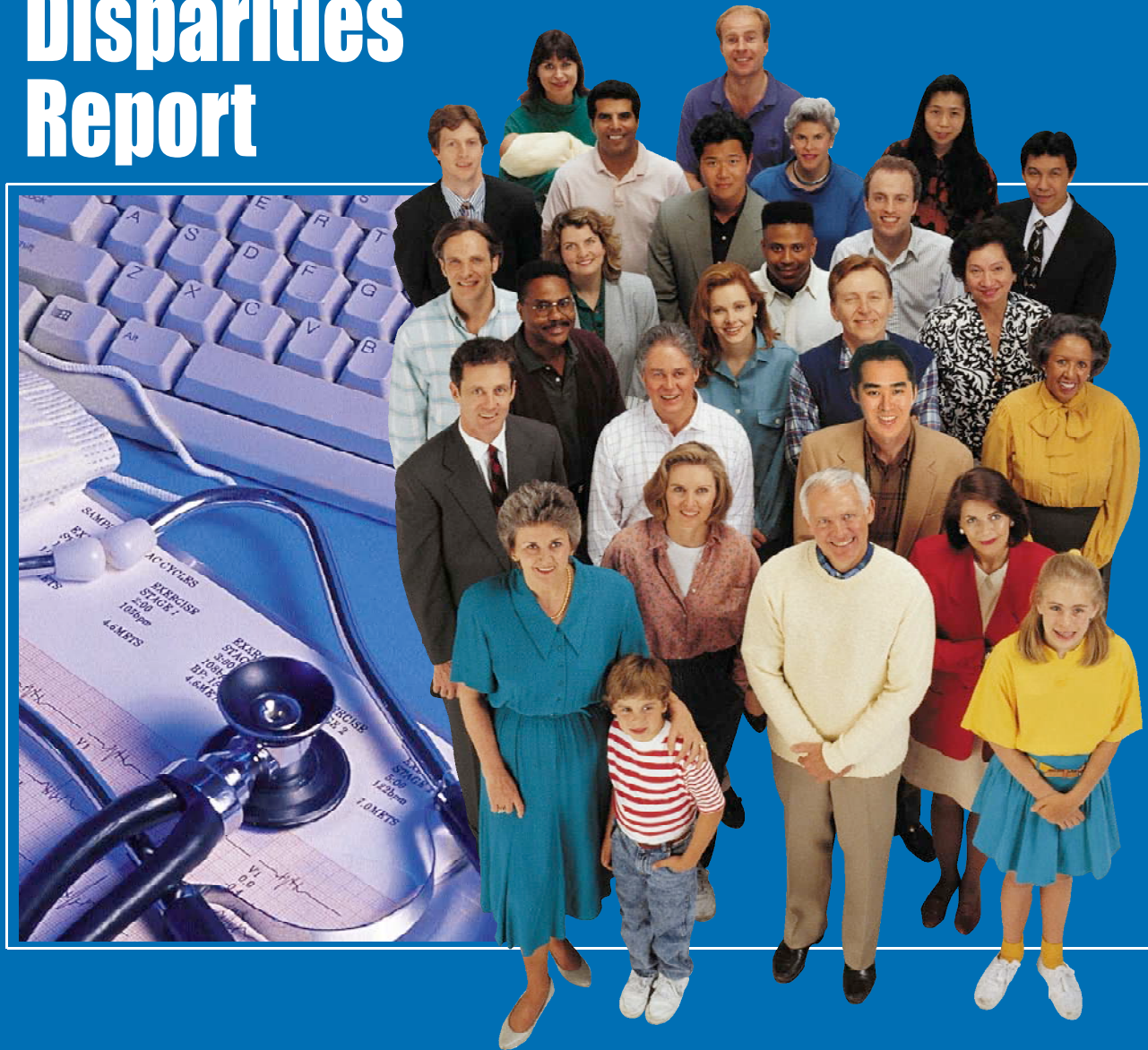
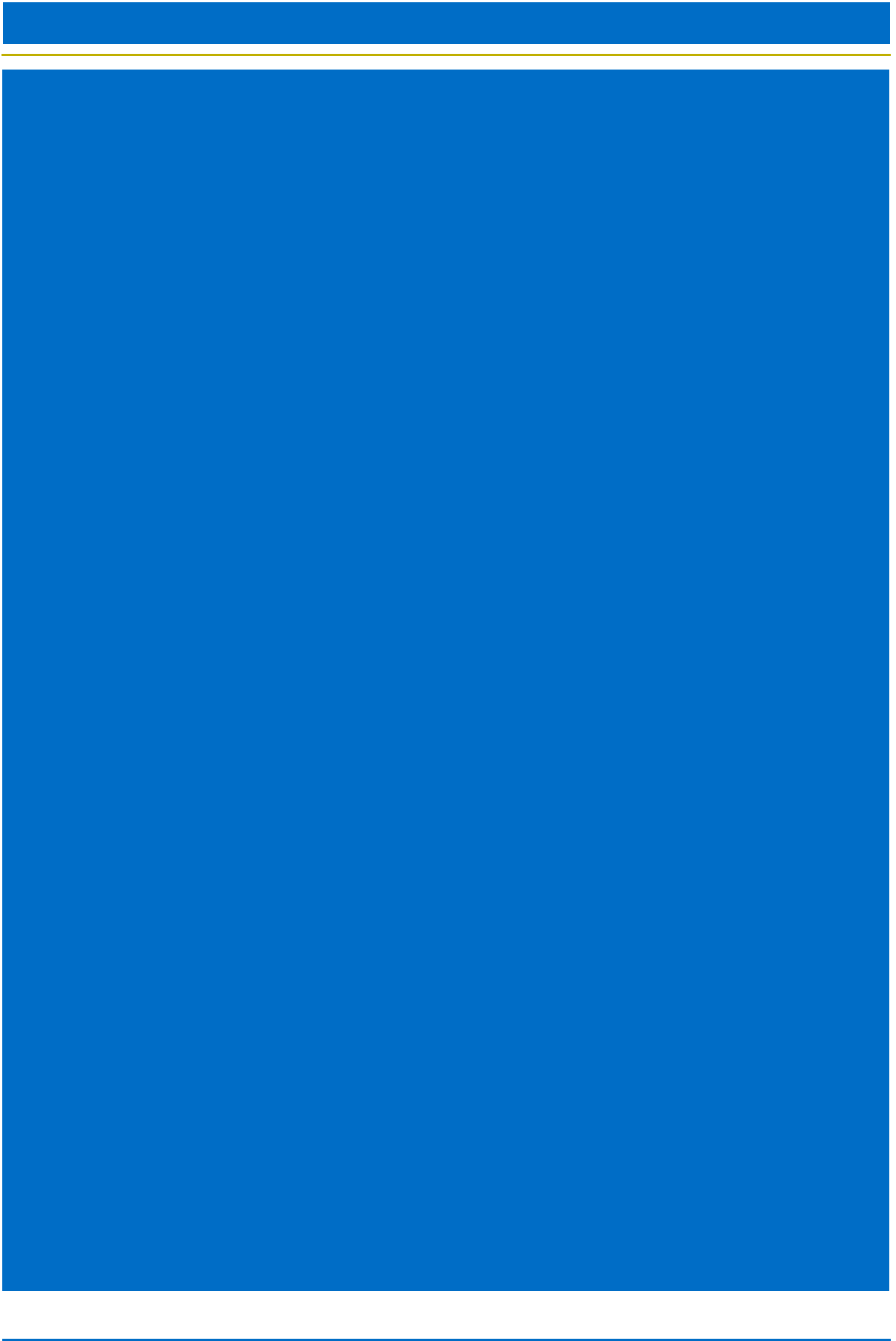


