



# Building a Foundation of Equity Data for Action: *Experience from national quality efforts*

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# No Quality without Equity: NCQA's Approach

## RESEARCH



**Tools for sustainable partnerships** between health care and communities



**Accuracy, completeness and exchange of equity data** collected by health sector stakeholders



**Supporting equitable outcomes in key populations** such as birth equity



**Advancing approaches for health equity accountability** through measurement and scoring



**High-impact federal partner** providing research and policy services.

*In collaboration with community*



## MEASUREMENT & DATA

- > **Stratifying HEDIS measures** by race/ethnicity
- > **Measures of social needs** screening and intervention
- > **Making HEDIS more inclusive** of gender identity
- > **Advance equity for individuals with disabilities** through community-centered approaches.
- > **Digitalization of HEDIS®** measures allows for greater and more flexible measure configurations that can support insights into sub-populations.
- > **Align with data standards**, including USCDI, CARIN for Blue Button®, the Gravity Project and the Gender Harmony project.



## PROGRAMS



**Health Equity Accreditation**



**Health Equity Accreditation Plus**



**Embedding health equity in other programs**  
(e.g., LTSS Accreditation, Health Plan Accreditation, PCMH Recognition)

**BRIDGING INSIGHTS**



# The State of Race and Ethnicity Data

## Systematic review of US-based healthcare databases (2023)<sup>1</sup>:

- Race/ethnicity completeness varies substantially between sources (42% to 99%)
- Only 27% of databases had evidence of being evaluated for accuracy
- Disease registries have the most accurate data on race/ethnicity.
- Private health system EHRs had less accurate data for race/ethnicity.
- Asian, AI/AN, and Pacific Islanders are the most misclassified across databases.
- Systems-based interventions improve data availability and accuracy.

To address disparities, we must do better.  
How do we build a foundation of complete and high quality data?

# Structural Incentives for Collecting and Acting on Sociodemographic Data: Health Equity Accreditation



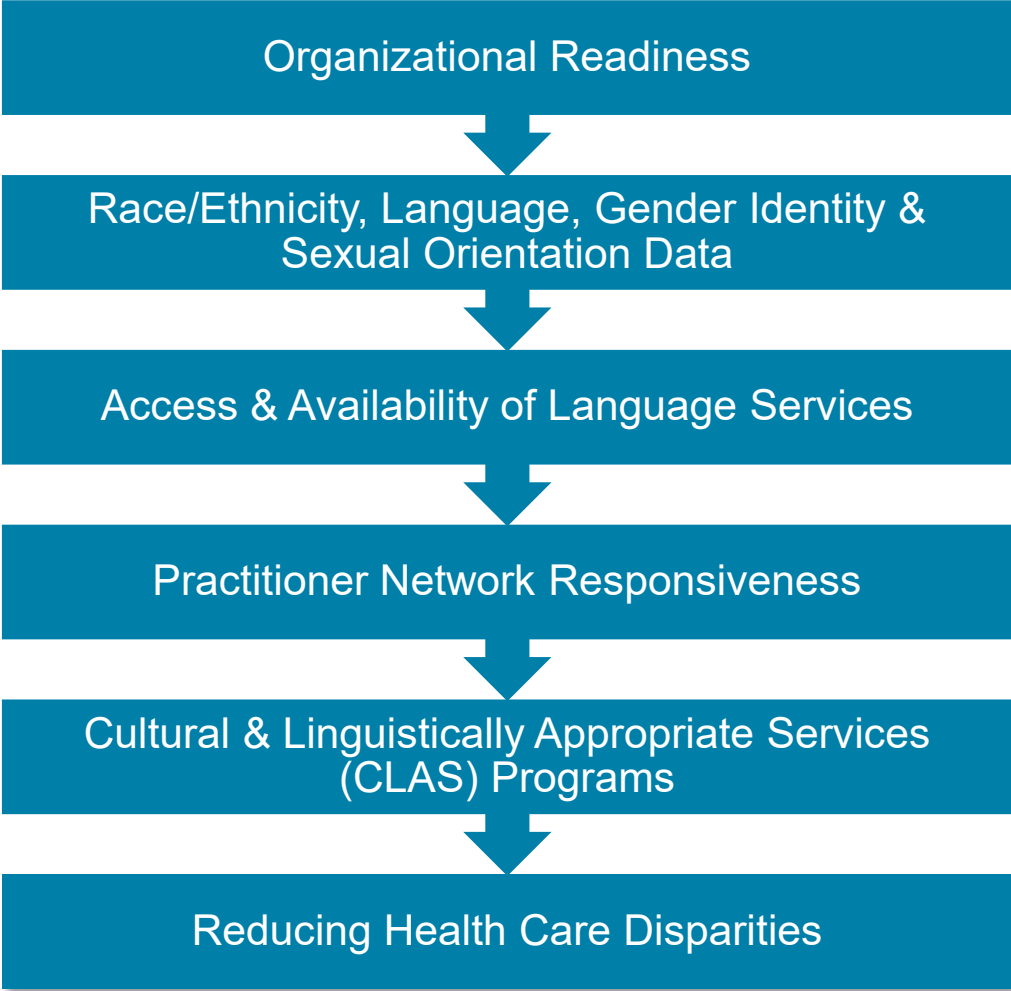
3-Year Standards-based program



Designed for **organizations beginning their health equity journey** or **looking for structure and accountability to improve existing health equity work.**



