

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADVISORY COMMITTEE ON MINORITY HEALTH (ACMH)

Omni Shoreham Hotel
Washington, D.C. 20008

July 8-9, 2014

Committee Attendees

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

Federal Staff

Howard K. Koh, MD, MPH, Assistant Secretary for Health, U.S. Department of Health and Human Services
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 Campbell, Acting Director, Consumer Support Group, Centers for Medicare & Medicaid Service, U.S. Department of Health and Human Services
Cara V. James, PhD, Director, Office of Minority Health, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services
Onyemaechi Nweke, DrPH, MPH, Team Lead, National Partnership for Action to End Health Disparities, Office of Minority Health, U.S. Department of Health and Human Services
Catherine Oakar, MPH, Director of Public Health Policy, Office of Health Reform, U.S. Department of Health and Human Services
Lydia Sermons, MA, Director, Division of Information and Education, Office of Minority Health, U.S. Department of Health and Human Services

MEETING SUMMARY

TUESDAY, JULY 8, 2014

Call to Order, Welcome, and Introductions

Roderick K. King, MD, MPH, Chair

Dr. King called the meeting to order at 9:13 a.m. He noted that the Committee had many new members, it was his first meeting as Chair, and it was the first meeting for the Committee's new Designated Federal Officer (DFO), Dr. Dorsey.

Dr. King reviewed the objectives for this meeting:

Provide new Committee members with a clear understanding of the work of the Office of Minority Health (OMH) and the Department of Health and Human Services (HHS), and the ACMH's support

Highlight key HHS and White House initiatives

Identify focus areas for the Committee's work.

Dr. King reviewed the meeting schedule and noted that the Committee has an opportunity to shape the agenda around minority health issues. To achieve that, the Committee must be focused, and its work must be aligned with OMH and HHS priorities. It is also incumbent upon the Committee to bring forward issues concerning minority communities and to clarify how OMH and HHS could address them.

Dr. King invited Committee members to introduce themselves and to identify one goal for their participation on the ACMH.

Office of Minority Health Overview

Overview and Priorities of OMH

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

Dr. Gracia provided an overview of the background, mission, functions, and structure of OMH, which included areas of leadership and coordination, strategic priorities, and the relationship between OMH and the ACMH.

Dr. Gracia reiterated the Committee has new members, a new DFO, and a new Chair and added that HHS has a new Secretary, Sylvia Burwell. One of Secretary Burwell's key priorities will be to ensure that HHS programs are driven by impact and results.

The charge for the ACMH, then, will be to advise her office on improving the health of racial and ethnic minority groups and on developing goals and program activities of OMH. The Committee's work should be guided by this and by the strategic priorities of OMH.

Dr. Gracia highlighted a number of issues for the Committee's consideration:

Data: This is an important component of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, particularly data collection and analysis for smaller populations and data misclassification.

Workforce issues: These issues, including diversity and cultural competency of the workforce and the use of Community Health Workers (CHWs) —are critical under the Affordable Care Act. It will be important to determine how the healthcare system can become more equitable and responsive to a rapidly diversifying population.

Social determinants of health: This is a key focus of the National Partnership for Action to End Health Disparities (NPA). This issue presents opportunities for the ACMH to form sub-committees or to work in partnership with other federal advisory committees to measure social determinants that create disparities and to develop a framework to address them.

Questions and Answers

A Committee member requested information about the review process for OMH grants.

Dr. Gracia responded by saying OMH utilizes objective review committees that are comprised of experts in relevant areas.

A Committee member asked what data mining protocol would be used for the Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS) Health Disparities Service Fellowship and if the Committee could contribute to or access the results of that effort.

The OMH Division of Policy and Data and NCHS, Dr. Gracia replied, would develop a data policy and research plan itself. Dr. Gracia would welcome the Committee's thoughts regarding how to advance this partnership and the opportunities that would arise from it.

A Committee member noted that the lack of access to health data, particularly at the sub-county area, makes it difficult to design targeted interventions. County health departments often cite the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) when they decline to share this data.

Dr. Gracia acknowledged the importance of building community capacity to collect local data to drive policy and programs and recommended this topic be addressed at a future meeting.

Dr. King suggested the Committee form a sub-committee to address data concerns.

A Committee member asked if the Partnerships to Increase Coverage in Communities (PICC) program targeted states that did not develop health insurance exchanges under the Affordable Care Act.

The purpose of the grant is to help support health coverage enrollment of racial and ethnic minorities. Organizations in state-based marketplace and federally facilitated marketplaces were eligible to apply.

Division of Policy and Data (DPD)

Rashida Dorsey, PhD, MPH, Director, Division of Policy and Data

Per Dr. Dorsey's overview, DPD leads the implementation of the HHS Disparities Action Plan and provides support for other HHS and federal action plans with disparities goals and action plans, including the National Stakeholder Strategy for Achieving Health Equity.

DPD coordinates the ACMH, the American Indians and Alaska Natives Health Research Advisory Council (HRAC), the HHS Health Disparities Council, and the White House Initiatives on Minority-Serving Institutions and Educational Excellence. It also provides support for initiatives led by other HHS agencies that have a disparities focus.

DPD plays a role in policy research and evaluation, including performance measurement. For example, DPD developed a strategic planning framework logic model that is a resource for those working in minority health (<http://www.minorityhealth.hhs.gov/images/78/PrintFramework.htm>).

DPD's work in the area of statistical and data policy and analysis is focused on three areas:
Using data to develop policy for racial and ethnic minority populations
Building data capacity at the community level
Improving the availability and quality of racial and ethnic data collection and reporting.

DPD played a role in developing the Affordable Care Act Section 4302 data collection standards and continues to work with the HHS Data Council regarding the implementation of those standards.

