

# Race, Ethnicity, Language Data Collection Best Practices

Guidelines Recommended by  
Cincinnati Expecting Success  
Race, Ethnicity, & Language Data Collection Workgroup



*Creating connections. Improving care.*

GREATER CINCINNATI HEALTH COUNCIL

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# Race, Ethnicity, Language Data Collection Best Practices

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## Guidelines Recommended by Cincinnati Expecting Success Race, Ethnicity, & Language (REL) Data Collection Workgroup

These Best Practice Guidelines were developed by Cincinnati Expecting Success (CES): Race, Ethnicity, & Language Data Collection Workgroup (the Workgroup). The Workgroup is convened by the Greater Cincinnati Health Council (Health Council). See Appendix 1 for a complete list of participating health systems and hospitals.

In 2010, twenty-eight Cincinnati health systems participating in CES took a bold comprehensive approach to health system disparity identification and reduction. The foundation of disparities work is health system capacity to segment quality data by race, ethnicity and language preference (REL). To establish region-wide data segmentation capacity, CES hospitals implemented standardized categories and methods for collecting REL data directly from their patients. As a result, almost all hospitals and many primary care practices across the Greater Cincinnati region are utilizing: (1) broad, standardized REL data-collection categories (consistent with the Office of Management and Budget (OMB) federal standards); and (2) patient self-reporting methodology.

Initially, the purpose of the CES project was to ready Health Council member hospitals to identify and improve any existing health disparities in their systems. In 2011, the initiative was expanded to include primary care practices. However, these best practices were developed primarily for use by hospitals and health systems. Many systems will apply these practices enterprise-wide and may include primary care practices and other ambulatory services.

The Health Council would like to thank participating CES health systems for their transformative work to identify and address health disparities. Their work is being recognized nationally and will ultimately result in better care for patients across our region.

*Cincinnati Expecting Success is convened by the Greater Cincinnati Health Council as a partner of Cincinnati Aligning Forces for Quality (AF4Q), an initiative of the Health Collaborative and the Robert Wood Johnson Foundation that seeks to improve the value of health care across the region by achieving better health, better care, and lower costs through initiatives involving consumers, care providers, health plans and employers. Support for the development of this document is provided by Cincinnati AF4Q. [Support has also been partially provided under cooperative agreement 90BC0016-01 from the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services.](#)*

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## I. Best Practice Recommendations

### A. Recommended REL categories.

**Best Practice Recommendation:** Health systems and hospitals participating in Cincinnati Expecting Success have adopted standards in the collection of race, ethnicity and language data consistent with the recommendations of leading national organizations. These organizations include: the Institute of Medicine, the Robert Wood Johnson Foundation’s national Expecting Success program, the Health Research & Educational Trust, and the American Medical Association. The standards include a list of the categories that should be included under each heading (race, ethnicity, and language). These categories are consistent with Office of Management and Budget (OMB) categories, meet meaningful use requirements, meet NCQA PCMH requirements and meet Joint Commission requirements for REL data collection. (See Appendix 1 for the Cincinnati Expecting Success Recommended Standards.)

### B. REL data collection methods.

**Recommended Best Practice:** The method by which REL data is collected from the patient is critical.. The following best practice guidelines are recommended when collecting REL data:

1. REL information must be self-reported by the patient. Never assume from observation or name alone.
2. Ask for ethnicity prior to race.
3. Collect data during patient registration either verbally or with registration paperwork.
4. Assure patients that data will be used to monitor and ensure high-quality care.

### C. Establishing Data Integrity Checks and Protocols

**Recommended Best Practice:** 93% of patients discharged from inpatient care or from emergency department care should have all REL fields completed. No more than 7% of discharges from inpatient care and no more that 7% of discharges from emergency department care should be completed as: Patient Refused, Unknown, or Unavailable.

1. A system may choose to use a “hard stop” or a “yield” option for REL fields in accordance with their own information technology needs and capabilities. Note that the choice of “hard stop” means that virtually all patients will have the fields completed. Thus, analysis of the percentages of “Patient Refused, Unknown, or Unavailable” is a valuable tool for identifying

problems with the patient self-reporting data collection methodology. In addition, quality assurance methods are valuable to assure data integrity regardless of a system selecting the hard stop or yield option.

2. For CES participants: target 7% benchmark in first year (10/1/12-9/30/13) for combined results reported as Patient Refused, Unknown, or Unavailable.
3. Re-evaluate the target benchmark annually and eventually lower it to 5%.
4. Track data and train staff to minimize number of Patient Refused responses. This may be a signal that staff needs additional data collection training.
5. A health system should develop protocols in the inpatient and emergency department environments outlining a standard approach to obtaining patients REL data when the Unknown or Unavailable categories are selected for patients upon initial registration and entry to the health system. The protocols should provide a process for collecting REL data post patient registration.

