New York State Toolkit to Reduce Health Care Disparities: Improving Race and Ethnicity Data
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Introduction

How to Use the Toolkit

The Toolkit is designed to help hospitals, ambulatory care centers, community health centers, and other users understand the importance of collecting accurate data on race and ethnicity.

By using this Toolkit, health care organizations can assess their organizational capacity to collect this information and implement a systematic framework designed specifically for obtaining race and ethnicity data directly from patients/enrollees or their caregivers in an efficient, effective and respectful manner.

This toolkit is divided into sections. Scan the table of contents to see each of the major areas of focus divided into sections in the toolkit. At the beginning of each section, you will find a brief overview, a list of goals relevant to the section and a description of the tools that are included in the section for your use in your facility.

Useful resources in this toolkit include:

A. Sample tools, forms, training materials
B. Resources for implementation
C. Frequently asked questions
D. Patient/consumer Materials
E. Resources for hospital leaders
F. Quality improvement resources

Who Should Use this Toolkit

This toolkit contains targeted information for:

- Hospital Leaders
- Quality Improvement Advisors
- Clinicians
- Registration/Admissions Supervisors and Staff
- SPARCS Coordinators and Information Technology Staff
About Each Section

Section I: Reducing Healthcare Disparities

This section provides a brief overview of the importance of addressing disparities in health care and the importance of analyzing quality-of-care and health outcomes data using patient demographics to specifically identify disparities and implement actions to reduce such disparities.

Section II: Hospital Leaders Role in Improving Health Equity

The goal of this section to provide the basic recommendations and tools for hospital leaders to ensure standardized data collection and developing systems to improve quality and address equity in care.

Section III: The Quality Improvement Imperative

This section highlights the central role of quality improvement in reducing disparities and provides resources to integrate targeted disparities measures into quality improvement.

Section IV: Registration/Admission Supervisors and Staff: The Nuts and Bolts

The goal of this section is to provide guidance on staff training which focuses on the reasons for collecting this information, how to ask patients and address their concerns, so staff feel comfortable asking for this information and patients respond positively as well.

Section V: SPARCS Coordinators and Information Technology Staff

The goal of this section is to provide a brief overview of expanded race and ethnicity data collection for SPARCS Coordinators and IT staff.
Section I
Reducing Health Care Disparities
Reducing Health Care Disparities

A. About this Section

To meet the needs of their diverse populations, hospitals and health systems will need to bridge the gap between collecting meaningful patient data and reviewing the data to identify inequities in health care provision and utilization, and to implement effective interventions to improve care for patients. This section provides a brief overview of the importance of addressing disparities in health care and the importance of analyzing quality-of-care and health outcomes data using patient demographics to specifically identify disparities and implement actions to reduce such disparities.

B. Tools in this Section

- Resources
Introduction: Linking Disparities and Quality

The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (2002) called attention to poorer access to health care and worse health outcomes among certain racial and ethnic groups. Evidence from the last 20 years shows that racial and ethnic disparities continue in health care. Achieving health care equity and eliminating healthcare disparities are priority goals of hospitals and health systems. Health care equity has gained importance nationally as policymakers aim to improve quality of care while lowering costs through a variety of strategies, including changing existing incentives. Data measurement and outcomes have become increasingly important for demonstrating the effectiveness of health care.

Eliminating racial and ethnic disparities in health care is a central issue in overall efforts to improve quality of care. Information on racial and ethnic characteristics of the New York State (NYS) population is needed to target quality improvement efforts, identify the nature and extent of health disparities, and monitor progress. Measurement, reporting, and benchmarking are critical to improving care. In addition, federal and certain state statutes and laws require reporting data by race and ethnicity to monitor discriminatory practices. Enforcement of laws that prohibit discrimination on the basis of race, color, national origin, and disability rely on data collection to monitor compliance. Ultimately, hospitals and other facilities need to be responsive to the communities they serve. A first step towards accomplishing this goal is understanding who the community is and working collaboratively to address problems and concerns.

The health system serves three critical functions (Eliminating Health Disparities: Measurement and Data Needs, National Research Council, 2004):

1. **Ensuring the health of the population.** This is the ability to provide consistent and reliable epidemiological data on the incidence and prevalence of various health conditions and related risk factors among different racial and ethnic populations.
2. **Ensuring equitable access to care.** Access to care is a prerequisite for entering and staying in the health care system. Available racial and ethnic data have been used to document important differences in access between racial and ethnic groups. More accurate data can also be used to document differences in access within racial groups (e.g., Puerto Rican, Mexican, Cuban, etc.).
3. **Ensuring quality of care.** Language and cultural barriers can have a negative impact on quality of care. For example, African Americans were nearly twice as likely as whites to report being treated with disrespect during recent health care visits; Hispanics, regardless of language skills, were more likely than other patients to report having difficulty communicating with and understanding their doctors (Collins, Tenney, and Hughes, The Commonwealth Fund, 2002; Doty and Ives, The Commonwealth Fund, 2002). These findings underscore the importance of ensuring culturally competent care to patients by health care providers.

