

Moving Toward Racial and Ethnic Equity in Health Care

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The quality of health care in America varies significantly depending on a number of factors, including the race and ethnicity backgrounds of patients. In the past decade, hundreds of research studies confirmed that patients from specific race and ethnicity backgrounds experience lower-quality care than other groups. These differences may be caused in part by factors such as income, education and insurance coverage. But even after adjusting for these determinants, disparities often persist. Given the rapidly growing diversity of this nation, an increasing number of minority Americans find themselves at risk for disease and not getting the care they need.

A key challenge to reforming the U.S. health care system is the need to make health care equitable for all Americans. A necessary first step to increasing health care quality is to assess disparities in treatment and outcomes for the most vulnerable patients, including the poor, disabled, children, elderly, and racial and ethnic minorities. Since 2001, the Institute of Medicine (IOM) has urged health care organizations to collect, report, and monitor information about patients' race, ethnicity and primary language (R/E/L) to document gaps in care for specific patients, develop targeted interventions and improve care for all.

Created to meet these challenges, the Racial/Ethnic Health Care Equity Initiative represents one component of a larger effort known as the High-Value Health Care Project (HVHC). The Quality Alliance Steering Committee (QASC), a multi-stakeholder collaborative comprised of leaders among physicians, hospitals, health insurers, accrediting agencies and the public-sector, developed the HVHC Project in part to support its goals. The Robert Wood Johnson Foundation (RWJF) sponsors the HVHC project with support from the Engelberg Center for Health Care Reform at the Brookings Institution.

The Racial/Ethnic Health Care Equity Initiative engaged stakeholders from across public and private sectors to develop standards and models for collecting and reporting race and ethnicity data, and ensuring that performance measures are stratified accordingly. In addition, this effort focused on making improvements to the "gold standard" of obtaining direct self-reported data.

Self-Reporting vs. Indirect Estimation.

While self-reported race and ethnicity data obtained from individual members are considered the “gold standard” for monitoring differences in health care quality within diverse populations, gathering sufficient self-reported data has proven to be a challenging and lengthy process for health plans.¹

Although a number of health plans recently began voluntarily collecting self-reported race and ethnicity data and some states now require reporting information about race and ethnicity along with quality performance scores, progress is slow. To help accelerate plans’ and states’ efforts, the IOM and others recommend the use of advanced analytic methods to indirectly estimate the race and ethnicity of a plan’s enrollees as an interim step to fill gaps in currently available self-reported data.

The limited availability of self-reported race and ethnicity data creates analytic problems that complicate the ability to understand health care disparities because the small samples are not representative of the population that plans serve, therefore other measurement tools are important to obtain this data.

Indirect Methods Have Evolved.

Indirect estimation methods represent a promising short-term strategy for assessing population-level race and ethnicity health care disparities. While initial indirect estimation algorithms enabled health plans lacking collected race and ethnicity data to assess the composition of their membership, they did not work well on all race and ethnicity groups. However, these methods have been significantly refined over the past several years, effectively addressing limitations and improving their accuracy. More recent versions of estimation algorithms, which employ both name analyses and geocoding, appear to substantially increase accuracy. Some of these approaches have been fully validated in several regions of the United States.

A new method developed by RAND, a nonprofit institution that helps improve policy and decision-making through research and analysis, is perhaps the most well-studied and closest to the advanced indirect methods endorsed by the IOM.² Though the algorithm itself is complex, it requires plans to have only two readily available pieces of information about each member – their last name and address. The RAND method employs a far more comprehensive surname list than was previously available and uses Bayesian statistical methods – an algorithm that combines data collected previously with current data – and Census data describing race and ethnicity characteristics of residential neighborhoods.³ This new, indirect estimation method achieves substantial increases in accuracy and reliability over previous methods, particularly for Blacks and Asians.

Testing The Methodology.

