

Brief Summary of CSTE Health Disparity Methodology Meeting in Atlanta, May 24, 2011

The CSTE Health Disparities Subcommittee is interested in working toward developing guidance to enable most local and state health departments to analyze their own local and state public health datasets, starting with a simplified method to assess geocoded disease data for socioeconomic and racial/ethnic health disparities. This approach is inspired by ‘the Public Health Disparities Geocoding Project’ (PHDGP) from Prof. Nancy Krieger of the Harvard School of Public Health, which focuses on using area-based socioeconomic status (SES) measures with public health surveillance data to monitor health inequalities in the U.S. population. A meeting was convened in Atlanta on May 24, 2011 with CSTE and CDC representatives with the following objectives:

- to review the main points of the PHDGP;
- to discuss recent examples of its application to different local datasets; and
- to discuss and find agreement on a simplified and updated geocoded analytic method that local and state health departments can use with current limited resources and levels of epidemiologic/statistical expertise.

From this meeting, the anticipated outcome will be a draft method guidance document that can be used by some state/local public health agencies to apply to select nationally notifiable condition(s) to analyze for health disparities.

Pam Waterman, MPH, Project Director of the Harvard PHDGP, presented an overall summary of this project from its inception to the current elements available on its webpage. She described geocoding a wide range of datasets from the Massachusetts and Rhode Island health departments and linking them to area-based SES measures, and presented key findings and recommendations from the resulting analyses. Jim Hadler, MD MPH, Public Health Consultant and currently with the Connecticut Emerging Infections Program (EIP) and the New York City Department of Health and Mental Hygiene, presented several applications of the PHDGP method to CT EIP surveillance data and to NYC data.

The meeting participants were then led through a discussion of the major method elements of the PHDGP to come to agreement, where possible, on how each element can be simplified or updated for use at the local/state level. There was general agreement on these aspects of the method elements:

- A. Geocoded public health data have great value, and state/local health departments should consider geocoding some of their data to enable linkage with census tract SES measures to assess health disparities.
- B. For denominators, use 1990, 2000, or 2010 census tract data for population counts.
- C. Based on the PHDGP findings, consider using the census tract poverty variable, “% of persons living at or below the federal poverty level.” Six poverty cutpoints (0-<5%, 5-<10%, 10-<20%, 20-<30%, 30-<40%, and $\geq$ 40%) should be considered for comparison across jurisdictions; these can be collapsed to 4 cutpoints or expanded depending on the size of the population and poverty level spread within each jurisdiction. Independent of which cutpoints are used, we recommend allowing a break at <20%, $\geq$ 20% to enhance comparability across jurisdictions and because at $\geq$ 20% jurisdictions are eligible for some federal programs. Advanced users can also explore the use of other census tract poverty related indicators.
- D. To merge and analyze datasets, there are several statistical software that can be used. SAS has been popular among several users.
- E. To show results of data analysis, use simple histograms, with accompanying text.

Details of the presentations and discussion are in the attached meeting summary. A guidance document based largely on the meeting discussion will be developed to encourage use of this methodologic approach to assess and monitor health disparities at the local and state level.