Provider Directories

Special (EX) Committee on R&I Workstream #5
July 26, 2022
2:00 – 3:30 EST

Topics

- General overview of provider directories and the associated challenges
- Collaborative work around the collection, maintenance and use of race and ethnicity data
- Inclusion of race and ethnicity information in provider directories

Current state of provider directories

1. Despite regulation, significant effort, and spend, there has been minimal improvement to provider directory accuracy.
2. Patient expectations for provider directory information are expanding.
3. Provider directories are becoming increasingly important.
4. New legislation/regulations are introducing additional complexity that the industry is trying to understand and navigate.

Common challenges and issues

Practice Perspective

Inundated with multiple directory requests from plans lacking consistency

Health plans do not apply updates that are provided

Siloed data and responsibilities

Financial and claims-oriented mindset when interacting with health plans

Health Plan Perspective

Compliance with disparate regulations

Updates often conflict with another source of data and require investigation

Siloed data and responsibilities

No authoritative source, chasing multiple sources of directory data

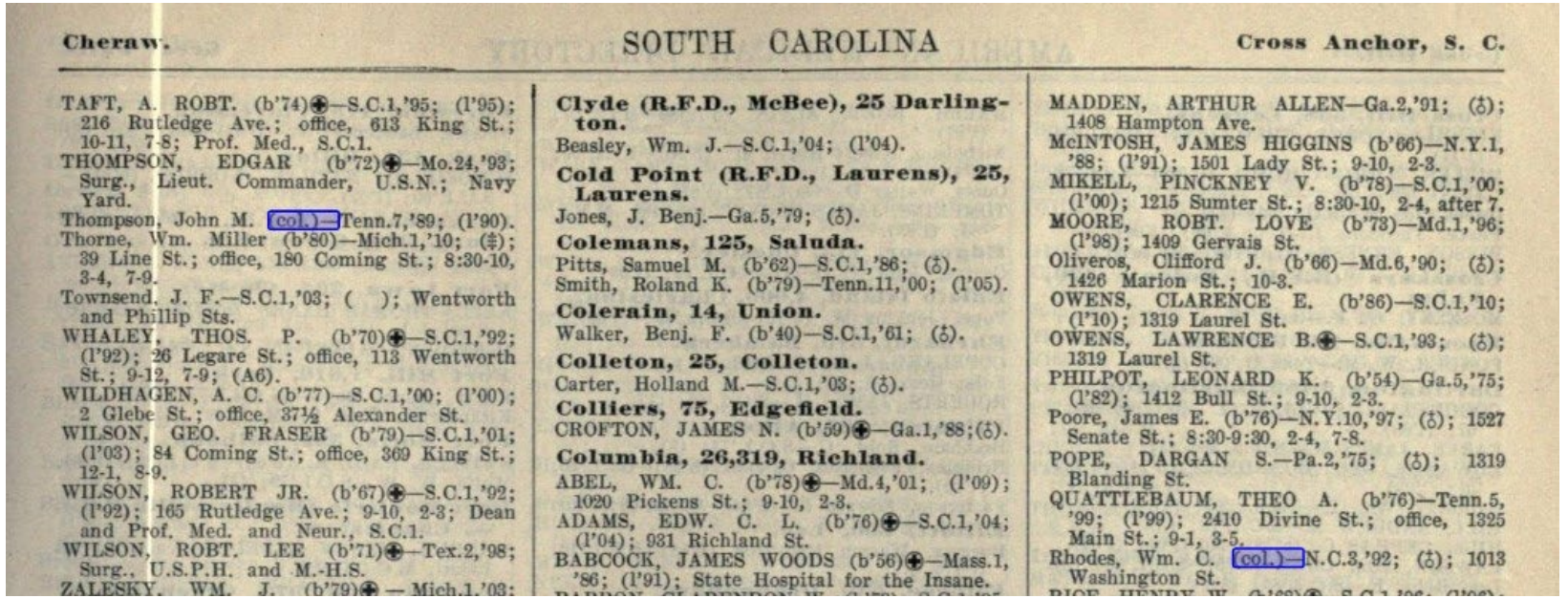
White paper with CAQH

1. Find common ground and recognize that practices and health plans each have a role to play in keeping directories accurate in the service of patients
2. Identify root causes for issues and recommend options to address
3. Facilitate transparency between health plans and practices
4. Strive for and promote standardization to ease administrative burden
5. Create stakeholder awareness and cultivate a different approach
6. Start moving in the right direction to resolve this issue

Collaborative work around race and ethnicity

The AAMC, ACGME, and AMA are working together to establish best practices for data sharing and standards **for sociodemographic data, including race and ethnicity, sexual orientation, gender identity, language proficiency, disability, and more. These efforts will** enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum.

