researchers. If the ACMH were to lead that effort, it would be well received.

Committee Business

- Roderick K. King, MD, MPH, Chair

Committee members discussed the Data Subcommittee; the status of committee products and deliverables; and issues that emerged from the presentations.

Data Subcommittee Update and Discussion

Dr. Thorpe noted that the idea of forming a Data Subcommittee emerged during the July 2014 meeting and became more formal during the November conference call.

The proposed charge for the Data Subcommittee was to:

- Conduct an inventory of datasets within HHS and other federal agencies that provide useful information related to the health of racial and ethnic minority populations
- Provide recommendations on approaches to better assess the health of racial/ethnic minorities and to link health, ecological, and administrative data at a local level.

Proposed areas of work include:

- Data disaggregation and improving data on hard-to-survey racial and ethnic minority populations; and
- Methods that enable the use of health data on small geographic areas.

Dr. Thorpe stated that the working group would draft a memo for review by the full committee.

ACMH Products and Deliverables

Dr. King noted that the committee wanted to develop a clear process for developing products. To assist in that discussion, OMH provided examples of various types of deliverables generated by ACMH and other federal advisory committees (i.e., letter, memo, and report).

Dr. Dorsey stated that deliverables are products of the committee. She and Dr. Wendt would vet all committee products for review by Dr. Gracia and would assist with dissemination. The final version of all committee products are posted on the OMH website, as required by the charter. OMH would also consider other avenues of dissemination, such as *Public Health Review*.

Dr. King noted that the review and approval process was longer for more complex products.

Public Comment

Dr. King opened the floor for public comment.

Erin Board introduced herself as a medical student from West Virginia working with immigrant and refugee populations at a community health center. She raised the following points:

- The advisory committee is focused on minority health, yet racial and ethnic minorities will soon become the majority in this country.
- West Virginia has few racial minorities, but it has a significant amount of poverty, which contributes to health disparities.
- Health system reform pilot projects are not located in states that are experiencing high levels of health disparities. The advisory committee should make a recommendation to address that issue.

Dr. Dorsey clarified that the advisory committee was established to serve OMH and the four racial and ethnic populations it is mandated to serve (African Americans; Latinos; American Indians and Alaska Natives; and Asian Americans, Native Hawaiians, and Pacific Islanders).

Dr. King thanked Ms. Board for her comments and assured her that committee members were aware of the impact of poverty and the social determinants of health on health disparities.

Adjourn

The meeting was adjourned for the day at 4:36 p.m.

Day Two – Friday February 13, 2015

Call to Order and Remarks

- Roderick K. King, MD, MPH, Chair

Dr. King called the meeting to order and invited committee members, OMH staff, and invited guests to introduce themselves.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: Setting the Research Agenda

- Rashida Dorsey, PhD, MPH, Director, Division of Policy and Data, Office of Minority Health, U.S. Department of Health and Human Services

Dr. Dorsey provided an overview of the National CLAS Standards and the research agenda for those standards. Key points were as follows:

- Culturally and linguistically appropriate services are respectful of and responsive to cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs. They are employed by all members of an organization, regardless of size, at every point of contact.
- The National CLAS Standards were developed by OMH in 2000 to provide a framework for health care organizations to best serve diverse communities. In 2013, OMH released the enhanced National CLAS Standards. Notable changes were as follows:

Expanded Standards	National CLAS Standards 2000	National CLAS Standards 2013
Culture	Defined in terms of racial, ethnic, and linguistic groups	Defined in terms of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics
Audience	Health care organizations	Health and health care organizations
Health	Definition of health was implicit	Explicit definition of health to include physical, mental, social and spiritual well-being
Recipients	Patients and consumers	Individuals and groups

- The enhanced National CLAS Standards consist of 15 standards that are organized in three thematic areas under one overarching standard:
 - Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
 - Theme 1: Governance, Leadership, and Workforce (Standards 2-4)
 - Theme 2: Communication and Language Assistance (Standards 5-8)
 - Theme 3: Engagement, Continuous Improvement, and Accountability (Standards 9-15)
- Detailed information regarding the National CLAS Standards is provided in the *Blueprint for Advancing and Sustaining CLAS Policy and Practice* (www.thinkculturalhealth.gov).
- In 2003, OMH partnered with Agency for Healthcare Research & Quality to establish a research agenda that would create an evidence base to establish the value of cultural competence in health care. The research agenda included 15 individual agendas organized into three areas: Culturally Sensitive Interventions, Language Assistance, and Organizational Support for Cultural Competence. Each research agenda included a definition of the category; a synthesis of findings in the literature; key research questions; and methodological and policy considerations influencing future research.

Dr. Dorsey stated that OMH is seeking recommendations on how to revise, update, or expand the 2003 research agenda to address research needs for the enhanced National CLAS Standards.

Key issues include:

- Several aspects of the 2003 research agenda have not been implemented.
- The enhanced standards include health, as well as health care.
- The definition of culture has been expanded.
- The field of cultural competence has grown.

