How States Can Use Measurement as a Foundation for Tackling Health Disparities in Medicaid Managed Care

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Introduction

Medicaid programs serve a disproportionate share of populations that are negatively impacted by health disparities. Less advantaged populations are “those who have often suffered discrimination or been excluded or marginalized from society and the health promoting resources it has to offer.”[1] Examples of less advantaged groups include, but are not limited to, people of color, people living in poverty, religious minorities, people with physical or intellectual/developmental disabilities, LGBTQ persons and women.[2] Systematic reviews suggest that health disparities for less advantaged populations persist.[3,4]

The general practice of improving health care quality using measurement to inform, guide and assess performance is commonplace. However, addressing health disparities and pursuing equity for less advantaged populations is typically not a focus of health care quality improvement initiatives.[5] In fact, our research has found that Medicaid managed care programs generally do not even routinely measure health disparities using standardized measures. When quality improvement initiatives seek to improve the health of the general population, and do not specifically measure and otherwise consider the needs of less advantaged populations, quality improvement initiatives may have the unintended effect of exacerbating health disparities.[6]

In May 2016, the Centers for Medicare and Medicaid Services (CMS) released a final rule with dramatic changes to state requirements for Medicaid managed care, including provisions related to quality of care.[7] This final rule specifically requires states contracting with managed care entities to draft and implement a written strategy for “assessing and improving the quality of health care and services furnished” by these managed care entities,[8] and as part of its quality plan, “identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status.”[9]

This brief provides examples from a handful of states that have begun the work of identifying, evaluating, and reducing health disparities within their Medicaid managed care programs. Additionally, it offers a step-by-step approach for other states interested in measuring disparities in health care quality in Medicaid managed care as the first step towards achieving health equity, such that everyone enrolled in Medicaid managed care has a fair and just opportunity to be as healthy as possible.

Steps for Using Measurement in the Pursuit of Health Equity

- *Step 1:* Assess the landscape through stratification of existing quality measures
- *Step 2:* Monitor health disparities on an on-going basis and produce annual reports of health disparities
- *Step 3:* Identify a health disparity reduction target(s) and select an intervention(s)
- *Step 4:* Determine and implement a measurement approach
- *Step 5:* Assess performance and reassess program design

Step 1: Assess the Landscape Through Stratification of Existing Quality Measures

Before launching an effort to address health disparities, it is important to understand the nature of the disparities in the state's Medicaid managed care program. Comparing the relative performance rates of each subpopulation of interest (e.g., each racial and ethnic group) on the state's standardized quality measures is a tool for identifying disparities in health. Health equity experts advise that comparisons should be made not to the total population average, but to the subpopulation with the highest quality score for a given measure. The availability of reliable demographic data is a prerequisite for this type of analysis. The Affordable Care Act requires states to collect demographic data on race, ethnicity, sex, primary language, and disability status in all Medicaid and Children's Health Insurance Program (CHIP) programs.[10] Yet, many states either lack certain demographic data, the data are incomplete, or the data are of questionable reliability. Therefore, if a state is interested in beginning to stratify its quality measures, a useful place to start is an examination of demographic data.[11]

States should ask "do we consistently collect information on race, ethnicity, gender, language, and disability status for all beneficiaries?"

If the state determines that any demographic data are sufficiently complete and reliable, they can then be used to compare the performance of different subgroups (e.g., African Americans, or Spanish language speakers). They can also potentially be used to compare performance of these subgroups across competing managed care organizations or in specific provider organizations [e.g., Accountable Care Organizations (ACOs)]. This "landscape" analysis should be used to identify not only where disparities exist, but where they are most pronounced, and where they may have the most deleterious impact.

