Achieving Meaningful Use of Disparities Data

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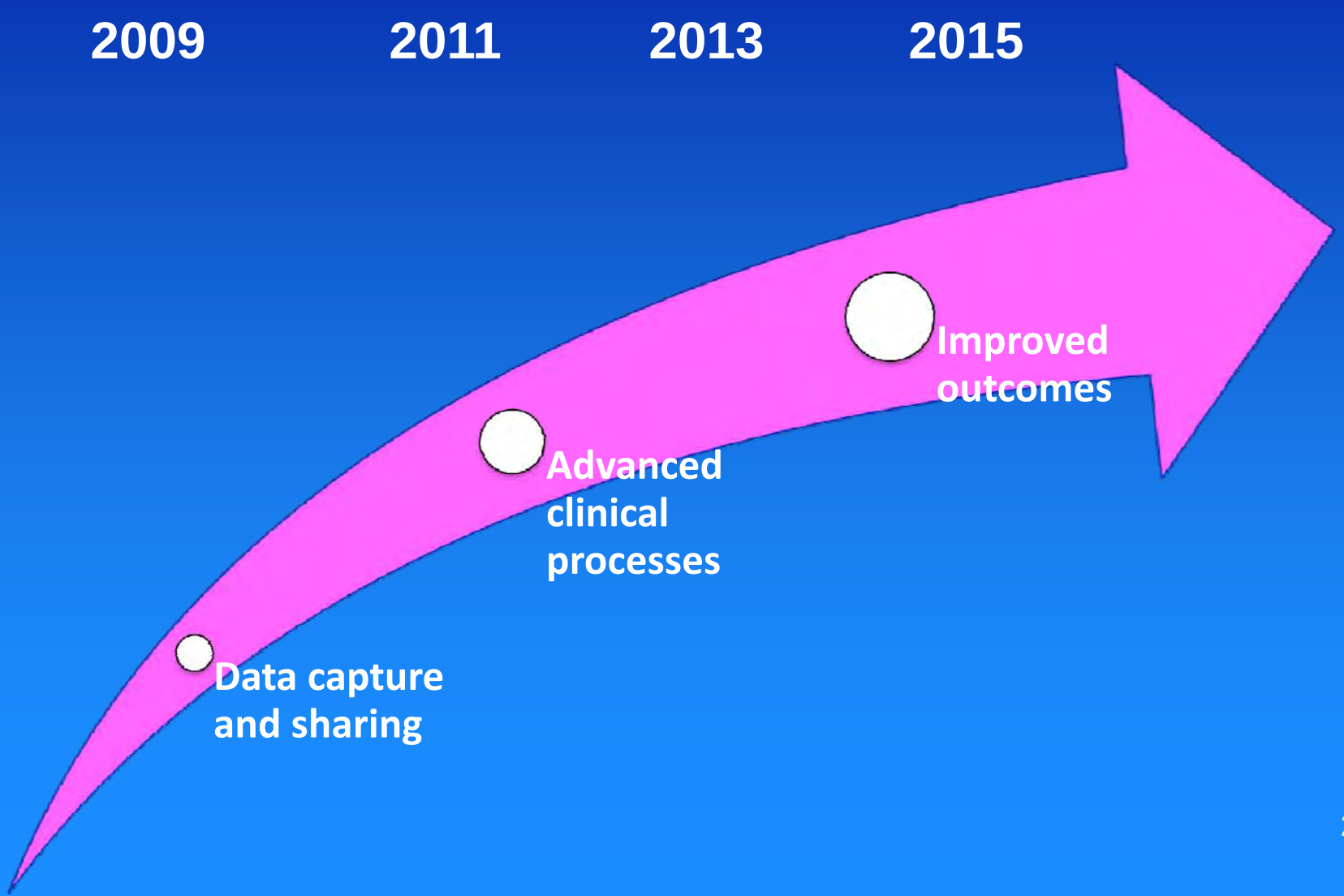
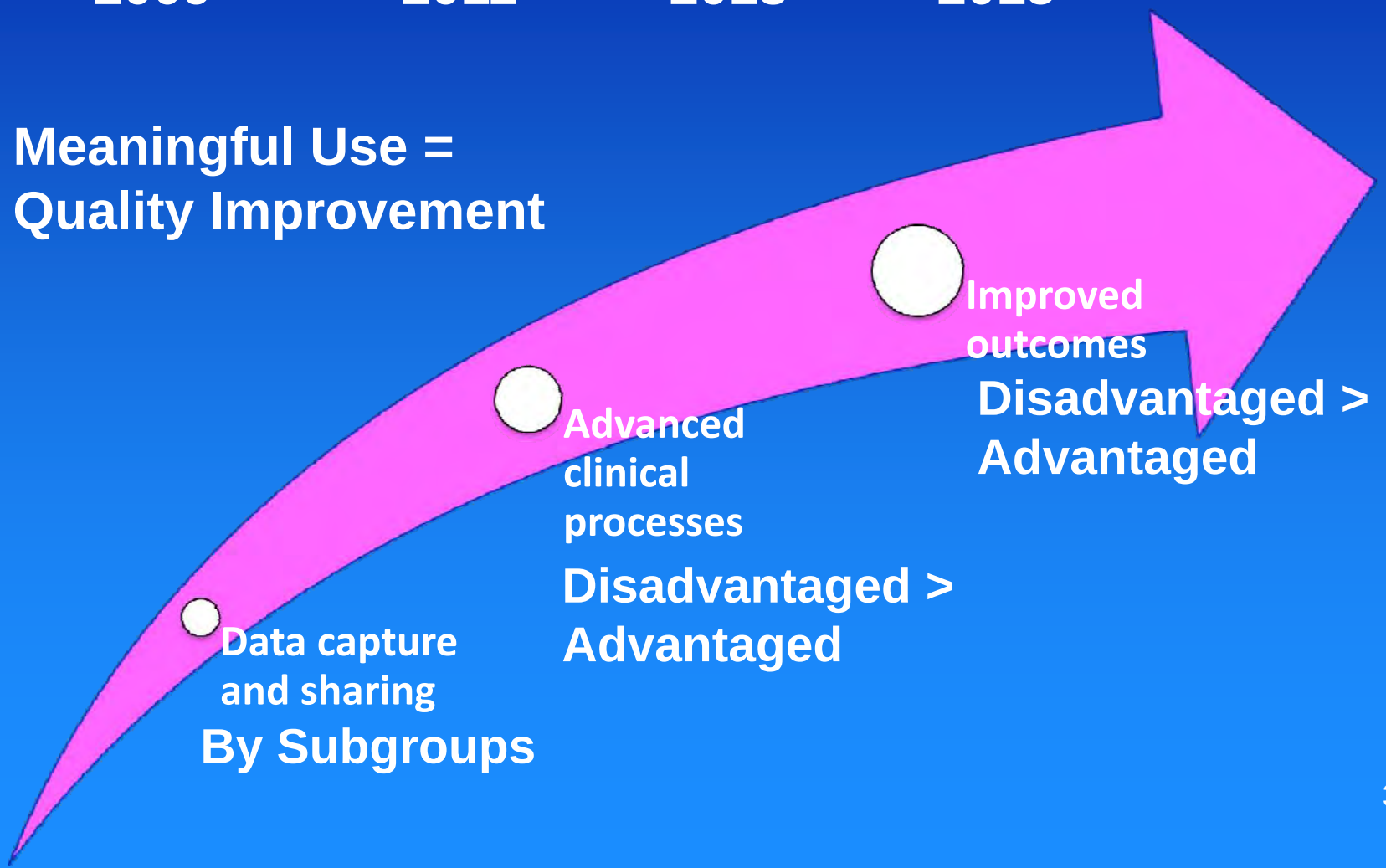
Bending the Curve Towards Transformed Health