Focused **on collecting data** to understand members' or patients' needs, then **identify and act on opportunities to reduce disparities and improve the cultural and linguistic appropriateness of care.**



# Plan-Identified Race and Ethnicity Data Sources

## Contracts

- Enrollment files

## Internal or Enterprise Records

- Health risk assessments
- Member surveys
- Member portals
- Case management systems
- Health plan marketing campaigns
- Health plan call center logs

## Clinical Interactions

- Provider organization feeds
- Electronic health records
- Health Information Exchanges

## State Records

- Immunization registries
- Supplemental state race/ethnicity files
- Risk corridor files
- Social service records
- State Children's Services files
- Supplemental Nutrition Assistance Program repositories

## Imputation

- RAND Corporation Bayesian Improved Surname Geocoding
- Third party vendor solutions (ex., Acxiom)

Participants in NCQA's Race and Ethnicity Stratification Learning Network identified a wide variety of sources.

Highlights importance of **data standardization.**

**Opportunity:**  
Need for "data provenance" (metadata on data source) to appropriately track and manage diversity of sources

# Understanding Policy Environment for Plan Collection of R/E Data

*Challenging received wisdom*

RESEARCH REPORT

## Collection of Race and Ethnicity Data for Use by Health Plans to Advance Health Equity

Opportunities, Barriers, and Solutions

2022 evaluation led by the Urban Institute investigated legal and regulatory environment for health plan ability to collect race and ethnicity data

**Opportunity:**  
Clear state signal  
clarifying legality

**Reduce legal concerns and uncertainty.** A legal analysis conducted as part of this project found no state and federal laws that bar employers, third-party administrators, and group health plans from collecting and sharing R/E data for a permitted purpose, such as reducing health disparities. However, employers are often hesitant to do so because of a lack of clarity around legality and permissibility. Summit participants suggested stronger signals from federal and state governments clarifying the legality of collecting and sharing R/E data could be helpful.

# Healthcare Quality System Levers Can Improve Data



Incentivize collecting and managing data using best practice terminology

*Examples:* Accreditation (structural) standards  
Quality measures of data completeness  
Score organizational quality on data maturity  
Contracting design and requirements