**Recommended Best Practice:** There may be multiple barriers to collecting patient self-reported REL data from patients entering Emergency Departments, therefore special attention needs to be paid to processes and training in these departments. The CES REL Data Collection workgroup, in consultation with hospital emergency department staff, recommend the following procedures to ensure patient self-reporting occurs:

1. Ask language question during “quick registration” process. Race and ethnicity should be captured at the point of full registration.
2. Each system should develop a process for follow-up if it is not possible to collect the data during pre-triage/pre-treatment.
3. Through a revised REL retraining of emergency department registration staff, each system should work to create the expectation that emergency department registration will include REL questions via revised training. Accountability to the REL dashboard should be established.

**Best Practice Recommendation:** Determine a method for validating individual Patient REL Data within a Hospital, Health System, or Primary Care Database

1. Ensuring that accurate REL data is in a hospital/health system database is a top priority. A variety of challenges, such as IT conversions, legacy data obtained prior to registration staff REL training, and other unforeseen problems can corrupt existing REL data. For this reason, hospitals/systems should establish a method for determining when and how to validate individual patient REL data. Following are some considerations and example validation methods:

- When a patient enters a hospital/system for the first time or the first time since REL data collection training has occurred, REL should always be collected using patient self-reporting methodology.
  - When registration staff find REL data fields marked Unknown or Unavailable during a patient registration encounter, staff should be trained to validate the fields by asking the patient their REL.
  - If the hospital/system IT system will allow, document the date that the patient’s REL collection took place. This method will allow registration staff to verify that REL data was entered after REL training occurred.
  - Throughout the first year or two of an REL data collection program, when the dated validation approach outlined above cannot be used and when systems are concerned about the accuracy of REL data, the hospital/system should devise a method for verifying REL data in the IT system. Hospitals/systems should view the validation process as temporary and should re-evaluate their methods each year to determine how rigorous their program needs to be. Example methods might be:
    - i. Ask the REL question at every first patient encounter and then verify<sup>1</sup> the data every three months thereafter.
    - ii. Ask the REL question at every first patient encounter and verify REL responses at every follow-up patient visit.
    - iii. Have patients sign a form validating their REL and keep it in the patient’s electronic file.
2. Each health system should re-evaluate the need for ongoing validation/verification in 3 years (with monitoring for minor revisions in process every 6-12 months).

**Best Practice Recommendation:** Validate individual patient data for patients transferred from another health system.

If REL data points are not included, not clear, or are in conflict with existing patient records, data should be collected using patient self-reported methodology. Otherwise validate/verify in accordance with the validation recommendations above.

#### D. Training For Quality Assurance

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<sup>1</sup> Patient self-reporting methodology as outlined in the hospital/health system’s training and is the method that should be used to collect REL data at the patient’s first encounter with the system. Verification is a softer approach where the registration staff might say, “And confirming you indicate your race is “African American or Black?”

**Best Practice Recommendation:** Managers Training. Managers should participate in a yearly training update on REL data collection & health disparities.

1. Include all managers and team designees (i.e. anyone responsible for REL data, including registration + IT) identified by Director of Patient Access.
2. Require training at orientation plus annual refresher course.
3. Use the Greater Cincinnati Health Council training program to standardize content.
4. Offer session multiple times/year (e.g. quarterly) and in multiple modes (e.g. class at the Health Council, webinar at rotating hospital locations, online presentation, etc.)
5. Highlight significance of REL data and health disparities, clarify need for self-disclosure vs. staff determination, note local and national changes, update the Health Council guidelines, validate standardized processes, brainstorm solutions to data collection problems, etc.

**Best Practice Recommendation:** Staff Training. Training is the most important tool we have to ensure registration staff are prepared to collect REL data. All registration staff (inpatient, ambulatory and primary care) should be trained in REL data collection during orientation and once per year as a part of the system or practice general training program.

1. Include all front line registration staff.
2. Require training at orientation plus annual refresher course.
3. Use the Greater Cincinnati Health Council training module to standardize content, possibly with customization for internal use at each system.
4. Incorporate role playing into training when possible.
5. Incorporate multiple topics and multiple training modes, as per Management Training recommendations above.

#### **E. Auditing for Quality Assurance**

**Best Practice Recommendation:** Quality assurance is an important aspect of REL data collection. Systems and hospitals should conduct regular quality checks for telephone and in-person registrations.

1. Phone registrations to be monitored by call monitoring + cross-referencing documents.

- a. Initial benchmark: Systems monitor 5 calls per quarter per person to include 100% of registration/scheduling center staff.
  - b. As able, depending on resources, systems should move to monitoring 5 calls per month per person for 100% of registration/scheduling center staff.
2. On-site (inpatient + ED) registrations to be monitored initially using a two-tiered system.
- a. Initial benchmark: Face-to-face audits at 5 observations per quarter to include 100% of registration staff;
  - b. As able, depending on resources, systems should move to face-to-face audits at 5 observations per month to include 100% of registration staff.
  - c. If a system does not have resources committed to achieve the auditing benchmarks outlined above, an alternative option is to audit by post-registration document checks or other system-specific validation process.