Achieving Meaningful Use of Health Data

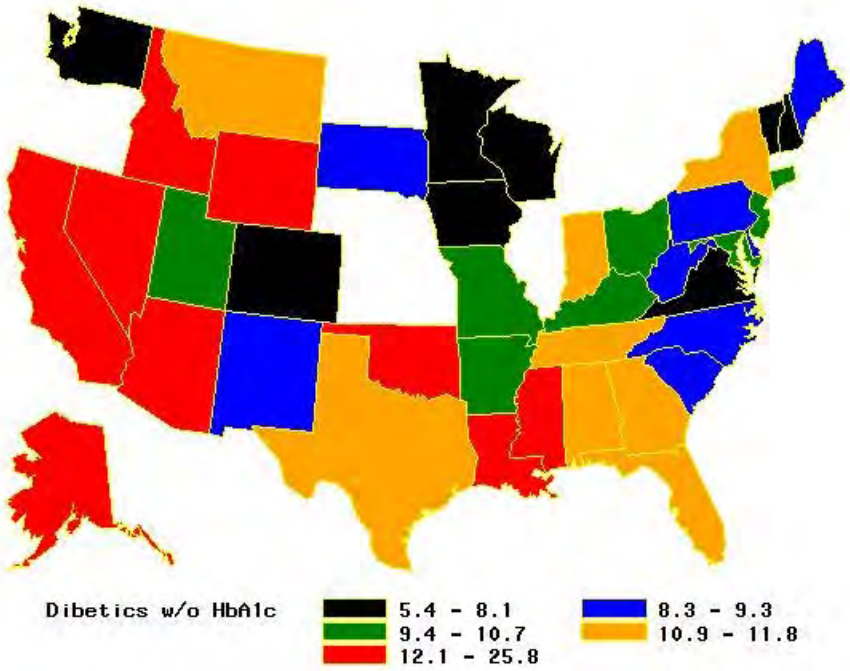


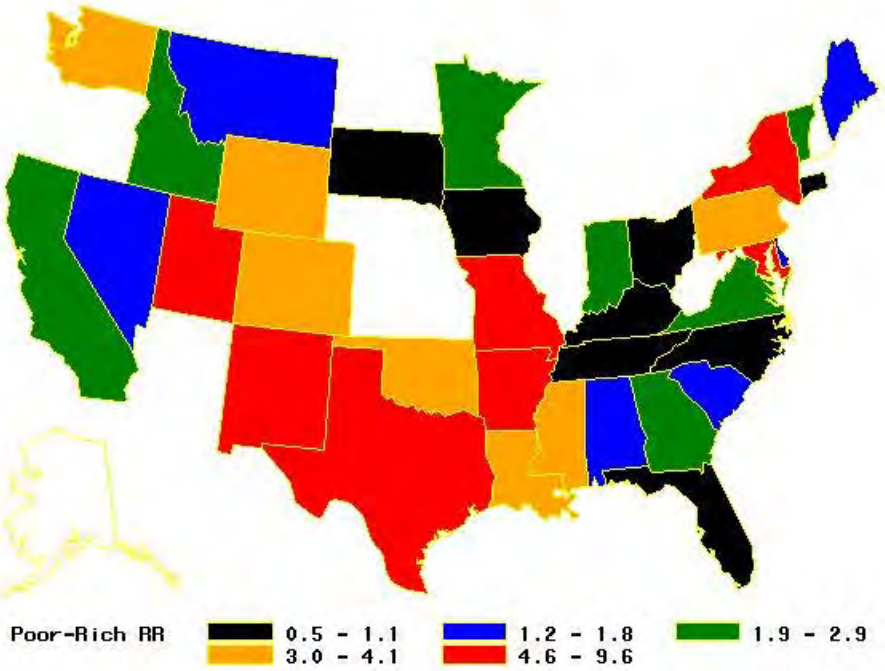
Bending the Curve Towards Equitable Health Care

Achieving Meaningful Use of Disparities Data



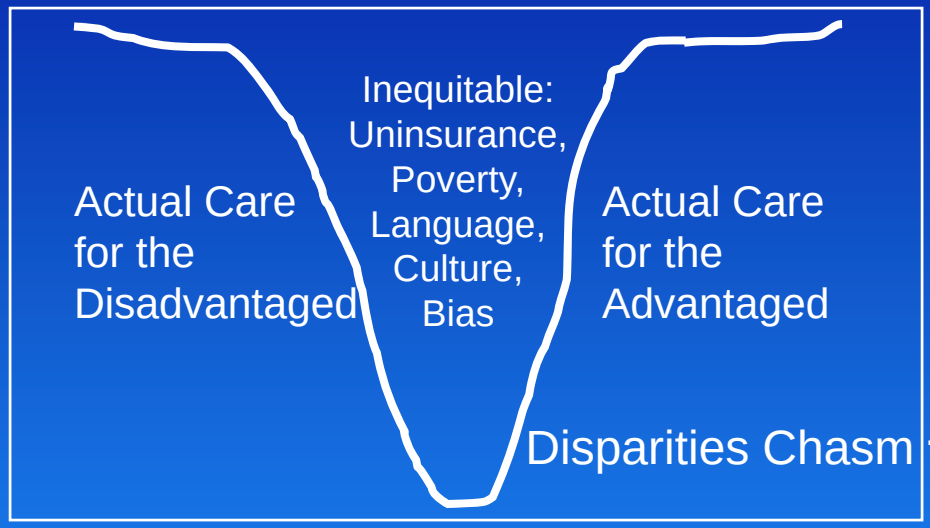
Do we need disparities data to improve quality?