There are a number of disparity monitoring initiatives conducted by the federal government. Eliminating health care disparities is one of the primary goals of **Healthy People 2020**, a long-term national agenda aimed at improving health in the United States. Beginning in 1999, Congress also required the Agency for Healthcare Research and Quality to develop an annual **National Healthcare Disparities Report (PDF)** to track the extent of disparities in health care and monitor whether progress has been made toward eliminating them.

It is important to maintain both a national and state focus on this issue to present national and state data to assess our progress in eliminating disparities in care. However hospitals and other health care facilities need to also monitor the care they deliver within their own "backyards." Many experts have called for health care organizations to stratify their quality reports by race and ethnicity to identify disparities and to undertake targeted interventions. Hospitals and other health care organizations should be able to stratify race and ethnicity data by service quality indicators (patient satisfaction, wait times, etc.) as well as by technical quality indicators (clinical measures).

For example, the Robert Wood Johnson Foundation national initiative to reduce disparities in cardiac care, **Expecting Success: Excellence in Cardiac Care**, focuses on improving cardiac care to minority populations in a hospital learning collaborative. A major emphasis of this initiative focuses on reporting cardiac care quality measures by race, ethnicity, and primary language.

In addition, **Finding Answers: Disparities Research for Change**, a national program of the Robert Wood Johnson Foundation, suggest promising strategies for reducing racial and ethnic disparities in care for depression, diabetes, and cardiovascular disease.

Section I: Resources
Section I Resources

Resources

Hospitals in Pursuit of Excellence (http://www.hpoe.org/resources/hpoehretaha-guides/1431)

A growing collection of resources—in the form of guide and research studies and other content regarding equity in care from hospitals in pursuit of excellence.

Institute of Medicine 2009 Report Brief

(http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx)

Resources Produced by the Disparities Solutions Center at Massachusetts General Hospital made possible by a grant from the Robert Wood Johnson Foundation

The Disparities Solutions Center has released several publications that highlight practical solutions to identify and address disparities within hospitals and other health care organizations. It also features other resources related to health care disparities elimination.

- **Healthcare Disparities Measurement**
- **Improving Quality and Achieving Equity: A Guide for Hospital Leaders**
- **Assuring HealthCare Quality: A Healthcare Equity Blueprint**
- **Creating Equity Reports: A Guide for Hospitals**

Agency for Healthcare Research and Quality AHRQ

AHRQ's mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services (HHS) and other partners to make sure that the evidence is understood and used.

- **Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals**
Section I Resources

Other Disparities Resources

- HHS Advisory Committee on Minority Health: A Statement of Principles and Recommendations
  (http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/ACMHHealthDisparitiesReport.pdf)

- Center for Prevention and Health Services Issue Brief
  (http://minorityhealth.hhs.gov/Assets/pdf/checked/1/Eliminating_Racial_Ethnic_Health_Disparities_A_Business_Case_Update_for_Employers.pdf)
Section II

*Hospital Leaders Role in Improving Health Equity*
Hospital Leaders Role in Improving Health Equity

About this Section

Hospital leaders play a critical role in addressing health care disparities. Effectively addressing the issue of disparities in health care will require a two-fold approach from health care leaders. The first step—collecting data on patients’ race and ethnicity is focused on gaining a complete understanding of the community served by the hospital and the characteristics of patient population. Data collection, if done properly, can facilitate the second step, which involves analyzing quality-of-care and health outcomes data using patient demographics to specifically identify disparities and implement actions to reduce such disparities. The goal of this section to provide the basic recommendations and tools for hospital leaders to ensure standardized data collection and developing systems to improve quality and address equity in care.

Tools in this Section

- Frequently Asked Questions for Hospital Leaders
- Recommendation Checklist
- Resources for Hospital Leaders
A. Hospital Leaders

Chief Executive Officer

Health care leaders are charged with advancing and managing individual organizational priorities. As hospitals and health care organizations work toward serving diverse populations, leaders must recognize the importance of understanding the unique characteristics of the communities they serve. Efforts to improve health care delivery require working with key staff. Leaders can be most effective by helping others develop the abilities and tools to create the best responses to problems and opportunities.

Improving the quality of care for all patients and eliminating health care disparities are central challenges facing our health care system. As emphasized by two reports from the Institute of Medicine (Crossing the Quality Chasm and Unequal Treatment), the need for better data about patients' race, ethnicity, and primary language is critical.

Legal Affairs Department

The law permits health care organizations to collect race and ethnicity information from patients for quality improvement purposes. For example, the collection of race, ethnicity, and primary language data is permitted under Title VI of the Civil Rights Act of 1964. Additionally, the collection and assessment of information about the communication access needs of individuals with a sensory disability promotes compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

Quality Improvement

The ultimate goal of collecting information about patient's race and ethnicity is to improve the quality of care for all patients. Evidence indicates that quality improvement efforts, when linked to demographic data such as race and ethnicity, can improve quality of care and reduce health care disparities. These data can be linked to assess technical quality (clinical measures) and service quality (wait times, patient experience of care) within your health care organization.

