

Reducing Disparities: The Importance of Collecting Standardized Data on Patient Race, Ethnicity and Language

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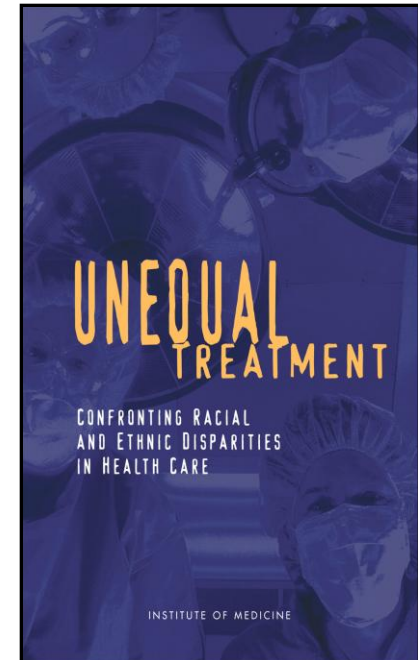
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Learning Objectives

- Understand the role of standardized R/E/L data collection in reducing disparities
- Identify and consider the key decision points to successfully implement standardized R/E/L data collection in your practice
- Understand how to use standardized data to identify and measure any existing disparities and reduce disparities over time

Defining disparities in health care quality

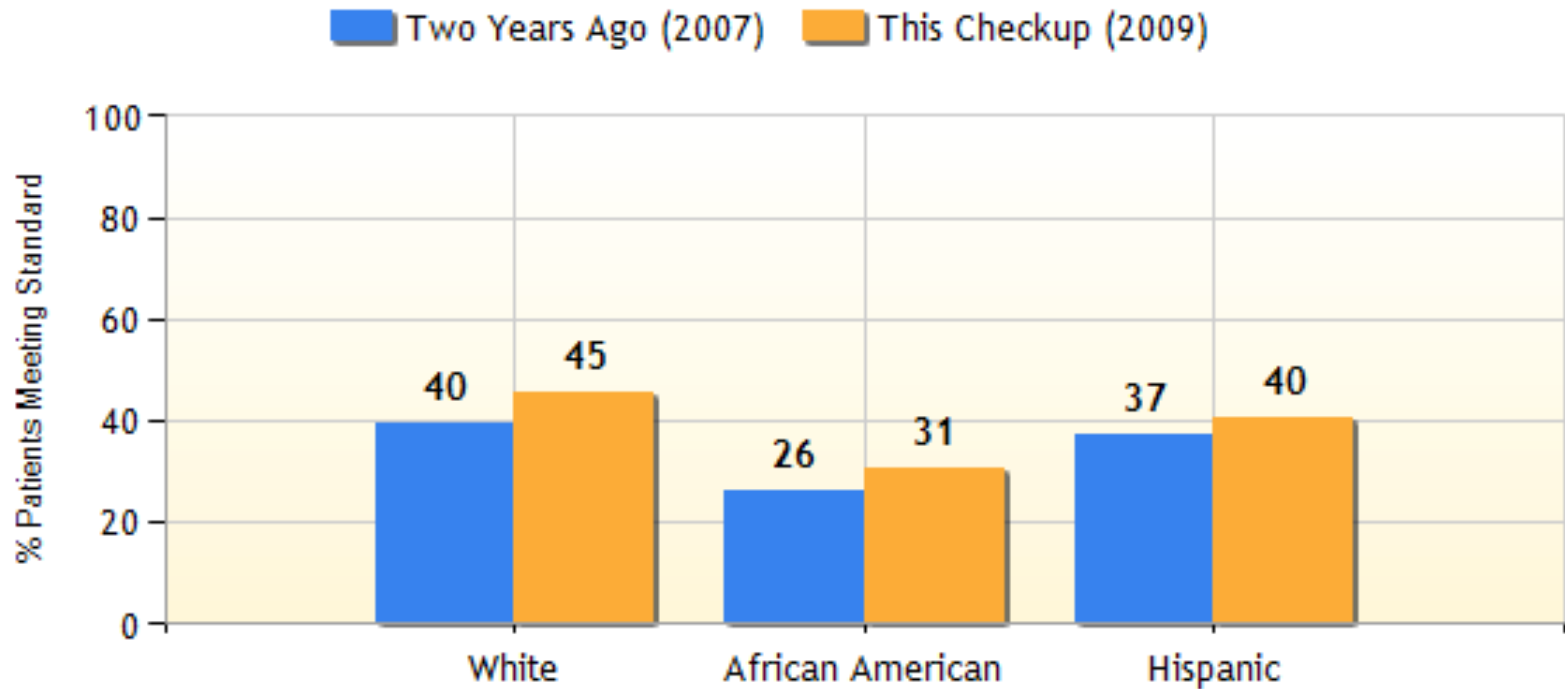
- “Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities”
- Less likely to receive:
 - Cancer screening
 - Cardiovascular therapy
 - Kidney dialysis
 - Transplants
 - Curative surgery for lung cancer
 - Hip and knee replacement
 - Pain medicines in the ER



