Data to Reduce Disparities & Advance Equity

Advancing equity in healthcare starts with data, but more specifically, reliable, and disaggregated data that sheds light on where disparities exist, their causes, and potential solutions.

Without it, we depend on assumptions of equitable care, ignoring the needs of a diverse patient population. And that isn't just a missed opportunity, it's a systemic bias. Current health data perpetuates structural inequities in its lack of detail (and disaggregation). **In other words, it serves to keep disparities across social groups invisible.**

> **Health Disparities**
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> Preventable differences in health status (e.g., burden of disease, injury, or violence, rates of mortality) that stem from broader inequities.
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> **Health Equity**
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> The state in which everyone has the opportunity to reach their full health potential. No one is disadvantaged from achieving this potential due to social position or socially determined circumstances.

So, we may have hunches based on anecdotes or observations, but, without reliable data, disparities remain hidden, and it's hard to know what to do or whether our efforts to eliminate them are truly making a difference.

Race, ethnicity, and language (or REaL) are the most commonly collected demographic data when looking at disparities. However, there are many categories to consider. For example:

- Race
- Sexual Orientation
- Physical/Intellectual Ability
- Ethnicity
- Gender Identity
- Tribal/Indigenous Affiliation
- Language
- Education
- Income
- Citizenship Status
- Age
- Religion
- Incarceration Status
- Employment

And data to reduce disparities also includes information to further shed light on root causes of those disparities. This often involves patient surveys, interviews, focus groups, and advisory councils, as well as collaborating with other community entities who have data, information, or experiences of their own.

QUALITY IMPROVEMENT AND HEALTH EQUITY

When looking at overall, aggregate data related to a quality improvement (QI) effort, we may observe an improvement in quality or outcomes overall—*but did it improve for everyone? Did it do anything for disparities? Did one group benefit from the improvement more than others?* To answer these questions, we need to engage in data disaggregation.

What is Data Disaggregation?
- Breaking down data into smaller, more detailed sub-categories, to illuminate underlying patterns or trends and to better reflect the actual experiences of people.
- Goal: To identify disparities by ensuring populations that have been historically excluded are visible. This allows for healthcare approaches to address specific needs and create solutions that can eliminate health disparities. In other words, it allows for equitable care.

Disaggregating data is critical in QI efforts for a number of reasons, two of which being:
1. It is a tool to reduce disparities by targeting interventions.
2. When an equity lens is *not* taken and data is *not* disaggregated, QI can affect different populations differently and unintentionally worsen disparities.
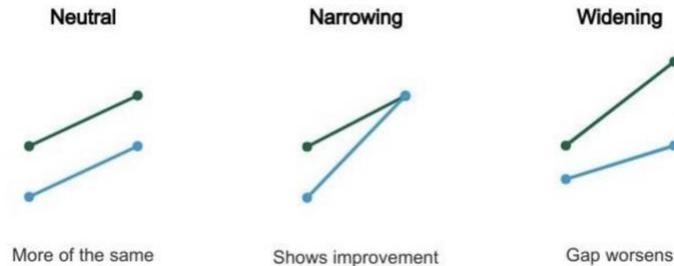
Source: Advancing Health Equity

Reflection

Consider racial, ethnic, and language (REaL) data on your patient population and reflect on the following questions related to using that data to reduce disparities:

1. How is REaL data collected and used in your organization?

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2. How might REaL data be used to design new policies, practices, or quality initiatives?

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3. How can you play a role in ensuring data is being used to reduce disparities?

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When it comes to using data to reduce disparities, a common sentiment among healthcare organizations is, *'How do we focus on this when we're already inundated with data'?* In approaching this concern, focus on a few actionable measures to identify and target health disparities. Consider the following (AMA STEPS Forward):

- Identify 2 measures already meaningful to your practice based on current patient care-related priorities.

- Using those measures, analyze care delivery and practice performance to identify disparities by REaL data and use graphs or charts to visualize that stratified data.

- Choose 1 measure to remind staff that certain populations are disproportionately impacted or neglected (e.g., percentage of patients who have controlled vs uncontrolled hypertension, stratified by REaL data).

- Share this data transparently, engaging all team members in efforts to improve outcomes as well as expand data collection.

GETTING A HANDLE ON YOUR DATA (BAILIT ET AL., 2022)

For those in healthcare, some questions you might ask to better understand how health equity performance is being measured (or not measured) in efforts to reduce disparities include:

- Does your current data infrastructure allow you to collect data in a culturally sensitive manner?