Clinicians

Doctors, nurses, and other health care practitioners are central to the functioning of health care systems and to societies as a whole. However, few societies have been as racially, ethnically, and culturally diverse as the United States, presenting challenges and opportunities. Each new wave of immigration provides a reminder of these challenges and opportunities.
In their individual encounters with patients, other clinical professionals who care for diverse populations need to incorporate knowledge about their patients’ perceptions of illness and disease, belief systems, individual preferences, communication styles, and preferred language. In doing so, clinicians can provide the best possible care to their patients and equip them with appropriate resources. The need for accurate data is critical so hospitals can provide the resources clinicians need to provide quality health care to their patients.

B. Why Should Hospital Leaders Care?

Racial and ethnic disparities in health care have an impact on quality, safety, cost, and risk management. Disparities can lead to increased medical errors, prolonged length of stay, avoidable hospitalizations and readmissions, and over and under-utilization of procedures. Addressing disparities is no longer just a moral or ethical imperative – it has now taken on greater importance with significant bottom line implications, and has been acknowledged by Joint Commission and the National Quality Forum as an essential component of quality of care, and as part of community benefit principles.

Implications for Quality, Cost and Accreditation

Equity is the only pillar of quality that is seen as ‘cross-cutting’, meaning that it has implications for safety, effectiveness, patient-centeredness, timeliness, and efficiency.

Quality implications

Disparities in care can have a detrimental effect on the quality of care that is provided to patients. Patients who are racial and ethnic minorities may be more susceptible to being subject to medical errors; they may also have longer hospital stays and more frequent avoidable re-hospitalizations, and experience other adverse health outcomes. According to the Institute of Medicine Report Unequal Treatment, patients with the same insurance and socioeconomic status, and when comorbidities, stage of presentation and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts. Racial and ethnic minorities are also less likely to receive evidence-based care for certain conditions, which explains the disparities in health outcomes and management of patients with conditions such as diabetes, congestive heart failure, and community-acquired pneumonia.
Financial Implications

Disparities may increase the cost of care, through excessive tests to compensate for communication barriers, medical errors, increased length of hospital stay, and avoidable re-hospitalizations. The financial implication is further compounded in that payers are linking financial penalties to these outcomes.

Regulatory and Accreditation Implications

The Joint Commission has released new disparities and cultural competence accreditation standards, and the National Quality Forum has released cultural competence quality measures. Several provisions to reduce disparities were included in the Affordable Care Act. All these national efforts have further enhanced the need for providers to re-examine health care disparities in their organizations and identify solutions to provide more equitable care.

C. What Hospital Leaders Can Do

These recommendations are meant to provide an overall outline for how to move forward on this issue, and are in no way exhaustive.

Getting Started

Create a Disparities Committee or Task Force of individuals representing quality, operations, patient registration, social services, human resources, nursing and physician-leaders from several clinical services. This team should be charged with assessing what is being done to identify and address disparities, including whether patient’s race and ethnicity data are being collected. Develop initial strategic plan. Educate leadership team on disparities, quality, equity via champion, local national expert.

Creating the Foundation

Develop a plan to collect patient race/ethnicity data (if not already done) and create medical policies to support this work. Assign an organizational leader as the key report for this work and engage in efforts to raise awareness of the issue among faculty and staff. Ensure all staff are trained. Solidify community partnership and relationships in anticipation of future interventions.
Moving to Action

Create a “disparities dashboard” composed of key quality measures stratified by race and ethnicity (e.g. National Hospital Quality Measures, HEDIS outpatient measures, patient satisfaction, etc.) that can be routinely presented to leadership and monitored. If disparities are found, create pilot programs to address them (examples include disease management programs with health coaches, navigators, or community health workers).

Evaluate, Disseminate, Reengineer

Evaluate pilot studies and develop a dissemination strategy to post results; chart a new course and reengineer strategies from lessons learned. Embed successful practices into standard programs of care.

Section II. Tools/Resources
Q: Why is equity an important component of quality?

A: The Institute of Medicine Report *Crossing the Quality Chasm* suggests health care systems must focus on six key elements: efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity. Equity is achieved by providing care that does not vary in quality by personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Q: Given all the competing interests and priorities our hospital is facing, why should we focus on equity?

A: Research has shown that racial and ethnic disparities in health care, and their root causes, have an impact on quality, safety, cost, and risk management. For example, patients with limited-English proficiency suffer from more medical errors with greater clinical consequences than their English proficient counterparts; have longer lengths of stay for the same clinical condition; may undergo more high-priced diagnostic tests due to challenges related to communication; and have higher rates of readmission for chronic conditions and more avoidable hospitalizations. All of these situations may pose significant risk management issues as well. Furthermore, addressing disparities will likely soon become a key part of the Joint Commission’s Accreditation Standards, the National Quality Forum’s quality measures, a key aspect of pay-for-performance contracts, and a more central component of community benefit principles that are now under close federal scrutiny.