Given the improvements in indirectly estimating race and ethnicity, and the potential for indirect estimates to help fill gaps in self-reported data and support analytic efforts, one might expect plans to quickly adopt the method and accelerate their efforts to address disparities. However, just as with other promising new approaches, widespread uptake and implementation is far from guaranteed.

As part of the Racial/Ethnic Health Care Equity Initiative, the Brookings Institution and RAND conducted a study that examined the varied experiences of 11 health plans in three states – California, Massachusetts and Texas – and their efforts to estimate the race and ethnicity makeup of their membership. The study sought to address three key questions:

1. Is it feasible for health plans to routinely produce indirect estimates in-house using the new method?
2. How do plans typically use indirect estimates and what challenges do they encounter?
3. What other opportunities for using indirect estimates did plans identify?

A brief on the study and results can be found here: <http://www.healthqualityalliance.org/userfiles/RAND%20issue%20brief%20031810%281%29.pdf>

Lessons Learned from the Acquisition of Race, Ethnicity and Language Data in Hospitals.

Hospitals have the lead in collecting R/E/L data. According to two hospital surveys conducted by the Commonwealth Fund and the American Hospital Association, almost 80 percent of hospitals collect race and ethnicity data and 60 percent collect language data. In fact, 22 states require hospitals to collect race and ethnicity data.⁴

Unlike state requirements for hospitals, only two states, California and Massachusetts, require the collection and reporting of race and ethnicity and language data by health plans. Further, although 61 percent of commercial health plans report voluntarily collecting this information, few produce response rates robust enough to measure and address disparities.⁵ For example, among commercial health plans since 2002, Aetna leads the way with data collection, but only has race and ethnicity data on approximately 30 percent of actively enrolled members.⁶ Limited data collection methods, cost prohibitive storage and maintenance processes, and membership turnover continue to challenge health plans in effectively acquiring and utilizing R/E/L information.

Massachusetts: Addressing the Need.

In July 2008, the Massachusetts Health Care Quality and Cost Council (QCC) established a requirement for health plans to report R/E/L data as part of their uniform reporting system for health care claims data sets.⁷ The effort included interviews with health plan employees to identify the current procedures and strategies for collecting and reporting R/E/L data, as well as to highlight the challenges they faced. In addition, consumer focus groups assessed perceptions and concerns about R/E/L data collection by health plans, as well as preferences for race and ethnicity categories. The findings were used to develop a training program for health plan representatives in addressing the challenges associated with acquiring R/E/L data.

Interviews with Massachusetts health plans helped identify the challenges faced by the plans in acquiring data, which resulted in the development of specific strategies for improving self-reported acquisition of R/E/L health plan member data. Some of the biggest challenges identified in collecting R/E/L data were:

- Restrictive, inconsistent and costly IT systems present significant challenges for health plans to store, maintain and effectively use R/E/L information;
- Multiple methods of data collection. While hospitals have face-to-face contact with each patient during administration, facilitating the collection of race and ethnicity information, health plans have few direct interfaces with health plan members, limiting their abilities to acquire race/ethnicity information;
- Consumer skepticism of health plans; and
- High membership turnover and portability.

The challenges identified by health plans in Massachusetts illustrate the many obstacles plans face to collect consistent, reliable R/E/L data.

Standard processes and protocols to facilitate data transfer from employers and providers to plans will increase the availability of R/E/L data and minimize the problems associated with membership turnover. IT software with standard R/E/L fields will simplify health plans' abilities to collect and report these data as will the development of standardized R/E/L categories that take into account regional variation in ethnicity.

More information on the Massachusetts challenges and findings can be found here: <http://www.healthqualityalliance.org/userfiles/file/QASC%20issue%20brief%20021810.pdf>

Montgomery County Hospital Care Initiative.

Health care policy-makers have invested in national efforts to identify and document health care disparities, but there have been few initiatives to document disparities at a local or regional level.