DPD is providing support for the 2014 Native Hawaiian and Pacific Islander (NHPI) National Health Interview Survey (NHIS), which is an unprecedented opportunity to collect health data on this population. Data should be available in 2015.

DPD prepared a research brief on eligible uninsured Asian Americans, Native Hawaiians, and Pacific Islanders, in collaboration with the Assistant Secretary for Planning and Evaluation (ASPE) (http://aspe.hhs.ov/health/reports/2014/UninsuredAANHPI/rb_UninsuredAANHPI.pdf).

In June, DPD released a data brief on *Characteristics of Uninsured Adult Males by Race and Ethnicity (Ages 19 to 64 years)*. This was the first HHS report on minority men (http://minorityhealth.hhs.gov/assets/pdf/OMH_Mens_Health_Data_Brief.pdf).

Questions and Answers

A Committee member requested clarification regarding DPD's role in special initiatives.

Dr. Dorsey explained that DPD leads several interagency steering committees. It represents OMH on the federal task force for Healthy People 2020 (HP2020) and the HHS Oral Health Initiative to ensure that racial and ethnic populations are included in their work.

A Committee member asked if DPD's participation in these groups reduced the responsibility of other workgroup members to address the issue of disparities.

Dr. Dorsey replied that eliminating disparities is a departmental priority, and the responsibility falls across all of the Operating Divisions.

Dr. Gracia noted that she serves as an advisor to the Secretary and departmental leadership on minority health and health disparities. In every group, OMH works to ensure that all members understand that the HHS Disparities Action Plan holds agencies responsible for addressing disparities and requires them to report on their actions.

The Committee member concluded that this could serve as a model for the rest of the country. Too often, the work of eliminating disparities falls upon the group that is designated as the voice of racial and ethnic minorities.

A Committee member inquired if the goal of DPD's work (to improve data collection and availability) included changing the Office of Management and Budget's (OMB's) categories of race.

Dr. Dorsey answered by saying that the new data standards include more granularity, but HHS is required by law to align them with OMB standards.

A Committee member thanked OMH for its leadership with the NHPI NHIS. This study could empower and motivate other small, vulnerable populations that fall under the radar.

Division of Information and Education (DIE)

Lydia Sermons, MA, Director, Division of Information and Education

The DIE is the principal office for increasing public awareness of OMH's mission, programs, and initiatives. For example, DIE has helped increase awareness of initiatives which OMH leads, such as Minority Health Month (April) and Men's Health Month (June). It conducts strategic media outreach, public information campaigns, and public education activities.

DIE is the project director for the OMH Resource Center (OMHRC), which is a one-stop source of minority health literature, research, and resources for consumers, community organizations, health professionals, and the media. The Knowledge Center is the nation's largest repository of information on health issues specific to minority populations. OMHRC can be reached at 800-444-6472 or info@minorityhealth.hhs.gov.

DIE hopes to serve as a resource to the ACMH, and Ms. Sermons encouraged Committee members to contact OMHRC for materials that can amplify and support their efforts.

Questions and Answers

A Committee member queried if OMHRC facilitates access to materials developed by other agencies, such as through links to PubMed.

ACMH members, Ms. Sermons answered, could be added to the OMH e-blast list and would receive newsletters, Funding Opportunity Announcements, and other information.

A Committee member wondered how DIE determined the focus areas for its media campaigns.

Ms. Sermons responded that the focus areas were determined by the OMH mission and priorities, the OMH calendar (i.e., Minority Health Month), and the input from stakeholders and partners.

National Partnership for Action to End Health Disparities (NPA)

Onyemaechi Nweke, DrPH, MPH, Team Lead, National Partnership for Action to End Health Disparities (NPA)

The NPA was established to mobilize a nationwide, comprehensive, community-driven approach to combating health disparities. Its mission is to "increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and

stakeholders committed to action.” The NPA is a multi-level effort that includes the federal government, state and local government, and local communities. Vital partners include: Federal Interagency Health Equity Team (FIHET): Twelve federal agencies, including HHS, promote cross-agency collaboration and maximize the impact of federal programs.

Regional Health Equity Councils (RHECs): Ten councils (one in each HHS region) with representation from diverse sectors identify health disparities issues for populations in their region and propose solutions to address them.

State Offices of Minority Health (SOMHs): The offices serve as a conduit between local communities and the RHECs.

National partners: A multitude of partners, such as the National Conference of State Legislators (NCSL) and the Association of State and Territorial Health Officers (ASTHO) provide access to policy makers and other resources.

Five NPA goals outline the areas that must be addressed to achieve health equity:

Awareness: Raising awareness of health disparities at all levels and across all sectors and capacity-building to communicate about social determinants of health (SDH)

Leadership: Ensuring leadership across all sectors and increasing the diversity of leadership

Health, System, and Life Experience: Assuring strategies achieve health equity by addressing all systems that impact the SDH

Cultural and Linguistic Competency: Promoting the diversity and the cultural and linguistic competency of the healthcare workforce and setting standards that services and information provided to consumers are culturally and linguistically appropriate

Data, Research, and Evaluation: Collecting data that advance the conversation around health disparities and health equity and utilizing those to change policies.

During the past year, the FIHET identified five priority areas to focus this work:

Educate the uninsured and underinsured about the benefits of the Affordable Care Act

Support the implementation of the National Standards for Culturally and Linguistically

Appropriate Services in Health and Health Care

Inform youth and emerging leaders about the SDH and health disparities and provide practical learning opportunities

Strengthen the nation’s network of CHWs to meet the needs of underserved communities

Promote the integration of health equity in policies and programs.

Detailed information is available at <http://www.minorityhealth.hhs.gov/npa>.