Source: BRFSS, 2005

Quality and Disparities Data can be used together to target interventions.



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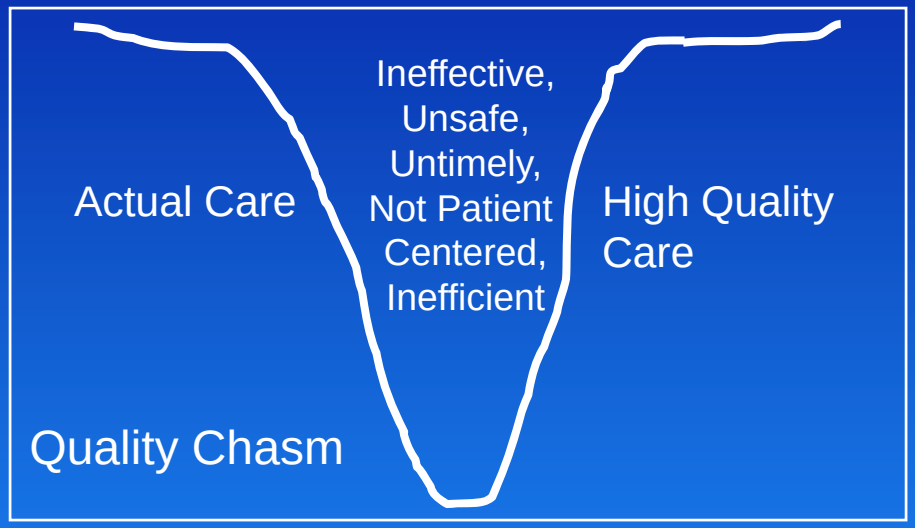
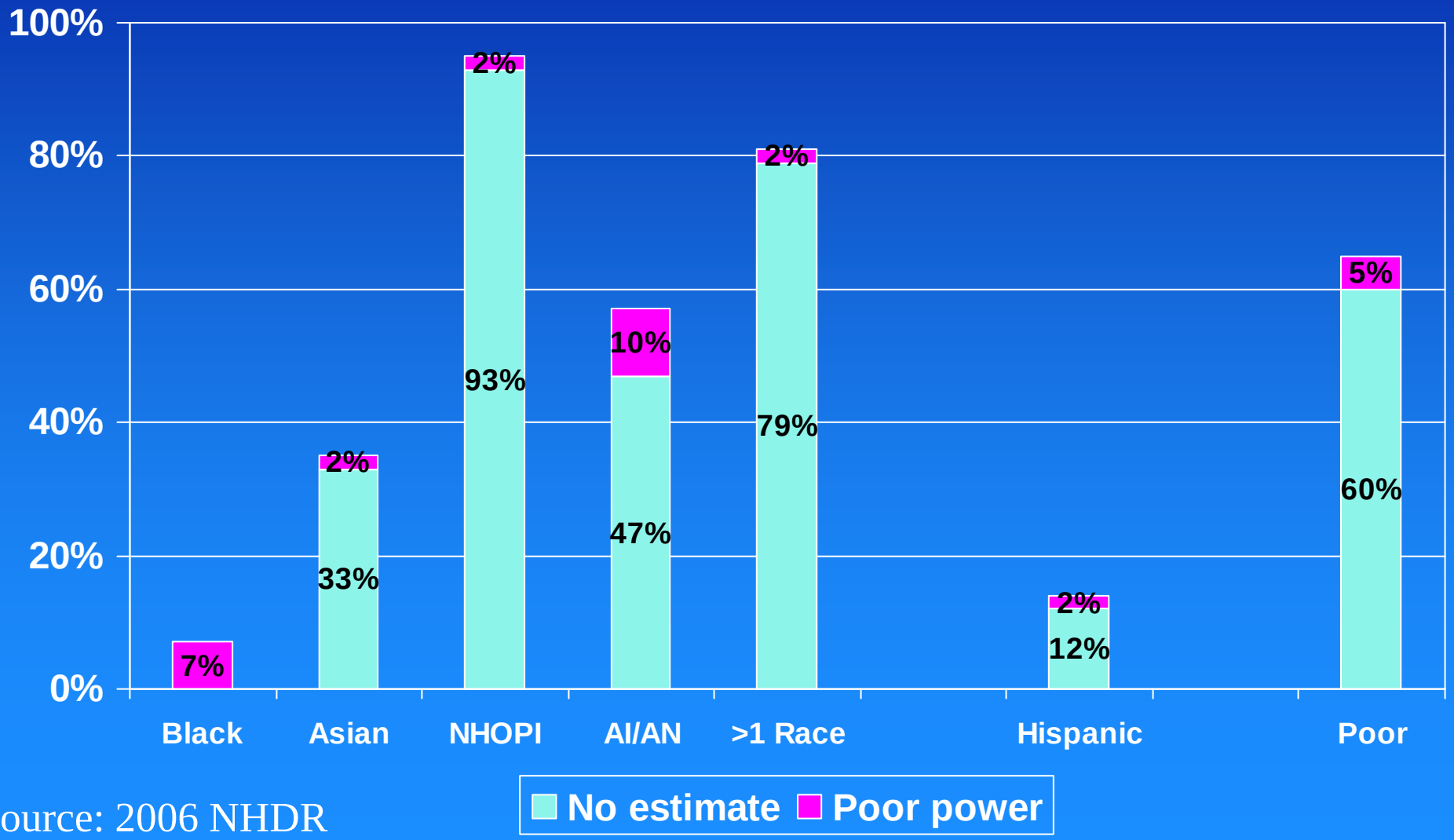


= Quality Improvement for the Disadvantaged

How are we doing?