2006

National Healthcare Disparities Report



Agency for Healthcare Research and Quality
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2006 National Healthcare Disparities Report

**U.S. Department of
Health and Human Services**

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2006 National Healthcare Disparities Report—At A Glance

For most core quality measures, Blacks (73%), Hispanics (77%), and poor people (71%) received worse quality care than their reference groups. For most measures for poor people (67%), disparities were *increasing*; for most measures for minorities, significant changes in disparities were not observed.

Increasing disparities were especially prevalent in chronic disease management. Compared to their reference groups—

- Blacks had 90% more lower extremity amputations for diabetes.
- Asians were restrained in nursing homes 46% more often.
- American Indians and Alaska Natives were hospitalized from home health care 15% more often.
- Hispanics had 63% more pediatric asthma hospitalizations.
- Poor people were 37% less likely to receive recommended diabetes care.

All of these disparities were increasing over time. However, better and improving quality was also observed for at least 1 measure for every population.

For most core access measures, Hispanics (83%) and poor people (100%) had worse access to care than their reference groups. Disparities were *increasing* for most measures for Hispanics (80%) and poor people (100%).

Better access was only observed for Asians compared with Whites, although improving access was observed for at least 1 measure for every population.

Key Themes and Highlights From the National Healthcare Disparities Report

The Agency for Healthcare Research and Quality (AHRQ) is pleased to release the 2006 National Healthcare Disparities Report (NHDR) on behalf of the U.S. Department of Health and Human Services (HHS) and in collaboration with an HHS-wide Interagency Work Group. Like previous reports, the 2006 NHDR also received significant guidance from AHRQ leadership and AHRQ's National Advisory Committee. This fourth annual report to Congress provides a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomicⁱ groups in the general U.S. population and within priority populations and tracks the progress of activities to reduce disparities.

The NHDR tracks disparities related to quality of health care and access to health care. Measures of health care quality address the extent to which providers and hospitals deliver evidence-based care for specific services as well as the outcomes of the care provided. They are organized around four dimensions of quality—effectiveness, patient safety, timeliness, and patient centeredness—and cover four stages of care—staying healthy, getting better, living with illness or disability, and coping with the end of life. Measures of health care access include assessments of how easily patients are able to get needed health care and their actual use of services. They are organized around two dimensions of access—facilitatorsⁱⁱ and barriers to care and health care utilization.

The NHDR is complemented by its companion report, the National Healthcare Quality Report (NHQR), which uses the same quality measures as the NHDR to provide a comprehensive overview of the quality of health care in America. Both reports measure health care quality and track changes over time but with different orientations. The NHQR addresses the current state of health care quality and the opportunities for improvement for all Americans as a whole. This perspective is useful for identifying where we are doing well as a Nation and where more work is needed. The NHDR addresses the distribution of improvements in health care quality and access across the different populations that make up America. This perspective is useful for ensuring that all Americans benefit from improvements in care. Perspectives from both reports are needed for a complete understanding of quality of health care, and both reports support HHS Secretary Mike Leavitt's 500-Day Plan to fulfill the President's vision of a healthier America, specifically in the areas of better transparency of health care quality information and eliminating inequities in health care.

This year's NHDR and NHQR continue the tracking of trends across a broad array of measures of health care quality and access for many racial and ethnic minority groups and socioeconomic groups. In addition, the 2006 reports incorporate improved measures and methods for summarizing quality and disparities in health

ⁱ Socioeconomic differences include differences in education and income levels.

ⁱⁱ Facilitators to health care are factors that increase the likelihood that people will get the health care they need, such as having health insurance and a usual primary care provider.

care, including new composite measuresⁱⁱⁱ and expanded analyses of trends in disparities. This section offers a concise overview of findings from the 2006 NHDR. More detailed findings are presented in the chapters that follow.

In the 2006 NHDR, four key themes are highlighted for policymakers, researchers, clinicians, administrators, and community leaders who seek information to improve health care services for all Americans:

- Disparities remain prevalent.
- Some disparities are diminishing while others are increasing.
- Opportunities for reducing disparities remain.
- Information about disparities is improving, but gaps still exist.

Disparities Remain Prevalent

Consistent with extensive research and findings in previous NHDRs, the 2006 report finds that disparities^{iv} related to race, ethnicity, and socioeconomic status still pervade the American health care system. Although varying in magnitude by condition and population, disparities are observed in almost all aspects of health care, including:

- Across all dimensions of quality of health care including: effectiveness, patient safety, timeliness, and patient centeredness.
- Across all dimensions of access to care including: facilitators and barriers to care and health care utilization.
- Across many levels and types of care including: preventive care,^v treatment of acute conditions,^{vi} and management of chronic disease.^{vii}
- Across many clinical conditions including: cancer, diabetes, end stage renal disease (ESRD), heart disease, HIV disease, mental health and substance abuse, and respiratory diseases.
- Across many care settings including: primary care, home health care, hospice care, emergency departments, hospitals, and nursing homes.
- Within many subpopulations including: women, children, elderly, residents of rural areas, and individuals with disabilities and other special health care needs.