Despite many barriers, it is clear that local-level data will be instrumental in developing targeted interventions that ultimately improve care quality. A pilot program in Montgomery County, Maryland, collected regional hospital performance data stratified by race and ethnicity from five area hospitals to create a local-level model for measuring and monitoring health care disparities. The goals of the pilot were to:

- Improve patient demographic data collection in order to accurately quantify race and ethnicity disparities in health care;
- Engage and communicate with the hospital and broader public health community about race and ethnicity data collection and use; and
- Build greater collaboration among community stakeholders to address disparities in health care.

To ensure the data collected was uniform, the Montgomery County pilot trained admitting staff at all participating hospitals. This training emphasized the importance of directly asking each patient their race and ethnicity, and the prohibition against guessing or “eyeballing” as a substitute.

Each of the participating hospitals collected results for four sets of quality measures – pneumonia, surgical care, acute myocardial infarction, and heart failure stratified by race and ethnicity – for the second and third fiscal quarter of 2009. This represented 27 different measures of care quality.

Only one of the 27 hospital quality measures showed statistically significant evidence of a disparity. In the pneumonia measurement set, data showed that pneumonia patients who identified themselves as Hispanic were significantly less likely than non-Hispanic patients to receive a blood culture, a recommended procedure for inpatient treatment of severe pneumonia cases, within 24 hours of arriving at the hospital. No other measures showed evidence of a race or ethnicity disparity.

The model developed by Montgomery County for measuring disparities on the local level demonstrated an effective way to aggregate regional hospital performance data stratified by race and ethnicity in order to assess and monitor disparities in care. The study underscored the importance of choosing ‘disparities sensitive’ and patient-centered measures to assess and monitor care disparities. It also documented the need, even among broad regions, to have at least one year worth of data in order to acquire sufficient sample sizes to monitor disparities. Further, identifying regional trends in health care disparities can allow hospitals and communities to collaboratively

consider interventions to address disparities in a cost-effective way, rather than identifying piece-meal approaches. This program acknowledged a need to further address data and measurement limitations in order to appropriately identify and monitor disparities in care.

For additional information on this pilot, click on the following link: <http://www.healthqualityalliance.org/userfiles/FINAL%20MoCo%20issue%20brief%20072110.pdf>

Examining the Business Impact of Quality and Health Disparities in King County, Washington.

Some employers have taken action towards improving health care quality and eliminating health disparities. For example, Verizon Communications, after noticing race and ethnicity disparities in health care treatment, worked with health plans to address these inequalities.⁸ However, a recent survey revealed that little more than half of employers recognize the existence of health disparities.⁹ And even when recognized, many continue to perceive race and ethnicity health disparities as a fairness or equity problem, not necessarily a business problem.

Due to the lack of data demonstrating how these disparities directly affect health care costs and worker outcomes, such as productivity and absenteeism, it is a challenge to make the business case for measuring and improving quality by addressing race and ethnicity health disparities has been challenging. To address this issue, King County, Washington, a self-insured employer, explored how employer data can be linked with claims data to develop equity reports and begin measuring the relationship between health care inequality and indirect costs to employers.

King County was able to obtain data on race and ethnicity, and then link that data, as well as data on absenteeism and productivity, with claims data. This provided the ability to determine the quality of care their employees receive, as well as whether inequalities in health care directly affect outcomes and indirect costs.

Using data from approximately 17,000 employees and dependants, researchers developed an integrated database of self-reported race and ethnicity, absenteeism and productivity data from insurance claims data and King County's Health Risk Assessment (HRA) survey. The HRA is an annual survey of those covered under King County's medical plans – employees, as well as their spouses or partners. It includes questions on race and ethnicity, personal health/medical history, and non-health questions like job category and absenteeism or productivity. Nationally-vetted quality measures and quality algorithms were applied to the dataset to examine potential relationships between quality of care, disparities in quality and workplace outcomes.

Researchers focused on measures of quality of care for patients and dependents with asthma, depression or cardiac disease, since poor quality care for these conditions could conceivably lead to recurrence, and ultimately absenteeism or productivity loss.

