Health Equity and Health Disparities

The Role of Health IT and the Need to Standardize Data Collection

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Introduction

Health disparities are a long-standing challenge in the United States and worldwide. More recently the COVID-19 pandemic and its higher impact on vulnerable and marginalized groups, has helped highlight and direct more attention towards achieving health equity. With a focus on the relationship between health, social factors, and their role in public health, researchers, policy makers and the public at large have noticed and documented health disparities between a range of population groups.

The health information technology field has progressively recognized that addressing health disparities to achieve health equity needs to be a cross-sector effort. Yet, there is still groundwork to be done to raise awareness about the differences between health equity, health disparities and the social determinants of health; how health disparities affect different populations around the country; and how healthcare organizations and entities can work to begin addressing health equity.

This eBook will identify some of the key areas for healthcare organizations to make a measurable impact in improving health equity by promoting the consistent collection of health equity data and evaluating how health IT software can support data exchange and analytics to improve patient care and public health policy development at the local, state, and federal level.

What is the Difference between Health Equity and Social Determinants of Health?

Health equity and social determinants of health are often used interchangeably. The Centers for Disease Control and Prevention (CDC) defines health equity as when every person has the opportunity to "attain their full health potential" without being "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."

Achieving health equity requires removing obstacles to health like poverty and discrimination that adversely affect excluded or marginalized groups to provide better access to healthcare.

The social determinants of health, on the other hand, are conditions in the places where people learn, live, and work that affect health, quality of life, and health outcomes. Addressing the social determinants of health is an approach to achieving health equity.

What are Examples of Health Disparities?

Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations." The key word in this definition is "preventable." These disparities include life expectancy, access to healthcare, morbidity, and mortality, and can manifest differently for various populations.

Health disparities can be seen in many aspects of healthcare and health outcomes. Asthma, for example, is a chronic disease that has a higher prevalence for multiple socially disadvantaged populations, including women, multiracial, American Indian, Alaska Native, Hawaiian, and Pacific Islander adults compared with white adults.[1]

According to the Asthma and Allergy Foundation of America, Black Americans are 1.5 times more likely to have asthma, 5 times more likely to visit the emergency department due to asthma, and 3 times more likely to die from asthma.[2]

Beyond race, asthma is more prevalent among adults with a high school or lesser education than college graduates and adults with an annual income of $25,000 or less compared to those with higher income levels. Asthma can be controlled using inhalers and other therapeutics; however, factors like access to healthcare, insurance coverage, and lack of education on environmental triggers present challenges in treating severe asthma and reducing asthma related deaths, hospitalizations, and emergency department visits.[1]

Asthma is a chronic disease that has a higher prevalence for multiple socially disadvantaged populations.

[1]https://www.americashealthrankings.org/explore/disparity/measure/asthma/
[2]https://aafa.org/asthma-allergy-research/our-research/asthma-disparities-burden-on-minorities/

What are Examples of Health Disparities?

Health disparities also exist beyond racial and ethnic categorization but can be difficult to identify and measure. Many public health surveys and health care providers do not generally ask about other demographic characteristics, like sexual orientation and gender identity.[3] Gay and bisexual men, especially those who are young and people of color, have higher risk of contracting HIV and other STIs than other populations.[4] Additionally, lesbian women are 25% less likely than heterosexual women to get timely pap smears for cervical cancer screening.[5]

According to the Office of Disease Prevention and Health Promotion, enhancing efforts to improve LGBTQ health disparities can include reductions in disease transmission and progression, increased mental and physical well-being, reduced health care costs, and increased life expectancy.[4]

Consistent collection and adoption of sexual orientation and gender identity data is needed to help accurately characterize LGBTQ health and disparities to implement effective, widespread interventions.

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[3]https://wayback.archive-it.org/5774/20220413203148/https://www.healthypeople.gov/2020/topics-objectives/ topic/lesbian-gay-bisexual-and-transgender-health
[4]https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf
[5]https://link.springer.com/article/10.1007/s11113-017-9425-5

Health equity data has generally been under reported due to a lack of standards for collecting this information and limited adoption of reporting measures in standard healthcare operations. The healthcare and public health sectors are prioritizing better collection and analysis of health equity data to identify areas of improvement and institute initiatives to reduce health disparities and improve health equity.

