Operationalizing Health Equity Practices in Real Data Collection, Session 1 of 3

August 24, 2022

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Learning Objectives

- Explain the importance of REAL data collection in relation to improving health equity.
- Describe strategies and actions to verify the accuracy and completeness of patient self-reported demographic data.
- Discuss additional demographic data (beyond REAL) that can be collected to advance health equity such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors.

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What is Health Equity?

An imperative.
A journey.
A goal.

The state in which everyone **has the opportunity** to attain full health potential, and **no one is disadvantaged** from achieving this potential because of social position or any other socially defined circumstance.

Source: Weinstein JN, Geller A, Negussie Y et al. Key terms. In: Communities in Action: Pathways to Health Equity. National Academies Press; 2017:10.17226/24624

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Key terms

Health Disparities

An avoidable health difference that puts an economically or socially disadvantaged group at further disadvantage

- signify more than just difference or variation; reason for concern
- they are measurable, but do not necessarily imply definitive knowledge of the causes

Health inequities and their causes (who.int)

Social Determinants of Health

The non-medical factors that influence health outcomes; the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life including economic policies and systems, development agendas, social norms, social policies and political systems

Social determinants of health (who.int)

Maginalized Communities

Communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions

Marginalized Community Definition | Law Insider

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Health disparities are not new

1985

The Heckler Report

U.S. Department of Health and Human Services reported major disparities existed and noted "the burden of death and illness experienced by blacks and other minority Americans as compared with the nation's population as a whole."

1999 - 2001

IOM Reports

The Institute of Medicine (IOM), now the National Academy of Medicine, reports To Err is Human and Crossing the Quality Chasm laid out six aims for health care to be:

- safe, effective, patient-centered, timely, efficient, and equitable.

2003 - 2021

AHRQ Annual Reports

The 19th annual Agency for Healthcare Research and Quality (AHRQ) National Healthcare Quality and Disparities Report was published December 2021 and shows significant disparities persist in all domains of healthcare quality.

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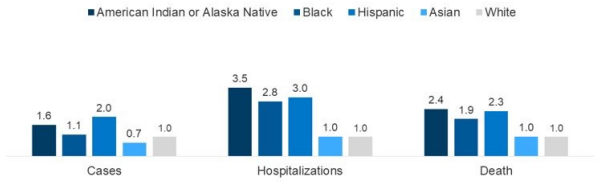
Human costs: COVID-19

Figure 4

People of color have had higher rates of infection, hospitalization, and death due to COVID-19.

Risk of infection, hospitalization, and death compared to White people in the U.S., adjusted for age:



NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.
SOURCE: CDC, Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity, as of 5/12/2021, www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html, accessed 5/12/2021.

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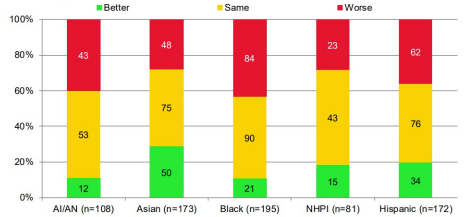
Human costs: Quality

Figure 1. Number and percentage of quality measures for which members of selected groups experienced better, same, or worse quality of care compared with White people for the most recent data year, 2015, 2017, 2018, or 2019



Key: n = number of measures; AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander.
Note: The difference between two groups is meaningful only if the absolute difference between the two groups is statistically significant with a p-value <0.05 on a two-tailed test **and** the relative difference between the two groups is at least 10%. The most recent data years are used for this analysis. Different data sources have different data years for most recent data year. For example, the most recent data year from the National Institute of Diabetes and Digestive and Kidney Diseases United States Renal Data System (NIDDK USRDS) is 2015 and from the Centers for Disease Control and Prevention National Health Interview Survey (CDC NHIS) is 2019.