ⁱⁱⁱ Composite measures provide readers with a summarized picture of some aspect of health care by combining information from multiple component measures. For example, the NHDR composite measure for “complications following surgery” includes measures for persons who develop pneumonia, bladder infection, and blood clots in the legs following surgery.

^{iv} Consistent with Healthy People 2010, the NHDR defines disparities as any differences among populations. In addition, all disparities discussed in the NHDR meet criteria based on statistical significance and size of difference described in Chapter 1, Introduction and Methods.

^v Preventive care includes counseling about healthy lifestyle behaviors and medical screenings to diagnose diseases at as early a stage as possible. For example, the NHDR includes measures for various screenings, counseling, maternal and child health care, and vaccinations.

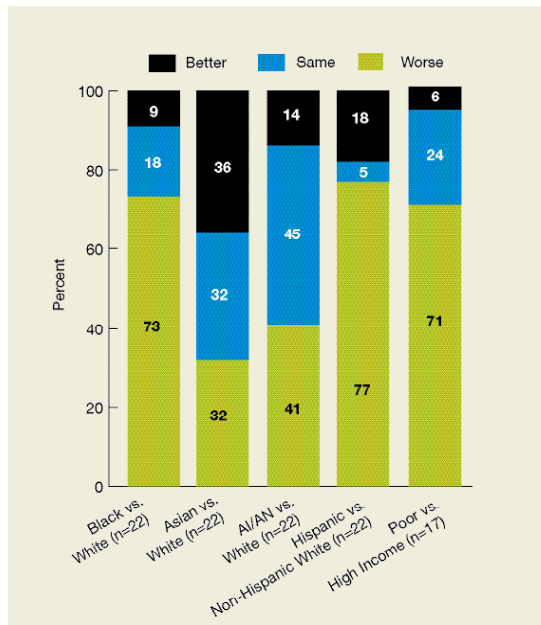
^{vi} Acute care is short-term medical care. For example, the NHDR includes measures for heart disease, pneumonia, and patient safety.

^{vii} Chronic care is long-term medical care. For example, the NHDR includes measures for nursing home, home health, and hospice care and chronic diseases such as diabetes, asthma, ESRD, and cancer.

Highlights

To quantify the prevalence of disparities across the core measures tracked in the 2006 report, racial and ethnic minority groups and socioeconomic groups are compared with an appropriate reference group^{viii} for each core measure.^{ix} Each group could receive care that is poorer than, about the same as, or better than the reference group. To facilitate comparisons across racial and ethnic groups, contrasts this year focus on 22 core measures of quality and 6 core measures of access which support reliable estimates for Whites, Blacks,^x Asians,^{xi} American Indians and Alaska Natives (AI/ANs), and Hispanics. Comparisons by income group focus on 17 core measures of quality and 6 core measures of access which support reliable estimates by income.^{xii}

Figure H.1. Core quality measures for which members of selected group experienced better, same, or poorer quality of care compared with reference group



Better = Population received better quality of care than the reference group.

Same = Population and reference group received about the same quality of care.

Worse = Population received poorer quality of care than reference group.

Key: AI/AN=American Indian or Alaska Native.

Note: “Asian” includes “Asian or Pacific Islander” (API) when information is not collected separately for each group. Data presented are the most recent data available. Totals may not add to 100% due to rounding.

For sizable proportions of measures, racial and ethnic minorities and the poor receive lower quality care.

- Blacks received poorer quality care than Whites for 73% (16/22) of core measures (Figure H.1). Blacks received better quality care than Whites for 9% (2/22) of core measures.^{xiii}

^{viii} For all measures, Blacks, Asians, and American Indians and Alaska Natives are compared with Whites; Hispanics are compared with non-Hispanic Whites; and poor individuals are compared with high income individuals.

^{ix} For a list of all core measures and the core measures included in these summary analyses, see Chapter 1, Introduction and Methods.

^x The NHDR officially uses the term “Blacks or African Americans” in accordance with the U.S. Office of Management and Budget (OMB). However, the text of the NHDR often refers simply to “Blacks.”

^{xi} “Asian” includes “Asian or Pacific Islander” (API) when information is not collected separately for each group.

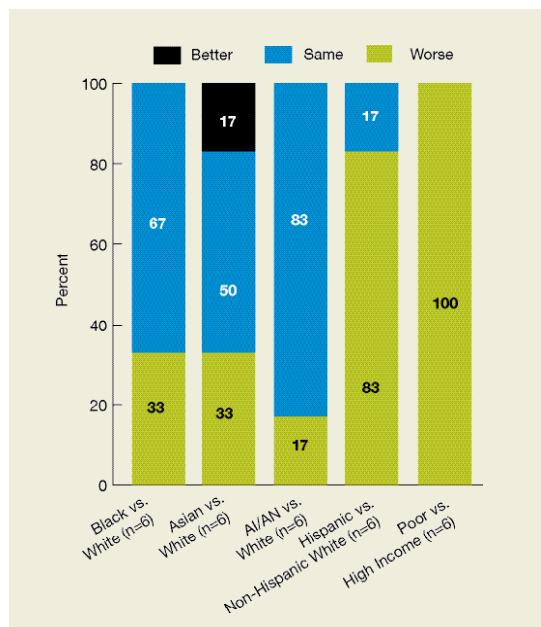
^{xii} Readers will note that findings in the 2006 Highlights suggest a snapshot of disparities similar to that shown in 2005. However, there are some differences, which are in part due to improved methods developed and approved by the HHS-wide Interagency Work Group that advises the NHDR. Specifically, in the 2005 NHDR, comparisons for each racial, ethnic, and income group included all measures with data available for that racial, ethnic, and income group. For example, although data were available for 46 quality measures for Blacks, data were only available for 21 quality measures for AI/ANs. In the 2006 NHDR, a uniform set of quality measures and access measures is analyzed for all racial, ethnic, and income groups. This change should be considered when comparing findings from the 2006 NHDR Highlights versus the 2005 NHDR Highlights.

^{xiii} Blacks had significantly lower rates of physical restraints among nursing home residents and suicide deaths than Whites.