- Are your organization's process and/or outcomes measures stratified by subpopulations (e.g., c-section rates by race)?

- Are your organization's process and/or outcome measures targeted at specific subpopulations (e.g., ED use for people with severe and persistent mental illness)?

- Are process and/or outcome measures targeted at strategies intended to reduce inequities (e.g., % of patients with timely and appropriate access to translator services)?

- Have those measures evolved from assessing whether patients receive an intervention to measuring the impact of those actions (e.g., improved health outcomes following receipt of services for an identified need)?

Reflection

How might your organization commit to finding ways to structure and standardize the collection of all types of demographic data? What challenges might exist in data collection and getting the right data to the right place and the right people?

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Use of Qualitative Data

Whether it is an alternative to or enhancement of quantitative data, qualitative data should not be ignored when working to identify and reduce disparities. That is because qualitative data can tell a fuller story than quantitative data alone. Such data may be gathered from patients, families, staff, community members, and other stakeholders via focus groups, surveys, interviews, and advisory groups to gain insights and inform the development and implementation of potential solutions.

Some things to consider regarding qualitative data include:
- Ensure patients', caregivers, and community members' points of view are represented, with a genuine desire to incorporate those perspectives into understanding reasons for disparities and recommendations for eliminating them.
- Non-provider staff members have practical experience and valuable observations regarding how care is delivered that is often overlooked.
- Qualitative data are especially useful for organizations where the populations within certain social categories are small or for those with substantial diversity across several social categories (e.g., race, language) resulting in small sample sizes for a given measure.

Healthcare's Role in Disparities

To reduce disparities and advance equity, healthcare must strive to provide two types of care:

Equitable Care

Rather than 'treating all patients the same,' it requires providing resources and care based on the needs of the patient to ensures optimal outcomes for all patients regardless of their background or circumstances.

Culturally Responsive Care

Emphasizes the capacity to respond to patients' cultural beliefs & values by engaging them in their care, integrating those beliefs & values into the care plan, & adapting care to align with their culture. This requires cultural humility on the part of providers & other staff.

BIAS IN HEALTHCARE

Unfortunately, in healthcare, bias – and its manifestations of stigma and discrimination – contribute to health disparities and inequities on 3 levels:
- **Provider level** – through implicit bias, negative patient interactions, differential treatment decisions & care quality, etc.
- **Practice level** – such as recruitment & retention of staff as well as organizational policies, practices, & norms (e.g., decisions on where to locate facilities, what insurance to accept, patient financial protections, etc.).
- **Policy level** – like federal, state, and local resource allocation, research focus & participant inclusion, insurance coverage laws, & healthcare education opportunities.

HEALTHCARE'S CONTRIBUTORS TO DISPARITIES & INEQUITIES

Now, imagine - you've looked at the data and know there's a disparity. ***But then what?*** Knowing that bias, stigma, and discrimination exist on multiple levels across the healthcare system, what might be behind the disparity that you (or your practice) can make a meaningful impact on?

This means that, when we find a disparity across patient populations, we must avoid focusing exclusively on patients and begin to design programs that intervene with providers, practices, and policies. Therefore, healthcare providers and practices must begin to look internally and, at minimum, ask themselves 2 questions:

- *What are we doing that might be contributing to disparities or inequities?*
- *What could we be doing (or not doing) to reduce those disparities or inequities?*

Below are some considerations to think about when asking those questions:

PROVIDER CONSIDERATIONS
- Resistance to change
- Implicit biases
- Cultural competency & humility
- Comfort engaging on issues related to social/culture identity
- Knowledge of community & available resources
- Health/medical fluency in languages other than English
- Training & education

PRACTICE/ORGANIZATION CONSIDERATIONS
- Clinic schedule
- Recruitment, retention, training of staff
- Use of biased care coordination algorithms & clinical assessments
- Insurance accepted
- Access to interpretation services
- Patient/family & community advisory boards
- Financial policies
- Location
- Collection/use of patient data (e.g., REaL data)
- History/reputation in community
- Meaningful partnerships with CBOs

POLICY CONSIDERATIONS
- Needed services not reimbursed
- Pay-for-performance may encourage patient cherry-picking/dumping
- State/local support for healthcare programming & infrastructure
- State-level health insurance legislation & reform efforts

Reflection:

Consider a disparity that you see in your own patient population.

1. Which of the considerations listed above might be contributing to that disparity?

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2. What data (quantitative or qualitative) might you want to gather to design an effective intervention related to that contribution?

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3. How might you go about collecting and analyzing the data you identified above?

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References & Resources

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