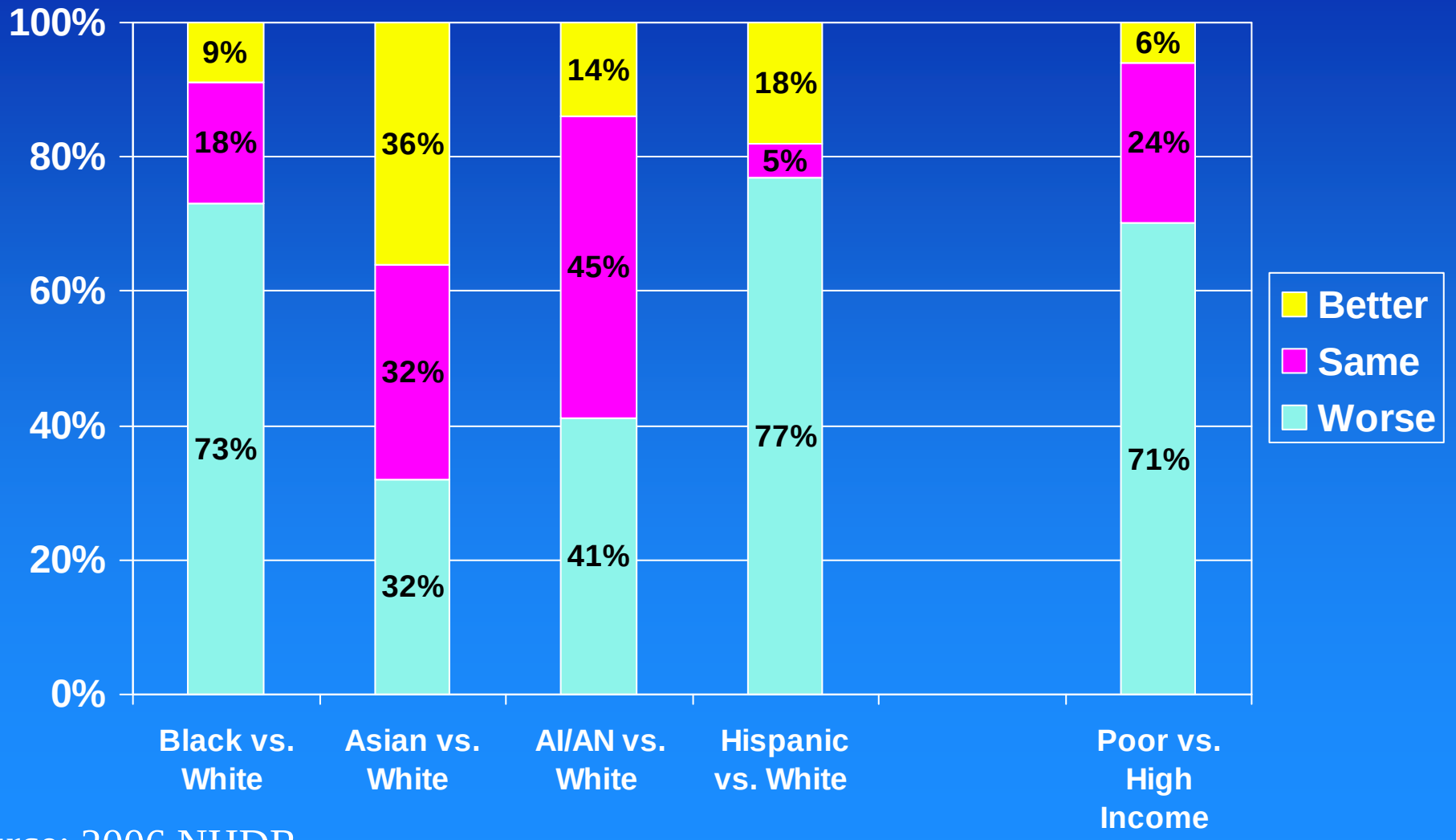
Data capture by subgroup is spotty.



Source: 2006 NHDR

How are we doing?

Disparities in most processes and outcomes are not narrowing.



Source: 2006 NHDR

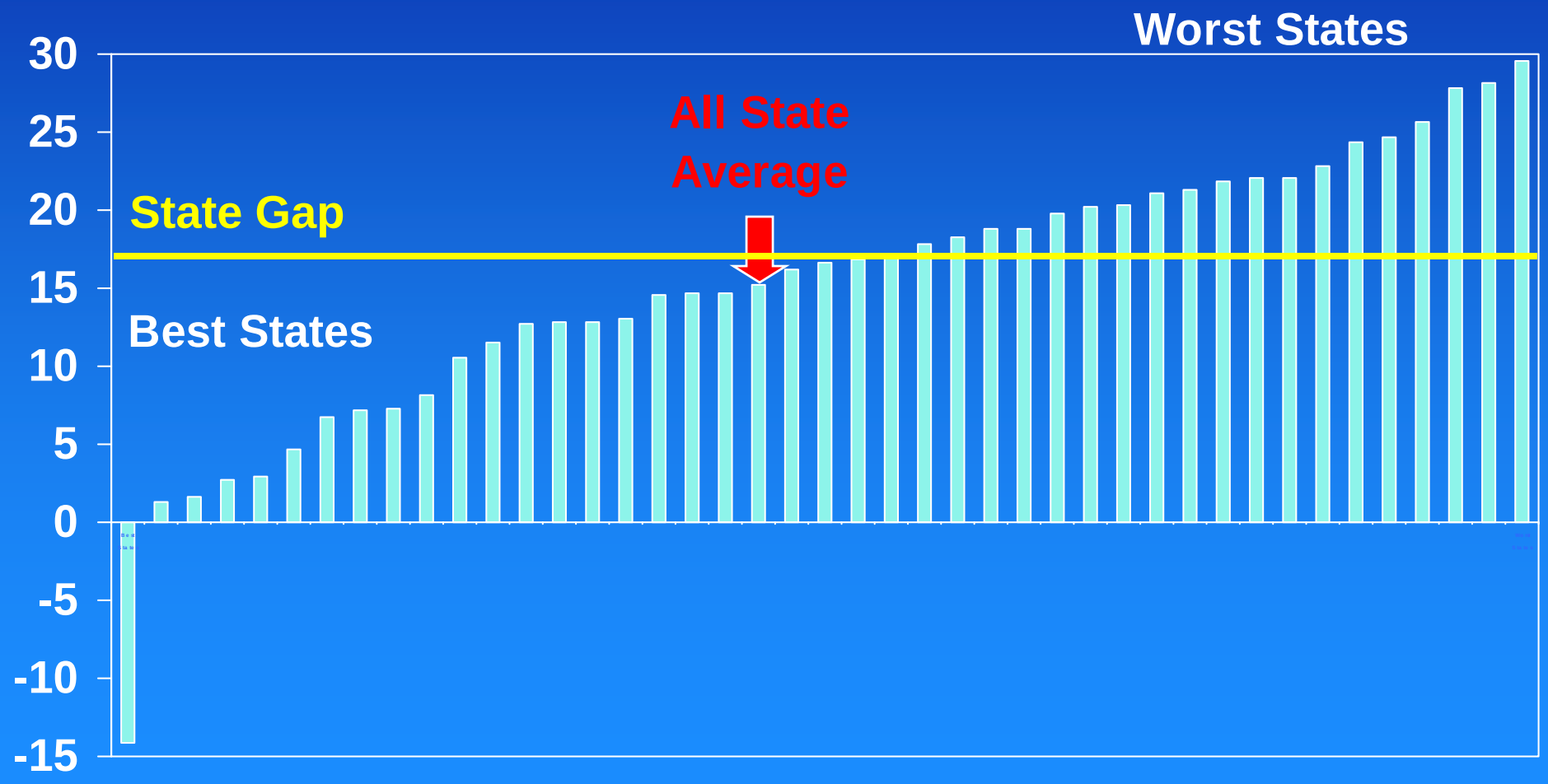
Making disparities data meaningful
How could they be used for QI?