**Best Practice Recommendation:** A System may have affiliated primary care practices leasing the use of the system’s EPIC IT. REL Workgroup Data Collection Representatives make the following recommendations to health system leadership:

- 1. Do not let PCP strip REL data out of patient registration form, as all patient level data becomes part of the medical record and no fields can be excluded from EPIC databases.
- 2. Encourage system executives to clarify need for sharing all data fields between hospitals and physician practices.
- 3. Educate community physicians regarding the need for and use of REL data (referencing both meaningful use and patient center medical home models of care).

**Best Practice Recommendation:** Provide assurance to health system executives that REL data is accurate.<sup>2</sup>

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<sup>2</sup> The Health Council will: (1) Review this issue in the future as REL data is used more regularly by hospitals and PCPs; and (2) Work with HealthBridge and each individual Health System to establish data analysis techniques for auditing data across systems.

Some health system executives may be concerned about data collection discrepancies with inpatient data collected versus data collected at the primary care level and about overall data integrity. The following assurances should be implemented to allay their concerns:

1. When patients register in the inpatient or emergency department environment, REL data should be collected using standard patient self-reported methodology. Thereafter, validation/verification should occur as outlined in the Validation recommendations above.
2. Rely on automatic correction for shared data systems (EPIC).
3. Communicate correction to PCP if system allows, at least for hospital-affiliated practices.
4. Participate in audit processes comparing data collected through internal query vs. data submitted to OHA. Report outcomes to executives quarterly.

## II. Thank you.

On behalf of the Health Council and the Health Collaborative, we thank you for your interest in REL data collection. For more information, please contact the Greater Cincinnati Health Council at (513) 531-0200.



## APPENDIX 1

### Cincinnati Expecting Success Hospitals Collect REL Using Broad Standard Categories & Patient Self-Reporting

Adams County Regional Medical Center

The Christ Hospital

Cincinnati Children's Hospital Medical Center

Dearborn County Hospital

Lindner Center of HOPE

Mercy Health – Anderson Hospital

Mercy Health – Clermont Hospitals

Mercy Health – Fairfield Hospitals

The Jewish Hospital – Mercy Health

Mercy Health -- Mt. Airy

Mercy Health - Western Hills

St. Elizabeth Edgewood

St. Elizabeth Florence

St. Elizabeth Fort Thomas

St. Elizabeth Grant

TriHealth - Bethesda North Hospital

TriHealth - Good Samaritan Hospital

UC Health - Drake Center

UC Health - University Hospital

UC Health - West Chester Medical Center

Veteran's Affairs Medical Center

## Appendix 2

### **Cincinnati Expecting Success: Hospital Representatives Recommendations for Race, Ethnicity, and Language Data Standards For the Greater Cincinnati Region**

Hospital representatives serving on the Cincinnati Expecting Success work group recommend that area hospitals adopt standards in the collection of race, ethnicity and language data consistent with the Institute of Medicine's recommendations. Following is a summary of the recommendations relevant to hospitals:

- Hospitals should, at a minimum, collect race and ethnicity data for categories set forth by the Office of Management and Budget (OMB) with additional fields added to accommodate circumstances when the patient declines to respond or when the data is otherwise not available. Recommended categories include:
  - Race:
    - White
    - Black or African American
    - Asian
    - American Indian or Alaska Native
    - Native Hawaiian or Pacific Islander
    - Declined
    - Unavailable (or Unknown)
  - Ethnicity:
    - Hispanic or Latino
    - Non-Hispanic or Latino
    - Declined
    - Unavailable (or Unknown)
  - Language:
    - English
    - Spanish
    - Other, Please Specify
    - Declined
    - Unavailable (or Unknown)
- Hospitals may choose to collect more granular data using race and ethnicity categories that are appropriate for the population it serves and/or research needs. Categories should be selected from a standard national set established by OMB. This standard

national set is also consistent with the 2010 Census Bureau categories. Granular categories should be organized in a manner consistent with the attached standard national set so that granular data may be rolled up into the broader OMB categories, allowing for data analysis across sites, and across hospitals.

- Hospitals may choose to offer an optional bi-racial or multi-ethnic category, but should note that they will not be able to use that data for the purpose of rolling up to broader OMB categories unless they choose to also request that patients select a “primary” category. (Currently, a local urban hospital that offers patients the option of selecting multiple categories sees about one percent of patients choosing more than one race category.)
- Hospitals may choose to include additional language categories to meet the needs of their patient population and/or research interests. Choices should be informed by local service area data. An example of local service area data is the top ten languages most frequently requested from language interpretation services utilized by the region’s hospitals, as reported by the Health Council. Additional languages may be selected from a standard national set, such as one set forth by the American Hospital Association’s Health Research and Education Trust.