Questions and Answers

A Committee member asked if the NPA’s leadership work also taught “followership.”

Dr. Nweke returned that some NPA partners might be interested in incorporating that concept in leadership programs for youth exiting the juvenile justice system.

A member solicited how the NPA differed from the HHS Disparities Action Plan.

Dr. Gracia explained that the NSS is implemented through the FIHET, RHECs, SOMHs, and national partners. The HHS Disparities Action Plan is a commitment at the federal level that includes agencies across the Department. The NPA, NSS, and the HHS Disparities Action Plan are complementary initiatives, and some HHS agencies are involved in both.

A Committee member requested clarification regarding the difference between patient navigators and CHWs and the role of the NPA in the OMH initiative on CHWs.

Dr. Nweke clarified the difference and explained the role of NPA as ensuring RHECs have the right partnerships

Dr. Gracia added that OMH and the Health Resources and Services Administration (HRSA) co-chair a departmental working group, looking at promising practices to integrate CHWs into health promotion and disease prevention programs.

A Committee member noted that Medicaid is being merged with managed care in many states, making it difficult to access Medicaid data. It would be helpful if HHS would encourage states and third-party payors to allow the data to be shared along with the rest of the Medicaid data. A Committee member queried if there had been any efforts to integrate the NPA with HP2020 and whether OMH had addressed issues related to the built environment.

Dr. Nweke replied that the NPA has worked closely with the HP2020 task force. HP2020 includes the built environment as one of five domains of the SDH.

Dr. Dorsey noted that DPD was working with the HHS Office of Disease Prevention and Health Promotion (ODPHP) to expand HP2020 indicators to include data on racial and ethnic minorities.

A member asked whether organizations representing minority populations could become NPA partners and whether ASTHO leadership included health officers from the territories.

Dr. Nweke replied that ASTHO's members include state and territorial health officials, plus representatives of 23 organizations. She offered to put Committee members in touch with the NPA's contact at ASTHO.

Dr. Nweke offered that national organizations that want to partner with the NPA contact her to discuss the best way to get involved.

Dr. Nweke further commented that Committee members could serve as RHEC members. A list of RHECs is at: <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=42>.

Public Comments

Dr. Laurén Doamekpor read a statement on behalf of the National Center for Health Research (NCHR). It began with the non-profit think tank's frustration with the lack of racial and ethnic minorities in clinical trials used in FDA approval of drugs and medical devices, despite the fact that these same drugs and devices are used and relied upon by millions of people of color.

Dr. Doamekpor further explained that most of the focus on diversity in clinical trials is directed at NIH studies, which virtually ignores FDA decisions about medical products sold in the US. When these products are studied on few people of color, the drugs and devices may not be equally effective on men and women of color, contributing to health and mortality disparities.

While Dr. Doamekpor participates in an FDA Advisory Committee, her concerns are not always addressed. She gave an example of a weight loss study in which 93% of the participants were white, even though Black and Hispanic women are far more likely to be overweight or obese. The device was approved. Even the FDA concedes, in their "907 Report" that studies do not adequately represent diverse segments of the population. It is NCHR's hope that requirements

for diversity will be taken seriously and opportunities for partnerships, such as with the FDA's Center for Drugs and Center for Medical Devices, will encourage subgroup analysis and labeling.

HHS Welcome

Howard K. Koh MD, MPH, Assistant Secretary for Health, U. S. Department of Health and Human Services

Dr. Koh thanked the Committee members for their service to the ACMH. He congratulated Dr. King and Dr. Dorsey on their new roles and commended Dr. Gracia for her leadership at OMH. His remarks highlighted the following points:

The ACMH is vital because the increasing diversity of the U.S. affects health care and public health.

HHS is at an historic transition. Former Secretary Sebelius was dedicated to issues of minority health and led the development of the Department's first strategic plan to eliminate health disparities. Secretary Burwell would continue that momentum.

The expanded coverage for high-value preventive services under the Affordable Care Act is important for minority populations, who represent one-half of the uninsured. The Affordable Care Act also has made significant investments in community health centers (CHCs), where racial and ethnic minorities represent two-thirds of the patient population, and it more than doubled the number of physicians in the National Health Service Corps. It is essential to communicate these benefits to minority communities.

The ACMH 2012 report, *Assuring the Full Participation of Racial and Ethnic Minorities in Health Insurance Exchanges*, was very important. Many Affordable Care Act outreach groups did extensive work, including translation services.

HHS is in the midst of a new campaign, "From Coverage to Care," to ensure that the newly insured understand their benefits and access care. Committee members can help in this effort because they understand the needs of their communities.

The recent OMH data brief on the characteristics of uninsured men of color is an important analysis. HHS looks to the ACMH to help disseminate this study.

OMH is working with CDC on the historic NHPI survey. Dr. Koh acknowledged Dr. Panapasa's support of the NHPI National Health Interview Survey

A prospective, co-authored by Drs. Koh and Gracia, and OMH Associate Director, Mayra Alvarez, "Advancing Health with CLAS," will appear in the next issue of the *New England Journal of Medicine*.

Dr. Koh responded to the questions below and then conducted a ceremony to swear in the new Committee members and the Chair.

Questions and Answers

A Committee member thanked Dr. Koh for his leadership with the NHPI survey and other initiatives. The NHPI survey would empower populations and have a significant impact on reducing health disparities.

Dr. Koh recalled that his memorable visit to Chuuk, Micronesia, gave him a clear understanding of the disparities faced by Pacific Islanders.

A Committee member asked what issues Dr. Koh would like the ACMH to address.

He cited two issues: 1) support the Affordable Care Act to reach minority populations and reduce disparities, and 2) implement the National CLAS Standards. He urged the Committee to review the HHS strategic plan to identify areas where progress could be accelerated.