State examples: Massachusetts is currently in the early stages of work to stratify the state's quality measures to assess equity and disparities. The state's Quality Measure Alignment Taskforce is presently working with stakeholders offering consumer, plan, and provider perspectives to assess the quality of the available data for stratification based on race/ethnicity and other variables.[12] Pennsylvania plans to publish health disparity data for its Medicaid managed care program specific to treatment of asthma, diabetes and hypertension.[13]

Step 2: Monitor Health Disparities on an On-Going Basis and Produce Annual Reports of Health Disparities

After the initial assessment, the most basic approach to promoting equity is through measurement, and the one most commonly adopted by states in their Medicaid managed care programs is the ongoing monitoring of stratified performance measures and the corresponding production of annual "disparity reports." By monitoring health disparities over time, states can put subtle pressure on managed care plans to make changes to advance health equity and create a body of evidence to support future efforts to address health disparities.

Table 1: Examples of states that actively monitor health disparities in their Medicaid managed care programs

State	Subpopulations	Measures	Level of Analysis	Publishes Annual Report Publicly?
California[14]	Seniors and persons with disabilities	9 Healthcare Effectiveness Data and Information Set (HEDIS) measures	Statewide, and "reporting unit" [usually a county or group of counties served by a managed care organization (MCO)]	Yes
California[15]	By age, gender, race/ethnicity, and primary language group	11 HEDIS and 1 state-developed measure	Statewide, and county	Yes
Louisiana (pending)[16]	By geography, ethnicity, race, and disability status	61 measures[17]	MCO	No
Michigan[18]	By race and ethnicity	13 measures	Statewide	Yes
Minnesota[19]	By race and Hispanic ethnicity	5 HEDIS measures	Statewide	Yes
New York[20]	By race/ethnicity, members with non-English as their spoken language, members with serious mental illness (SMI), members with a substance use disorder (SUD), members who received cash assistance, and members who received Supplemental Security Income (SSI)	70 measures	Statewide	Yes
North Carolina (pending)[21]	By age, race, ethnicity, sex, primary language, and disability status, and where possible, long-term services and supports (LTSS) needs status and urban/rural and geography	Up to 67 based on measure population[22]	Medicaid "prepaid health plans" (PHPs), State Medicaid Agency and External Quality Review Organization[23]	Not yet; NC will publish annual report after prepaid health plans go live

While a state could monitor *all* its required performance measures and publish the results in annual disparities reports, it makes sense to focus such efforts on particular areas in which the state can have the most impact. In a 2017 report, the National Quality Forum (NQF) proposed the following criteria to help select and/or prioritize measures for health disparities monitoring:

1. *Measures for which the denominator includes a large number of patients affected by a social risk factor or set of risk factors.*
2. *Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings).*
3. *Outcome measures where there is a clear link between the outcome being measured and a set of actions.*[24]

As a part of that same report, NQF provided a list of “disparities-sensitive measures” that are likely to identify health disparities in the population. Please see Appendix A for NQF’s list of disparities-sensitive measures.[25]

Further, Anderson et al. suggest that states use the following criteria to prioritize measures for inclusion in such efforts:

- The prevalence of the target condition.
- The size of the disparity.
- The strength of the evidence for the strategies to reduce the disparity.
- The ease and feasibility of improvement.[26]

These reports could be produced by the state, as is the case in California,[27] Minnesota,[28] and New York,[29] or the state could require the MCO to perform the analysis for its population and report the results to the state, as is the anticipated approach in North Carolina.[30] While publishing statewide data is a useful first step and assists policy makers in setting state level priorities, producing MCO-specific or even provider-level reports (or requiring the production of such data) provides information that is more relevant and actionable for plans or providers.

Step 3: Identify a health disparity reduction target(s) and select an intervention(s)

Ongoing monitoring of health disparities in and of itself is insufficient to make meaningful strides towards health equity. Therefore, once the data have been analyzed, a state should conduct a process for determining a health disparity reduction target(s) in terms of subpopulation and level (e.g., state-wide or MCO-specific). As discussed in the University of Chicago’s *Roadmap to Reduce Disparities*, while “it can be tempting to jump to ‘doing something’ about disparities,” it is important to diagnose the disparity and its root cause. Speaking directly with persons in the disparity population about their barriers—and potential solutions—can be particularly instructive.[31] As a part of this process, the state should consider:

- Using the tools described in the *Roadmap to Reduce Disparities* including, the Root Cause Analysis and the Priority Matrix.[32]
- The criteria set forth by Anderson et al. described above.
- Stakeholder input.
- The ease of measurement and the availability of data.