Q: Is there evidence that hospitals may be providing care that is not equitable?

A: The Institute of Medicine Report *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation, and other confounders are controlled for, minorities often receive a lower quality of health care than do their non-minority counterparts.

Racial and ethnic disparities have been found in the quality of hospital care delivered to patients with cardiovascular disease (including acute myocardial infarction and congestive heart failure), diabetes, and cancer screening and management. **Health-system level factors** (related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for minority patients or those with limited-English proficiency), **care-process variables** (related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication), and **patient-level variables** (patient’s mistrust, poor adherence to treatment, and delays in seeking care) all contribute to disparities.
Section II: Tools

Frequently Asked Questions on Collecting Expanded Race and Ethnicity Data for Hospital Leaders

Q: How do disparities apply to our hospital? We treat all patients the same regardless of race/ethnicity?

A: While most health care professionals and hospitals strive to provide the same level of quality of care to all patients, evidence shows this may not be the case. Research highlights racial/ethnic disparities in care across a wide range of institutions, geographic regions and services. The bottom line is that if you have not looked at your hospital’s quality data stratified by race and ethnicity, you cannot assume that your hospital does not have disparities.

Another key point is that treating everyone the same may not be enough. Patients may respond differently when presented with the same information from a clinician. Ensuring the highest quality of care possible to all patients requires understanding and adapting care to the patient’s unique needs and perspectives, which are often influenced by their social and cultural backgrounds. Only then can high-quality care be achieved in a patient-centered manner.

Q: Aren’t racial and ethnic disparities in health mainly due to socioeconomic factors like poverty, poor education, and lack of insurance?

A: There is no doubt that socioeconomic status, educational attainment, and the environment – social determinants of health – as well as access to care, contribute to racial and ethnic disparities in health. However, the Institute of Medicine Report Unequal Treatment reviewed hundreds of articles that controlled for these factors and still found differences in quality of care based solely on the race and ethnicity of the patient.

These are termed racial and ethnic disparities in health care. Efforts to improve quality and achieve equity should focus on the root causes of racial and ethnic disparities in health care.

Q: New studies suggest that racial and ethnic disparities in health care are primarily due to where and by whom patients are seen. Shouldn’t disparities efforts focus on improving quality at institutions predominately serving minorities?

A: Research, including those studies presented in Unequal Treatment, shows that racial and ethnic disparities in health care can happen anywhere, and among patients cared for by any provider. Efforts to address disparities should include quality improvement strategies in predominately minority-serving institutions, as well as institutions that serve a diverse patient population. The bottom line is that in order to assure equity, all hospitals need to collect data on patient race and ethnicity and stratify quality measures accordingly to determine if disparities exist – regardless of the size of the minority population being served.
Frequently Asked Questions on Collecting Expanded Race and Ethnicity Data for Hospital Leaders

Q: Are there hospitals actively engaged in disparities work across the country?

A: Many hospitals in New York State and across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity. Activities have included the development of a strategic plan to address disparities, standardized collection of patient’s race and ethnicity, stratification of quality measures by race and ethnicity, development of quality measurement tools to monitor for disparities, implementation of community-based efforts to improve primary care services and medical homes, development and expansion of interpreter services, and interventions to address disparities when found.
Hospital Leader Recommendation Checklist

Getting Started

☐ Create a Disparities Committee or Task Force.
  - A multidisciplinary team, charged with assessing what is being done to identify and address disparities, including whether patient’s race and ethnicity data is being collected. Develop initial strategic plan.

☐ Educate leadership team on disparities, quality, equity via champion, local national expert.

Creating the Foundation

☐ Begin to build foundation to address disparities (including race/ethnicity data collection, stratification of quality measures, etc.).
☐ Develop medical policies to support all new work.
☐ Finalize a strategic plan of action with 1, 3 and 5 year goals.
☐ Assign an organizational leader who can liaison with Disparities Committee; align with other hospital champions.
☐ Engage in efforts to raise awareness of the issue among faculty and staff, and provide broad education on the issue.
☐ Develop any community-based relationships that are necessary.

Moving to Action

☐ Monitor for disparities by stratifying quality measures by race/ethnicity and presenting findings routinely to leadership via a disparities dashboard.
  - Examples include National Hospital Core Measures of congestive heart failure, acute myocardial infarction, community acquired pneumonia, surgical infection prophylaxis as well as other high-impact measures of interest, such as diabetes and breast, cervical, and colon cancer screening.
  - Standardize processes related to stratification of quality measures.

☐ Develop pilot interventions to address them
☐ Expand measurement capabilities to other areas.