My Brother's Keeper Initiative

J. Nadine Gracia, MD, MSCE

My Brother's Keeper is a presidential initiative, launched on February 27, 2014, to improve the expected educational and life outcomes for and address the persistent opportunity gaps faced by boys and young men of color.

A federal interagency task force was created and charged with reviewing public and private programs that impact boys and young men of color to identify best practices. OMH is the designated representative of HHS on the task force. To ensure a coordinated strategy across the Department, OMH has engaged several agencies across HHS such as the Administration for Children and Families (ACF), CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), and HRSA.

The task force submitted an initial report on May 28, 2014 that identified opportunity gaps and steps to address those gaps. The report noted the importance of data on race, ethnicity, and gender to identify disparities in education, health, and economic status.

As a result of the report, the task force is looking at ways in which federal departments can collaborate across sectors and with partners in the field. Federal stakeholder meetings and feedback from communities will be an ongoing process.

Questions and Answers

A Committee member asked how the task force would respond to criticism that girls were not included in the Initiative.

Dr. Gracia highlighted many of the ways the Administration is addressing the needs of girls and women, including the White House Council on Women and Girls that was established in 2009.

A Committee member added that the California Endowment faced similar feedback when they launched their Boys and Young Men of Color Initiative.

Another member suggested that some people consider My Brother's Keeper to be an African American and Latino initiative. OMH can play a role in ensuring that it is inclusive of all boys and young men of color.

A Committee member responded that his paper on the economic burden of health disparities recommended the creation of an Office of Men's Health at the federal level, similar to the Office of Women's Health.

A Committee member asked how the Initiative would be sustained.

Dr. Gracia acknowledged sustainability as a focus of the Initiative.

A Committee member asked if there were any plans to link maternal and child health to the role of fathers and to evaluate the impact of unplanned parenthood on young men.

Dr. Gracia confirmed that the task force report addressed teen parenthood, including the impact on high school dropout rates.

A Committee member proffered that the National Institute on Minority Health and Health Disparities (NIMHD) had two funding opportunities that targeted African American men.

A Committee member recommended expanding the indicators to include contextual measures that can impact the lives of young men, including family and household measures. She suggested comparing data on young men and women, regardless of race and ethnicity.

A Committee member suggested that the Promise Zone Initiative would be a natural fit with My Brother's Keeper.

A Committee member stated that sustainability is a challenge for any presidential initiative. It is important to institutionalize the initiative within agencies, such as by developing a new office or new partnerships. The Committee can provide guidance in that area.

A Committee member asked if the Initiative would look at mental health aspects.

Dr. Gracia replied that the Initiative has a holistic concept of health. SAMHSA has been actively engaged in the initiation and advancing the integration of behavioral health in areas such as criminal justice and early education.

A Committee member asked if there were plans to engage directly with young men of color at the community level and to involve grassroots and/or faith-based organizations.

The president, Dr. Gracia replied, became engaged in this issue through the work of community-based organizations. Initially, it included listening sessions around the country, and subsequently, there will be an ongoing dialog and partnership.

A Committee member pointed out that work on this issue had been going on for more than 10 years, but there had never been a common platform. My Brother's Keeper is a call to action, with the president using the bully pulpit of the White House to raise awareness of the issue.

Committee Business

Roderick K. King, MD, MPH, Chair

The Committee discussed potential topic areas for the Committee's work going forward, with an emphasis on pivotal issues that could be addressed in the next two years. Members raised the issues below. :

Ensure safety nets exist for states that decided not to expand Medicaid.

Provide guidance to states about the benefits available under the Affordable Care Act.

Make data available, addressing the challenges of collecting data in small populations and identifying ways to move data into action.

Bring communities together and focus on similarities as the U.S. moves toward a "majority-minority" nation.

Recruit and retain racial and ethnic minorities into studies. Acquire data to disentangle race and economic status and data on place-based disparities.

Discuss health care reform, which should include looking at how health systems can be involved in community prevention.

Clarify what kinds of data are restricted by HIPAA.

Get involved in "big data," which is an important topic in the private sector. The healthcare industry has the data, but it will not share them.

Propose recommendations to increase the visibility of OMH.

Assist researchers regarding public use files.

Look at best practices in social media to promote minority health issues in various communities. Provide leadership on issues related to My Brother's Keeper, such as school suspension and drug possession policies.

Dr. King proposed the formation of a sub-committee for issues related to data. Dr. King further suggested it would be important to determine whether the language of the Federal Advisory Committee Act (FACA) would allow a subcommittee to invite other individuals to participate.

Dr. Dorsey noted that part of her role as DFO is to consider how the ACMH could connect with or utilize the work of other federal advisory committees. She offered to look into partnering with the National Committee on Vital Health Statistics (NCVHS) and leverage their work on the collection of socio-economic data and other demographic factors.

Dr. King commented that two priority areas had emerged: 1) the issues related to data, and 2) the status of the safety net in states that did not expand Medicaid. He encouraged Committee members to identify potential speakers who could inform the Committee on such issues. He said he had spoken with Bruce Siegel, President and CEO of America's Essential Hospitals, about safety net institutions.

Lastly, a Committee member asked about future schedules of meetings. Dr. Dorsey said the schedule was tied to the fiscal year. It might be difficult to conduct another face-to-face meeting during this fiscal year, but the Committee could also meet via conference call or webinar.

New Member Orientation

New Committee members were briefed on their duties and responsibilities under the Federal Advisory Committee Act. This portion of the meeting was conducted in a closed session.

WEDNESDAY, JULY 9, 2014

Call to Order and Remarks

Roderick K. King, MD, MPH, Chair

Dr. King called the meeting to order at 9:03 a.m. and reviewed the agenda for the day.