Once the target for the intervention has been defined, the state should determine the intervention approach(es). The state may choose to require the use of a specific, ideally evidence-based, intervention[33] or may choose to give flexibility to its MCOs to innovate and implement different interventions based on their specific needs and strategies. For example, Minnesota gives flexibility to its Integrated Health Partnerships (IHPs) to implement an intervention intended to address a disparity in the IHP’s population and propose a corresponding measure to assess the success of the intervention.[34] Even if the state opts to give flexibility to its contractors, the state may facilitate improvement by regularly sharing performance data with the MCOs or providers, offering technical assistance (e.g., supporting the creation of learning communities), and/or offering incentives for improvement. If the state chooses to define a specific intervention approach, it should consider exploring the suggestions and tools offered by the *Roadmap to Reduce Disparities* as a part of this process. The *Roadmap* offers tools to help states explore various approaches to disparities reduction and strategies for securing buy-in from critical stakeholders who will determine the success or failure of the intervention. It also offers suggestions for increasing the likelihood of a successful implementation.[35] Regardless of the path taken, some customization to the specific context is often required.

State Example: Michigan's work to address disparities in the Medicaid program began in 2005, when it participated in the Center for Health Care Strategies' (CHCS) Practice Size Exploratory Project (PSEP) which was designed to identify disparities in health plans and providers by stratifying measures by racial/ethnic categories.[36] Michigan continued to build on this work and in 2011, the Michigan Medicaid Managed Care Plan Division (MCPD) launched the Medicaid Health Equity Project to systematically collect data to identify health disparities and publish an annual report.[37] From this effort, MCPD, in partnership with the Michigan Department of Health and Human Services identified low birth weight (LBW) as a health disparity target and launched a three-year performance improvement initiative starting in fiscal year 2018 that requires Medicaid health plans to develop both regional and plan-specific interventions to improve LBW. In addition to providing plans with a literature review, workplan development support, and other technical assistance to support plan efforts, MCPD has implemented a multi-year pay-for-performance incentive program for the health plans on a regional and plan-specific level. The project utilizes the 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) *Live Births Weighing Less Than 2,500 Grams* measure and pays plans for meeting milestones related to intervention planning, implementation, and reporting.[38]

Step 4: Determine a Measurement Approach and Consider Offering Incentives for Improvement

Once the intervention has been selected, the state should identify a measurement approach for assessing progress towards equity. While this could be done at the state level, it is likely to provide the MCOs with more actionable information and incentive for change if the measurement is done at the MCO level. The state then needs to define success for the project. Options for evaluating success include assessing progress based on:

- A reduced gap between the performance of the population of interest and the performance of the general population or the highest performing subpopulation.
- Improved performance independent of the performance of the general population and relative to the baseline assessment of performance or a national benchmark.
    - **State example:** In 2016, the Oregon Health Authority (OHA) conducted a process to identify measures that could be used to reduce health disparities in the Coordinated Care Organization (CCO)[39] program and decided to focus on emergency department utilization among individuals with mental illness.[40] In 2017 OHA implemented the disparity-specific measure "Emergency Department Utilization for Individuals Experiencing Mental Illness."[41] This measure has the advantage of having robust data and supporting a narrowly defined goal. OHA has designated this measure as an "incentive measure" and CCOs are rewarded for strong performance and improvement relative to baseline performance on this measure, beginning with performance in 2018.[42] Using this approach, OHA clearly and narrowly defined the goal but gave the CCOs the flexibility to implement their own interventions.
- Adherence to a pre-defined intervention that is expected to reduce disparities. Examples include, the assessment of a cultural competency intervention using *NQF 1904: Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set*[43] and the assessment of an intervention to increase screening of patients for their preferred spoken language using, *NQF 1824: Screening for Preferred Spoken Language for Health Care*.[44] In 2012, the National Quality forum endorsed 12 measures that are specifically designed to evaluate health disparity reduction efforts, these measures are included in Appendix B.[45]

While it is more typical to examine each measure separately, a state could also create a disparity composite measure that examines subpopulation performance on a group of selected measures. For example, the state could create a cancer screening composite measure that combines the scores of three standardized cancer screening measures (e.g., breast cancer, cervical cancer, colorectal cancer). The state could stratify the results of this cancer screening measure by subpopulations of interest to determine whether health disparities exist in cancer screening more broadly.

