

## Collecting Race, Ethnicity and Primary Language Data in Physician Practices: The Minnesota Community Measurement Experience

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### Introduction

Disparities in care can occur within a wide range of health care settings and are associated with lower quality of care and higher mortality among racial and ethnic minorities and individuals with limited English proficiency. To reduce disparities in care and develop appropriate interventions, health care organizations first need to identify where and why they exist; hospitals, physician practices, and health plans can start by systematically collecting patients' race, ethnicity, and language data to provide a basic foundation for measuring and monitoring care for different groups over time.<sup>1</sup> However, systematically collecting these data remain a challenge for most health care organizations.

The need for the collection of accurate race, ethnicity, and language data have remained at the forefront as an important and necessary first step to reducing disparities in care within our health care system. Yet, almost a decade has passed since the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* asked, “How can disparities exist, when health systems and health care professionals have dedicated themselves and work hard to provide the highest possible quality of care to all patients?”<sup>2</sup> The Aligning Forces for Quality initiative (AF4Q) emphasizes the importance of reducing racial and ethnic disparities in health care as a

### Aligning Forces for Quality

The Robert Wood Johnson Foundation (RWJF) is investing in efforts to improve health systems in 17 communities across the nation.

Called Aligning Forces for Quality (AF4Q), the initiative brings a commitment of resources, expertise and training to turn promising practices into real results at the community level. AF4Q asks the people who get care, give care and pay for care to work together toward common fundamental objectives to lead to better care.

The initiative aims to lift the overall quality of health care, reduce racial and ethnic disparities and provide models for national reform.

It advances three interrelated reforms that experts believe are essential to improving health care quality:

- **Performance measurement and public reporting**
- **Consumer engagement**
- **Quality improvement**

For more information about AF4Q, please visit

<http://www.rwjf.org/qualityquality/af4q/index.jsp>

For more information about RWJF, please visit

<http://www.rwjf.org/>

## Introduction (continued)

key component of improving health care quality in 17 communities across the country. A major barrier to eliminating disparities in care is the lack of reliable race, ethnicity, and primary language data of patients within health care organizations. Minnesota Community Measurement (MNCM), a community-based nonprofit organization comprising representatives from Minnesota's state medical associations, medical groups, hospitals, local businesses, health plans and consumer groups, is participating in the AF4Q program. As part of its efforts to improve quality and reduce disparities in care, MNCM is working with medical groups in Minnesota to standardize the collection of race, ethnicity, and primary language data. In this research summary, we highlight MNCM's efforts to incorporate systematic data collection in physician practices to reduce disparities and improve quality.

## A Call to Action to Reduce Disparities in Health Care

National and state-level calls to action can provide an important catalyst in bringing the topic of health care disparities to the forefront, help to frame the issue and what needs to be addressed, and assist in developing and identifying common tools and resources to move forward. Organizations such as the Joint Commission, the American Hospital Association, the National Committee for Quality Assurance, the Institute of Medicine, and the American Medical Association, have recognized the importance of systematically collecting race, ethnicity, and language data to eliminate disparities in care. In addition, the recently passed Health Reform Bill (*Patient Protection and Affordable Care Act*) has provisions for the collection of these data to

## A Call to Action to Reduce Disparities in Health Care (continued)

eliminate disparities in care. Further, the American Recovery and Reinvestment Act provides \$19 billion for health information systems and the *“use of electronic systems to ensure, among other things, the comprehensive collection of patient race, ethnicity, and language data.”*<sup>3</sup> The “meaningful use” of electronic systems — which will determine whether physicians qualify for federal incentive payments — includes the use of electronic systems to collect data on race, ethnicity, and language of patients.

Ultimately, the successful elimination of health care disparities requires local involvement by providers in the community. Understanding how specific communities implement data collection strategies can provide important insights and lessons to those communities just embarking on this process. Health care providers can address disparities and use data to empower their community and improve health care.