The pilot project revealed that King County employees generally experienced high-quality care on most performance measures. This made it difficult to observe relationships between quality of care and absenteeism and productivity. The analysis did, however, reveal significant disparities in asthma medication use, with Black patients less likely than other groups to receive adequate medication.

The analyses revealed instances where poor quality of care was associated with greater absenteeism or reduced productivity, but it was also possible to identify individual measures and years in which a relationship in the opposite direction occurred. Future efforts to measure and address disparities in health care should consider the following:

- Use larger, more detailed data sets, perhaps involving data from multiple employers;
- Understand the available data;
- Construct the right database; and
- Analyze appropriate measures for determining race and ethnicity disparities in care.

Results neither confirmed nor refuted hypotheses about a relationship between disparities in quality and indirect costs to employers. However, the successful methodology used in the pilot study shows the potential that exists for others interested in further examining these issues. The King County pilot offers a replicable and feasible approach for employers, policymakers, health plans and others to use in determining whether race and ethnicity health care disparities affect workplace outcomes.

For additional information on the King County pilot, click on the following link: <http://www.healthqualityalliance.org/userfiles/FINAL%20KingCo%2042210.pdf>

Conclusion and Next Steps.

The sources of racial and ethnic health care disparities include differences in geography, lack of access to adequate health coverage, communication difficulties between patient and provider, cultural barriers, provider stereotyping and lack of access to providers. Closing the health care disparities gap is a difficult, multifaceted task.

As evidenced above, there is no simple and easy solution to closing the health care disparities gap, but it is imperative that appropriate resources be brought to bear to address these differences. While improving access to quality care, further refining estimation methods and self-reporting, reforming the health care delivery system, improving cultural and linguistic understanding, diversifying the health care workforce and improving the inequities in the social influences of health may not fully close the disparities gap, achieving these worthy goals would dramatically improve the lives of all people and the future of the nation.

More information about the Racial/Ethnic Health Care Equity Initiative is available online at <http://www.healthqualityalliance.org/hvhc-project/racial/-ethnic-health-care-equity-initiative>

¹ Lurie N, Somers SA, Fremont A, et al. Challenges To Using A Business Case For Addressing Health Disparities. *Health Aff.* 2008b;27(2):334-338.

² Elliott MN, Klein DE, Fremont AM, Lurie N. "Using Medicare CAHPS Data to Validate Indirect Estimation of Racial/Ethnic Disparities." *Presented at Annual AcademyHealth Meetings.* June 27, 2009a. Chicago, IL.

³ Elliott, MN, Morrison PA, Fremont AM, McCaffrey DF, Pantoja P, Lurie N. "Using the Census Bureau's Surname List to Improve Estimates of Race/Ethnicity and Associated Disparities." *Health Services Outcomes and Research Methodology.* 2009b 9:69-83.

⁴ Hasnain-Wynia R, Pierce D, and Pittman MA. "Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals," *The Commonwealth Fund* (2004).

⁵ "Collection and Use of Race and Ethnicity Data for Quality Improvement," *AHIP-RWJF Survey of Health Insurance Plans* (2006).

⁶ Hassett P. "Taking on Racial and Ethnic Disparities in Health Care: The Experience at Aetna," *Health Affairs* (2005): Millwood 24(2):417-20.

⁷ For more information on the Massachusetts Health Care Quality and Cost Council's Uniform Reporting System, see: http://www.mass.gov/lhqcc/docs/regs/129_2_Adopted_2009_07_17.pdf

⁸ Weinstock, Britt. *Why Companies are Making Health Disparities Their Business: The Business Case and Practical Strategies.* National Business Group on Health, 2003.

⁹ Rosenthal, M.B., B.E. Landon, S.T. Normand, et al. "Engagement of Health Plans and Employers in Addressing Racial and Ethnic Disparities in Health Care." *Medical Care Research and Review*, vol. 66, 2009, pp.219-231