Although selection of valid and reliable measures that are nationally recognized is encouraged, a state may decide to develop a new measure that is specific to the intervention selected and relies on data that are readily available. The primary disadvantages of this approach are that it precludes the possibility of using national benchmark data for future assessments, contributes to the problem of measures proliferation, and it is resource-intensive for a state to create a valid and reliable measure.

Once the measures have been established, the state should consider implementing various incentives to encourage additional focus on disparities reduction. Just as many states have begun to move from simply publishing performance measures to paying for improvement and achievement in quality, states should consider linking incentives to disparities reduction work. These incentives could be directly financial (e.g., pay-for-performance models or tying shared savings payments to disparities reduction work) or they could offer other benefits such as prioritizing high equity plans for auto-enrollment or state contacts.[46] For example, as described above, Oregon pays CCOs for strong performance on the state-defined disparity measure, emergency department utilization for individuals with mental illness. In addition to the funds distributed for work on the Low Birth Weight project, Michigan offers its MCOs additional bonus funds if the MCO is able to demonstrate statistically significant improvement on MCO-specific HEDIS measures for which Michigan has identified a health disparity.[47]

Step 5: Assess Performance and Reassess Program Design

After the measurement period, the state should use the measurement strategy to assess the MCO/provider performance, share the data either publicly or privately, and distribute any applicable incentive payments. In the interest of continuous process improvement, the state should also consider assessing the success of the program as a whole and making refinements to the program. Consumers, plans, and providers should all be invited to inform the assessment.

Conclusion

Tackling health disparities is a challenging task. States should anticipate confronting multiple barriers along the way, including data limitations, stakeholder buy-in, questions about intervention selection, and resource limitations. For states interested in pursuing health equity as a goal, it may be helpful to ground the process by adopting the data-driven approach outlined in this brief. Further, addressing health disparities is not solely the responsibility of Medicaid or its contracted plans. Since in many states health disparities work has traditionally been the domain of the public health agency, states interested in addressing health disparities in their Medicaid managed care programs should convene representatives from Medicaid and public health as well as stakeholders from consumer organizations, community organizations addressing social determinants of health, provider groups, and managed care plans to develop partnerships and leverage ongoing efforts within communities and across the state.

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ABOUT BAILIT HEALTH

This brief was prepared by Kate Reinhalter Bazinsky and Michael Bailit. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see *www.bailit-health.com.*

Appendix A: National Quality Forum Disparities-Sensitive Measures

In the 2017 report, *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity,* NQF provided the following list as examples of "disparities-sensitive" measures, that were anticipated to be high-impact or address highly prevalent conditions as well as measures that cut across conditions and populations.[48]