Race: Race is often self-identified. Examples include American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and white, with additional subcategories available.

Ethnicity: Ethnicity is often used to identify people of Hispanic, Latinx, and/or Spanish Origin and sometimes includes more granular options to identify specific countries.

Preferred Language: Preferred languages identifies the non-English language needs of the patient to determine whether an interpreter is required at the patient level or whether language access services need to be modified at the organizational level.

Sexual Orientation: Common terms for sexual orientation include "gay/lesbian," "bisexual," "straight/heterosexual," and "queer." These are several examples of many terms people use to identify their sexual orientation.

Gender Identity: Gender identity refers to a person's internal sense of being male, female, both, neither, or another gender, and impacts the pronouns by which a person prefers to use. Examples include she/her, he/him, and they/them.

Disability Status: Disability status assesses hearing; vision; difficulty concentrating, remembering, or making decisions; mobility; difficulty dressing, bathing, and doing errands alone

Health Equity Data

Discussions of Health Equity: COVID-19

The COVID-19 pandemic brought health disparities and health equity into mainstream conversations. Headlines from across the country broadcasted statistics about higher rates of COVID-19 infection, hospitalization, and death in people of color than white people.[6]

Since January 2021, the Biden administration has renewed the federal government's focus on health equity, promulgating a policy to "pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Affirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our government."[7]

The pandemic also illustrated that data related to health equity, like race, ethnicity, and language preferences, was not consistently being recorded across the healthcare and public health systems. According to an article in Health Affairs, at the first peak of the pandemic in 2020, only 24 states had reported race and ethnicity data of people who had died from COVID-19.[8]

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[6]https://www.npr.org/sections/health-shots/2020/06/22/881886733/black-medicare-patients-with-covid-19-nearly-4-times-as-likely-to-end-up-in-hosp

[7]https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

[8]https://www.healthaffairs.org/content/forefront/centering-equity-design-and-use-health-information-systems-partnering-communities-race

Discussions of Health Equity: COVID-19

Published best practices encourage state and local leaders to disaggregate COVID-19 case data, and consistently measure access to testing and treatment and other relevant measures, by age, race, ethnicity, gender, disability, neighborhood, and other sociodemographic characteristics.

Analyzing data in this way illustrates the interplay between race and social factors, allowing for informed decision- making based on a better understanding of the rate of infection, testing, and vaccinations across populations to ensure equitable access to resources. This approach should also be utilized for other healthcare data not related to COVID-19; however, challenges remain in ensuring adoption of standards and consistent inclusion in medical records.

During the first month of vaccine distribution, **race and ethnicity data were missing for 48% of people** – even though this was required for collection – leading to inconsistencies in the collection and uniformity of health equity data.[9]

[9]https://www.sciencedirect.com/science/article/pii/S0140673621004657?via%3Dihub

Advancing Health Equity: 'By Design'

The Office of the National Coordinator for Health IT (ONC) and CDC have both taken steps to advance health equity. The National Coordinator for Health IT, Micky Tripathi, talks about "health equity by design" whereby standards and processes explicitly consider the impact they can have on health equity. Tripathi asserts that health equity considerations should be baked in as a fundamental design criterion to have a better understanding of health equity through improved reporting and analytics. Similarly, former CDC director, Rochelle P. Walensky, called racism a "serious public health threat that directly affects the well-being of millions of Americans."

Tripathi has further noted that addressing health equity begins with the standardized collection of health equity data. This data is key to identifying disparities, understanding why they exist, and developing and evaluating interventions.

As part of its Health IT Certification Program, ONC currently requires the implementation of standards for race, ethnicity, and language. The CDC also supports a data set with over 900 categories to capture race, ethnicity, and language data.[10]

The ONC has **updated interoperability standards to support the electronic exchange of sexual orientation, gender identity, and social determinants of health** to help build a path forward for health IT.