Highlights

- Asians received poorer quality care than Whites for 32% (7/22) of core measures and better quality care for 36% (8/22) of core measures.^{xiv}
- American Indians and Alaska Natives received poorer quality care than Whites for about 41% (9/22) of core measures and better quality care for 14% (3/22) of core measures.^{xv}
- Hispanics received poorer quality of care than non-Hispanic Whites for 77% of core measures (17/22) and better quality care for 18% (4/22) of core measures.^{xvi}
- Poor people^{xvii} received lower quality of care than high income people for 71% (12/17) of core measures and better quality care for 6% (1/17) of core measures.^{xviii}

Figure H.2. Core access measures for which members of selected group experienced better, same, or worse access to care compared with reference group



Better = Population had better access to care than the reference group.

Same = Population and reference group had about the same access to care.

Worse = Population had worse access to care than reference group.

Key: AI/AN=American Indian or Alaska Native.

Note: “Asian” includes “Asian or Pacific Islander” when information is not collected separately for each group. Data presented are the most recent data available. Totals may not add to 100% due to rounding.

For many measures, racial and ethnic minorities and the poor have worse access to care:

- Blacks and Asians had worse access to care than Whites for a third (2/6) of core measures (Figure H.2).
- AI/ANs had worse access to care than Whites for 17% (1/6) of core measures.
- Hispanics had worse access than non-Hispanic Whites for 83% (5/6) of core measures.
- Poor people had worse access to care than high income people for all 6 core measures.

^{xiv} Asians had lower rates of late stage colorectal cancers, colorectal cancer deaths, new AIDS cases, suicide deaths, pressure sores among high-risk nursing home residents, and hospitalizations among home health care patients and higher rates of adequate hemodialysis and being on a transplant waiting list among dialysis patients.

^{xv} AI/ANs had lower rates of late stage colorectal cancers, colorectal cancer deaths, and suicide deaths.

^{xvi} Hispanics had lower rates of late stage colorectal cancers, colorectal cancer deaths, and suicide deaths and higher rates of adequate hemodialysis.

^{xvii} “Poor” is defined as having family incomes less than 100% of the Federal poverty level and “high income” is defined as having family incomes 400% or more of the Federal poverty level.

^{xviii} Poor people had higher rates of needed treatment for illicit drug use.

Some Disparities Are Diminishing While Others Are Increasing

The Department of Health and Human Services leads many initiatives aimed at reducing health care disparities and improving health care quality. Many private organizations also work to improve care and reduce disparities. To quantify the success of such efforts to reduce disparities, the 2005 NHDR began tracking changes in core measures over time. This year, methods for tracking trends in disparities have been improved. For each core measure, racial and ethnic minority groups and socioeconomic groups are compared with a designated reference group at different points in time:^{xix}

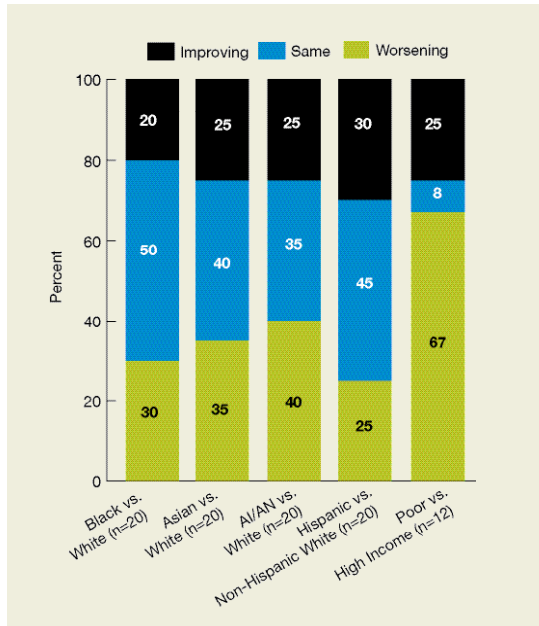
- Core measures for which the relative differences are changing less than 1% per year are identified as staying the same.
- Core measures for which the relative differences are becoming smaller at a rate of more than 1% per year are identified as improving disparities.
- Core measures for which the relative differences are becoming larger at a rate of more than 1% per year are identified as worsening disparities.

To facilitate comparisons across racial and ethnic groups, contrasts in the 2006 NHDR focus on 20 core measures of quality and 5 core measures of access which support reliable estimates for Whites, Blacks, Asians, American Indians and Alaska Natives, non-Hispanic Whites, and Hispanics at more than one time point. Comparisons by income group use these same 5 core measures of access. However, the income contrast uses 12 core measures of quality because less information is available by income group for quality measures and only 12 of the 20 core measures of quality support estimates by income group at more than one time point.^{xx}

^{xix} Consistent with Healthy People 2010, disparities are measured in relative terms as the percent difference between each group and a reference group; changes in disparity are measured by subtracting the percentage differences between the baseline and the most recent year. The change in each disparity is then divided by the number of years between the baseline and most recent estimate to calculate change in disparity per year. Note that statistical significance is not required to label a disparity as improving or worsening; very few changes in disparities over time are statistically significant at the 0.05 level.

^{xx} As noted earlier, findings for disparities trends in the Highlights of this report suggest the same general trends identified in the 2005 NHDR Highlights. Some differences are noted, which are in part due to improved methods. Methods changes in this report include the following: (1) measures with only a small amount of change may be identified as the “same,” whereas last year all measures were identified as “improving” or “worsening” regardless of the magnitude of change; and (2) a uniform set of quality measures and access measures is analyzed for all racial, ethnic, and income groups, whereas last year comparisons included all measures with data available for each racial, ethnic, and income group. These changes should be considered when comparing findings from the 2006 Highlights versus the 2005 Highlights.

Figure H.3. Change in disparities in core quality measures over time for members of selected groups compared with reference group



Improving = Population-reference group difference becoming smaller at rate greater than 1% per year.

Same = Population-reference group difference not changing.

Worsening = Population-reference group difference becoming larger at rate greater than 1% per year.

Note: “Asian” includes “Asian or Pacific Islander” when information is not collected separately for each group. The most recent and oldest years of data available are compared.

For racial and ethnic minorities, some disparities in quality of care are improving and some are worsening. For the poor, most disparities are worsening.

- Of disparities in quality experienced by Blacks, Asians, AI/ANs, and Hispanics, about a quarter were improving and about a third were worsening (Figure H.3).
- Two-thirds of disparities in quality experienced by poor people (8/12) were worsening.