Dr. Dorsey emphasized that there is still a need to build the evidence base for The National CLAS Standards, particularly for Themes 1 and 3, in order to encourage organizations to adopt the standards.

Questions and Answers

1. *Dr. Thorpe asked if OMH had issued funding opportunities for evidence-based research.*
 - Dr. Dorsey replied that OMH sponsored five large studies, including a national study of CLAS in managed care organizations, a study on cultural competency assessment tools, and a study on implementation of the National CLAS Standards at the Alameda Alliance for Health. OMH also provided resources to assist state partners in developing assessment tools. OMH would like to partner with academic researchers to incorporate the National CLAS Standards into existing studies.
2. *Ms. Pañares asked if some elements of the initial research agenda could be promoted while other elements were added or revised.*
 - Dr. Dorsey stated that the original research agenda does not need to be a totally revamped. It might be sufficient to add a new research agenda that would focus on health and revise the introduction to highlight the expanded definition of culture.
3. *Dr. King identified four areas where the committee could assist OMH:*
 - *Revamping the research agenda to reflect the enhanced National CLAS Standards.*
 - *Assistance with disseminating the research agenda.*
 - *Creating incentives for researchers to study the National CLAS Standards (e.g., integrating the National CLAS Standards into funding requirements; identifying funding sources to support research; and ensuring that grant reviewers see the National CLAS Standards as a priority).*
 - *Reframing the research agenda to include health as well as health care.*
4. *Dr. Panapasa asked whether OMH had identified the methodological and data challenges associated with the research agenda. She noted that health care and health outcomes would entail two different types of measures.*
 - Dr. Dorsey replied that the challenges were identified when the 2003 research agenda was developed. The primary data challenge was the absence of data on race, ethnicity, and language, which has since been addressed. Methodological challenges had to do with study design and recruiting participants. Dr. Dorsey noted that there is no single model for implementation of the National CLAS Standards.
5. *Dr. Juarez suggested that the research agenda should look at the implementation of the National CLAS Standards at four levels: consumers and patient educators, health care providers, health care systems, and communities.*

Dr. Dorsey stated that she would provide an update on the research agenda at the next meeting.

Committee Business

Committee members discussed administrative issues, including upcoming meetings, compensation, and the Heckler Report anniversary.

Meetings

Committee considered proposed dates for the remaining meetings in 2015:

- Face-to-face meeting: July 29-30
- Conference call: October 21.

Committee members agreed to tentatively schedule the face-to-face meeting for July 21-22. Committee members confirmed the proposed date for the conference call.

Small Group Discussions

The Committee broke into groups to discuss potential deliverables in three areas:

- CLAS research agenda;
- Census Bureau minority health data; and
- Health system transformation.

Discussion Group Reports

Health System Transformation

Overarching theme: The role of OMH in influencing the discussion of health system reform.

Key issues:

1. Reframe the enhanced National CLAS Standards as a tool to operationalize the Affordable Care Act and health system transformation
 - Charge to improve health and health care for all Americans
 - Standards 12 and 13 and form the bridge between individual health and population health
 - Support community engagement
 - Interdisciplinary teams contribute to quality care.
2. Contribute to the discussion of population and community health
 - Clarify the definition of population health
 - Different from patient management
 - Requires community engagement
 - Address the process for Community Health Needs Assessments
 - How assessments are conducted
 - How data are used

Strategies:

- Short-term: Memo framed as a way for OMH to weigh-in on the issue.
- Long-term: Formal report.

Resource needs: Technical writer (for report).

Timeline: Preliminary draft memo in April, final draft between May and July.

Census Bureau Minority Health Data

Product: Memo on Census Bureau testing of questions on race and ethnicity for the 2020 census

- Support for granularity of data
 - Implications for minority populations of having more granular data
- Include recommendation to increase funding for the ACS.

Resource needs: Technical writer for final edit of the memo.

Timeline: Draft by March 15, final draft April 15.

Public Comment

Dr. King opened the floor for public comment. No comments were offered.

Wrap up

Dr. King thanked committee members and OMH and contractor staff for a productive meeting.

Adjourn

The meeting was adjourned at 12:36 p.m.

ACTION ITEMS

WHAT	WHO	WHEN
Confirm dates for the July meeting and inform all committee members	Dr. Dorsey and Dr. Wendt	TBD
Draft a memo proposing the formation of a Data Subcommittee, for review by the full committee	Data Subcommittee working group (Dr. Thorpe, Dr. Panapasa, and Dr. Juarez)	TBD
Provide information on the FIHET inventory of federal databases on racial and ethnic populations and the National Committee on Vital and Health Statistics work on community-level data	Dr. Dorsey	TBD
Provide a copy of the CMS progress report on Medicaid data collection standards for race, ethnicity, sex, primary language, and disability status	Dr. Dorsey	TBD