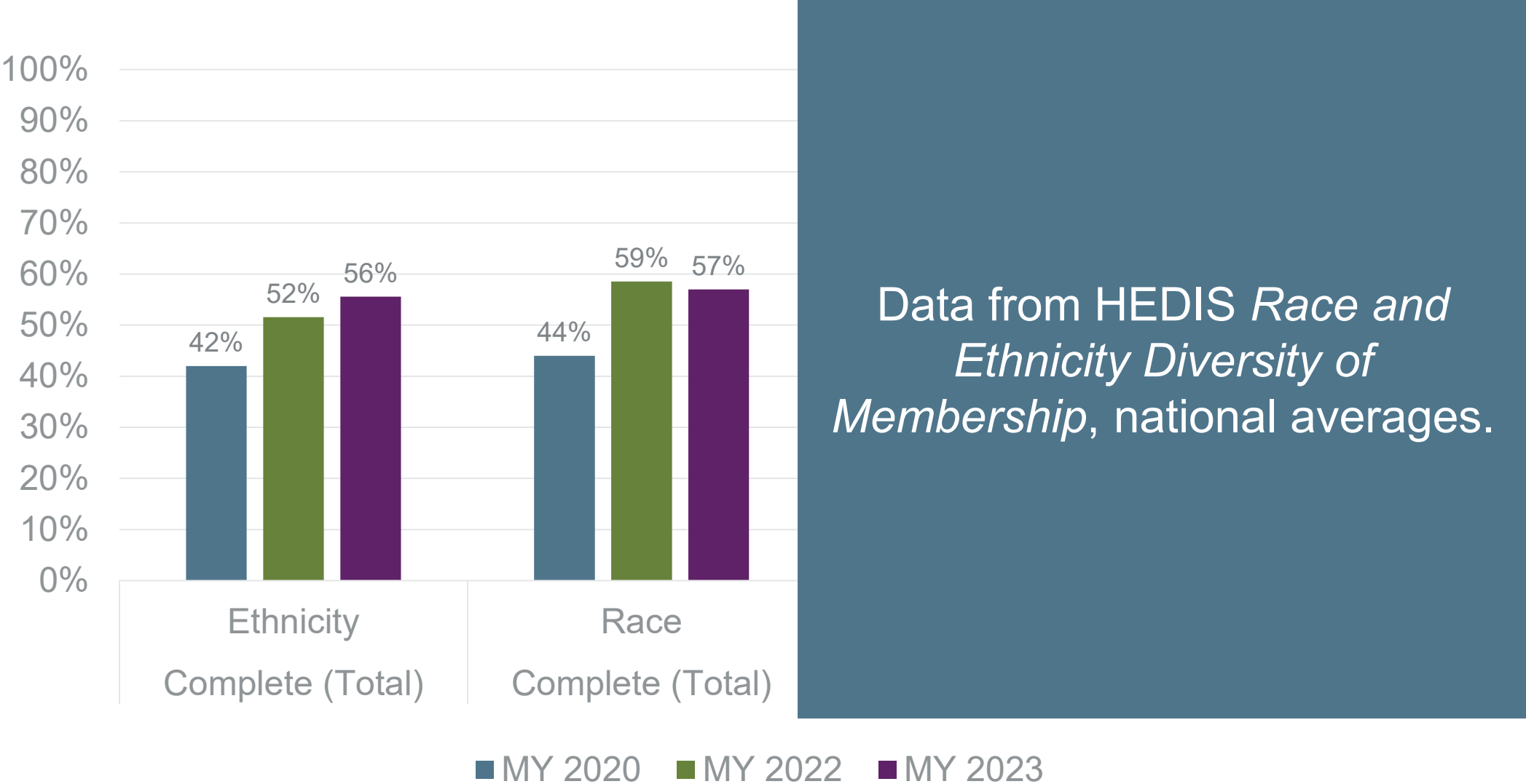


Leverage standardized terminology to re-define “high quality care” targets

*Examples:* Measures of social needs  
Revised measure population definitions  
Stratification using standardized terminology