2021 National Healthcare Quality and Disparities Report. Content last reviewed January 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr21/index.html

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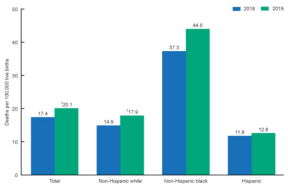
Human costs: Mothers & Babies

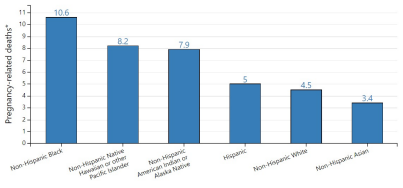
Figure 1. Maternal mortality rates, by race and Hispanic origin: United States, 2018–2019



¹Statistically significant increase in rate from 2018 to 2019 ($p < 0.05$).
Note: Race groups are single race.
Source: National Center for Health Statistics, National Vital Statistics System, Mortality.

Products - Health E-Stats - Maternal Mortality Rates in the United States, 2019 (cdc.gov)

Infant Mortality Rates by Race and Ethnicity, 2019



*Per 100,000 live births

Infant Mortality | Maternal and Infant Health | Reproductive Health | CDC

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Economic costs

– $93 B
Excess medical costs

– $42 B
Loss in productivity
(e.g., morbidity and mortality)

+$135 B per year
if racial disparities in health are eliminated

The Business Case For Racial Equity: A Strategy For Growth, Altarum Institute, 2018, https://altarum.org/RacialEquity2018

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What can we do?

Build systems to identify and address disparities

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Assess your current practices

Health Equity Organizational Assessment (HEOA)

- Developed 2017-2018; Grass roots effort supported by CMS
- Aim to assess hospital's
  1) preparedness to address health disparities through the consistent collection of accurate demographic data;
  2) use of demographic data to identify and resolve disparities; and
  3) implementation of organizational and cultural structures needed to sustain the delivery of equitable care.
- More than 2,000 hospitals have taken the HEAO

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HEOA Assessment Categories & Standards

Metric #	Category	Standard
1	Data Collection	Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.
2	Data Collection Training	Hospital provides workforce training regarding the collection of self-reported patient demographic data.
3	Data Validation	Hospital verifies the accuracy and completeness of patient self-reported demographic data.
4	Data Stratification	Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data.
5	Communicate Findings	Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.
6	Resolve Differences	Hospital implements interventions to resolve differences in patient outcomes.
7	Culture & Leadership	Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations.

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Category 1: Data Collection

Hospital uses a self-reporting methodology to collect demographic data from the patient and/or caregiver.

Intent of the Category:

- Best practice recommendations include the collection of patient demographic data to help hospitals and healthcare systems understand their patient populations and measure patient outcomes to ensure health equity.
- National/State reporting requirements emphasize the need for obtaining REAL and disability information.
- Federal policies govern racial, ethnic, and primary language data collection and reporting.
- Meaningful Use Certification Criteria requires the recoding of demographic information including Race and Ethnicity in accordance with the OMB Standards.
- Using a self-reporting methodology to collect patient demographic data removes "guess-work" and ensures accurate data is being collected.

Race
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Ethnicity
- Hispanic or Latino
- Not Hispanic or Latino

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Metric 1: Basic level of data collection

Hospital uses self-reporting methodology to collect race, ethnicity and language (REAL) data for all patients. All race and ethnicity categories collected, at a minimum, roll up to the OMB categories and are collected in separate fields.

Questions to ask yourself

- What's our policy on patient demographic data collection?
- If we're not using patient self-reporting to collect patient demographic data, what's getting in our way?
- What are the race and ethnicity categories we collect?
- Do we allow more than one selection or have a way to allow for bi- or multi-racial selections?
- How do they "roll up" to the OMB categories?

Strategies & Actions

- Review you REAL data categories and your policy on REAL data collection
- Meet with or observe registration staff; ask what the barriers are to collecting patient demographic data
- Consider implementing "We ask because we care" campaign

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Metric 1: Intermediate level of data collection

Hospital collects REAL data for at least 95% of their patients.

Questions to ask yourself

- How are we doing with REAL data collection?
- What % of patients have an assigned REAL data category?