## Aligning Forces for Quality and the Minnesota Experience with Data Collection

### Minnesota

As the twelfth largest state, Minnesota comprises 87 counties and is home to over 5.1 million residents, the majority of whom live in the Twin Cities (Minneapolis and St. Paul).<sup>4</sup> Although Minnesota’s racial/ethnic minority population makeup is less than half the national average (MN:12.2%/US:26.1%), the state is showing a significant increase in the diversity of its population. Between 2000 and 2006, Minnesota’s African American population grew at a rate almost five times faster than the national average (MN:33.0%/US:6.9%) while the Hispanic/Latino (MN:36.1%/US:25.3%) and foreign born (MN:30.2%/US:20.7%) populations grew at rates 10% higher than the nation as a whole.<sup>6</sup> These dramatic demographic changes challenge the health care system to meet the needs of an increasingly diverse population. Although the overall health of Minnesota residents is better than the national average, racial and ethnic minorities fare worse than their White counterparts on a number of key indicators such as insurance status, mortality rate (adult and infant), and childhood immunization status.<sup>5,6</sup>

## Aligning Forces for Quality and the Minnesota Experience with Data Collection (continued)

### A Brief History

With much of its efforts rooted in working with physicians on collecting and publicly reporting performance data, MNMCM has an established track-record of working with physician groups on collective goals to improve quality. The collection of race, ethnicity, and language data to improve quality for diverse populations was a natural next step in achieving high quality care in Minnesota.<sup>7</sup> In 2007, the Minnesota Department of Health's Office of Minority and Multicultural Health formed an agreement with MNMCM whereby MNMCM would facilitate and lead the state's efforts to achieve systematic, community-wide race, ethnicity, and language data collection.<sup>8</sup>

MNMCM did not have a formal contract with the state to take on these responsibilities, however due to MNMCM's work with the state on disparity reduction efforts and its role as an active member of the Minnesota Health Care Disparities Task Force coupled with its AF4Q efforts to improve quality of care, MNMCM was an organization poised to lead data collection efforts in Minnesota.

### Getting Physician Practices on Board: The Early Adopters Model

To begin work on the systematic statewide

collection of race, ethnicity and language data in medical practices, MNMCM convened an Early Adopters Work Group to discuss the barriers and facilitators to collecting these data. The Early Adopters Work Group consisted of representatives from six health care organizations (physician practices, federally qualified health centers, and hospitals) that had already implemented systematic data collection or were soon in place to do so. Some of the early adopters had been collecting data since 2003. As other organizations learned about the Early Adopters Work Group they also wanted to be part of the dialogue and offer their insights. The Early Adopters Work Group took advantage of this momentum and developed a list of recommendations for data collection, which they then circulated to the larger group (designated as the "Ready and Willing") to elicit their specific feedback and to engage them in the dialogue and development of final recommendations. *"We got very specific feedback from members of the 'Ready and Willing' group. We really rely on these clinical champions when we are developing measures and data collection systems to be champions back in their own groups. These are individuals who have their feet grounded in quality and who are listened to back in their community and group. We couldn't do it without them but we at MNMCM also take a leadership role, so it is a partnership."* (Diane Mayberry, MNMCM Chief Operating Officer)

## Getting Physician Practices on Board: The Early Adopters Model (continued)

Together, members of both work groups created a race, ethnicity and language data collection handbook which included recommendations on data collection.<sup>5</sup> The *Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups* was published in 2009. It contains instructions for implementing the collection of race, ethnicity and language data in the ambulatory care setting and includes information about:

- The Rationale for Collecting Data
- Implementation Considerations
- Administrative Concerns
- Data Quality Assurance
- Community Engagement
- Data Use and Reporting

### Strengths

Today, MNMCM attributes its progress in systematic data collection to the strong collaborative efforts of the Early Adopter Work Group and the “Ready and Willing” partners. Participants in both work groups were attuned to the importance of race, ethnicity and language data collection as vital components for measuring quality in diverse populations. Work group members served as educators and leaders in their own organizations around this topic. These clinical and operational champions not only recognized the importance of measurement in improving quality, but they have also been able to communicate this information to leaders and staff in their own organizations, which has been key to MNMCM’s progress.

### Barriers

Moving forward, it is important to recognize both perceived and real barriers that medical groups face in collecting and using race, ethnicity, and language data to address disparities in care. Nationwide, physician practices have cited multiple barriers to collecting these data and these same concerns are mirrored by medical groups in Minnesota.<sup>9</sup>

Commonly cited barriers include:

- Data collection is not a priority for many physicians, especially among those who serve in areas with very little diversity
- Staff are reluctant to ask patients about their race, ethnicity, and language
- Information technology systems cannot accommodate data collection requirements
- Small numbers do not allow for reliable analysis of performance in different groups
- Perceptions by clinical staff that disparities do not exist in own practice
- Limited resources to dedicate to data collection activities

## Take Away Lessons

MNCM's partnership with community health care organizations which had already gained experience with collecting race, ethnicity, and language data allowed for identifying promising practices. In addition, by eliciting feedback from organizations which were interested in data collection but were still working out the details, MNMCM engaged in a semi-formal consensus-driven approach to develop its recommendations for data collection. In doing this, MNMCM increased the number of organizations involved in the process and thereby increased its buy-in. Clinical and operational champions from the participating organizations were able to articulate a clear message to other organizational leaders and staff in the community that the focus was on data collection to improve quality of care, which helped to keep the momentum.