Committee members raised the issues of children, mostly of minority status, at the border and the killings in Chicago during the July Fourth weekend. Dr. King said Dr. Gracia informed him that Commissioned Corps Officers of the U.S. Public Health Services had been deployed to provide assistance at the border. He noted that the situation in Chicago was relevant to My Brother's Keeper.

Affordable Care Act - Panel I

Catherine Oakar, MPH, Director of Public Health Policy, Office of Health Reform, U.S. Department of Health and Human Services

Ms. Oakar shared best practices and lessons learned from the first open enrollment period and provided a preview of the next open enrollment period. The following are some of the lessons learned from the former.

Coordinated and consistent messaging drove enrollment.

People must be reached multiple times with multiple messages.

Follow-up was critical to keep people engaged; those efforts would be expanded going forward.

Locally-elected officials were very effective in communicating messages because they are trusted voices in the community.

Newly enrolled individuals need information on how to use their coverage.

Reaching those who did not enroll during the first period will be challenging. HHS anticipates a need for more translation assistance and is recruiting enrollment assistants who speak other languages. HHS is engaging as many federal partners as possible to assist with outreach. Another priority will be to ensure that those who enrolled last year re-enroll for coverage.

HHS will continue to encourage states to participate in Medicaid expansion and will conduct outreach and education to address misinformation about the marketplace. Ms. Oakar requested the Committee's input regarding approaches to reach communities of color.

Questions and Answers

A Committee member asked whether individuals in states that did not expand Medicaid were eligible to enroll through the exchange.

Ms. Oakar stated that those individuals would be eligible.

A Committee member asked if HHS was making an aggressive effort to reach Asian and African American populations.

Ms. Oakar assured the Committee that HHS was making extensive efforts to reach all populations and to recruit assisters from these communities, as well.

A Committee member asked Ms. Oakar to elaborate on educational efforts going forward.

Ms. Oakar noted the next open enrollment will be shorter. HHS will use more media, starting in August or September. HHS welcomes Committee members' thoughts regarding effective approaches.

A Committee member noted that a "shotgun" approach reaches the mainstream first.

Communities of color are overrepresented among the uninsured, and those communities do not trust the government or their elected officials. Outreach and enrollment staff need cultural competence training to reach communities of color. OMH is an excellent resource to develop a more thoughtful and tailored approach.

A Committee member offered several comments and questions:

The Census Bureau can be an important resource for cultural competence.

To get an idea of the demographics of the 30 percent of enrollees who did not report their race or ethnicity, data on the 70 percent who did provide that information could be compared to baseline demographic data on the overall uninsured population.

Enrollment data on Pacific Islanders would be helpful. They are a large migrant population that is linguistically and culturally diverse, and they could contribute to outreach efforts going forward.

It would be helpful to know when re-enrollment efforts would begin and how enrollment would be measured.

Ms. Oakar replied that HHS was trying to make it as easy as possible for people to re-enroll in their current plan. They recently released information about a proposed rule for automatic re-enrollment. They were also working with insurers about when to notify consumers about changes to or potential terminations of their plan. Re-enrollment efforts will begin in the months leading up to open enrollment.

Ms. Oakar asked the Committee member to elaborate on how to estimate the composition of the 30 percent of enrollees who did not identify their race or ethnicity.

The Committee member stated that that enrollment data, such as age and geographic location, could be reviewed to identify patterns, concentrations, or clusters. If small populations were in the 30 percent, their results would be under-reported.

A Committee member agreed that ministers are a trusted source of information, especially for communities that mistrust the government.

Ms. Oakar noted that the HHS Center for Faith-Based and Neighborhood Partnerships provided places of worship with webinars, toolkits, and talking points on Affordable Care Act enrollment. *A Committee member noted that CHWs in states that did not expand Medicaid would like to be able to inform people about their options.*

Ms. Oakar recommended those individuals who were not eligible for the marketplace or could not afford coverage visit healthcare.gov, which will refer them to a community health clinic, based on their zip code.

A Committee member noted that some of her colleagues do not understand the Affordable Care Act or how health insurance works. Health care reform is new for everyone. In addition, there is a need to connect more deeply to churches, beauty shops, and the African American community, in general. For example, if a pastor knew how many members of his congregation had enrolled, he could ask the church to help with outreach efforts.

A Committee member suggested that access to insurance does not translate to access to care. People who use their coverage and experience the benefits will re-enroll.

Ms. Oakar verified that HHS was conducting a campaign to educate those who enrolled on how to use their coverage.

A Committee member asked if there was a special enrollment period for those who would not requalify for Medicaid.

Ms. Oakar stated it would depend on the system in each state. Synchronizing private insurance with the Medicaid system had never been done before.

The Committee member suggested that it would be helpful to know the process to re-qualify in each state and to develop a message for people who are in that window.

A Committee member mentioned HHS was trying to determine the next phase for navigators in states that did not expand Medicaid. He suggested that navigators could anticipate when people would enter the “churn” window and could educate them regarding their options.

A Committee member said that national and state organizations could help identify trusted local partners. For example, the Asian and Pacific Islander American Health Forum works with communities to conduct Affordable Care Act enrollment events at CHCs that serve those

populations. HHS should look at whether its funds are going to community organizations or major media.

Dr. Dorsey confirmed that OMH was working through NPA partners and other organizations that have a relationship with OMH and would like to expand that effort.

A Committee member shared that local partners and faith communities were not created to enroll people into insurance and did not have the capacity to do that. The next phase, he suggested, needs to be more targeted and must provide support for local organizations. Leverage depends on the messenger. Local elected officials, he continued, can be effective if they have a strong relationship with the community.

A Committee member suggested that it would be useful to provide partner organizations with information about what people in specific income brackets would pay for coverage through the federal exchange.

