

California's Rural North: Health Equity Principles Guiding Data Practices

Prepared by: Crane Conso, Leigh Pierre-Oetker, and Devin Flynn

Enhancing the quality of health equity data in the Rural North requires looking at existing challenges and developing measurement standards (Arledge & Flynn, 2023).

Rural Data Challenges

Data Fragmentation



Internal Silos: systems are not in place for departments and regions to share data.

Aggregated Counties: individual county data cannot be analyzed accurately.

Data Granularity



Broad Metrics: ZIP codes and data platforms do not capture nuances of rural areas.

Micro-community Variance: health differences within small communities are overlooked.

Sample Size Constraints



Exaggerated Rates: small population data can skew per capita data.

Legal Restrictions: some small sample data cannot legally be shared, due to data anonymity.

Data Stability



Event Sensitivity: minor events can dramatically affect data reliability.

Data Breakdown Difficulty: analysis at finer levels become unstable due to small numbers.

Population Representation



Invisible Demographics: certain small populations (specific racial groups) are under-represented in data. This can lead to misrepresentation regarding health and data outcomes.

Geographic Complications



Shared ZIP Codes: broad, overlapping geographic identifiers affect data organization.

Rural Data Misrepresentation: the combination of small populations and geographic dispersion lead to inaccuracies.

Health Equity Performance Measures

To effectively track and improve health equity, rural regions can work to establish standardized performance measures through a sequential, four-step process where each step builds on and assesses the effectiveness of the previous action (Bailit & Kanneganti, 2022). This approach, adapted from recommendations found in recent literature, provides clear steps to improve health equity and address the data challenges listed above. Steps range from data collection to evaluation of targeted interventions.

Recommendations for developing health equity performance measures

Step 1: Enhance Data Infrastructure

Goal: establish a robust foundation for collecting comprehensive demographic data.

Action: improve the methods for gathering data on race, ethnicity, language, disability status, sexual orientation, and gender identity, ensuring these methods are culturally sensitive.

Example: upgrade electronic health records to include detailed, self-reported demographic information (voluntary), enabling patients in the community to accurately represent their identities.

Step 2: Stratify Measures by Subpopulation

Goal: use the enhanced data from Step 1 to identify inequities and strengths in healthcare processes and outcomes across different groups.

Action: analyze existing health metrics by breaking them down into subpopulations based on the improved demographic data.

Example: stratify control rates of chronic conditions like hypertension or diabetes by race and ethnicity to uncover and understand inequities in disease management.

Step 3: Focus on Specific Subpopulations

Goal: directly address the inequities identified in Step 2 with focused quality improvement efforts.

Action: tailor interventions and assessments on specific populations identified as experiencing significant health inequities.

Example: develop and implement a diabetes management program in communities identified in Step 2 as having higher rates of unmanaged diabetes, providing tailored support.

Step 4: Evaluate Reduction Strategies

Goal: assess the impact of interventions at reducing health inequities.

Action: measure the effectiveness of the targeted interventions in Step 3 by comparing pre- and post-intervention outcomes.

Example: evaluate the success of the diabetes management program by analyzing changes in diabetes control rates within the focus community, assessing both health outcomes and any reduction in diabetes.

Additionally, research suggests regions should strive to develop a system that:

- builds on complexity and diversity

- addresses structural health determinants
- shifts to a strength-based paradigm
- includes rural voices in research and policy
- adapts to changing standards in health equity measurement (Reynolds et al., 2024).

Strategic Considerations

In addition to the data equity approach above, rural regions can consider:

Building trust and transparency in data collection

To advance health and data equity, all community members need to be treated as equal partners and have their voices heard. Rural organizations who seek to collect data or want to improve the quality of their data on race, ethnicity, language, disability status, sexual orientation, and gender identity can consider engaging with advocates of subpopulations (ex. LGBTQ+ advocates) and community organizations. Engagement allows organizations to gain feedback, communicate why the information is needed, ensure that information is only for improving well-being, and encourage self reporting.

Example: Vermont’s Medicaid and Exchange Advisory Committee is composed of health insurers, medicaid members, advocates for consumer organizations, healthcare professionals, and public health professionals. The committee has been meeting virtually since 2020 to advise state officials on culturally appropriate communication materials and

health campaigns (Department of Vermont Health Access, n.d.).