Evaluate, Disseminate, Reengineer

☐ Evaluate pilot interventions.
☐ Disseminate points of actions and success.
☐ Reengineer efforts as necessary.

Section II: Tools

Resources

The Disparities Solutions Center at Massachusetts General Hospital

- Improving Quality and Achieving Equity: A Guide for Hospital Leaders
- Healthcare Disparities Measurement
- Assuring Healthcare Quality: Healthcare Equity Blueprint

American Hospital Association: Hospitals in Pursuit Excellence

- Improving Health Equity Through Data Collection and Use: A Guide for Hospital Leaders
- Leading Improvement Across the Continuum: Skills, Tools and Teams for Success
Section III
The Quality Improvement Imperative
Addressing Healthcare Disparities: The Quality Improvement Imperative

Section Overview

Data collection has long been central to the quality assurance process. If consistent standardized data on race and ethnicity are available, disparities in health care can be addressed through a quality of care framework. This section highlights the central role of quality improvement in reducing disparities and provides resources to integrate targeted disparities measures into quality improvement.

Improved quality of race and ethnicity data will help hospitals and NYS:

- Better identify areas of health care disparity in their communities
- More objectively assess their community needs
- More effectively plan programs and service interventions that would address the identified needs
- Respond to the individual needs of racially and ethnically diverse patients
- Close the existing gaps by providing culturally sensitive and appropriate services to racial and ethnic groups; and
- Improve access and quality of care for all New Yorkers

Tools in this Section

- Quality Improvement to Address Disparities Resources and Toolkits
A. Bringing Equity into Quality Improvement

Despite evidence documenting disparities in virtually all areas of care, health care organizations have been slow to focus on equity. Equity is a fundamental component of quality of care. Disparities in health care (e.g., in access, in the rate at which a treatment is provided when indicated, or in the incidence of adverse events in care) can be the cause of disparities in health (e.g., in the incidence or severity of a disease, in functional level, or in mortality rate) and have an impact on quality, safety, cost, and risk management. Disparities can lead to increased medical errors, prolonged length of stay, avoidable hospitalizations and readmissions, and over and under-utilization of procedures. Efforts to reduce disparities need to be mainstreamed into routine quality improvement efforts. Analyses of disparities in health care can help identify opportunities for quality improvement in care provision that will reduce disparities in health.

B. Quality Data

Identifying problems, targeting resources, and designing interventions all depend on reliable data. To assure the value of analyses, organizations should assess the quality of the data. Completeness of the data can be assessed by reviewing missing data as well as instances where patients declined to respond. Although patients who decline to respond should be respected, examining the rate of such responses can inform whether or not the data collection protocol may need to be adjusted and/or if additional training is required.

It is highly recommended that hospitals standardize:

- Who provides information, patient (self-identification is best)
- When data are collected,
- Use the NYS required race and ethnicity categories


- Why race/ethnicity data are being collected,
- How data are stored, and
- How patients’ concerns are addressed.

*Section IV of this document provides tools and resources for staff training on data collection.*
C. Establish Measures for Addressing Disparities

The hospital’s focus on measurement in reducing disparities is to ensure that all patients receive the appropriate standard of care. If this standard is not met, it is important for hospitals stratify data by race and ethnicity to determine if gaps in quality care are present.

The National Quality Forum (NQF) has developed a set of criteria to determine whether a quality measure would qualify as “disparities sensitive.” Disparities-sensitive measures are those that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (race and ethnicity, etc.).

NQF has established guiding principles for assessing performance measures using “Disparity-Sensitive Principles”:

- Prevalence—How prevalent is the condition among minority populations?
- Impact of the Condition—What is the impact of the condition on the health of the disparity population?
- Impact of the Quality Process—How strong is the evidence linking improvement in the measure to improved outcomes in the disparity population?
- Quality Gap—How large is the gap in quality between the disparity population and the group with the highest quality for that measure?
- Ease and Feasibility of Improving the Quality Process (Actionable)—Is the measure actionable among the disparity population?

Some examples include:

- Compare the hospital’s service population by race, ethnicity, and language data with those of the catchment community to identify disparities in access or accessibility.
- Analyze clinical quality indicators for all patients to determine if gaps in quality exist by race, ethnicity, or primary language.
- Link patient demographic information to patient satisfaction surveys and analyze grievances and complaints filed to determine if differences in satisfaction fall along racial or ethnic lines.
- Analyze medical errors by patient race, ethnicity, and primary language to identify and address patterns.
- Determine the percent of clinical staff trained in culturally and linguistically competent care.
The goal of eliminating health disparities can be achieved by using race and ethnicity data to measure quality to identify those disparities that can be addressed by quality improvement initiatives.