Strategies & Actions

- Examine your data for completeness (do your "homework")
- Regularly check your data; create a scorecard or dashboard
- Name a leader who is responsible for REAL data collection completeness

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Metric 1: Advanced level of data collection

Hospital uses self-reporting methodology to collect additional demographic data (beyond REAL) for patients such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors.

Questions to ask yourself

- Have we mastered our REAL data collection?
- Are we ready to collect more data?
- What other patient demographic data could we/should we collect?
- What can we do with the information?

Strategies & Actions

- Compare your patient data to your community data; use tools such as the Census Bureau interactive maps or other resources such as Data USA
- Learn from others collecting additional demographic data like Kaiser Mid Atlantic collecting Veteran status

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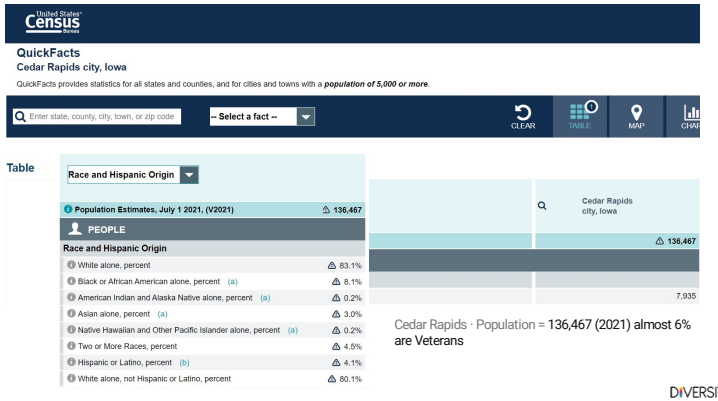

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Metric 1 – Polling Question

What action can you take from the information provided?

- Review you REAL data categories and your policy on REAL data collection
- Meet with or observe registration staff; ask what the barriers are to collecting patient demographic data
- Consider implementing "We ask because we care" campaign
- Compare your patient data to your community data; use tools such as the Census Bureau interactive maps or other resources such as Data USA
- Learn from others collecting additional demographic data like Kaiser Mid Atlantic collecting Veteran status
- Examine your data for completeness (do your "homework")
- Regularly check your data; create a scorecard or dashboard
- Name a leader who is responsible for REAL data collection completeness

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Category 2: Data Collection Training

Hospital provides workforce training regarding the collection of self-reported patient demographic data.

Intent of the Category:

- At a minimum, training is provided to registration/admission staff. Training additional staff in patient self-reported demographic data collection should be completed as needed.
- Standardized procedures are in place to train staff to use patient self-reporting methodologies to collect demographic data, ensuring this data is accurately and consistently collected.
- Training must be provided during orientation for staff who collect patient demographic data and the effectiveness of training should be periodically evaluated.
- Annual training updates for staff are highly recommended.

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Metric 2: Basic level of data collection training

Workforce training is provided to staff regarding the collection of patient self-reported REAL data.

Questions to ask yourself

- How often do we train our registrars?
- What does that training include?
- Do we offer education on the importance of REAL data collection to other staff?

Strategies & Actions

- Meet with or observe registration staff training; ask what their barriers are to collecting patient demographic data
- Research available training curriculum such as the AHA Disparities Toolkit
- Train leaders and staff "why" it's so important to collect REAL data

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Metric 2: Intermediate level of data collection training

Hospital evaluates the effectiveness of workforce training on an annual basis to ensure staff demonstrate competency in patient self-reporting data collection methodology.

Questions to ask yourself

- How do we know our training is effective?
- What do we measure?
- What does success look like?

Strategies & Actions

- Examine your REAL data by service line or unit
- Regularly check your data; create a scorecard or dashboard that can be stratified by area
- Meet with leaders within service lines or unit to make sure they understand the importance of REAL data collection

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Metric 2: Advanced level of Data Collection Training

Workforce training is provided to staff regarding the collection of additional patient self-reported demographic data (beyond REAL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors.