- Target problem: Disparities data ↑ efficiency.
  - What process defect?
  - What geographic area?
  - What subgroup?
- Guide intervention: Disparities data ↑ effectiveness.
  - What media?
  - What language?
  - Cultural sensitivity
- Track progress : Disparities data ↑ efficiency.

What geographic area?

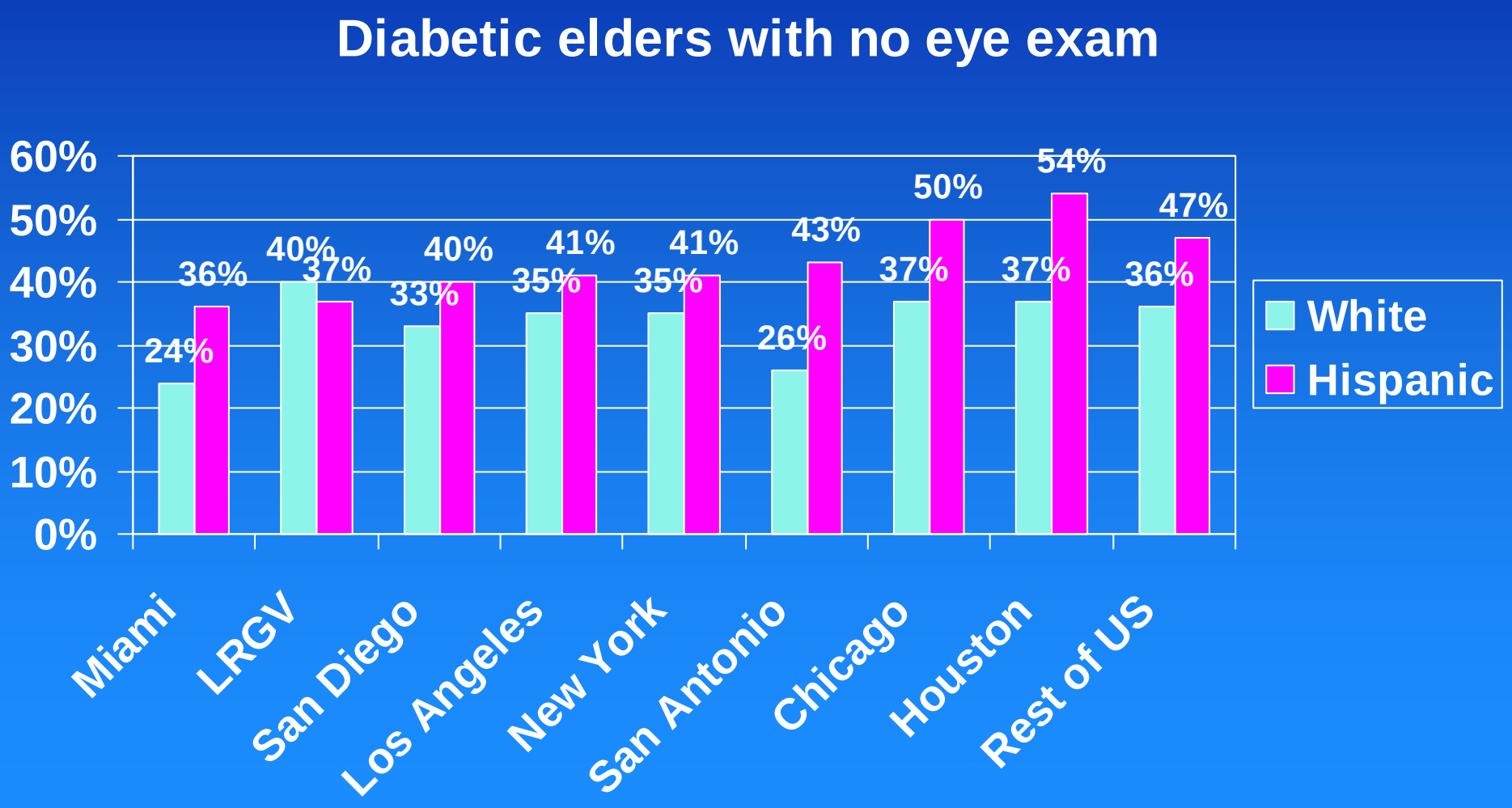
Disparities vary across States.