Diabetes Outcomes

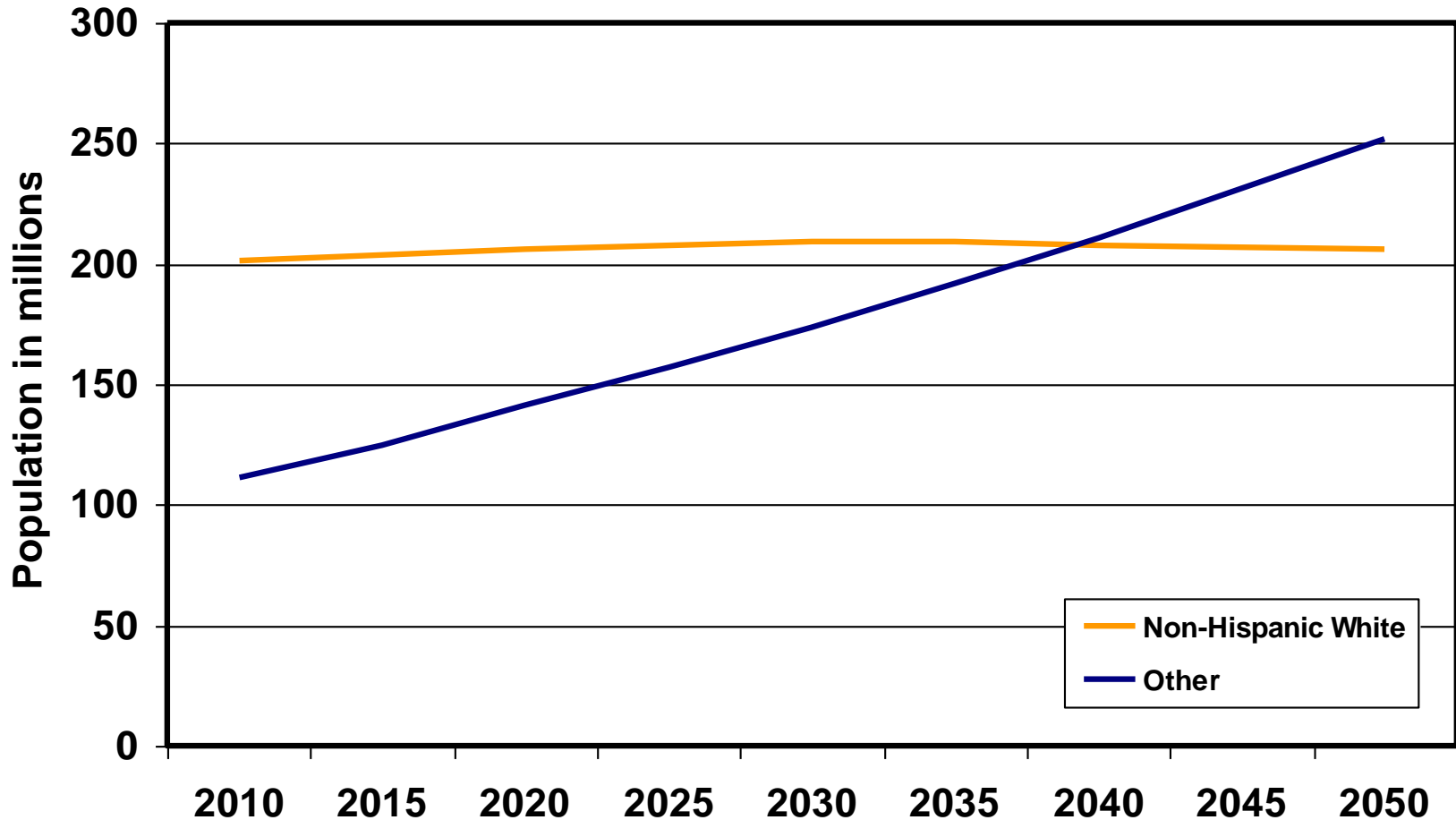
Better Health *Greater* Cleveland

% Patients Meeting 4 of 5 Outcomes, by Race/Ethnicity



Growing U.S. minority population

Population Projections, 2010 to 2050



Increasing legislative and regulatory attention to R/E/L data

- American Recovery and Reinvestment Act of 2009
 - Hospitals and providers will need to collect R/E/L data to be eligible for “meaningful use” incentive payments
 - Race/Ethnicity categories to follow Office of Management and Budget guidelines
- Patient Protection and Affordable Care Act of 2010
 - Health programs receiving federal money are required to collect R/E/L data
- Revised Joint Commission standards
 - Expand requirements related to the collection of patient language data, including preferred spoken language and written communication needs
 - New requirement to collect patient-level demographic data on race and ethnicity

Office of Management and Budget

Race and ethnicity categories

Race

- Black
- White
- Asian
- American Indian/Alaska Native
- Native Hawaiian/Pacific Islander

Ethnicity

- Hispanic
- Not Hispanic

Three steps in addressing disparities

- Standardized collection of self-reported R/E/L data
 - Categories are standardized
 - Patient self-reports
- Stratification and analysis of performance measures
 - Compare patients within an organization
 - Consolidate data to identify community-level trends
- Use of stratified data to identify and develop quality improvement interventions targeted to specific patient populations

Do disparities exist in your practice?

- We don't know until we look at the data
- We can't look at the data until we ask patients about their race, ethnicity and language



What change needs to happen?

- Develop the capacity and infrastructure to collect standardized race, ethnicity and language information from all patients
- This will affect:
 - Registration system and processes
 - Staff training and workflow
 - Patient communications
 - How data are used to monitor quality

Key decision points to consider

- Where are data currently collected?
- Who needs to be engaged?