Questions to ask yourself

- Have we mastered our REAL data collection?
- Are we ready to collect more data?

Strategies & Actions

- Research what tools and resources already exist that outline data collection practices for populations such as the Human Rights Campaign LGBTQ-Inclusive Data Collection or the CDC's Collecting Sexual Orientation and Gender Identity Information

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Metric 2 – Polling Question

What action can you take from the information provided?

- Meet with or observe registration staff training; ask what their barriers are to collecting patient demographic data
- Research available training curriculum such as the AHA Disparities Toolkit
- Train leaders and staff "why" it's so important to collect REAL data
- Examine your REAL data by service line or unit
- Regularly check your data; create a scorecard or dashboard that can be stratified by area
- Meet with leaders within service lines or unit to make sure they understand the importance of REAL data collection
- Research what tools and resources already exist that outline data collection practices for populations such as the Human Rights Campaign LGBTQ-Inclusive Data Collection or the CDC's Collecting Sexual Orientation and Gender Identity Information

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Category 3: Data Validation

Hospital verifies the accuracy and completeness of patient self-reported demographic data.

Intent of the Category:

- Hospital has a standardized process in place to evaluate and validate the accuracy of patient self-reported demographic data including percent of "unknown", "unavailable", or "declined" for REAL data (aiming for a cumulative goal of <5%).
- Hospital evaluates and addresses system-level issues throughout evaluation processes to continually improve the collection of self-reported patient demographic data.

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Metric 3: Basic level of data validation

Hospital has a standardized process in place to evaluate the accuracy and completeness (percent of fields completed) of REAL data. Hospital has a standardized process in place to evaluate and compare hospital collected REAL data to local demographic community data.

Questions to ask yourself

- What are the procedures in place to have patients validate their own data?
- Do we leverage patient portals to ask patients to validate their data?

Strategies & Actions

- Research validations methods used by registration staff (hard stops, soft stops, semi-annual or annual verification process)
- Investigate if other patient data is being verified such as insurance information

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Metric 3: Intermediate level of data validation

Hospital addresses any system-level issues (e.g., changes in patient registration screens/fields, data flow, workforce training, etc.) to improve the collection of self-reported REAL data.

Questions to ask yourself

- How can we identify barriers to data collection?
- What are our procedures to make changes to improve data collection?

Strategies & Actions

- Create a steering or governance committee or workgroup to track and monitor the accuracy and completeness of patient demographic data and make adjustments to processes and systems as needed

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Metric 3: Advanced level of data validation

Hospital has a standardized process in place to evaluate the accuracy and completeness (percent of fields completed) for additional demographic data (beyond REAL) such as disability status, sexual orientation/gender identity (SOGI), veteran status, geography and/or other social determinants of health (SDOH) or social risk factors -- and has a process in place to evaluate and compare hospital collected patient demographic data to local demographic community data.

Questions to ask yourself

- Have we mastered our REAL data collection?
- Are we ready to collect more data?

Strategies & Actions

- Leverage validation procedures used for REAL data for any additional data you collect
- Compare hospital data to national data tools like the CDC's Social Vulnerability Index or the Area Deprivation Index

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Metric 3 – Polling Question

What action can you take from the information provided?

- Research validations methods used by registration staff (hard stops, soft stops, semi-annual or annual verification process)
- Investigate if other patient data is being verified such as insurance information
- Create a steering or governance committee or workgroup to track and monitor the accuracy and completeness of patient demographic data and make adjustments to processes and systems as needed
- Leverage validation procedures used for REAL data for any additional data you collect
- Compare hospital data to national data tools like the CDC's Social Vulnerability Index or the Area Deprivation Index

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Next steps

- Take action! Use the question and strategies & actions to guide your next steps
- Complete the homework and share it with your Clinical Advisor
- Join us for the next session to learn more about metrics 4 – 6 to identify and address disparities