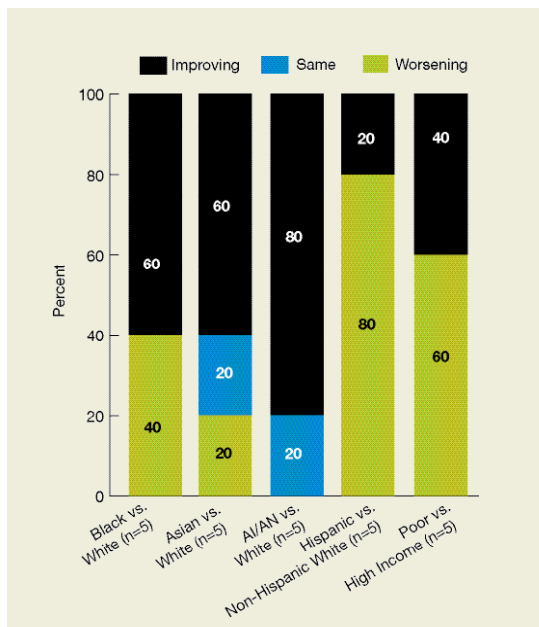
To illustrate these changing disparities in the quality of health care, examples include:

- From 2000 to 2003, the proportion of adults who received care for illness or injury as soon as wanted decreased for Whites (from 16.2% to 13.4%) but increased for Blacks (from 17.5% to 18.4%). This corresponds to an increase of 9.8% per year in this disparity. However, from 2000 to 2004, the rate of new AIDS cases remained about the same for Whites (from 7.2 to 7.1 per 100,000 population age 13 and over) but decreased for Blacks (from 75.4 to 72.1 per 100,000 population), corresponding to a decrease of 7.9% per year in this disparity.
- From 1999 to 2004, the proportion of adults age 65 and over who did not receive a pneumonia vaccine decreased for Whites (from 48% to 41%) but increased for Asians (from 59% to 65%). However, from 1998 to 2004, the proportion of children ages 19-35 months who did not receive all recommended vaccines decreased somewhat for Whites (from 26% to 17%) but even more for Asians (from 31% to 17%).
- From 2000 to 2003, the proportion of adults that had not received a recommended screening for colorectal cancer decreased for Whites (from 49% to 47%) but increased for AI/ANs (from 51% to 58%). However, from 2002 to 2003, the proportion of adults that reported communication problems with providers decreased somewhat for Whites (from 10.4% to 9.4%) but even more for AI/ANs (from 18.4% to 8.3%).

Highlights

- From 2001 to 2003, the rate of pediatric asthma hospitalizations remained the same for non-Hispanic Whites (139 hospitalizations per 100,000 population) but increased for Hispanics (from 188 to 226 per 100,000 population). However, from 2001 to 2003, the proportion of children without a vision check decreased somewhat for non-Hispanic Whites (from 40% to 38%) but even more for Hispanics (from 48% to 42%).
- From 2000 to 2003, the proportion of adults age 40 and over that did not receive three recommended services for diabetes decreased substantially for high income persons (from 54% to 41%) but less for poor persons (from 68% to 63%). However, from 2001 to 2003, the proportion of children whose parents or guardians reported communication problems with providers remained about the same for high income persons (from 3.6% to 3.3%) but decreased for poor persons (from 12.5% to 9.5%).

Figure H.4. Change in disparities in core access measures over time for members of selected groups compared with reference group



Improving = Population-reference group difference becoming smaller at rate greater than 1% per year.

Same = Population-reference group difference not changing.

Worsening = Population-reference group difference becoming larger at rate greater than 1% per year.

Key: AI/AN=American Indian or Alaska Native.

Note: “Asian” includes “Asian or Pacific Islander” when information is not collected separately for each group. The most recent and oldest years of data available are compared.

For racial minorities, most disparities in access to care that could be tracked are improving; for Hispanics and the poor, most disparities are worsening. Of core measures of access that could be tracked over time:

- Most disparities experienced by Blacks (3/5), Asians (3/5), and AI/ANs (4/5) were improving (Figure H.4).
- Most disparities experienced by Hispanics (4/5) and by poor people (3/5) were worsening.

Opportunities for Reducing Disparities Remain

Although some disparities are diminishing, many opportunities for improvement can still be found. For all groups, measures could be identified for which the group not only received worse care than the reference group but for which this difference was getting worse rather than better.

Table H.1. Disparities in quality of health care that are getting worse for selected groups by domain

Group	Preventive Services	Acute Illness Treatment	Chronic Disease Management	Timeliness	Patient Centeredness
Black vs. White	<ul style="list-style-type: none"> •Late stage colorectal cancer •Children with all vaccines •Elderly with pneumococcal vaccine 	<ul style="list-style-type: none"> •Hospital treatment of pneumonia 	<ul style="list-style-type: none"> •Patients with diabetes with amputations •Patients with adequate hemodialysis •Children hospitalized for asthma 	<ul style="list-style-type: none"> •Illness/injury care as soon as wanted 	<ul style="list-style-type: none"> •Adults with provider communication problems
Asian vs. White	<ul style="list-style-type: none"> •Colorectal cancer screening •Children with dietary advice •Elderly with pneumococcal vaccine 	<ul style="list-style-type: none"> •Hospital treatment of heart attack •Hospital treatment of pneumonia 	<ul style="list-style-type: none"> •Nursing home residents in restraints 	<ul style="list-style-type: none"> •Illness/injury care as soon as wanted 	<ul style="list-style-type: none"> •Adults with provider communication problems •Children with parent-provider communication problems
American Indian/Alaska Native vs. White		<ul style="list-style-type: none"> •Hospital treatment of heart attack 	<ul style="list-style-type: none"> •Patients who complete TB treatment •Nursing home residents in restraints •Home health care patients hospitalized 		
Hispanic vs. non-Hispanic White	<ul style="list-style-type: none"> •Elderly with pneumococcal vaccine 	<ul style="list-style-type: none"> •Children hospitalized for gastroenteritis •Hospital treatment of pneumonia 	<ul style="list-style-type: none"> •Children hospitalized for asthma •Patients who complete TB treatment 	<ul style="list-style-type: none"> •Illness/injury care as soon as wanted 	<ul style="list-style-type: none"> •Adults with provider communication problems
Poor vs. high income	<ul style="list-style-type: none"> •Colorectal cancer screening •Smokers with advice to quit •Children with all vaccines •Elderly with pneumococcal vaccine 		<ul style="list-style-type: none"> •Recommended services for diabetes 	<ul style="list-style-type: none"> •Illness/injury care as soon as wanted 	<ul style="list-style-type: none"> •Adults with provider communication problems

Note: “Asian” includes “Asian or Pacific Islander” when information is not collected separately for each group. The most recent and oldest years of data available are compared. A blank cell indicates that no disparity in quality of care was getting worse for the group. This may reflect lack of data or small sample sizes for some populations.