Another member noted that the system was complex, and the message needs to be simplified.

Ms. Oakar agreed. HHS understands that the messages need to reach beyond the uninsured to include those who work with them.

A Committee member asked if there was a target for the next enrollment.

HHS, Ms. Oakar replied, had not released a specific target, but they will try to reach as many of the remaining uninsured as possible.

A Committee member pointed out that the states that did not expand Medicaid were almost the same as those that did not support Medicaid and Medicare when they were first introduced.

Another member suggested that a graphic illustration of that comparison would help to reassure the public.

A Committee member noted that the terms “deadline” and “open enrollment” could be confusing.

Ms. Oakar said the messages were phrased as simply as possible (e.g., “Enroll by December 31 if you want coverage to begin on January 1”).

A Committee member suggested that those who have coverage should be part of the conversation, and the messaging should highlight how they benefit from the process. Enrollment data at the state or county level could be shared with the local community to illustrate the success that has been achieved and to create motivation to move forward.

A member asked why the micro-targeting approach used to get out the vote was not used for Affordable Care Act enrollment.

Ms. Oakar replied that this was due to limitations of the federal procurement process. HHS would like to do micro-targeting for the next enrollment period, working with enrollment data by Congressional district and zip code.

A Committee member stated that using CHCs as a fallback strategy was not feasible, because they often have a waiting list of several weeks. There should be a way to link emergency rooms (ERs) and CHCs so that urgent care patients are referred to CHCs for future care.

Committee Business

Dr. King opened the floor for discussion of deliverables that communicate the Committee’s recommendations. He outlined the process, advantages, and challenges of the three main types of deliverables:

Report: One or two Committee members develop a draft, working with a technical writer provided by OMH. The Chair circulates the draft report to Committee members for review and comments. Once consensus is reached, the report is submitted to the DFO, who forwards it to Dr. Gracia.

Advantages: Opportunity to include a great deal of information.

Challenges: If the recommendations require the support of other HHS Operational Divisions (e.g., HRSA), they must vet the report before publication.

Memo: A short document highlighting the main recommendations (e.g., the 2013 memo on Affordable Care Act enrollment, written by Drs. King and Chen).

Advantages: Takes less time to write and gets to OMH more quickly.

Challenges: The shorter format limits the number of facts and figures that can be provided, and it can be difficult to capture nuances.

Letter: Shorter than a memo but still includes recommendations. Generally used to highlight a key concern, such as safety net hospitals.

Advantages: Shorter and less time intensive, with no vetting process.

Challenge: Very little space to delve into the issues.

Committee members raised the following points about deliverables:

Written guidelines about these mechanisms would be helpful for future reference.

Shorter formats are well received by OMH.

Anything created by the Committee is a public document.

The purpose of each type of deliverable is different. A memo is a short, time-sensitive, administrative request for immediate action. A letter can offer an informal recommendation. A report would be best for recommendations regarding long-term policies with national impacts and institutional changes.

The Committee's CLAS Standards report is a good example of the involvement of all Committee members and the collaboration of other HHS agencies.

Regardless of the format, the purpose of a deliverable is to provide the Committee's recommendations to Dr. Gracia.

A Committee member said that ACMH was supposed to have a dedicated page on the OMH website, with all letters and documents. The website, however, was being redesigned, and the new items had not been posted. She offered to provide a preview of the revised ACMH web page. A member requested an update on pending items from the last meeting, including the issue of foster children. Dr. King said he would work with Dr. Dorsey to determine the status of all prior reports.

A Committee member asked about the timeline for responses from Dr. Gracia and/or Dr. Dorsey. Dr. Dorsey stated that there was no fixed timeframe. The Committee should expect a memo acknowledging receipt, with follow-up to be determined at a later time regarding whether OMH could implement the recommendation and what actions, if any, would be taken.

Dr. Dorsey emphasized that the Committee's role is to advise the DASM, and every deliverable should be framed as a recommendation. She urged the Committee to consider how its recommendations would align with the OMH priority areas and core functions.

Affordable Care Act – Panel II

Lisa Campbell, Acting Director, Consumer Support Group, Centers for Medicare & Medicaid Service (CMS), U.S. Department of Health and Human Services

Cara V. James, PhD, Director, Office of Minority Health, Centers for Medicare & Medicaid Service (CMS), U.S. Department of Health and Human Services

Ms. Campbell reviewed the success of the first open enrollment period and highlighted accomplishments of the outreach efforts.

Lessons learned from the first open enrollment period included:

Paired messaging and combined outreach are important

Traditional channels should be leveraged

Information must be easier to understand

Testimonials with real people are important

Consumers respond to deadlines

Local enrollment events where consumers live, pray, and work are critical.

For the next open enrollment period, CMS will focus on:

Health literacy to help newly insured use their coverage, and to reach the uninsured

Targeted outreach for special enrollment periods

Research to determine what methods work with consumers

Enhanced training for Call Center representatives and navigators.

The main goals for the next open enrollment period are to strengthen the functioning of the marketplace, maximize enrollment, and improve technology use.

CMS released a new Funding Opportunity Announcement for navigator grants, with applications due on July 10. Applicants were required to specify the populations they would serve, their plans for language accessibility, and the counties in which they would operate and were asked to provide a detailed outreach plan.

Questions and Answers

A Committee member asked how champions, such as Certified Application Counselors (CACs) and navigators, were located and funded.

Only navigators are funded, said Ms. Campbell, and they only operate in states with a federally facilitated marketplace (FFM) or partner exchange. Champions and CACs are volunteers, trained through HHS.

A Committee member asked if CMS could provide demographic data on those who enrolled through federal exchanges versus state exchanges.

