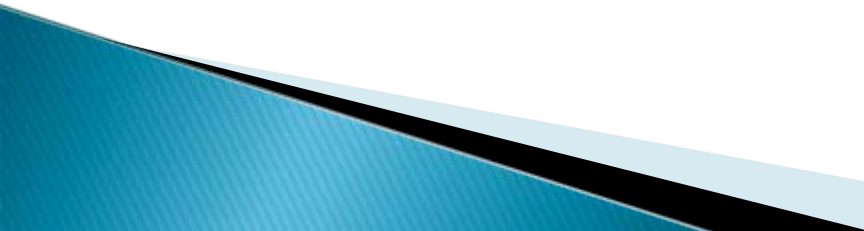




Equity Data Collection Specifications and Best Practices

Diane Mayberry – MNMCM Senior Program Executive

MN Health Disparities Journey


- ▶ 2001 Minnesota passed landmark legislation
 - ▶ Distributed funds to 52 community organizations and tribes; these organizations charged to develop strategies for eliminating disparities
 - ▶ MDH issued a series of reports in 2008 with emerging lessons learned from the collective experience of the 52 grantees
 - ▶ Also Governor appointed a task force to explore collection of race and ethnicity data
- 

MNCM Enters the Picture

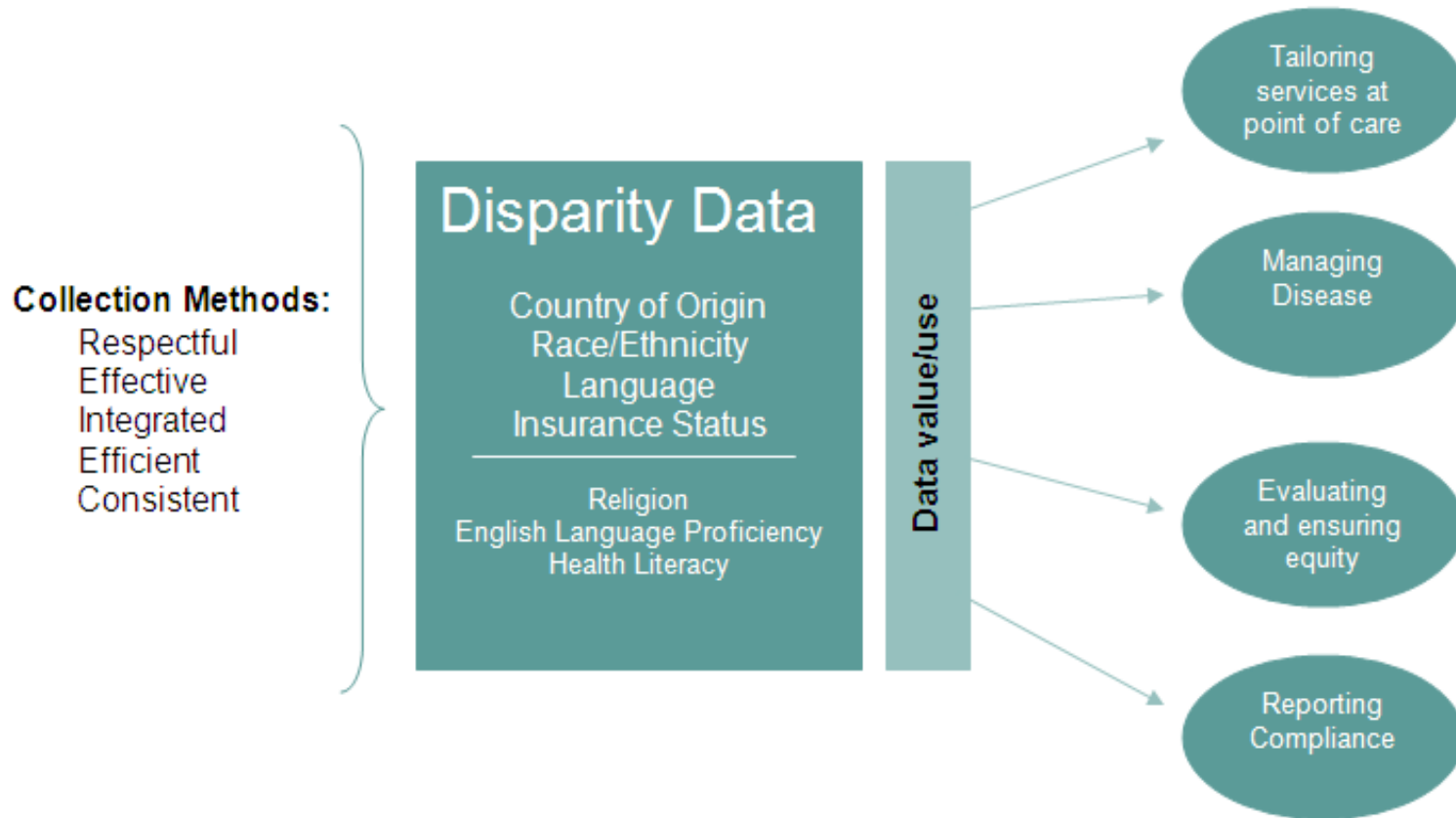
- ▶ In August, 2007, MNMCM was asked to join the Governor's task force – members had learned of the RWJF – *Aligning Forces for Quality* grant award and new requirements
- ▶ MNMCM agreed to take the lead for the state in the design of a best practice for the collection of R,E,L data in the ambulatory care setting