Highlights

- All groups had several measures for which they received worse care and for which the difference was getting worse (Table H.1). For Blacks, Asians, and Hispanics, these disparities involved all domains of quality that could be tracked: preventive services, treatment of acute illness, management of chronic disease and disability, timeliness, and patient centeredness. For AI/ANs, these disparities appeared concentrated in the treatment of acute illness and the management of chronic disease and disability.^{xxi}
- Some disparities in quality of care were prominent for multiple groups; these disparities include:
 - Colorectal cancer screening
 - Vaccinations
 - Hospital treatment of heart attack
 - Hospital treatment of pneumonia
 - Services for diabetes
 - Children hospitalized for asthma
 - Treatment of tuberculosis (TB)
 - Nursing home care
 - Problems with timeliness
 - Problems with patient-provider communication

Table H.2. Disparities in access to health care that are getting worse for selected groups

Group	Access to Health Care
Black vs. White	Usual primary care provider Unable or delayed in receiving care due to financial or insurance problems
Asian vs. White	
American Indian/ Alaska Native vs. White	
Hispanic vs. non-Hispanic White	Health insurance Source of ongoing care Usual primary care provider
Poor vs. high income	Source of ongoing care Usual primary care provider Unable or delayed in receiving care

Note: “Asian” includes “Asian or Pacific Islander” (API) when information is not collected separately for each group. The most recent and oldest years of data available are compared. A blank cell indicates that no disparity in access to care was getting worse for the group. This may reflect lack of data or small sample sizes for some populations.

The 2006 NHDR also finds that Hispanics and the poor faced many disparities in access to care that were getting worse (Table H.2):

- For Hispanics, not having health insurance and a usual source of care were getting worse.
- For the poor, not having a usual source of care and experiencing delays in care were getting worse.

^{xxi} In interpreting these findings it is important to note that there are significant gaps in data availability for AI/ANs.

Information About Disparities Is Improving, But Gaps Still Exist

New Data Sources and Measures

The 2006 NHDR provides more information about disparities than previous reports. Improvements include the addition of new data sources and new measures that have allowed analyses of new disparities:

- **Obesity.** New measures of counseling of overweight and obese persons from the National Health and Nutrition Examination Survey and the Medical Expenditure Panel Survey have been added to this year's report. One of these measures—obese adults who were given advice about exercise—is a new core measure.
 - Only 68% of obese adults age 20 and over reported being told by their provider that they were overweight. Obese Blacks and Mexican Americans^{xxii} were less likely to be informed than obese non-Hispanic Whites; obese persons with less than a high school education were less likely to be informed than obese persons with any college education.
 - Only 37% of overweight children and teens ages 2-19 reported being told by their provider that they were overweight. Disparities were not observed.
 - Only 58% of obese adults reported being given counseling about exercise. Among obese adults, counseling was reported less often by Hispanics compared with non-Hispanic Whites; by poor, near poor, and middle income persons compared with high income persons; and by persons with a high school education or less compared with persons with any college education.
- **Asthma management.** Supplemental measures from the 2003 National Asthma Survey, coordinated by the National Heart, Lung and Blood Institute at the National Institutes of Health, have been included in the 2006 NHDR.
 - The National Asthma Education and Prevention Program develops and disseminates science-based guidelines for the diagnosis and management of asthma. It recognizes assessment and monitoring, controlling factors contributing to symptom exacerbation, pharmacotherapy, and education for partnership in care as four essential components of asthma management. However, considerable variation was observed. Among persons with current asthma, only 70% were taught to recognize early signs of an attack, 49% were told how to change their environment, 40% were given a controller medication, and 27% were given an asthma management plan.
 - Compared to persons with any college education, persons with less education were less likely to report receiving information about assessing their asthma and controlling environmental triggers.
 - Blacks were less likely than Whites to receive controller medications.
- **Hospice care.** New supplemental measures of hospice care from the National Hospice and Palliative Care Organization's Family Evaluation of Hospice Care survey are included in this year's report.^{xxiii}
 - Only 6% of families reported that hospice providers did not provide the right amount of medication for pain. However, rates were higher among Blacks and APIs compared with Whites and among Hispanics compared with non-Hispanic Whites.

^{xxii} This data source collects data for Mexican Americans rather than Hispanics.

^{xxiii} This survey provides unique insight into end-of-life care and captures information about a large proportion of hospice patients but is limited by non-random data collection and a response rate of about 40%. In addition, race and ethnicity were not reported by large numbers of respondents.

Highlights

- Only 5% of families reported that hospice providers gave care inconsistent with stated end-of-life wishes. However, rates were higher among Blacks, APIs, and AI/ANs compared with Whites; among Hispanics compared with non-Hispanic Whites; and among persons with a high school education or less compared with persons with any college education.
- **Patient safety.** The patient safety section has been redesigned this year to accommodate the availability of a new measure from the Centers for Medicare & Medicaid Services (CMS) Medicare Patient Safety Monitoring System and another adopted by the Hospital Quality Alliance (HQA) from the CMS Quality Improvement Organization program.
 - Postoperative complications^{xxiv} occur at a rate of 6 per 100 Medicare patients having surgery. Rates were higher among Blacks compared with Whites.
 - Timing of prophylactic antibiotics for surgery is appropriate 58% of the time. Blacks, AI/ANs, and Hispanics were less likely than non-Hispanic Whites to receive prophylactic antibiotics at the correct times.
 - Although rates of inpatient death following complications of care are falling, they remained higher among APIs compared with non-Hispanic Whites.
 - About 10% of inpatients receiving anticoagulant or hypoglycemic medications experienced complications. Blacks were more likely than Whites to experience complications from hypoglycemic medications.
- **Patient centeredness in hospital care.** Supplemental measures from the CAHPS[®] Hospital Survey have also been included for the first time this year.
 - Only 6% of hospitalized patients reported communication problems with doctors and 7% reported communication problems with nurses.
 - However, 26% of hospitalized patients reported problems with communications about medications and 21% reported problems with discharge information.
- **Workforce diversity.** New supplemental measures of the health care provider population by race and ethnicity from the U.S. Census and Community Tracking Study have been added.
 - Whites and Asians are overrepresented in the U.S. physician population. Whites comprise 69% of the U.S. population and 74% of the physician population; Asians comprise 3.6% of the U.S. population and 15% of the physician population.^{xxv}
 - Hispanics, Blacks, Native Hawaiians and Other Pacific Islanders (NHOPIs), and AI/ANs are underrepresented in the U.S. physician population, composing 12.6%, 12.1%, 0.1% and 0.7% of the U.S. population and 5%, 4.5%, 0.03%, and 0.2% of the physician population, respectively.
- **Hispanic subpopulations.** Analyses by Hispanic subpopulation have been added to the NHDR to begin to shed additional light on disparities among the highly heterogeneous U.S. Hispanic population.
 - Among Hispanic subpopulations, Mexicans reported the lowest rates of advice to quit smoking (42.4%) and the highest rates of delayed care for illness or injury (24.1%) and uninsurance (31.1%) of all Hispanic subpopulations. Central or South Americans reported the highest rates of patient-provider communication problems (18%).