Equity Considerations



Cheraw. SOUTH CAROLINA Cross Anchor, S. C.

TAFT, A. ROBT. (b'74)⊕—S.C.1,'95; (l'95); 216 Rutledge Ave.; office, 613 King St.; 10-11, 7-8; Prof. Med., S.C.1.
THOMPSON, EDGAR (b'72)⊕—Mo.24,'93; Surg., Lieut. Commander, U.S.N.; Navy Yard.
Thompson, John M. (col.)—Tenn.7,'89; (l'90).
Thorne, Wm. Miller (b'80)—Mich.1,'10; (♯); 39 Line St.; office, 180 Coming St.; 8:30-10, 3-4, 7-9.
Townsend, J. F.—S.C.1,'03; ( ); Wentworth and Phillip Sts.
WHALEY, THOS. P. (b'70)⊕—S.C.1,'92; (l'92); 26 Legare St.; office, 113 Wentworth St.; 9-12, 7-9; (A6).
WILDHAGEN, A. C. (b'77)—S.C.1,'00; (l'00); 2 Glebe St.; office, 37½ Alexander St.
WILSON, GEO. FRASER (b'79)—S.C.1,'01; (l'03); 84 Coming St.; office, 369 King St.; 12-1, 8-9.
WILSON, ROBERT JR. (b'67)⊕—S.C.1,'92; (l'92); 165 Rutledge Ave.; 9-10, 2-3; Dean and Prof. Med. and Neur., S.C.1.
WILSON, ROBT. LEE (b'71)⊕—Tex.2,'98; Surg., U.S.P.H. and M.-H.S.
ZALESKY, WM. J. (b'79)⊕—Mich.1,'03;

Clyde (R.F.D., McBee), 25 Darlington.
Beasley, Wm. J.—S.C.1,'04; (l'04).
Cold Point (R.F.D., Laurens), 25, Laurens.
Jones, J. Benj.—Ga.5,'79; (♁).
Colemans, 125, Saluda.
Pitts, Samuel M. (b'62)—S.C.1,'86; (♁).
Smith, Roland K. (b'79)—Tenn.11,'00; (l'05).
Colerain, 14, Union.
Walker, Benj. F. (b'40)—S.C.1,'61; (♁).
Colleton, 25, Colleton.
Carter, Holland M.—S.C.1,'03; (♁).
Colliers, 75, Edgefield.
CROFTON, JAMES N. (b'59)⊕—Ga.1,'88;(♁).
Columbia, 26,319, Richland.
ABEL, WM. C. (b'78)⊕—Md.4,'01; (l'09); 1020 Pickens St.; 9-10, 2-3.
ADAMS, EDW. C. L. (b'76)⊕—S.C.1,'04; (l'04); 931 Richland St.
BABCOCK, JAMES WOODS (b'56)⊕—Mass.1, '86; (l'91); State Hospital for the Insane.

MADDEN, ARTHUR ALLEN—Ga.2,'91; (♁); 1408 Hampton Ave.
McINTOSH, JAMES HIGGINS (b'66)—N.Y.1, '88; (l'91); 1501 Lady St.; 9-10, 2-3.
MIKELL, PINCKNEY V. (b'78)—S.C.1,'00; (l'00); 1215 Sumter St.; 8:30-10, 2-4, after 7.
MOORE, ROBT. LOVE (b'73)—Md.1,'96; (l'98); 1409 Gervais St.
Oliveros, Clifford J. (b'66)—Md.6,'90; (♁); 1426 Marion St.; 10-3.
OWENS, CLARENCE E. (b'86)—S.C.1,'10; (l'10); 1319 Laurel St.
OWENS, LAWRENCE B.⊕—S.C.1,'93; (♁); 1319 Laurel St.
PHILPOT, LEONARD K. (b'54)—Ga.5,'75; (l'82); 1412 Bull St.; 9-10, 2-3.
Poore, James E. (b'76)—N.Y.10,'97; (♁); 1527 Senate St.; 8:30-9:30, 2-4, 7-8.
POPE, DARGAN S.—Pa.2,'75; (♁); 1319 Blanding St.
QUATTLEBAUM, THEO A. (b'76)—Tenn.5, '99; (l'99); 2410 Divine St.; office, 1325 Main St.; 9-1, 3-5.
Rhodes, Wm. C. (col.)—N.C.3,'92; (♁); 1013 Washington St.