Condition Area	Measure Title	NQF Number
Cross-cutting	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Cross-cutting	LBP: Evaluation of Patient Experience	0308
Cancer	Breast Cancer Screening	0031
Cancer	Breast Cancer Screening	2372
Cancer	Breast Cancer Screening	2372
Cancer	Cervical Cancer Screening	0032
Cancer	Colorectal Cancer Screening	0034
Cardiovascular Disease	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients with ST Segment Elevation Myocardial Infarction (STEMI) or Cardiogenic Shock	0536
Cardiovascular Disease	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients Without ST Segment Elevation Myocardial Infarction (STEMI) and Without Cardiogenic Shock	0535
Cardiovascular Disease	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	0698
Cardiovascular Disease	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	0699
Cardiovascular Disease	Acute Myocardial Infarction (AMI) Mortality Rate	0730
Cardiovascular Disease	Adherence to Statin Therapy for Individuals with Cardiovascular Disease	0543
Cardiovascular Disease	Adherence to Statins	0569
Cardiovascular Disease	Adult Smoking Cessation Advice/Counseling	9999
Cardiovascular Disease	Congestive Heart Failure Rate (PQI 08)	0277
Cardiovascular Disease	Controlling High Blood Pressure	0018
Cardiovascular Disease	Controlling High Blood Pressure for People with Serious Mental Illness	2602
Cardiovascular Disease	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Cardiovascular Disease	Heart Failure Mortality Rate (IQI 16)	358
Cardiovascular Disease	Heart Failure Symptoms Assessed and Addressed	0521
Cardiovascular Disease	Heart Failure: Symptom and Activity Assessment	0077
Cardiovascular Disease	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
Cardiovascular Disease	Hypertension Plan of Care	0017
Cardiovascular Disease	Median Time to ECG	0289
Cardiovascular Disease	Median Time to Transfer to Another Facility for Acute Coronary Intervention	0290
Cardiovascular Disease	Optimal Vascular Care	0076
Cardiovascular Disease	Pediatric All-Condition Readmission Measure	2393
Cardiovascular Disease	Shared Decision Making Process	2962
Diabetes/Chronic Kidney Disease	Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus	2467

Condition Area	Measure Title	NQF Number
Diabetes/Chronic Kidney Disease	Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus	2468
Diabetes/Chronic Kidney Disease	CAHPS in-Center Hemodialysis Survey	0258
Diabetes/Chronic Kidney Disease	Comprehensive Diabetes Care	0731
Diabetes/Chronic Kidney Disease	Controlling High Blood Pressure	0018
Diabetes/Chronic Kidney Disease	Diabetes Composite	0729
Diabetes/Chronic Kidney Disease	Diabetes Long-Term Complications Admission Rate (PQI 03)	0274
Diabetes/Chronic Kidney Disease	Diabetes: Hemoglobin A1c Poor Control	0059
Diabetes/Chronic Kidney Disease	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	1789
Diabetes/Chronic Kidney Disease	LBP: Patient Education	0307
Diabetes/Chronic Kidney Disease	Monitoring Hemoglobin Levels Below Target Minimum	0370
Diabetes/Chronic Kidney Disease	Patient Education Awareness—Facility Level	0324
Diabetes/Chronic Kidney Disease	Patient Education Awareness—Physician Level	0320
Diabetes/Chronic Kidney Disease	Uncontrolled Diabetes Admission Rate (PQI 14)	0638
Infant Mortality	Adverse Outcome Index	1769
Infant Mortality	Birth Trauma	0742
Infant Mortality	Birth Trauma – Injury to Neonate (PSI 17)	0474
Infant Mortality	Gastroenteritis Admission Rate (PDI 16)	0727
Infant Mortality	Neonatal Intensive Care All-Condition Readmissions	2893
Infant Mortality	Pediatric All-Condition Readmission Measure	2393
Infant Mortality	PICU Standardized Mortality Ratio	0343
Infant Mortality	PICU Unplanned Readmission Rate	0335
Infant Mortality	Unexpected Complications in Term Newborns	0716
Infant Mortality	Unplanned Maternal Admission to the ICU	0745
Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1879
Mental Illness	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	1880
Mental Illness	Alcohol Screening and Follow-Up for People with Serious Mental Illness	2599
Mental Illness	Alcohol Use Screening	1661
Mental Illness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365
Mental Illness	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	1364
Mental Illness	Clinical Depression Screening and Follow-Up Reporting Measure	9999
Mental Illness	Depression Remission at Six Months	0711
Mental Illness	Depression Remission at Twelve Months	0710
Mental Illness	Depression Response at Six Months- Progress Towards Remission	1884
Mental Illness	Depression Response at Twelve Months- Progress Towards Remission	1885
Mental Illness	Gains in Patient Activation (PAM) Scores at 12 Months	2483
Mental Illness	Preventative Care and Screening: Screening for Depression and Follow Up Plan	3132
Mental Illness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	0418