Colorectal cancer screening, Hispanic-NHW gap



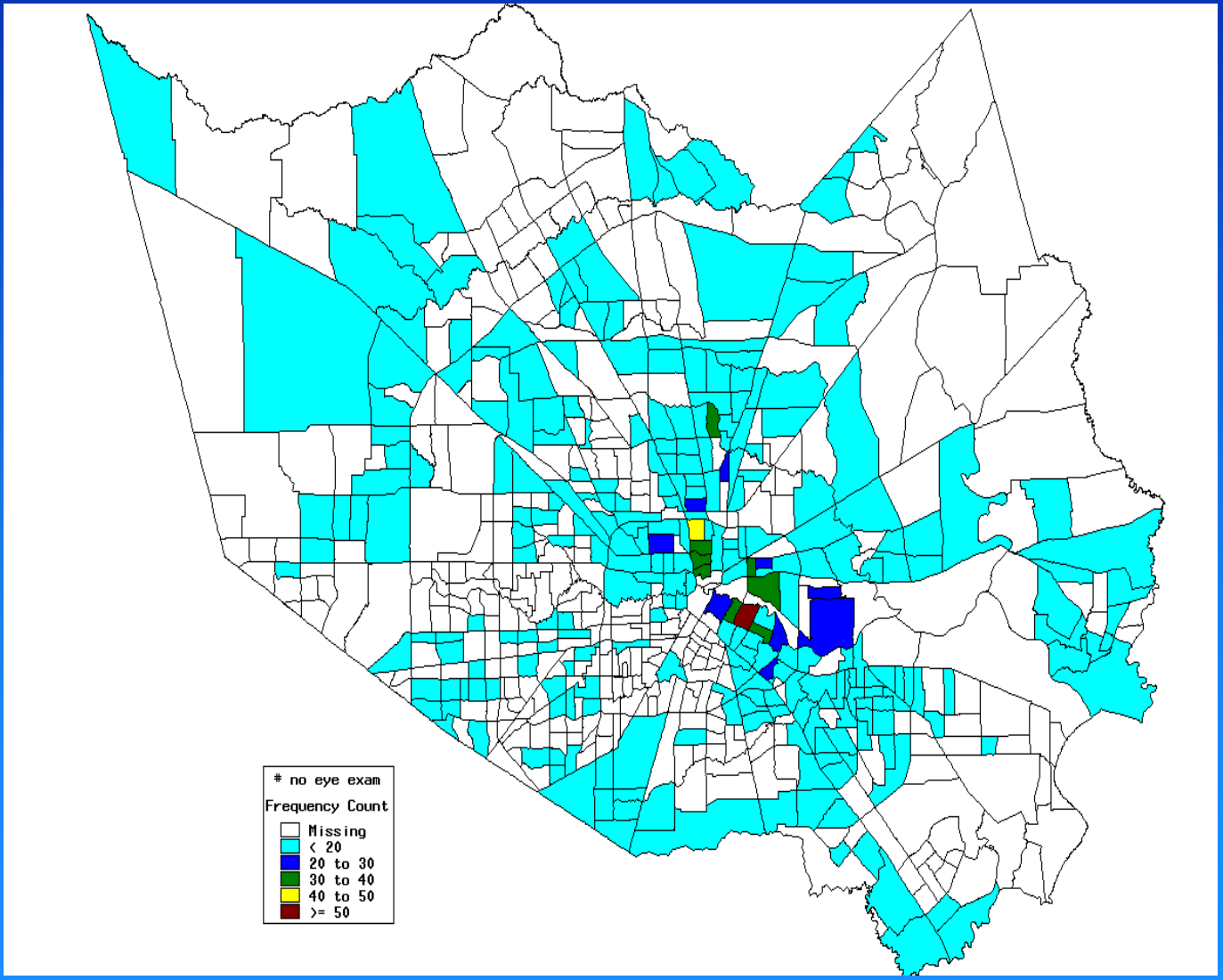
What geographic area?

Disparities vary across cities.



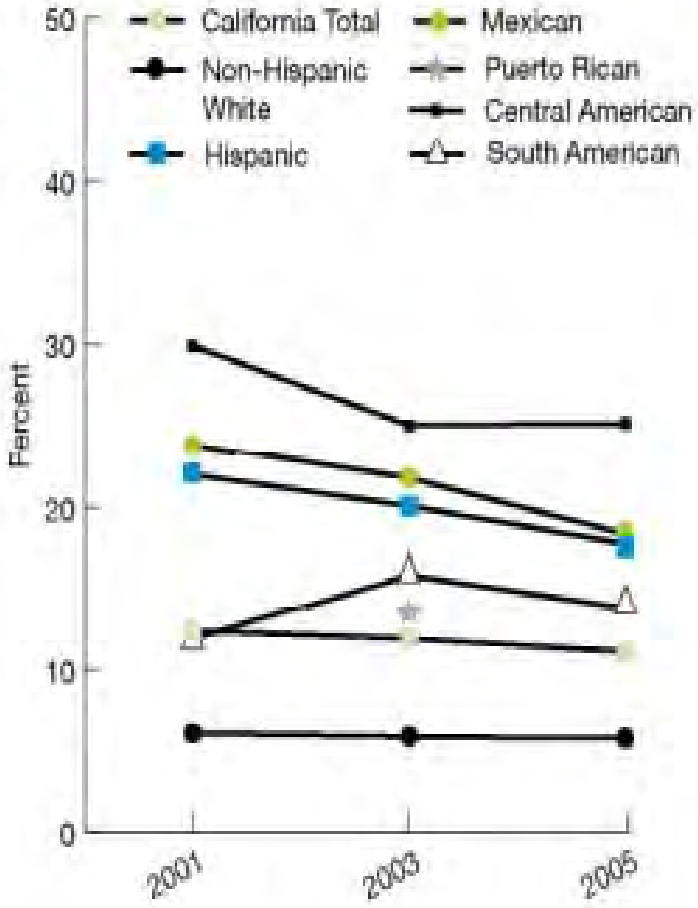
What geographic area?

Health care varies within a city.



What subgroup?
Care varies across Hispanic groups.

Figure 4.21. People under age 65 uninsured all year, by ethnicity and Hispanic subgroup, California only, 2001, 2003, and 2005