[10]https://www.healthit.gov/sites/default/files/page/2021-05/Standards_Bulletin_2021-2.pdf
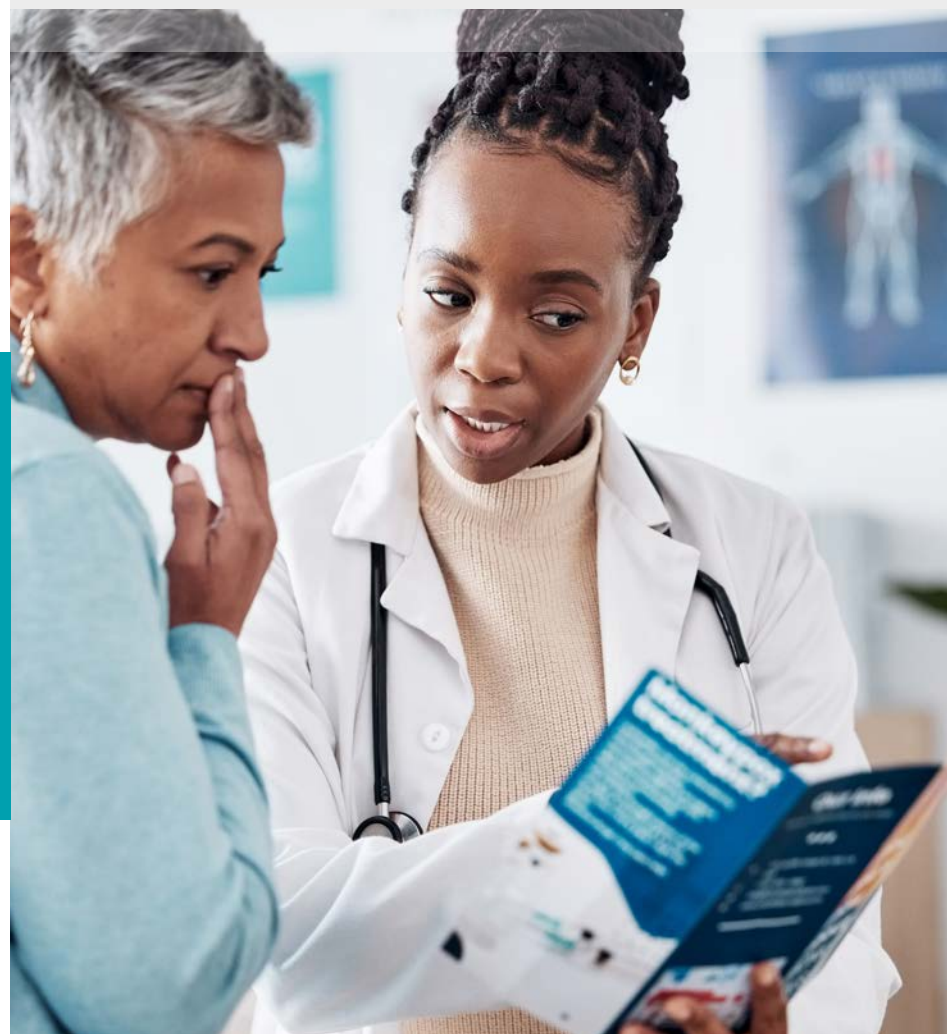
Advancing Health Equity: Gravity Project

Other non-governmental organizations like the Gravity Project are also identifying areas to improve data collection as evidence continues to demonstrate strong links between social risk, health and health care utilization.

The Gravity Project, initiated by SIREN and the Robert Wood Johnson Foundation, seeks to create and maintain a consensus-building community to expand available social determinants of health core data for interoperability. It aims to accelerate standards-based information exchange by using HL7® FHIR® to help healthcare organizations incorporate social risk data into clinical decision-making to improve health outcomes and reduce costs.