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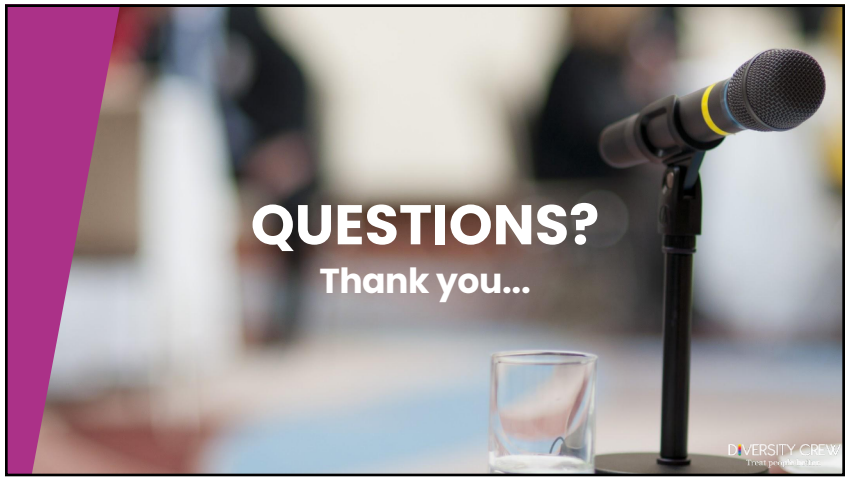

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Upcoming Events

+ **Operationalizing Health Equity Practices in Quality Improvement**
  + September 28 at 10:00 a.m. CT
  + **Register**
+ **Operationalizing Health Equity Practices in Organizational Processes + Procedures**
  + October 26 at 10:00 a.m. CT
  + **Register**

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iCompass Academy

- This webinar will be recorded and be available on iCompass Academy
- What is iCompass Academy?
  - iCompass Academy offers an online suite of eLearning products including webinars, courses and virtual events that can be accessed anywhere at any time.
- Learn more about the education platform by visiting https://education.ihconline.org/ (Link)
- To create an account, visit: https://education.ihconline.org/user/register?destination=homepage (Link)

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iCompass

- We encourage you all to also join us on our new communicative platform, iCompass.
- iCompass is an online IHC forum designed to share information throughout the entire industry and bring people together to drive sustainable healthcare transformation.
- Create an account today: https://www.ihconline.org/icompass/sign-up (Link)

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- Compass posts are available on the following platforms:
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  - LinkedIn:
    - Follow us: @iowa-healthcare-collaborative (Link)

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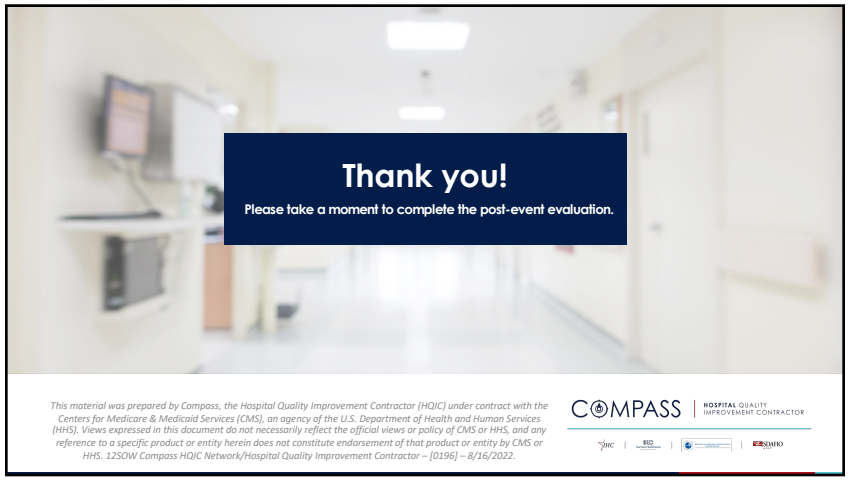
Thank you!
Please take a moment to complete the post-event evaluation.
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