- What registration system and IT modifications need to be made?
- How will changes be communicated?
- How will staff be trained?
- How will data be used to identify and address disparities?

Where are data currently collected?

- When scheduling/registering an office visit
 - Face-to-face
 - Written registration forms
 - Telephone
- All points of entry (inpatient, outpatient, emergency department, cardiac catheterization lab, etc.)
- “Downstream effect” – Registries and other databases

Who needs to be engaged?

- Senior Leadership
- Information Technology staff
- Registration/Admissions staff
- Quality Improvement
- Interpreter Services
- Clinicians
- Patient Advocacy/Diversity Team
- Community Relations/Marketing



What registration system and IT modifications need to be made?

- Will you need add data fields to accommodate new categories?
 - Will you use granular categories?
 - Can patients choose more than one race?
 - Will you collect both spoken and written language?
- What is your system's capacity to add a field?
 - Can the change be made 'in-house' and house-wide?
 - What departments need to be involved to make changes to the system?
 - Is there a need to create combined R/E categories?
- Will these fields be hard stops?

How will patients be informed about the new questions?

- Most patients believe health care providers should collect race and ethnicity data
- Letting your patients know that it is about improving quality helps everyone's comfort level

Letting your patients know

Wall Posters

Can be displayed in:

- Registration areas
- Waiting rooms



We Ask Because We Care.

By asking about your race, ethnicity and language, we are better able to deliver health care equally to all patients.

¿Cuál es su raza?
¿Cuál es su descendencia étnica?
¿Cuál es su idioma preferido?

Respecting every difference, treating each equally.

GET REAL
Race, Ethnicity, and Language

Your Logo

Aligning Forces for Quality | Improving Health & Health Care in Communities Across America



We Ask Because We Care.

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What is your race?
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How will staff be trained?