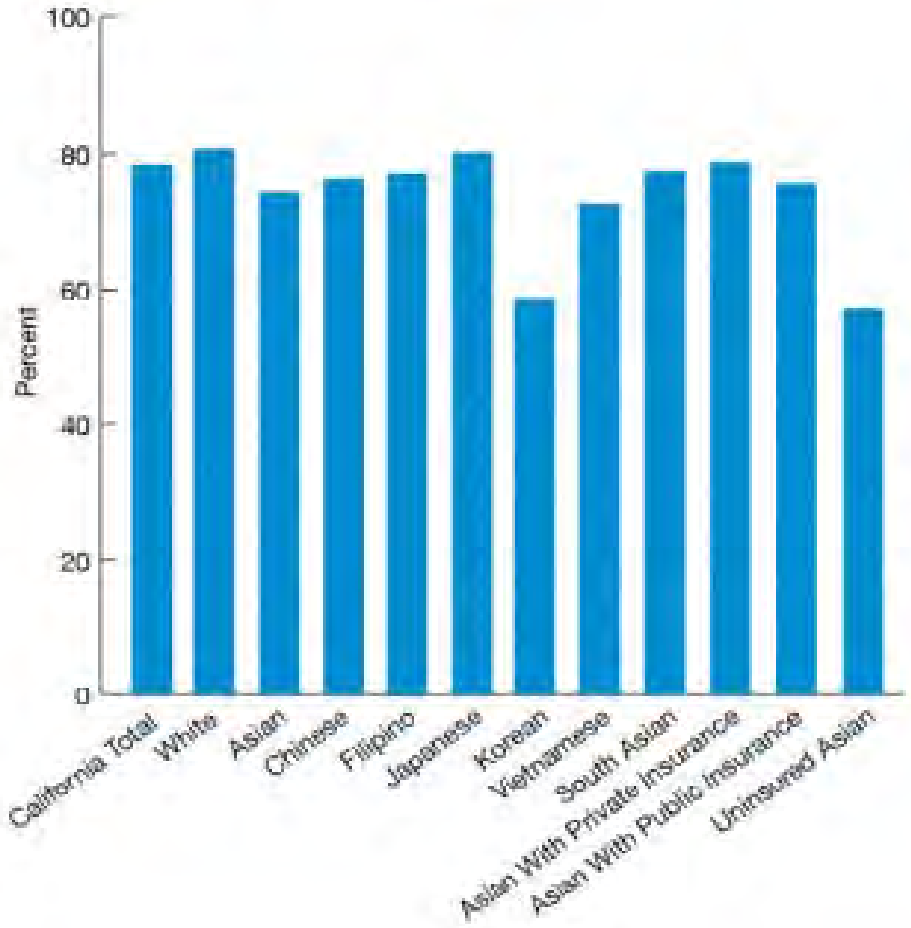


Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey.

Reference population: Civilian noninstitutionalized population under age 65 in California.

What subgroup?
Care varies across Asian groups.

Figure 4.7. Women age 40 and over who reported they had a mammogram in the past 2 years, by race, Asian subgroup, and insurance status, California only, 2005



Source: University of California, Los Angeles, Center for Health Policy Research, California Health Interview Survey.

Note: Public insurance includes people with Medicare and/or Medicaid coverage for this measure.

Reference population: Civilian noninstitutionalized women age 40 and over in California.

Recommendation 3-2: Any entity collecting data from individuals for purposes related to health and health care should collect granular ethnicity data in addition to data in the OMB race and Hispanic ethnicity categories and should select the granular ethnicity categories to be used from a national standard set. When respondents do not self-identify as one of the OMB race categories or do not respond to the Hispanic ethnicity question, a national scheme should be used to roll up the granular ethnicity categories to the applicable broad OMB race and Hispanic ethnicity categories to the extent feasible.

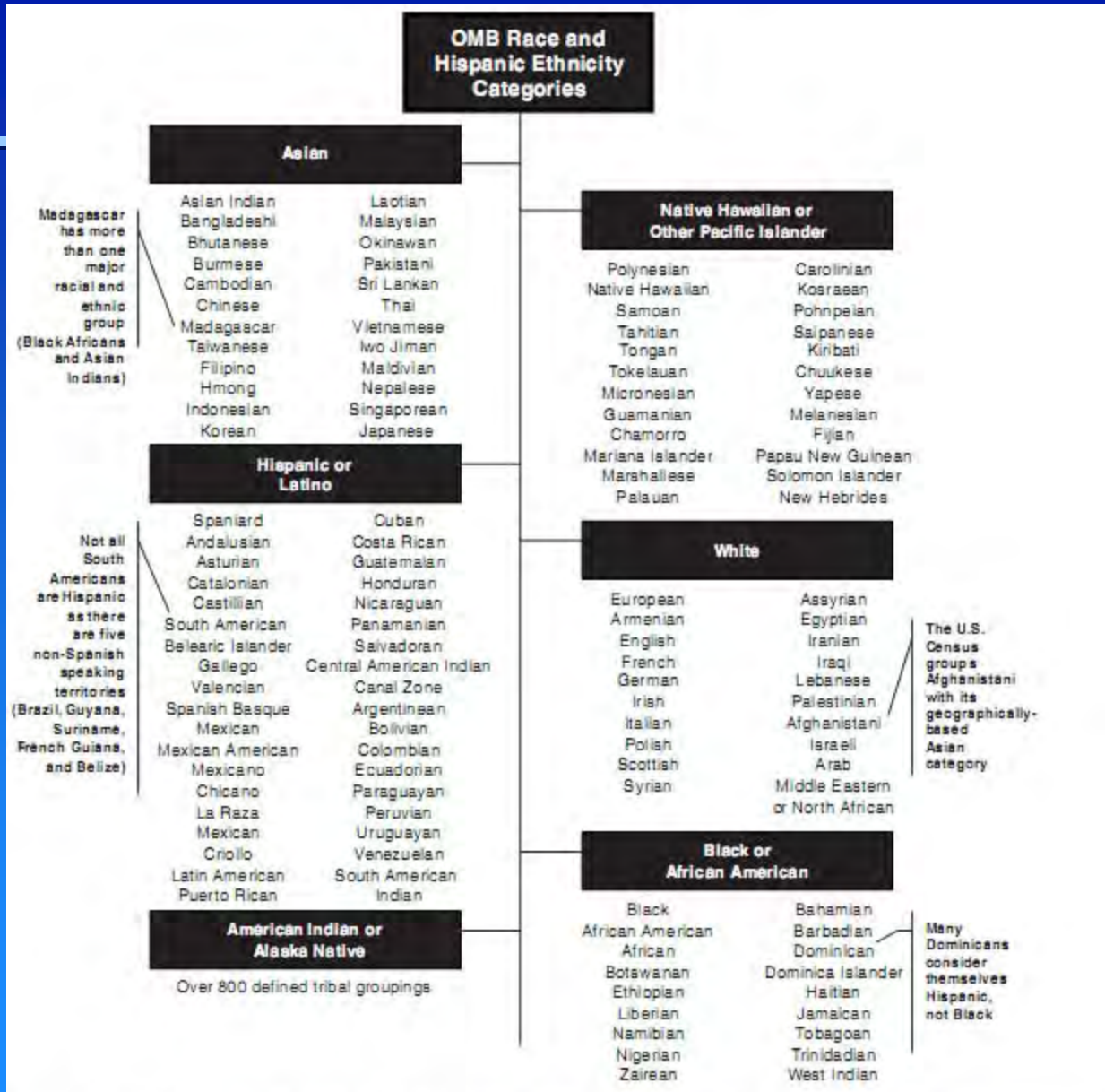
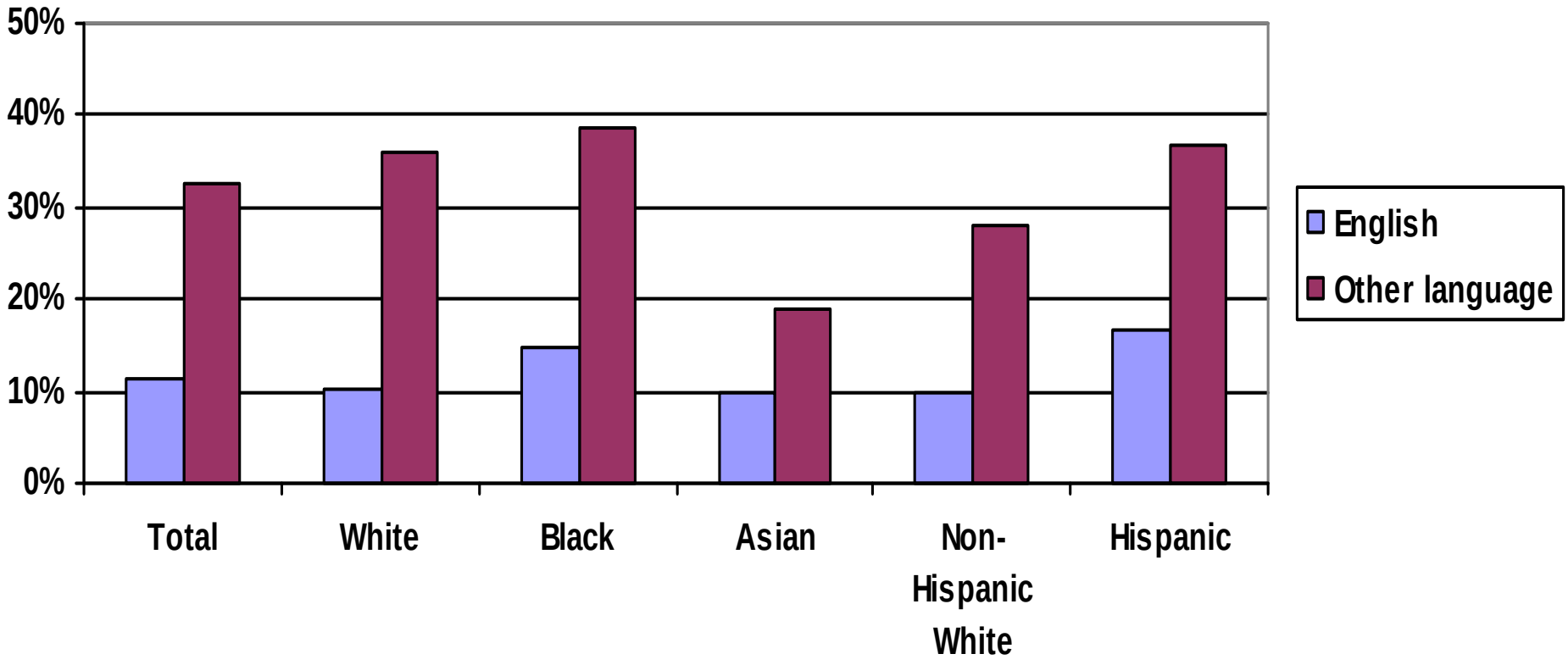