*Links to QI Toolkit and Guides developed by the Agency for Healthcare Research and Quality and other organizations are available in the Resources Section of this document.*
Section III

Tools and Resources
Section III Tools/Resources

Quality Improvement to Address Disparities Resources and Toolkits

Resources by the Disparities Solutions Center at Massachusetts General Hospital

- **Healthcare Disparities Measurement**

The report on *Healthcare Disparities Measurement* provides practical recommendations for healthcare organizations to increase their portfolio of race, ethnicity, and language data collection strategies - and consequently, utilize that data to develop disparities-sensitive measures. This report is intended to guide organizations in disparities and quality measurement through the following strategies:

1. Data Collection: Building the Foundation
2. Disparities Measures and Indicators: What to Measure
3. Methodological Approaches to Disparities Measurement: How to Measure and Monitor
4. Priorities and Options for Quality Improvement and Public Reporting of Healthcare Disparities

- **Assuring Healthcare Quality: A Healthcare Equity Blueprint**

The *Healthcare Equity Blueprint* offers strategies and practices that can be tailored to individual hospitals to address equity in providing quality care. The Blueprint is a starting point for designing and implementing interventions to address racial and ethnic disparities in health care. Aspects of this Blueprint apply to numerous health care settings, but the primary focus is on hospitals.

The proposed improvement strategies are grouped into the following five categories:

1. Create Partnerships with the Community, Patients, and Families
2. Exercise Governance and Executive Leadership for Providing Quality and Equitable Care
3. Provide Evidence-Based Care to All Patients in a Culturally and Linguistically Appropriate Manner
4. Establish Measures for Equitable Care
5. Communicate in the Patient’s Language — Understand and be Responsive to Cultural Needs and Expectations

The Blueprint also provides recommended tools, resources, and guidelines on the collection and measurement of data related to addressing health care disparities.
Section III Tools/Resources

Quality Improvement to Address Disparities Resources and Toolkits

Resource from National Committee for Quality Assurance (NCQA)

- Multicultural Healthcare: A Quality Improvement Guide

A comprehensive quality improvement guide and toolkit to help health care organizations to provide culturally and linguistically appropriate services and reduce health care disparities in the populations they serve.

Resources from the National Quality Forum (NQF)

- Comprehensive Framework and Practices for Measuring and Reporting Cultural Competency

NQF is working to advance measurement of disparities across settings and populations by analyzing the effectiveness of quality measures already in place and identifying gaps. This guide serves as a comprehensive road map for measuring and reporting cultural competency.

- National Voluntary Consensus Standards for Ambulatory Care- Measuring Healthcare Disparities

The report contains 36 disparities-sensitive voluntary consensus standards that address all levels of measurement, including practitioner practices, large and small groups, and health plans. In addition, the report includes performance measures at the community level for the purposes of quality improvement.

Resources from the Agency for Healthcare Research and Quality (AHRQ)

- AHRQ Quality Indicators(QI)™ Toolkit for Hospitals

The QI Toolkit is designed to help hospitals understand the QI’s from AHRQ and support the use of them to successfully improve quality and patient safety. The tools are practical, easy to use, and designed to meet a variety of needs, including those of senior leaders, quality improvement staff, and multi-stakeholder improvement teams.
Section IV.

Registration/Admission
Supervisors and Staff: The Nuts and Bolts
Registration/Admission Supervisors and Staff

About this Section

Registration and Admission staff are key to collecting accurate data. Patient registration/admission staff are often the first point of contact for many patients, and they are responsible for collecting information directly from patients or caregivers. The goal of this section is to provide guidance on staff training which focuses on the reasons for collecting this information, how to ask patients and address their concerns, so that staff feel comfortable asking for this information and patients respond positively as well.

Tools in this Section

- Why Should Hospitals Collect Patient Race and Ethnicity Data
- Frequently Asked Questions for Patients
- Patient Race and Ethnicity Questionnaire
- Definitions of Race and Ethnicity
- Scripts for Collecting Race and Ethnicity
- Answers to Questions Patients Might Ask
- Frequently Asked Questions Standardizing the Collection of Race and Ethnicity Data
- Reporting Race and Ethnicity in SPARCS for Newborn Infants
- Training Role Plays
- Training Resources
A. Staff Training

To ensure that data are collected accurately and consistently, organizations need to invest in training staff. Staff should be partners in this process. The training should provide information about why it is important to collect these data, how to collect data, how data will be used and how to answer questions or address concerns from patients. Patient registration/admission staff are often the first point of contact for many patients, and they are responsible for collecting information directly from patients or caregivers. Registration staff have expressed concern that asking patients to provide information about their race and ethnicity and other potentially sensitive information may alienate them. Research and field work have shown that when registration staff are partners in the process and receive training which focuses on providing them with information regarding the reasons for collecting this information, how to ask patients and address their concerns, registration staff feel more comfortable asking for this information and patients respond positively as well.

*Tools and resources for staff training are provided in the Tools Resources Section of this document.*

B. Separating Race and Ethnicity

The Patient Protection Affordable Care Act (PPACA) revised standards includes separate questions to assess race and ethnicity. The PPACA recommends first asking questions about ethnicity.

