

ELIMINATING RACIAL/ETHNIC DISPARITIES IN HEALTH CARE: CAN HEALTH PLANS GENERATE REPORTS?

David R. Nerenz
Vence L. Bonham
Robbaya Green-Weir
Christine Joseph
Margaret Gunter

Health Affairs
May/June 2002
vol. 21, no. 3
pp. 259–263

Copies of the full article are
available from:

Health Affairs
7500 Old Georgetown Road,
Suite 600
Bethesda, MD 20814-6133
Tel 301/656-7401 ext. 200
Fax 301/654-2845
www.healthaffairs.org

Commonwealth Fund Pub. #557

Over the past decade, there has been growing evidence of race-based disparities in access to health care services and the quality of care patients receive. Many studies show that even among insured individuals with the same type of health coverage, differences among racial and ethnic groups exist—with minorities generally faring worse. Current health plan efforts to improve quality of care are based on performance measures that apply to all patients. This approach may mask or miss key disparities in quality of care for minorities.

The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In a study published in *Health Affairs* and supported by The Commonwealth Fund and the Health Resources and Services Administration, David R. Nerenz, director of the Institute for Health Care Studies at Michigan State University, and his colleagues demonstrated that health plans are able to collect and analyze quality-of-care data by race and ethnicity.

The project involved eight volunteer health plans and Michigan State University, the Henry Ford Health System, the Lovelace Clinic Foundation, and the University of Texas School of Public Health.

The results suggest that, until direct methods of getting racial and ethnic data can be implemented, health plans can still obtain such data through one or more existing sources: Medicaid enrollment files, medical record data, self-reported items in surveys, and surname-recognition software. The data collected from such sources can be used to generate separate performance reports on members of major racial/ethnic groups.

In 2003, Medicare+Choice plans will be required by federal law to participate in one of two Quality Improvement System for Managed Care projects: racial and ethnic disparities in care or cultural and linguistically appropriate services. This mandate—as would any similar move by state Medicaid programs, the National Committee for Quality Assurance (NCQA), other accrediting bodies, or private purchasers—gives health plans a strong incentive to learn how to collect such data and use it to reduce disparities. While NCQA does not currently require health plans to report HEDIS (Health Plan Employer Data and Information Set) measures specifically by race/ethnicity, the committee is designing HEDIS standards that would encourage health plans to do so.

As part of the initiative to determine whether health plans can obtain data on members' race and ethnicity and whether

those data can be used to generate reports on quality of care stratified by race/ethnicity, researchers collaborated with African American, Hispanic, and Asian and Pacific Islander community leaders, as well as a wide range of technical experts. The advisory groups identified four basic components of a quality of care report card for health plans:

1. HEDIS effectiveness-of-care measures.
2. Information about plan members' experiences with care obtained from the Consumer Assessment of Health Plans Survey (CAHPS).
3. Surveys of patients with chronic disease (asthma or diabetes) or newly diagnosed prostate cancer, as a way to develop measures of provider-patient communication.
4. Survey of plans' cultural and linguistic competence.

At the project's outset, data on race and ethnicity were not available at the plan level, so alternative data sources had to be devised. The project was divided into two phases.

The first phase of the project focused on identifying minority populations. Some plans used three general measures to calculate HEDIS or other quality-of-care measures for different racial/ethnic groups:

- A self-report item on race/ethnicity in surveys was used to split survey participants into racial and ethnic groups, and analyses were done comparing responses across groups.
- Software that relies on surnames to distinguish Hispanic members from non-Hispanic members was used to calculate HEDIS scores for those two groups of plan enrollees.
- Information from providers' medical records and electronic encounter databases helped plans assign

patients to racial and ethnic groups. These data were then used to analyze disparities in processes of care.

The project's advisory groups favored self-reports as the best method of assigning persons to race/ethnicity groups. However, until health plans have self-reported data on race and ethnicity for all of their members, other methods—even with their inherent weaknesses—can be used as proxies, the researchers suggest.

The project's second phase involved working with the eight health plans to demonstrate the feasibility of separately reporting HEDIS, CAHPS, and other quality measures by race/ethnicity. The plans used five methods for obtaining such data in order to prepare comparative quality reports:

1. Self-reported data from CAHPS and chronic disease surveys.
2. State Medicaid data files.
3. Medical record information obtained during chart-review stage of the HEDIS hybrid method.
4. GUESS (Generally Useful Ethnicity Search System) software for estimating Hispanic ethnicity based on surname.
5. Geocoding, with race/ethnicity of selected persons imputed based on street address and Census data.

All plans were able to incorporate race/ethnicity data into their procedures for HEDIS and CAHPS in 2001 and nearly all were able to generate stratified reports. Lastly, the researchers said that there are no legal barriers, except possibly in four states, that would bar health plans from using data on race and ethnicity for the purposes of improving health care quality.