



Health Policy Snapshot

Disparities

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ISSUE BRIEF

July 2011

Can collecting data on patients' race, ethnicity and language help reduce disparities in care?

Takeaways:

- Collecting data on every patient's race, ethnicity and preferred language (REL) is a critical first step toward identifying and eventually eliminating disparities in care.
- REL data helps characterize patient populations, allowing providers to offer appropriate preventive care.
- Some hospitals, doctors' offices and health plans already track this information, but the process is neither consistent nor objective.
- The Affordable Care Act (ACA) expands and standardizes REL data collection.

Overview

For more than 20 years, research has shown that racial and ethnic minorities consistently receive lower-quality health care and have worse health outcomes than whites, even when demographic and socioeconomic factors are taken into account.

According to 2010 federal data, African Americans, American Indians and Alaska Natives receive worse care than whites for about 40 percent of core health care quality measures, such as whether pneumonia patients receive antibiotics within six hours of arriving at the hospital or whether older women are screened for osteoporosis. Hispanics received worse care than non-Hispanic whites for about 60 percent

of core health care quality measures.¹

In a landmark 2002 report titled *Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care*, the Institute of Medicine recommended collecting data on patients' race, ethnicity and preferred language as one strategy to eliminate disparities.

REL DATA IDENTIFIES PROBLEMS

Quite simply, providers cannot address disparities and improve health care services without knowing where the gaps occur. Consistently collecting and assessing robust REL data allows hospitals, health plans and physician practices to identify where disparities exist and then take steps to eliminate them.

For example, by collecting REL data, a hospital might learn that African-American patients with chest pain fail to receive an aspirin in the emergency room more often than their white counterparts, or that Hispanic patients are less likely than whites to receive discharge instructions, which tell them about the care they will need after they leave the hospital. This knowledge can then drive improvements.

Past quality-improvement efforts in hospital settings have shown that eliminating racial and ethnic disparities in health care can not only improve outcomes for the affected populations but improve care for all patients.²

REL DATA CAN IMPROVE COMMUNICATION

Having REL data can also improve communication generally between patients and providers. For example, with patients who do not speak English, REL data can help providers know which interpreters they will need before patients arrive. This enhanced communication can reduce the potential for misdiagnoses because of language barriers and increase the likelihood that patients will adhere to their treatment regimen once they go home.

Ten hospitals that participated in the Robert Wood Johnson Foundation's *Speaking Together* program used REL data to drive improvements in caring for patients who spoke Spanish, Chinese and other languages. Through a series of targeted actions, such as placing the patients' preferred languages next to their names on inpatient white boards, many of the hospitals improved care for these populations. The hospitals worked to increase the proportion of patients served by qualified interpreters, reduce the wait time for interpreters and make sure interpreters could spend adequate time with each patient.³

REL DATA SHOWS PATIENT POPULATIONS

Even when no specific problems are found, REL data can help providers characterize their patient population, enabling them to better anticipate the needs of different segments of that population.

For example, an analysis of REL data might reveal a population of immigrant Somali women who could benefit from education on the need for vitamin D. Appropriate outreach could avert costly emergency room visits for pain stemming from vitamin D deficiency. The analysis could also reveal populations at increased risk for a certain cancer. In those cases, a provider could organize more frequent or earlier screenings.

EXISTING EFFORTS ARE INSUFFICIENT

Nearly all hospitals and some doctors' offices and health plans collect data on patients' race and

ethnicity, but the process is neither consistent nor objective.

In many cases, the person recording a patient's information "eyeballs" the individual and makes a subjective determination of race or ethnicity. In these instances, data on a patient can vary because different staff members in different care settings have collected it.

Even when a patient is asked to specify race, ethnicity and preferred language—the optimal way to determine REL—different institutions use different nomenclature and categories when recording the answers.

ACA REQUIRES REL DATA COLLECTION

Under the ACA, all federally funded health and health care programs and population surveys will be required by 2013 to enhance and standardize their collection and reporting of data on race, ethnicity, primary language and other characteristics. It also requires that the Department of Health and Human Services lead efforts in analyzing and monitoring trends in health disparities gleaned from the data collected. The data collection mandated in the ACA is based on recommendations from the Institute of Medicine.⁴

WANT TO KNOW MORE?

- [*Advancing Health Equity for Racially and Ethnically Diverse Populations \(The Joint Center for Political and Economic Studies\)*](#)
- [*Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement \(Institute of Medicine\)*](#)
- [*2010 National Healthcare Disparities Report \(Agency for Healthcare Research and Quality\)*](#)

¹ <http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf>

² <http://www.rwjf.org/files/research/nhpctoolkit.pdf>

³ <http://www.rwjf.org/files/research/speakingtogetherreport.pdf>

⁴ http://www.nap.edu/catalog.php?record_id=12696