NYS uses the U.S. Centers for Disease Control and Prevention (CDC) Race and Ethnicity code set, version 1.0. The CDC has prepared a code set for use in coding race and ethnicity data. Hospitals are encouraged to track more detailed data (granular sub-categories); these subcategories must roll up into the following categories for reporting [http://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm](http://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm)
C. Why Ask Race and Ethnicity Data

A clear understanding of why it is important to collect race and ethnicity data is needed for staff of health care organizations to buy into the process. While most health care professionals and hospitals strive to provide the same level of quality of care to all patients, evidence shows this may not be the case. Research highlights racial/ethnic disparities in care across a wide range of institutions, geographic regions and services. The bottom line is that if you haven’t looked at your quality data stratified by race and ethnicity, you can’t assume that you don’t have disparities.

Another key point is that treating everyone the same may not be enough. Patients may respond differently when presented with the same information from a clinician. Ensuring the highest quality of care possible to all patients requires understanding and adapting care to the patient’s unique needs and perspectives, which are often influenced by their social and cultural backgrounds. Only then can high-quality care be achieved in a patient-centered manner.

Valid and reliable data are fundamental building blocks for identifying differences in care and developing targeted interventions to improve the quality of care delivered to specific populations.

D. Strategies for Success

Given the sensitive nature of soliciting race and ethnicity information, health care organizations may want to develop a protocol for how to collect the data. Training sessions can help staff become familiar with the protocol and comfortable with its implementation. Periodic trainings may be necessary because research on how best to collect and use race and ethnicity data is constantly evolving based on advances in health IT, the changing demographics of the United States and how individuals self-identify.

*Tools for staff training and patient information resources are provided in the tools section of this document.*
E. Prepare to Collect the Data

Define a preferred method for collecting race and ethnicity data based on your current registration process. Based on your registration process define one of two methods for collecting the data:

**Verbal Data Collection** – staff verbally ask each patient his/her race and ethnicity and then directly enters responses into the electronic medical record system.

**Paper Data Collection** – each patient indicates his/her race and ethnicity when completing other registration paperwork. Data are then entered into the electronic medical record system.

F. Who Provides the Data

Ask patients (or those who care for them) to identify the patient’s race or ethnicity (self-report) rather than inferring from observation or from name.

“We want to make sure that we identify and address each patient’s needs and ensure that all our patients get the best care possible. We’re going to ask you some questions about yourself such as: your name, your age, your address, your gender, your race, and your ethnicity. We’ll keep this information confidential and will update it in your medical record. This information will not be used for immigration purposes or reported to the authorities. The only people who see this information will be members of your care team and others who are authorized to see your medical record.”

*See the Tools and Resources Section for Patient Demographic Questionnaire*
G. Introducing the Topics

Although some people may have concerns about how race and ethnicity data may be used, most individuals are willing to provide their demographic information. Research has demonstrated that nearly 80 percent of patients strongly agree or somewhat agree that health care providers should collect information about their patients’ race and ethnicity, and nearly 97 percent feel it is important for hospitals and clinics to gather race and ethnicity data to ensure that all patients receive high-quality care. To ease any uncertainties that patients may feel, however, providers should share why the data are being collected prior to asking about race and ethnicity. One study revealed that of participants who originally were uncomfortable reporting their race and ethnicity, 25 percent said the explanation about how the information would be used to monitor quality of care made them somewhat more comfortable and 26 percent said the explanation made them much more comfortable.¹


H. Scripts

Although it is not necessary to have lengthy scripts, it is important to clearly communicate why you are asking patients to provide information about their race and ethnicity. Depending on what type of resources you have available, a script can be read directly from the computer screen or you can simply have it written on a laminated card to keep at your station. You will need to work with IT staff to ensure it is incorporated on the registration screen if you decide to go this route remember to ask the patient or designated caregiver to self-identify their race and ethnic background:

“We want to make sure that we identify and address each patient's needs and ensure that all our patients get the best care possible. We're going to ask you some questions about yourself such as: your name, your age, your address, your gender, your race, and your ethnicity. We’ll keep this information confidential and will update it in your medical record. This information will not be used for immigration purposes or reported to the authorities. The only people who see this information will be members of your care team and others who are authorized to see your medical record.”

When asking for race and ethnicity, be sure to ask ethnicity first then race.

“Are you Hispanic, Latino/a, or Spanish Origin?” Then ask, "What is your race?"
I. Addressing Concerns from Patients

Researchers have found that when you explain why you are asking people to report their race and ethnicity and do so in a nonthreatening and polite manner, resistance to providing this information is minimized. There may be individuals who do not understand the question or do not want to respond to it. It is very important to remember that if someone does not want to answer these questions, there is the option to record “Unknown” for ethnicity and “Other” for race.