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

Handbook Development Process

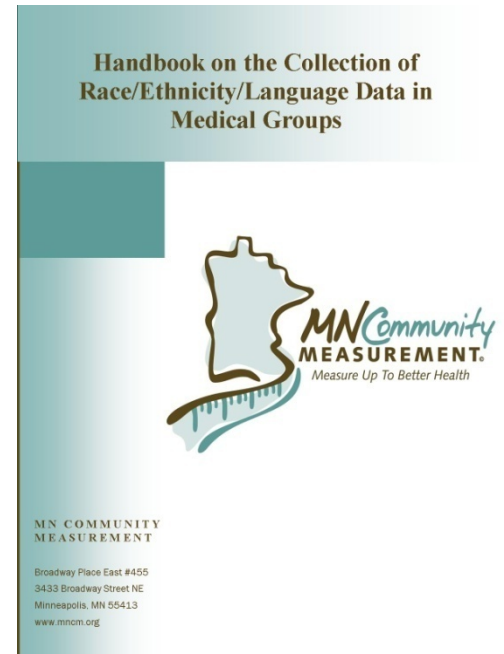
- ▶ Scan community to identify “Early Adopters”
 - ▶ Workgroup of six early adopter medical groups + a practicing physician
 - ▶ Crosswalk of current practice & data elements
 - ▶ Build on experience to develop ideal state
- 

Handbook “Project” Framework



The Handbook on the Collection of R/E/L Data in Medical Groups


- ▶ The data elements for reporting
- ▶ The rationale for collecting each of the elements
- ▶ Implementation considerations




First Steps First – get the principles straight

- ▶ Provide patients with a meaningful way to self-identify
 - ▶ Considerations for the data elements we would be collecting and for the implementation methods
- ▶ Recognize there is no perfect model that balances granularity with simplicity.
- ▶ Examine current systems and research existing literature on the subject.
 - ▶ HRET guide was our “gold standard”


The Data Elements

- ▶ Country of Origin (including U.S. territories)
 - ▶ Race and Ethnicity
 - ▶ Primary Language
 - ▶ Insurance Coverage
- 


Country of Origin

- ▶ MNCCM will collect through DDS the country in which patients were born.
 - ▶ Provides a meaningful way for patients to identify themselves and gives MNCCM more flexibility in analysis (e.g. matching country born with race data)
- 

Country of Origin cont.

- ▶ These data could also provide critical information to providers due to specific exposures related to refugees' country of origin
 - ▶ MNCM's data collection list will include 185 countries and will allow a free field to be entered if a person's country is not on the list.
- 

Race/Ethnicity = combined into one question

- ▶ American Indian or Alaska Native
 - ▶ Asian
 - ▶ Black or African American
 - ▶ Hispanic or Latino
 - ▶ Native Hawaiian/Other Pacific Islander
 - ▶ White
 - ▶ Choose not to disclose/Declined
 - ▶ Unknown
- 


Race and Ethnicity

- ▶ Patients will always self-report
- ▶ System designed to allow for multiple selections of race/ethnicity


For example: 1) Hispanic/Latino & White
2) Asian & Black

✓ *Patients will have the opportunity to decline*

Language Elements

- ▶ The objective in collecting language data is to evaluate outcomes for those comfortable speaking English and those comfortable speaking a language other than English.
 - ▶ The languages were selected from a list created by the MN Immigrant Task Force. See Page 10 of the Handbook.
- 


Insurance Status

- ▶ Used as an indicator for SES and provides MNCM the ability to compare outcomes based on what type of insurance patients have or don't have
 - ▶ See page 10–11 of Handbook for list of insurance categories
- 

Combining Best Practices


- ▶ Matching country of origin with race attempts to balance simplicity vs. granularity dilemma
- ▶ One EAWG has implemented a similar system and has been able to identify quality improvement projects.
- ▶ The Handbook is a combination of several EAWG systems and aligns with the Health Research Education Trust's (HRET) *Toolkit for Collecting Race, Ethnicity, and Primary Language from Patients*

R/E/L Data Collection Implementation

- ▶ Staff Training
 - ▶ Response Matrix (role playing)
 - ▶ Scripts including the rationale for collecting
 - ▶ Instructions for how to record data
- 

Implementation

Collecting the data

- ▶ Face-to-face data collection: *Appointment Setting, Registration, and Rooming staff*
 - ▶ Question order: country of origin, race, language
 - ▶ The answers must be provided by the patient rather than determined by the staff person.
- 

Collecting the data

Recommended Questions

- ▶ Country of Origin

Please tell me in what country were you born?

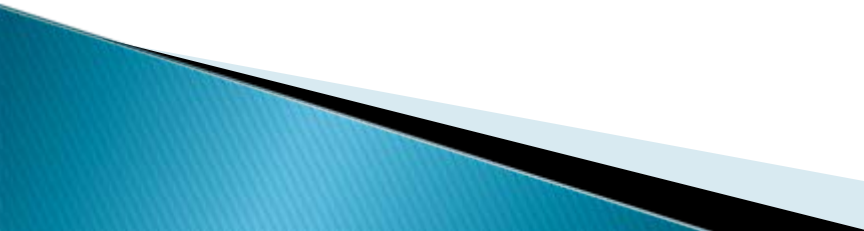
- ▶ Race

- *Please tell me the race/ethnicity groups that describe you?*

- ▶ Language

- *In what language can we best serve you?*

EAWG Success Factors

- ▶ Engage teams and leaders at the earliest possible stage to gain buy-in and obtain input.
 - ▶ Have visible support from a senior leader.
 - ▶ Ensure sustainability. Begin with the end in mind. Don't forget to include reports and audits in your specifications.
 - ▶ Be clear about and frequently communicate the reasons why the medical group is embarking on the project.
 - ▶ Develop and deliver clear, concise training and provide support for real-time learning again, and again, and again
- 

Next Steps

- ▶ Educating medical group staff on the data collection recommendations
 - ▶ Making ourselves available to answer questions about the process
 - ▶ Working with a local community resource to hold forums with communities of color
- 