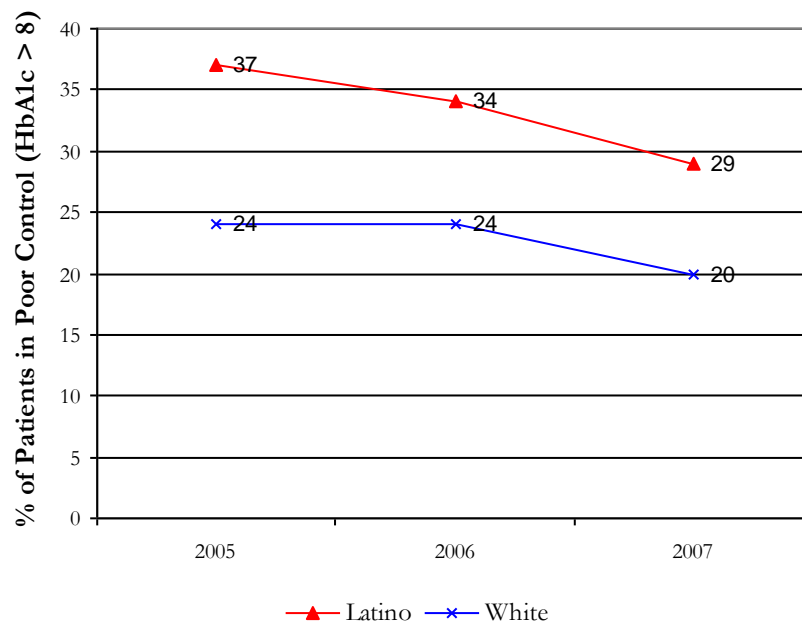
- Who needs to be trained?
- Who will provide training?
- How will the training be implemented?
 - Role-playing? Handouts/scripts? Screen content?
- How will you monitor quality of data collected?
 - Will feedback be given?
 - Will registrars see how data is used?

Using R/E/L data to monitor quality

Massachusetts General Hospital Chelsea Diabetes Project

- Identified disparity between white and Latino patients in diabetes control and recommended care
- Created culturally competent Diabetes Management Program
- Improved mean HbA1c values for all patients, reduced gap between white and Latino patients
- Increased overall number of patients with HbA1c test within past 9 months and eliminated disparity

Disparities in Diabetes Control
MGH Chelsea Clinic 2005-2007



Source: Disparities Solution Center at MGH <http://dx.confex.com/dx/8/webprogram/Paper2024.html>

Using R/E/L data to monitor quality

HealthPartners at Midway Clinic St. Paul, MN

- Identified disparity between white and minority patients receiving recommended breast cancer screening
- Worked with patient council to develop pilot same-day screening program
- Narrowed gap between white and minority patients screened from 16% to 2.5% over one year

Cambridge Health Alliance Breast Cancer Initiative

- Breast screening rates were in decline, especially among minority groups
- Tailored outreach efforts to better meet needs of uninsured & hard-to-reach patients
- Improved screening rates to over 80% for all patients

Source: HealthPartners <http://www.healthpartners.com/files/40901.pdf>

Using R/E/L data to monitor quality

University of Mississippi Medical Center

- “Eye-balling” indicated approximately 180 Hispanic patients/year
- Self-reported data revealed 600 Hispanic patients/month, additional 500 patients/month from other minority groups
- Hired three full-time Spanish interpreters
- Switched vendors to ensure phone system could handle required interpreter services

Federally Qualified Health Centers

- Survey found high numbers of limited English proficiency (LEP) patients in locations thought to be homogenous
- Satisfy patients’ needs by hiring interpreters

How else can you use R/E/L data?

- Provide more patient-centered care
- Develop cultural competency training for staff
- Compare utilization of health services among different patients
- Compare patient satisfaction with care provided among different patients
- Target marketing materials to specific patient populations
- Capture changes in demographic trends

Resources and Tools

- PowerPoint presentations with talking points
- Health Research and Educational Trust [*Disparities toolkit*](#)
- Institute of Medicines [*Unequal Treatment*](#)
- Institute of Medicine [*Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*](#)
- *I Speak* poster
- *We Ask* poster and tent card (English and Spanish)

Acknowledgements

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