^{xxiv} Complications following surgery include pneumonia, bladder infection, and blood clots in the legs.

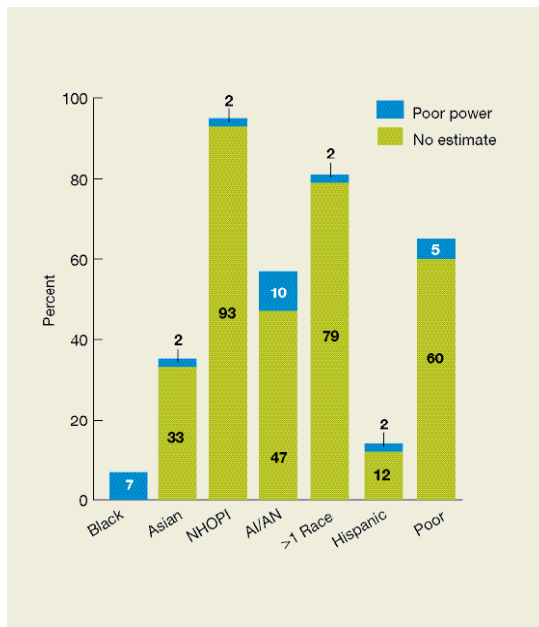
^{xxv} Note that physician estimates include both physicians born in the United States as well as physicians who immigrated into the United States.

- **Language assistance.** A new supplemental measure of adults with limited English proficiency with and without a usual source of care that offers language assistance from the Medical Expenditure Panel Survey has been added to this year's report.
 - Nearly half—47%—of individuals with limited English proficiency reported that they do not have a usual source of care. An additional 47% of individuals reported having a usual source of care that offers language assistance.
 - Only 6% of individuals with limited English proficiency reported having a usual source of care that does not offer language assistance.
- **Uninsurance.** Analyses of health care by health insurance status and income category are also included in the 2006 NHDR (see the section focusing on uninsurance in Chapter 4, Priority Populations).
 - For the total population and for every income group, the proportions of adults who reported receiving recommended colorectal cancer screening or a dental visit were lower for uninsured (21.8% and 18.7%, respectively) compared with privately insured persons (49.2% and 51.8%, respectively).
 - Being uninsured has a large negative impact on almost all aspects of health care quality and access. In fact, among adults, the negative effects of being uninsured are typically larger than the effects of race, ethnicity, income, and education. Multivariate analyses suggest that uninsurance is an important mediator of racial, ethnic, and socioeconomic disparities, although race, ethnicity, and socioeconomic position often have independent effects as well.

Unresolved Information Needs

The expanded capability of Federal data sources has allowed more reliable estimates to be made for more populations. However, considerable gaps remain. Information gaps can relate to insufficient data to produce reliable estimates or, when estimates are possible, to inadequate power to detect large differences.^{xxvi}

Figure H.5. Core quality measures with estimation or statistical power problems for members of selected racial and ethnic groups



No estimate = Data cannot provide an estimate for group that meets report criteria for reliability.

Poor power = Data can provide reliable estimate for group but statistical power is insufficient to detect a 20% difference relative to reference group.

Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native.

Note: Data presented are the most recent data available.

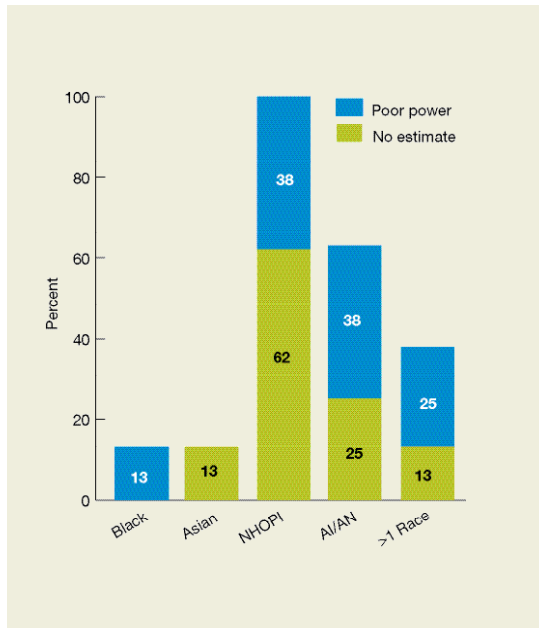
For example, of the core measures of quality, statistically reliable estimates were not possible for:

- Most measures for Native Hawaiians or Other Pacific Islanders and persons of more than one race (Figure H.5).
- About half of quality measures for American Indians or Alaska Natives.
- About a third of quality measures for Asians.
- About two-thirds of quality measures for the poor.

Power issues were also a problem, particularly for American Indians or Alaska Natives, in core measures of access. Data collection that focuses on specific groups may be needed to yield reliable information about these populations.

^{xxvi} “Statistical power” refers to the ability of a test to detect an effect of a given size and is strongly influenced by the sample size of the measurement taken.

Figure H.6. Core access measures with estimation or statistical power problems for members of selected racial groups



No estimate = Data cannot provide an estimate for group that meets report criteria for reliability.

