BHI EXPERTS WEIGH IN

The Importance of REL Data in Achieving Health Equity

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The COVID-19 pandemic brought attention to healthcare inequities long hiding in plain sight. Health plans are under pressure to redesign programs, benefits, and community outreach to address these health disparities. In this Q&A, Roxanna Cross and Deepak Goel discuss how race, ethnicity, and language (REL) data, and a means of tying those characteristics to population-level utilization and outcomes, is crucial to achieving health equity.

Q. Why is valid and comparable REL data so important?

Almost every commercial payer is looking to address ethnic and racial health disparities. The pandemic was a global wake-up call, revealing the true impact of unequal access to quality care and other components of good health. REL data creates a common jumping-off point so that everyone knows the nature of the challenge, on both a population level as well as the individual member level.

Q: What are some of the challenges associated with REL data collection?

The biggest hurdle is that health plans do not have self-reported data, which is the gold standard for REL data. This may be because members have been hesitant to share this data, or because they are not being asked in sufficient specificity to provide useful data. In measurement year 2019, the National Committee for Quality Assurance (NCQA) found that 76% of racial data and 94% of ethnicity data reported through HEDIS for commercial plans was incomplete.

Another problem is that there are no defined regulatory standards for the collection of REL data. At the federal level, the Office of Management and Budget (OMB), the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services' Office of Minority Health, and others all collect different data fields. The same is true among U.S. states.

We are anticipating changes to regulations. The NCQA is exploring the stratification of HEDIS measures by race, ethnicity, and socioeconomic status, to hold plans accountable for reducing disparities in care. There may be new measures explicitly addressing SDOH, such as assessing social risk or needs.

We can't begin to understand where disparities exist and how to target them if we can't collect the data or agree on what we are measuring. That is why Blue Cross Blue Shield Association and Blue Plans asked BHI to look at a common data set.

Q: What kinds of data sources are currently available?

All plans have access to American Community Survey (ACS) data, which is at the census tract level. This data is very general because it provides the composition of members within a geography but is not tailored to a health plan's membership. ACS data is also quite simplistic, whereas commercially available data can dive much deeper – providing enough information to be useful.

BHI's partner AnalyticsIQ compiles data on 242 million U.S. adults from more than 120 proprietary sources containing more than 1,000 unique attributes, including geo-credit data from the top two credit reporting agencies and econometric data from the U.S. government. Together with self-reported member data, we begin to get clear focus on the problem of disparities, block by block, by service area, and so on.

For members for which there is no ethnic or racial information, we impute REL data based on the member's residential nine-digit ZIP code, an area as small as 10 to 11 households.

BHI and AnalyticsIQ have a national geographic scope, providing increased reliability in the matched results and the ability to scale nationally. AnalyticsIQ also has a 4 million-member consumer panel against which it can validate its data.

Together, we are providing a much deeper dive into race and ethnicity with much more specificity. We can also layer on SDOH indicators to get at some of the underlying causal factors of health disparities.

Q: How do BHI and AnalyticsIQ protect the data? What about privacy?

BHI and AnalyticsIQ are part of an ecosystem of more than 120 healthcare organizations committed to securely connecting and sharing data such as REL by using tokenized linking software. Tokenization assigns data elements to individuals without identifying them, which enables health plans to understand their patient populations explicitly without any privacy issues.

Q: What will be the real-world impact of this project?

There are many use cases for this data. On a macro level, uses include the measurement of programs tracking health disparities, population health analyses, and informing care-management programs, which are already engaged in risk identification and stratification. From there, we can zero in on particular conditions such as maternal health, behavioral health, chronic disease – where the literature points to known disparities in outcomes – and gather data to inform improvement efforts. We can link race, ethnicity, and language to SDOH indicators to prioritize community investments such as outreach, mobile clinics, food banks, and transportation.

And, of course, health plans are not the only ones interested in this data. Employers are also upping their game, giving new attention to SDOH in work-site health promotion and/or well-being initiatives.

Q: How will you avoid being yet another part of a tangled web of measurement?

BHI and AnalyticsIQ are synching up nicely. We are achieving a high cumulative total match rate between their REL data on adult consumers and members in the National Data Warehouse by applying individual tokenized matches and subscriber/dependent relationship assignments. For the remaining unmatched members, we impute REL data with a high degree of accuracy.

What really differentiates BHI and AnalyticsIQ are our analytic capabilities. AnalyticsIQ's blend of cognitive psychology and sophisticated data science delivers the most comprehensive, accurate REL data available, while BHI's understanding of member-dependent relationships and households enables us to apply that data at the member level in the most accurately possible way. For Plans, these capabilities offer a first step to understanding the scope and nature of the challenge of addressing health disparities.

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