The first step in standardizing the consistent collection of health equity data at the federal and industry levels is recognizing the importance of better health equity data to improve health outcomes, lower costs, and expand access to healthcare and other necessary social interventions.

The Role of Health IT in Improving Health Equity

Making strides to improve health equity and reduce health disparities cannot happen unless healthcare organizations and their technology providers, as the enabling mechanism of healthcare data exchange, begin to critically assess and incorporate health equity into software development processes, partnerships, and policies.

As highlighted throughout this eBook, data is essential in uncovering and informing work to address inequities and disparities in healthcare.

Health IT provides the data standards to help ensure data is collected uniformly across settings and the infrastructure to support data exchange among those involved in patient care and public health policy development.

With standards and exchanges in place, health IT supports a data-driven, four-step approach to promoting health equity:

Identify: Use demographic and similar data elements to understand population composition, especially as it relates to those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.

Exchange: Share those data elements with others involved in the patient's care.

Analyze: Conduct simple and statistical analyses of the demographic data, alongside clinical data, to identify disparities among populations.

Intervene: Use the analysis to develop, execute, and evaluate interventions designed to promote health equity.

Using the four steps—identify, exchange, analyze, and intervene— healthcare organizations can leverage their technology to assess and evaluate their role in addressing health equity and develop a roadmap to examine whether they are receiving demographic and population information from data sources.

The Role of Health IT
in Improving Health Equity

For example, does the software include the option to document or record race, ethnicity, or language in patent records? Does the software include the option to document gender identity and preferred pronouns? If so, do workflows ensure data accuracy and completeness? Once collected, are there capabilities to analyze the data, identify trends, and begin to establish approaches that support consistent collection of health equity data—like developing resources to educate data sources on the importance of including health equity data in healthcare records?

While addressing equity may seem like an overwhelming task, it is important to remember that every person and organization can play a role. You can start by recognizing the effect of health equity, educating others who may not be aware of health equity or current health disparities, and begin to apply the data-driven, four-step approach to promote health equity to software and data standards internally. Talk to your partners about their health equity efforts and how your job as a data steward can help support their programs and services. Ensuring that health equity data is being recorded in a uniform way with widespread adoption across the United States will lead to better insights on the health disparities that currently exist and allow for better interventions to improve health equity at a larger scale.

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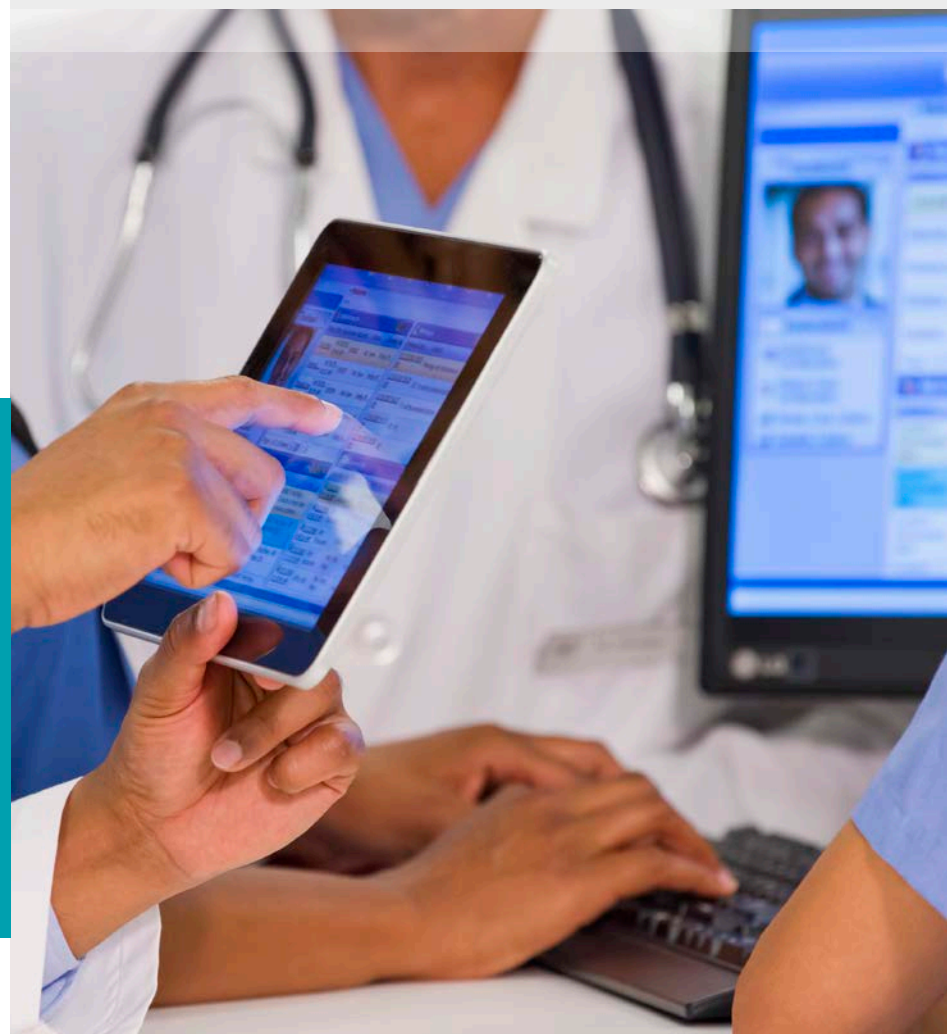
Choosing the Right Health IT Partner to Improve Health Equity