Poor power = Data can provide reliable estimate for group but statistical power is insufficient to detect a 20% difference relative to reference group.

Key: NHOPI=Native Hawaiian or Other Pacific Islander; AI/AN=American Indian or Alaska Native.

Note: Data presented are the most recent data available.

Of the core measures of access, statistically reliable estimates were not possible for:

- Most measures for Native Hawaiians or Other Pacific Islanders (Figure H.6).
- A quarter of measures for American Indians or Alaska Natives.

Power was insufficient to detect a 20% difference relative to Whites for:

- Over a third of access measures for Native Hawaiians or Other Pacific Islanders and American Indians or Alaska Natives.
- A quarter of access measures for persons of more than one race.

Estimation and power were not problems for Hispanics and the poor, so data are not presented for these groups.

Moving Forward: National Standards, Neighborhood Solutions

The NHDR continues to be the broadest annual examination of disparities in health care ever undertaken in the United States. As support for reducing disparities continues to grow, the ability to monitor and track improvements in disparities is becoming critical. In this 2006 report, the information infrastructure built in previous reports to track the Nation's progress toward the elimination of disparities in health care continues to mature. Multiple years of data are available to assess the direction of change across a large number of measures of health care quality and access.

As mandated by Congress, the NHDR concentrates on the national view of health care disparities. It is descriptive and not prescriptive about how to eliminate disparities. It defines national standards for the measurement of disparities in health care quality and access and provides national baselines needed for tracking progress toward eliminating these disparities.

However, neighborhood solutions are the key for achieving the elimination of health care disparities. Although some barriers to care, such as lack of insurance, affect numerous communities, many causes of disparities and priorities for addressing them vary across the country. Successfully addressing these disparities will require focused community-based projects that are supported by detailed local data. The methods and measures used in the reports are made available online in hopes that communities and providers will apply them to their own data. Communities that make this investment may use NHDR findings as annual national benchmarks against which to compare their progress.

To further support community-based approaches to reduce health disparities that affect racial, ethnic, and underserved populations, AHRQ has developed a variety of information products derived in part from data gathered for the annual production of the NHQR and NHDR. These products seek to translate disparities information for use by State and local health policymakers and include:

- **State Snapshots.** This interactive Web-based tool, produced by AHRQ annually using data from the NHRQ and NHDR, is designed to help State officials and their public- and private-sector partners understand health care quality and disparities in their State, including strengths, weaknesses, and opportunities for improvements. The State Snapshots provide State-specific information on health care quality measures for each State using user-friendly graphs and customized tables.^{xxvii}
- **Diabetes Care Quality Improvement: A Resource Guide for State Action.** Designed in partnership with the Council of State Governments for State elected leaders, executive branch officials, and other nongovernmental State and local health care leaders, this *Resource Guide* provides background information on why States should consider diabetes as a priority for State action, presents analysis of State and national data and measures of diabetes quality and disparities, and gives guidance for developing a State quality improvement plan. A companion interactive *Workbook* presents review exercises for State leaders on the key skills and lessons from the *Resource Guide* to use in making the case for diabetes care quality improvement, learning from improvement efforts already underway, measuring diabetes quality and disparities, and implementing diabetes care quality improvement plans using a State-led quality improvement framework.^{xxviii}
- **Asthma Care Quality Improvement: A Resource Guide for State Action.** Like the diabetes resources, this *Resource Guide* and its companion *Workbook* provide information about asthma quality and disparities and present exercises to hone skills useful for developing a State asthma quality improvement plan.^{xxix}

^{xxvii} Readers should consult the AHRQ Web site (www.ahrq.gov) for announcement of availability of the State Snapshots.

^{xxviii} Available at: <http://ahrq.gov/qual/diabqualoc.htm>.

^{xxix} Available at: <http://www.ahrq.gov/qual/asthmaqual.htm>.

For policymakers who are ready to make changes to reduce disparities, AHRQ supports community partnerships that engage public and private stakeholders to improve the quality of care for people with diabetes and asthma, to develop quality improvement action plans, and to evaluate innovative implementations of State and community efforts to improve quality and disparities. These partnerships seek to go beyond research to actively address problems with quality and disparities. They include:

- **National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality.** This partnership with nine of America's foremost health plans (Aetna, CIGNA, Harvard Pilgrim Health Care, HealthPartners, Highmark Inc., Kaiser Permanente, Molina Healthcare, UnitedHealth Group, and WellPoint, Inc.) is testing ways to improve the collection and analysis of data on race and ethnicity, matching these data to existing quality measures in the Health Plan Employer Data and Information Set (HEDIS[®]), and developing quality improvement interventions that close the gaps in care. Lessons learned by plans in the collaborative will be shared with other health plans so that they too can improve the care they provide.
- **Aim setting and State plans for quality improvement.** This partnership with five States (Maine, Rhode Island, Massachusetts, West Virginia, and Arkansas), reviews the State Snapshots in the context of the needs of these States to develop new tools that help States use data for quality improvement.
- **Improving diabetes care in communities.** This partnership with three of the Nation's leading business coalitions (Greater Detroit Area Health Council, MidAtlantic Business Group on Health, and Memphis Business Group on Health) supports local communities in their efforts to reduce the rate of obesity and other risk factors that can lead to diabetes and its complications and work together to ensure that people with diabetes receive appropriate health care services. Each of the coalitions has convened stakeholders—including businesses, providers, health plans, insurers, consumers, and academics—to set priorities in their efforts to improve diabetes care, reduce disparities, and develop solutions that fit within the community's needs and capabilities.
- **Diabetes disparities reduction in the Hispanic population.** This partnership with community providers in two States with large Hispanic populations supports the development of interventions to improve the quality of care for Hispanics with diabetes through care management and patient empowerment.
- **Decreasing disparities in pediatric asthma.** This partnership with coalitions in six States (Arizona, Maryland, Michigan, New Jersey, Oregon, and Rhode Island), focuses on developing action plans to improve disparities in pediatric asthma by addressing cultural competency; using data to target need, coordinate resources, and inform policy decisions; and increasing access and improving the quality of care for underserved populations.

Prevention and elimination of health care disparities for the Nation will result from coordinated actions at Federal, State, and local levels to extend the benefits of regional and community successes nationwide. Working together, using the NHDR as a guide, America's patients, providers, purchasers, and policymakers can make full access to high quality health care a reality for all.