FIGURE 3-3 CDC ethnicities rolled up to the OMB minimum categories for race and Hispanic ethnicity with subcommittee annotations.

What language?
Care varies by English proficiency.

Adults under age 65 uninsured all year, by race and ethnicity, stratified by language spoken at home, 2005



Challenge: Lots of Languages

Recommendation 4-1: To assess patient/consumer language and communication needs, all entities collecting data from individuals for purposes related to health and health care should:

- **At a minimum, collect data on an individual's assessment of his/her level of English proficiency and on the preferred spoken language needed for effective communication with health care providers. For health care purposes, a rating of spoken English-language proficiency of less than very well is considered limited English proficiency.**
- **Where possible and applicable, additionally collect data on the language spoken by the individual at home and the language in which he/she prefers to receive written materials.**

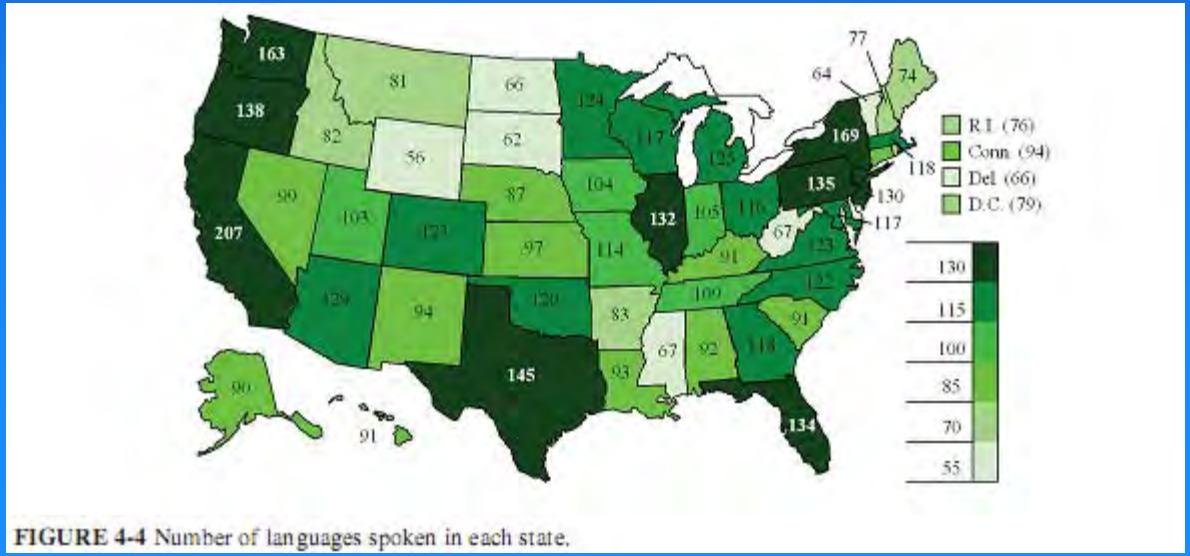


FIGURE 4-4 Number of languages spoken in each state.

Conclusions

- It is appropriate to define meaningfulness of measures in terms of quality improvement.
- So far, much disparities measurement has been spotty and has not led to faster improvement among disadvantaged groups.
- Disparities data should help to target, guide, and track interventions by focusing efforts on specific geographic areas and ethnic and linguistic groups.
- The large numbers of granular ethnicities and languages in the US is a challenge.

Recommendations

- Support collection of disparities data c/w IOM
  - Collect OMB race/ethnicity
  - Begin collection of English proficiency
  - Identify meaningful ethnicities and languages for national tracking
  - Develop methods to help States and private organizations identify their meaningful ethnicities and languages
- Collect enough data to support quality improvement
- Promote use of disparities measures to reduce disparities (maybe even improve quality)
- Assess disparities data measurement activities to ensure they support quality improvement