With access to demographic and clinical data beyond their four walls, healthcare organizations can more effectively analyze their population, leading to better insights about health disparities that exist to better inform action plans.

Value-Based Reimbursement Models: While these insights are valuable for all healthcare organizations, they may be of particular interest to ACOs and risk-bearing provider groups who are participating in value-based reimbursement models. These payment arrangements, which have traditionally prioritized cost management and quality improvement, are starting to incorporate additional components to advance health equity. Recent examples include the ACO REACH Model and Making Care Primary (MCP) Model.

For instance, the right health IT solutions can help participating ACOs and risk-bearing provider groups better understand their population and satisfy contractual health equity requirements by leveraging real-time demographic and social risk data from across the care continuum (for example, race captured in the patient's record at an out-of-state hospital, or presence of a referral to a food bank). These additional data sources can supplement the use of claims data, in-network EMR data, and other internal data sources.

Clinical Decision Making: In the busy ED setting, where throughput is a priority, providers typically do not have time to dig through a patient's chart or do additional legwork beyond what is necessary to treat the patient's immediate needs. This often leaves underlying barriers to care that contribute to social determinants of health unaddressed, perpetuating health inequities.

Technology partners can provide tools for ED providers and staff automatically alerting them to patients with pre-determined risks, such as frequent hospital utilization, substance use disorder, mental health conditions, and social determinants of health. Additional insights about SDOH, such as previous diagnosis (Z) codes and social needs referrals can be delivered at the provider's finger tips and most importantly directly in their workflow.

How PointClickCare Can Help

PointClickCare's care collaboration technology supports health equity by breaking down data siloes and facilitating the seamless exchange of patient data across the care continuum. Through our National Network and solutions, we enable better population-level analysis and clinical decision-making that incorporates insights based on patients' social risks.

Learn more about our Value Based Care for ACOs solution and how we can help ensure you have the right population, demographics and risk information from care settings across the continuum.

Or see how our Emergency Department (ED) Optimization solution supports health equity by arming ED providers and staff with individual patient insights to drive more informed decision-making at the point of care.