# Commercial Race and Ethnicity Data

*Completeness Trending Upward*

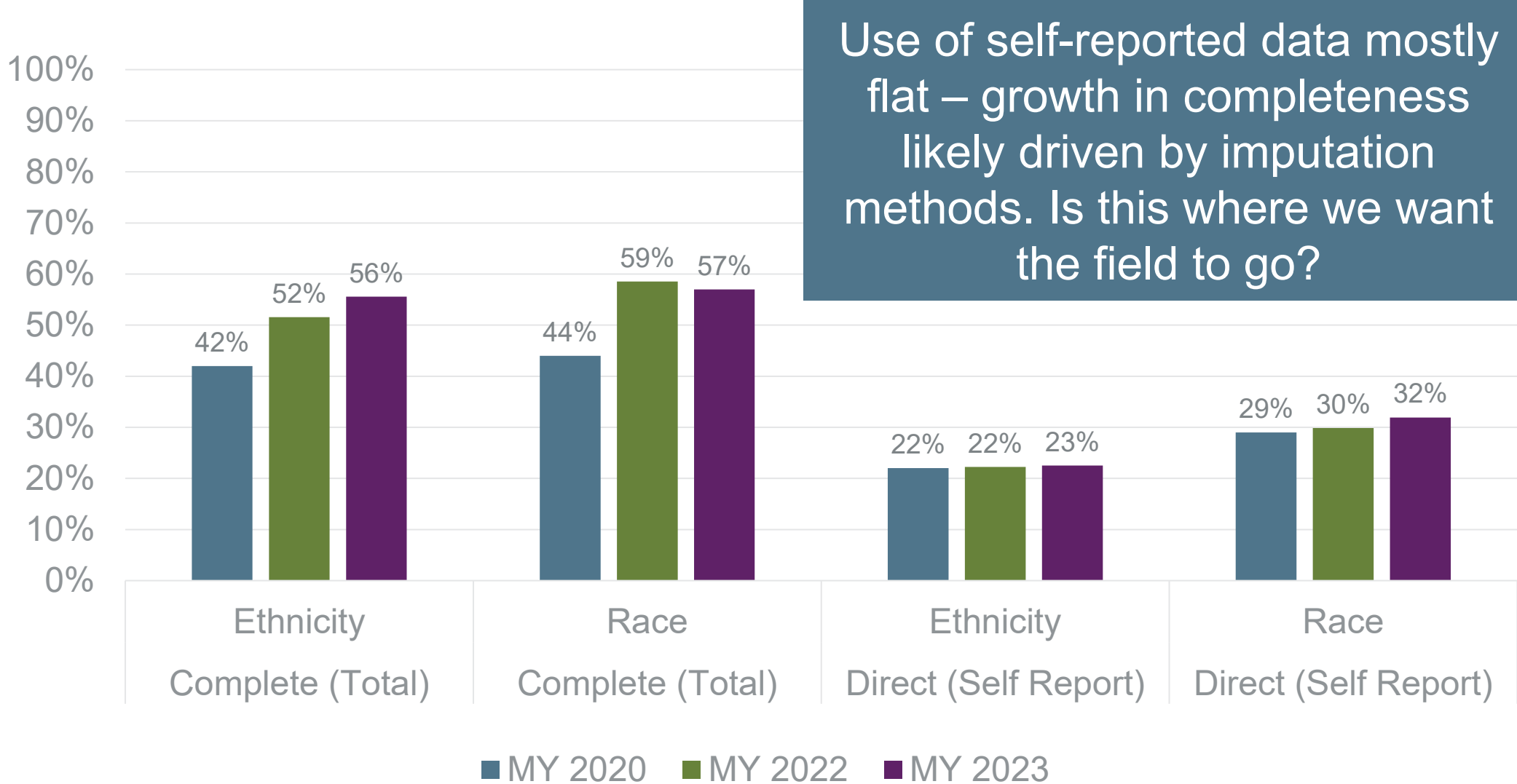


Internal NCQA analysis. MY 2021 omitted.



# Commercial Race and Ethnicity Data Trending Upward

## *Role of Self-Report vs. Imputed Data*



Internal NCQA analysis. MY 2021 omitted.

# Imputed Race/Ethnicity Data

*Using imputation methods is a common approach to facilitate measurement of inequities BUT comes with its own challenges and risks.*

## *Examples:*

- CMS Annual Medicare Advantage Disparities in Care report
- State health equity/health disparities reports
- Local County and City Health Dashboard



Institute of Medicine / National Academy of Medicine:  
Recommendation to use imputed data when self-report is not available for population-level evaluation.

### **Opportunity:**

Set clear expectations for appropriate (vs. inappropriate) use of imputed data and minimum level of self-reported data needed to validate imputation methods.

# Why these data matter:

## Disparities in Well-Child Visits among Commercial Health Plans (HEDIS MY 2022)

**Table 1: Child and Adolescent Well Care Visits National Commercial Health Plan Performance by Race and Ethnicity**

Group	Category <sup>+</sup>	Plans (n)	Mean	Median	StdDev	Within-Group Variation in Plan Performance (90 <sup>th</sup> vs. 10 <sup>th</sup> percentile)*
<b>Race</b>	American Indian or Alaska Native	135	54.8	55.8	13.2	34.1
	Asian	256	64.3	64.7	11.2	29.4
	Black or African American	249	54.1	53.0	10.5	27.6
	Native Hawaiian or Other Pacific Islander	68	52.7	50.3	13.6	35.2
	White	305	58.0	56.7	11.7	29.4
	Some Other Race	224	55.9	56.4	11.6	29.8
	Two or more Races	122	58.2	57.2	12.1	31.0
<b>Ethnicity</b>	Hispanic or Latino	290	54.6	53.7	11.7	30.8
	Not Hispanic or Latino	231	59.1	57.7	11.3	28.4
<b>Total</b>		400	57.0	56.4	11.2	28.8

<sup>+</sup> Individuals with unknown race or ethnicity omitted from table

<sup>\*</sup> Difference between group-specific 90<sup>th</sup> and 10<sup>th</sup> percentiles, expressed in absolute percentage points

# Putting Data into Practice



# Success Story

## *Conducting Targeted Member Outreach*

### Evaluation of COVID-19 vaccination rates

- Found that Black members had significantly lower rates
- Partnered with community organizations
- After 3 months, vaccination gap began to close
- COVID-19 vaccination rates among Black members rose from 48.7% to 54.8%

# Success Story

## *Evaluating Intersection of Race/Ethnicity and Other Social Drivers*

Application of HEDIS  
stratification to  
*Asthma Medication  
Ratio* measure

- Overlaid race/ethnicity information with geographic data
- Visualized where gaps existed in specific counties
- Plan working to increase delivery of services to areas with widest disparities

# Success Story

## *Connecting with Partner Organizations*

Identification of  
groups least likely  
to access care

- Hired member engagement specialists for Native American members
- Conducted targeted clinical and community outreach based on disparities
- Formed partnership with Native American resource center

# Success Story

## *Supporting Public Health Efforts*

Incorporation of race/ethnicity data into county-level quality improvement projects

- Set target metrics with county, focused on improving care for certain groups
- Visualized disparities in access to care
- Found that rural and Hispanic members experience worst gaps
- Plan and county organizations working to tailor interventions



# The Big Idea



Plans across the health care system are demonstrating innovative ways to use race/ethnicity data to address disparities.



Plans are helping drive the national effort to close disparities in health care.



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**Save the Date**

**April 7-8, 2025**

Baltimore Marriott Waterfront | Baltimore, MD

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