Ms. Campbell deferred that question until a later time.

A Committee member emphasized the importance of identifying those who are in transition, such as pregnant women who have short-term Medicaid benefits.

Ms. Campbell acknowledged that CMS was reaching out to that population.

A Committee member pointed out the consistency between the two Affordable Care Act presentations and asked how the offices coordinate their efforts.

Ms. Campbell replied that all HHS offices were working together. She solicited further feedback related to navigators and CACs.

Dr. James said she meets regularly with all HHS offices involved in Affordable Care Act outreach and enrollment to share information and lessons learned.

A Committee member inquired about how the Consumer Support Group works with communities, especially informal leaders, and how it motivates and inspires navigators.

Ms. Campbell replied that navigator grantees are funded by HHS and provide reports. CMS requires navigators to attend a 20-hour training, which will be updated this year, and offers weekly webinars and newsletters for grantees. Dr. Dorsey added that OMHRC offers a grant writing webinar for organizations that wish to apply for a grant.

A Committee member asked about the requirements to apply for a grant.

Ms. Campbell answered. She said that any individual or organization in an FFM or state partnership state could apply for a grant.

A Committee member queried whether CMS knew how many people enrolled through the navigators.

Ms. Campbell did not have complete data from CMS. They do receive self-report data from the navigator grantees. But while the application asks if the individual received help from an assister, the field is optional.

A Committee member asked whether CMS had any materials describing how Compact of Free Association (COFA) migrants might benefit from the marketplace.

Ms. Campbell replied that many navigator grantees work with Pacific populations. Her office is working to enhance their ability to help COFA migrants understand their options and enroll in the marketplace.

The Committee member noted that many COFA migrants were located in Arkansas and California and asked how materials were made available to them.

Ms. Campbell noted that there were no federal navigators in California. She would welcome suggestions on outreach to COFA migrants in other locations.

A Committee member asked if CMS was collecting information on the race and ethnicity of the populations that navigators are targeting.

Ms. Campbell replied that CMS modified its reporting requirements for grantees and published the new data fields for public comment. She offered to follow up on this matter and provide a response to the Committee.

A Committee member asked how closely the navigators work with the regional offices.

Ms. Campbell stated that most regional offices were quite involved with assisters.

Dr. James noted that the CMS regional offices worked closely with HHS regional offices, including the Regional Minority Health Consultants. *A Committee member noted that minorities in her state felt that the navigators were not well matched to their communities. The navigators need to be trusted members of the community, and outreach strategies should be targeted and culturally relevant.*

Ms. Campbell said she would welcome specific feedback regarding navigator grantees.

A Committee member noted that the Spanish language portal to healthcare.gov was difficult to navigate and asked if the interface would be revised to make it more user-friendly.

Ms. Campbell replied that the CMS Office of Communications was working with Spanish-speaking navigators to improve the translation.

A Committee member said that navigators in Florida would like more training to explain how to utilize insurance.

Ms. Campbell said Dr. James would describe a program that was designed to address that concern.

Dr. James described the “Coverage to Care” (C2C) program that was developed to help educate consumers about their health insurance coverage and connect them to primary care and preventive services.

The C2C developed a Roadmap, with stakeholder input, and pilot tested it. It includes eight steps: 1) Put your health first; 2) Understand your health coverage; 3) Know where to go for care; 4) Find a provider; 5) Make an appointment; 6) Be prepared for your visit; 7) Decide if the provider is right for you; 8) Next steps after your appointment.

The Roadmap booklet is currently available in English, and a Spanish translation is being prepared. A poster, one-page documents, discussion guide, and video vignettes are available in English and Spanish, and CMS is in the process of translating them into other languages.

C2C resources are available online at <http://marketplace.cms.gov/c2c>. Hard copies can be ordered from the CMS Clearinghouse. Additional information is at coverage2care@cms.hhs.gov.

Dr. James encouraged Committee members to:

Share the C2C resources with their organizations

Incorporate the materials into assister training programs offered through their organizations

Collaborate with their state Medicaid and Children’s Health Insurance Program offices

Bring the materials to the attention of providers, discharge planners, and ER coordinators

Support data collection and evaluation.

Questions and Answers

A Committee member asked if the C2C training emphasized the importance of keeping documents, such as the Explanation of Benefits.

Dr. James said that would be added to the training.

A Committee member noted that some hospitals control access according to payor mix. Patients who have insurance are frustrated when they cannot see the doctor they want. Many plans do not have out-of-network benefits, and consumers do not understand their coverage.

Dr. James replied that many people did not anticipate the implications of the decisions they made about coverage. It is important to ensure that people have networks that meet their needs. If people do not see the value, they will not keep their coverage.

A Committee member suggested that CMS work with providers to address that challenge.

Dr. James said that CMS tried to work with providers during the C2C pilot. She would welcome any suggestions about how to engage the provider community.

A Committee member posited that most primary care doctors in urgent care settings will take Medicaid. It might be valuable to get them involved in preventive care.

A Committee member asked if CMS planned to share the Roadmap materials with nursing school faculty or nursing conferences.

Dr. James replied that the Roadmap talks about nurses as part of the provider community. CMS is interested in strengthening partnerships with professional associations. During the pilot, they learned that caseworkers, social workers, and support staff were more likely to share the resources, because providers do not have time for patient education. CMS would appreciate suggestions to make the Roadmap more useful for providers.

A Committee member noted that many minority populations only have access to the Internet through their mobile devices. She asked if CMS had considered creating an app that could be linked to other apps, such as maps and healthcare checklists. Another Committee member suggested having a personalized health record on a smartphone app could facilitate conversations with providers.