Appendix B: National Quality Forum Measures to Assess Disparity Interventions

In the 2017 report, *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity,* NQF provided a list of measures that can be used to evaluate implementation of interventions designed to reduce disparities. Below are the measures that NQF identified that are not disease or condition-specific that could be used to assess such interventions.[49]

NQF-Assigned Domain	Measure Title	Measure Type	NQF #	Information Source
Culture of Equity	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Outcome	1904	NQF QPS
Culture of Equity	Cross-Cultural Communication Measure Derived from the Cross-Cultural Communication Domain of the C-CAT	Outcome	1894	NQF QPS
Culture of Equity	Health Literacy Measure Derived from the Health Literacy Domain of the C-CAT	Outcome	1898	NQF QPS
Culture of Equity	Individual Engagement Measure Derived from the Individual Engagement Domain of the C-CAT	Outcome	1892	NQF QPS
Culture of Equity	Language Services Measure Derived from Language Services Domain of the C-CAT	Outcome	1896	NQF QPS
Culture of Equity	Leadership Commitment Measure Derived from the Leadership Commitment Domain of the C-CAT	Outcome	1905	NQF QPS
Culture of Equity	Performance Evaluation Measure Derived from Performance Evaluation Domain of the C-CAT	Outcome	1901	NQF QPS
Culture of Equity	Workforce Development Measure Derived from Workforce Development Domain of the C-CAT	Outcome	1888	NQF QPS
Structure for Equity	L1A: Screening for Preferred Spoken Language for Health Care	Process	1824	NQF QPS
Equitable High-Quality Care	Care Coordination	Process		CMS
Equitable High-Quality Care	Care Coordination	Patient Engagement/ Experience		CMS
Equitable High-Quality Care	Cultural Competence	Process		CMS
Equitable High-Quality Care	Cultural Competency Implementation Measure	Process		CMS
Equitable High-Quality Care	Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator	Process	2842	NQF QPS
Equitable High-Quality Care	Family Experiences with Coordination of Care (FECC)-15: Caregiver Has Access to Medical Interpreter When Needed	Process	2849	NQF QPS
Equitable High-Quality Care	Follow-Up After ED Visit for Complex Populations	Process		CMS
Equitable High-Quality Care	Gains in Patient Activation (PAM) Scores at 12 Months	Outcome: PRO	2483	NQF QPS
Equitable High-Quality Care	LBP: Evaluation of Patient Experience	Process	0308	NQF QPS

Endnotes

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9. In this context, "disability status" means whether the individual qualified for Medicaid on the basis of a disability. In addition, the federal rule requires states to identify demographic information for each Medicaid enrollee and provide it to the managed care entity at time of enrollment.

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11. Some of those active in health equity work, including Kathy Ko Chin, suggest that the demographic categories traditionally collected by states and others may be too broad and may therefore unintentionally "erase" sub-populations that could be experiencing disparities. One example is using the umbrella term "Asian," rather than examining sub-populations such as "Vietnamese," etc. Ed Tepporn of The Asian & Pacific Islander American Health Forum explains, "Given the diversity of the 50 different ethnic groups that are included in the term "Asian American", "Native Hawaiian" and "Pacific Islander", this level of data stratification can reveal disparities that would otherwise not be discernible in aggregated data for these communities." (personal communication, March 25, 2019) The Asian & Pacific Islander American Health Forum also encourages states to follow the White House Office of Management and Budget's Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity which suggest collecting and reporting data for Asian American communities separate from Native Hawaiian and Pacific Islander communities. See: United States, Executive Office of the President, Office of Management and Budget (OMB), Office of Information and Regulatory Affairs. (1997). *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. Washington, DC. Retrieved from: www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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40. Interview with Kristin Tehrani, Oregon Health Authority, Health Policy and Analytics [Telephone interview]. (2018, November 20).

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