One of the most commonly asked questions about data collection by both patients and physicians is "why are we doing this and how will these data be used?" Also, based on preliminary national work and the experience of MNMCM, many practices cite concerns about the legality of collecting this information, violating patients' privacy, and experiencing pushback from both patients and registration staff about the need for this information.<sup>10</sup> These concerns are often the first and most pressing organizational and community obstacles to overcome. Therefore, the take away lessons from the MNMCM experience, which are described in Table 1, focus on engagement of key constituents, communication about plans and goals, and discussion about the utility of the data for quality improvement and disparities reduction at each step.

<i><b>Engage the Right People</b></i>	Find a small group which has been collecting race, ethnicity and language data (Early Adopters) to help guide first steps and development of recommendations. Enlist the support of a larger group which "wants to listen" (Ready and Willing) to the initial recommendations and is willing to provide constructive feedback.
<i><b>Plan and set goals</b></i>	Think ahead, be consistent, and set realistic goals.
<i><b>Involve Communities</b></i>	Make sure to engage and educate communities so that they know that their physician practices may be asking them to provide information about their race, ethnicity, and language and how this information will be used.
<i><b>Discuss and Ensure Data Utility</b></i>	Communicate and demonstrate that the data will be used to improve health care quality and reduce health care disparities.
<i><b>Stress Support</b></i>	Let physician practices know that your organization (i.e., organization leading data collection efforts) will be available to support their efforts and offer guidance.
<i><b>Be Patient</b></i>	Remember that this process, especially acquiring and then using the data to improve quality for diverse groups, takes time.

## Summary

MNCM continues to work on creating a model for data collection that could be effectively and practically implemented across the state and in other communities around the nation. MNMCM has been able to successfully implement data collection by: 1) facilitating the collaboration of early adopters to identify promising practices and strengths in the community, 2) recognizing both perceived and real barriers that medical groups face, 3) building the case for data collection off of national recommendations, and 4) utilizing tools and resources that are currently available.

There is strong evidence that quality of care varies as a function of race, ethnicity, and language, therefore collecting and using these data to identify disparities and target specific interventions to reduce gaps in care and in outcomes can facilitate improvement in health care quality.

This report was prepared by the Aligning Forces for Quality Evaluation Team at Northwestern University's Center for Healthcare Equity in collaboration with Penn State University's Center for Health Care and Policy Research which is studying the AF4Q initiative to gain insights about community-based reform that can guide health care practice and policy. The AF4Q Evaluation Team presents periodic research summaries on key findings and policy lessons gleaned from its ongoing mixed-method evaluation of the AF4Q program.

***For more information about the  
AF4Q Evaluation Team -***

***(<http://www.hhdev.psu.edu/CHCPR/alignforce/>)***

## Resources

- [Web-based Tool](#): *Health Research and Educational Trust Toolkit for Collecting Race, Ethnicity and Primary Language Data from Patients* ([www.hretdisparities.org](http://www.hretdisparities.org)) is designed to help hospitals, health systems, community health centers, medical group practices, health plans, and other users understand the importance of collecting accurate data on race, ethnicity, and primary language of persons with limited English proficiency and/or who are deaf or hard of hearing. Health care organizations can assess their organizational capacity to collect this information and implement a systematic framework designed specifically for obtaining race, ethnicity, and primary language data directly from patients/enrollees or their caregivers in an efficient, effective, and respectful manner. This section provides information about the Toolkit's design and contents.
- [Report](#): *Institute of Medicine Report on Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (2009)* ([www.iom.edu/Reports/2009/RaceEthnicityData.aspx](http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx)) recommends the use of existing Office of Management and Budget broad race and Hispanic ethnicity categories along with the additional collection of granular ethnicity (where an individual was born and/or their ancestry) and one's language proficiency and preferred language for receiving health-related information.

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