Dr. James replied that the Roadmap provides a link to www.healthfinder.gov, where people can get personalized recommendations for preventive services. CMS is working on an app that would work on various types of devices. The CMS Facebook page and Twitter account were posting about C2C on a weekly basis in English and Spanish.

A Committee member requested details about the pilot study.

Dr. James stated that in 2013, CMS conducted stakeholder interviews in four areas that were diverse in terms of demographics, urban and rural settings, uninsured populations, Medicaid expansion, marketplace status, English-language proficiency, and community services. The conversations included cohorts of consumers, providers, and community partners. The C2C resources were developed based on those interviews. From January to June, 2014, CMS shared the Roadmap resources in English and Spanish with a variety of community partners, including assisters, navigators, faith-based organizations, and social service organizations. A key learning lesson was that one-on-one conversations with consumers were most effective for retention of information.

A Committee member asked if the Roadmap addressed mental health.

Dr. James replied that the first step of the Roadmap (“Put your health first”) would be strengthened to state that preventive health care can also improve your mental and emotional well-being. CMS takes a “whole health” approach to health that would be reflected as additional tools were developed.

A Committee member asked what strategies CMS was using to engage providers.

Dr. James stated that CMS convenes “First Friday” discussions with a group of provider associations; they also disseminate information through the Medicare Learning Network. *Committee members suggested that a simulation or game might be a cost-effective approach to provide education. Some organizations are looking at this approach to train public health leaders in areas such as bio-preparedness.*

A Committee member asked how researchers could access Medicaid and Medicare data.

Dr. James replied that her office was working on creating public use files for those who want to do disparities research. Strengthening the data entails an education component, because data on race and ethnicity are missing from 30 percent of those who enrolled through the marketplace. It is important to ensure that provider settings report that data.

A Committee member expressed concern that the enrollment form was not flexible enough to allow for mixed-race reporting.

Dr. James stated that the HHS OMH and CMS OMH worked together to ensure that the Section 4302 data standards for multiple race selection were included in the streamlined application. Her office is responsible for incorporating those standards across CMS.

Committee Business

Formation of a Data Subcommittee

Committee members discussed the processes for forming a subcommittee, selecting outside members, and determining the charge for the subcommittee. Two options emerged for forming the subcommittee: holding a dedicated meeting of the full committee or forming a smaller group. The Committee did not make a decision about which option to pursue.

Dr. Dorsey stated that the subcommittee's members would determine its charge. Selection of outside members should be done by the entire Committee.

Key Topic Areas for 2014-2015

Issues for Data Subcommittee

Socio-economic status (SES) data

Collection and use

Integration with other data

Need for health data at sub-county/small population level

HIPAA compliance

Identify/understand health needs

Facilitating access to large health data sets

Utilizing big data

HIPAA

Costs

Medicaid and Medicare

Accessing data through partnerships

Social determinants of health (addressing issues beyond access and coverage)

Linking datasets across disciplines to inform policy and better understand the environmental context

Examining similarities across racial and ethnic minority groups.

Issues for ACMH

Social determinants of health (*see Data Subcommittee*)

Affordable Care Act

Role and use of social media

Dissemination of products

OMH as a hub for information around minority health and health disparities

Safety net

Those who have access and those who do not

Viability and sustainability of health centers

Importance of targeted outreach for "hard-to-reach" populations

Connect with the right messengers

New approaches

Best practices

Review elements of the Affordable Care Act that address health disparities.

ACMH core values

Funding for OMH offices in HHS agencies

HHS Health Disparities Strategic Plan and HP2020

Emerging issues in areas that are within the purview of OMH.

Deliverables

Recommendations on targeted outreach strategies for Affordable Care Act enrollment

Memo or letter prior to the next open enrollment period

Use data on enrollment (e.g., by race and ethnicity, geographic area) to guide recommendations

Build upon existing efforts and strategies as well as recommending new approaches and resources.

Dr. Dorsey offered to provide the following resources:

Notes of HHS town hall meetings with key stakeholders following open enrollment

The public report based on FFM enrollment data

Other reports as they become available.

Future meetings

Virtual meeting before the end of the fiscal year to address the topic of Affordable Care Act enrollment

Potential speakers

CMS navigator grantees

State-level navigator programs

Look into rotating geographic locations.

Meeting locations

Rotating locations would make them more accessible as a public forum

Washington, DC makes it easier and more cost-effective for HHS staff to attend

Worth exploring, depends on topic areas

OMH can publicize the location through its channels, in addition to the *Federal Register*.

Dr. Thorpe offered to work with Dr. Dorsey to contact other advisory committees regarding their experience meeting outside Washington.

Public Comment

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

Wrap up – next steps, next meeting

Roderick K. King, MD, MPH

Dr. King thanked Committee members and staff for a productive meeting.

The meeting was adjourned at 2:54 p.m.

ACTION ITEMS

WHAT	WHO	WHEN
Discuss next steps related to topic areas identified during this meeting.	Dr. King, Dr. Dorsey, Dr. Gracia	TBD
Determine the status of all prior deliverables.	Dr. King and Dr. Dorsey	TBD
Contact other federal advisory committees regarding their experience meeting outside Washington	Dr. Thorpe and Dr. Dorsey	TBD
Provide Committee with: NCVHS report on collection of SES data and other demographic factors in health surveys Preview of the revised ACMH web page Notes of HHS town hall meetings with key stakeholders following open enrollment Public report based on FFM enrollment data Other reports as they become available.	Dr. Dorsey	TBD
Put Committee members in touch with the NPA's contact at ASTHO.	Dr. Nweke	TBD
Provide Committee with: Demographic data on those that enrolled through federal exchanges versus state exchanges. Provide public comment on new reporting requirements for navigator grantees, including new data to collect data on race and ethnicity of target populations.	Dr. Campbell	TBD