American Medical Directory, 1912

Beginning in 1906, our AMA's American Medical Directory, which lists all U.S. physicians, officially marked African American doctors with the "col." notation for "colored."

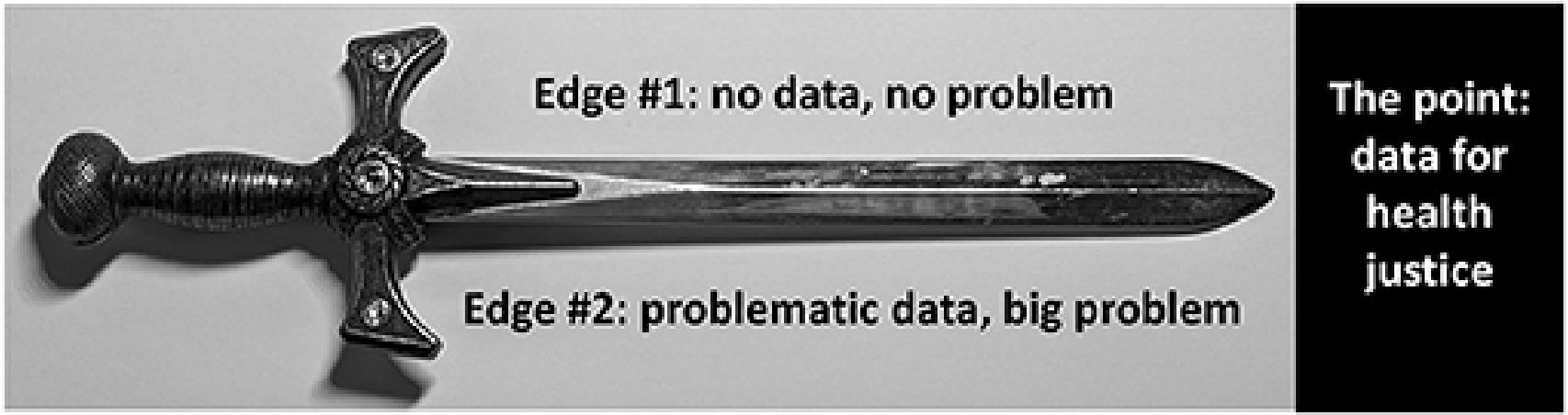
The AMA discontinued its policy of listing Black physicians as "col." in its American Medical Directory in 1939, after years of protest from the National Medical Association.

Source: AMA Archives; deShazo, R. *The Racial Divide in American Medicine*. Jackson: University of Mississippi Press.

Data as a two-edged sword

- One edge of the sword is **"no data, no problem"** -- where data suppression is done by those who want to keep problems invisible and to shirk accountability.

- The other side is **"bad data, big problem"** -- where data "gets used badly," often to entrench injustice



Source: Krieger N. (2021) Front. Public Health

Opportunities

- To ensure physician networks are appropriately diverse and align with patient population
- Establish a benchmark to measure improvement in diversity of physician networks
- Help regulators hold insurers accountable for creating diverse networks that meet the needs for their enrollees

Concerns

- Historically, designation of a physician's race has been used as a tool to discriminate and exclude physicians
- Displaying this information in provider directories could expose minoritized physicians to discrimination from patients

Suggestions

- Standardize race and ethnicity categories
- Evaluate benefits and unintended harms for both physicians and patients over time; share evaluation findings
- Be ready to adjust the program in real-time if necessary
- Support diversification and health equity in other ways

Questions to Consider

Questions around data collection:

- Does an insurer already have this information about the network physician, or would it be new data? If already collected, how has this information been used to date?
- What data categories/classification will an insurer use to capture race and ethnicity?
- **How will an insurer measure potential benefits/harms of this initiative?**

Questions around physicians:

- Is there support from the NMA, NHMA, and organizations representing Asian Americans, Pacific Islanders, and Native physicians?
- How will an insurer respond to harassment or other forms of discrimination racially minoritized physicians may experience from patients?
- How will insurers track / respond to cases where patients may choose to leave or not see racially minoritized physicians because of their race?
- Are racially minoritized physicians in an insurer's network prepared to take on additional patients who may seek them out as a result of this initiative?

Physicians' powerful ally in patient care