Developing interoperable systems for sharing health equity data and lessons

Rural organizations can consider the formation of a Community Information Exchange (CIE) or development of a learning hub to enhance the interoperability of their health equity efforts.

CIEs are community-governed infrastructures that enable information to be effectively and responsibly shared among many organizations (providers, researchers, decision-makers, community-based organizations). CIEs can enhance understanding of a communities’ needs, and improve service accessibility, service outcomes, and overall health and well-being (Grounds & Johnson, 2021). It is important to note that a CIE requires robust investments of time, capacity, and mutual cooperation to operate, and may be more challenging to implement for smaller rural communities.

Example: The North Coast Care Connect, lead by the North Coast Health Improvement and Information Network (NCHIIN), is a rural network of health and social service providers based in Humboldt County. The network partners coordinate care for individuals in need of assistance and, when community members consent to share their information, the network provides coordination and electronic referrals for services.

Learning Hubs are forums for representatives from different organizations to share best practices and discuss challenges, strategies, and lessons learned from their work in advancing health equity.

It is recommended that Learning Hubs have a trusted neutral convener (ex. trusted third-party organization) to facilitate the group and bring in outside experts to share insights.

Example: Since 2022, the California Center for Rural Policy has elevated the work of rural public health practitioners and subject matter experts in advancing health equity through a [series of webinars and trainings](#).

State and Federal Efforts

Efforts to promote health equity through improvements in data quality measurements have recently been directed through state and federal departments and agencies (CHCF, 2023).

Legislation, Assembly Bill 133 and 1204 for example, have acted as drivers of change for state departments and agencies. AB 133 requires managed health plans to report performance on quality and equity measures to the California Department of Managed Health Care (DMHC). AB 1204 developed a requirement for hospital equity reports and expanded the definition of underserved populations for hospital community benefits from the California Department of Health Care Access and Information (HCAI).

The California Governor's Office issued Executive Order N-16-22 during 2022, effectively establishing state agencies and departments engagement with equity activities, including the gathering of input from historically disadvantaged communities.

Similar efforts are occurring at the federal level with the U.S. Office of Management and Budget (OMB) revising Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

These revisions, the first since 1997, update definitions and terminology, require the use of a combined race and ethnicity question, add Middle Eastern or North African (MENA) to the set of minimum race categories, and require the collection of additional detail beyond the minimum race categories (Orvis, 2024).

References

- Arledge, D. & Flynn, D. (2023) California's Rural North: Health Equity Landscape Scan, CCRP at Cal Poly Humboldt.
- Bailit, M., Kanneganti, D. (2022). A typology for health equity measures. *Health Affairs Forefront*. doi:10.1377/forefront.20220318.155498.
- California Health Care Foundation. (December, 2023) , *Paving the Way to Health Equity Learning from California State Government*. [Issue Brief]. <https://www.chcf.org/publication/paving-way-health-equity-learning-ca-state-government/>.
- Department of Vermont Health Access. (n.d.). *Medicaid and Exchange Advisory Committee*. <https://dvha.vermont.gov/advisory-boards/medicaid-and-exchange-advisory-committee>.
- Grounds, K. & Johnson, B. (2021). *Leveraging Community Information Exchanges (CIEs) for Equitable and Inclusive Data: A Vision for the Future*. 211 San Diego, Community Information Exchange. <https://ciesandiego.org/data-equity/>.
- Melendez, M., Ubri, P., Leitz, S., & Nye, T. (2021). Framework for Advancing Health Equity in State Medicaid Programs. National Opinion Research Center (NORC) at the University of Chicago. <https://www.norc.org/content/dam/norc-org/pdfs/Framework%20for%20Advancing%20Health%20Equity%20in%20State%20Medicaid%20Programs.pdf>.

Orvis, K. (2024, March 28). *OMB Publishes Revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*. [Press Release]. <https://www.whitehouse.gov/omb/briefing-room/2024/03/28/omb-publishes-revisions-to-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity/>.

Reynolds, M, Kanneganti, D, Bailit, M, Filice, C, Dave, J. (2024). A health equity data and accountability infrastructure for Massachusetts. State Health & Value Strategies. <https://www.shvs.org/a-health-equity-data-and-accountability-infrastructure-for-massachusetts/>

About CCRP



Cal Poly Humboldt's California Center for Rural Policy is dedicated to improving the lives of rural people in California. Using methods tailored to the study of rural populations, environments, and their interactions, the CCRP researches a wide range of issues to inform policies and planning.