The Role of Health IT in Improving Health Equity
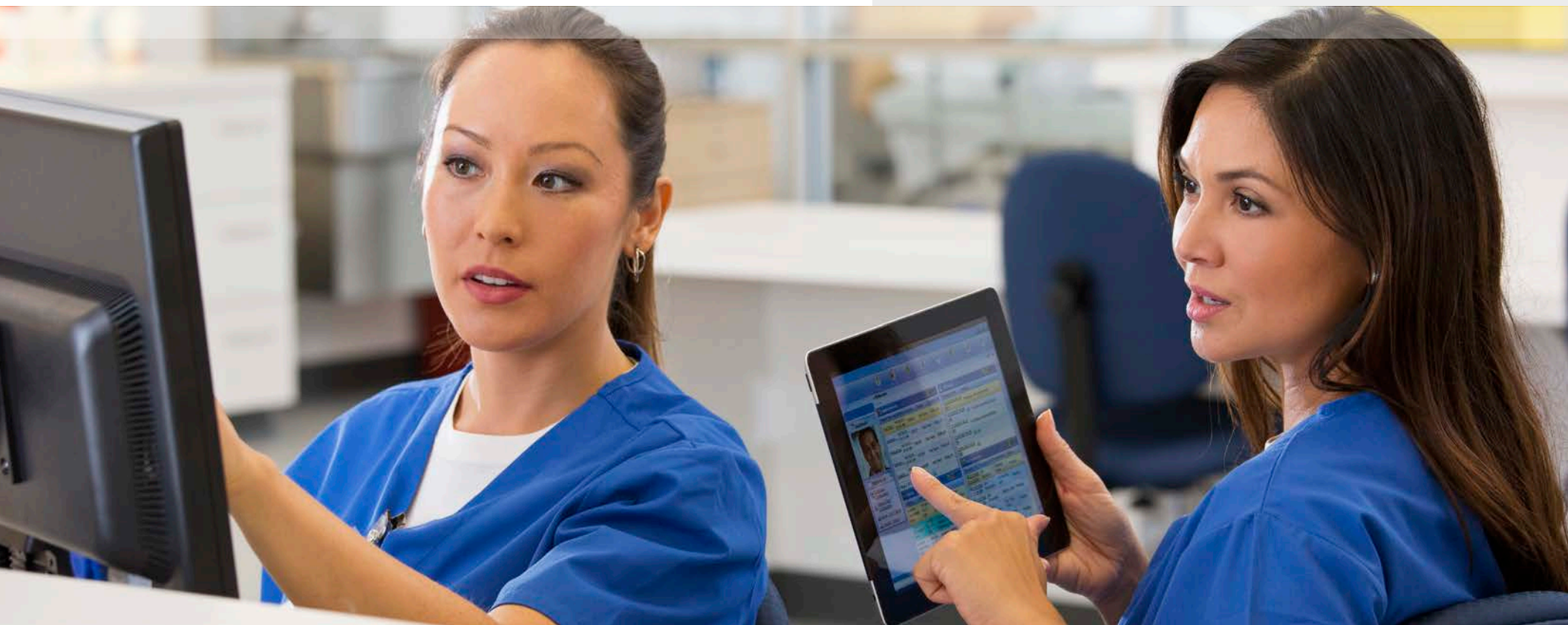
Conclusion

As the federal government continues to focus on a multi-agency plan to address health equity, healthcare organizations can begin to internally evaluate their role in identifying and ensuring health equity data is leveraged in their own software and services.

Additionally, public health agencies, payers, non-governmental organizations, and other stakeholders have been working to improve the use of technology as the enabler for health equity improvement plans, and looking to their health IT partners to support data collection to better inform policy and program development, support clinical decisions, lower costs of unnecessary utilization, and improve health outcomes.

Healthcare organizations have an opportunity to develop tangible goals and initiatives in support of this cross-sector call to achieve health equity for all individuals.

About PointClickCare

PointClickCare is a leading healthcare technology platform enabling meaningful collaboration and access to real-time insights at every stage of the patient healthcare journey. More than 27,000 long-term and post-acute care providers, over 3,100 hospitals and health systems, 2,200 ambulatory clinics, every major U.S. health plan, and over 70 state and Government agencies use PointClickCare, enabling care collaboration and value-based care delivery for millions across North America. For more information, visit pointclickcare.com.

Learn how PointClickCare's national care collaboration network supports providers with timely access to automated clinical documents as well as enhanced collaboration across the continuum through our Value Based Care for ACOs solution.

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