J. Informing the Community

It is important to inform the community that information is collected during the registration process on patient demographics such as: age, gender, race and ethnicity. This information helps to address and assure that all patients have the best care possible, although we share similarities, our racial and ethnic backgrounds may place us at differing risks for some diseases. By knowing this information the healthcare team can work to reduce these risks by making sure that everyone gets appropriate and high quality health care. Steps to inform the community can include your hospital newsletter, community meetings, email, and other available venues at your disposal. You may also want to display a poster or provide an informational flyer that registration staff can hand out to patients during registration.

We have developed flyer and poster tools to use and display in registration areas, waiting areas, cafeterias, and elsewhere in your hospital to let patients know that they will be asked about their race and ethnicity during registration. These tools are available in seven different languages. The flyer and poster files are available from http://improvepatientdatanys.org/

Section IV

Tools/Resources Section
Why Hospitals Should Collect Demographic Data

Target Audience: Admissions/registrations clerks and front-line personnel

Purpose: This document outlines the purposes of collecting patient demographic data and highlights the important role that front-line registration staff have in collecting complete, high quality information from patients.

“As a front-line hospital admissions/registration staff, you are vital to the patient experience and in helping the hospital better serve patients and the community. One of the key responsibilities you have is to accurately collect each patient’s personal information, including the patient’s race and ethnicity. Collecting this information is part of the process by which our hospital staff can identify and address unique patient needs. Patients are more likely to share personal information when asked by respectful, knowledgeable staff, and our hospital is better able to serve its patients when this information is collected for everyone in a consistent manner.

Information that you help collect during the registration process on patient demographic data such as: age, gender, race and ethnicity; becomes a part of the patient’s medical record. This information helps the care team communicate effectively with patients, as well as understand a patient’s culture, which may affect their health. By knowing more about the patients that we serve, our hospital will be better able to deliver services.

Because race and ethnicity affect patients’ health and healthcare, it is critical to collect this information. You, our front line staff, play a key role in this process.”
Frequently Asked Questions for Patients

Target Audience: Patients

Purpose: This document provides answers to questions that are frequently asked by patients during the admission/registration process. Hospitals can attach this list of questions and answers to registration forms that patients fill out themselves and may also choose to post this document in the registration area.
Frequently Asked Questions for Patients

Q: What do my race and ethnicity have to do with my health?
A: Although all people share similarities, our racial and ethnic backgrounds may place us at differing risks for some diseases. We can work to reduce these risks by making sure that everyone gets appropriate and high quality health care.

Q: Why am I being asked these questions?
A: To provide better health services and outcomes, hospitals need some basic information from patients; this includes address, age, gender, race and ethnicity. Improved collection of this information will allow hospitals and facilities to gain a better understanding of the patients and communities they serve and address the differences in health outcomes they may face.

Q: Why am I being asked my race and ethnicity?
A: Improving the quality and completeness of race and ethnicity data helps to better identify healthcare gaps and inform programs and policies to improve the health of all New Yorkers.

Q: What will my information be used for?
A: Information you give us will help us improve the health services and programs provided to our patients.

Q: Who will see my information?
A: Your information is kept private and confidential and is protected by law. The only people who will see your information are members of your care team and others who are authorized to see your medical record.

Q: Who are you collecting this information from?
A: We are collecting this information from all our patients.

Q: What if I don’t want to answer these questions?
A: It is perfectly alright if you do not want to answer some or all of the questions. However, this information does help our hospital provide better care. Regardless of whether you answer these questions, we will provide you care.

Q: What if I identify with more than one race?
A: You can check off all the races to which you identify.

Q: What if identify with more than one ethnicity?
A: You can check off all ethnicities to which you identify.
Frequently Asked Questions for Patients

Q: Who can I ask questions about this?

A: The hospital registration staff and their supervisors are happy to answer any questions that you may have about why you are being asked about your race and ethnicity.

Q: What if I don’t know my race or ethnicity?

A: If you don’t know your race or ethnicity, you can leave these questions blank.
Example Patient Race and Ethnicity Questionnaire

Target Audience:
Hospital admissions/registration staff

Purpose:
This sample questionnaire, to be administered by hospital or clinic personnel, asks patients to provide information on their race and ethnicity. A script is provided for staff to use to help introduce the questions that follow.

Race and Ethnicity Standards and Implementation Guidelines

Instructions for Use:

Following are:

- Patient Race and Ethnicity Questionnaire
- Ethnicity and Race Tables
- Definitions for Race and Ethnicity Categories

The definitions for race and ethnicity are for hospital personnel and patients to clarify the race and ethnicity categories.

The sample questionnaire was designed to follow the most current recommendations regarding accurate self-reported patient race and ethnicity data as set forth by the Institute of Medicine (IOM), while maintaining categories and rules for rolling up categories that are consistent with current state reporting requirements.

The questionnaire can be administered in-person or over the phone by hospital or clinic personnel.
Patient Race and Ethnicity Questionnaire

“We want to make sure that we identify and address each patient’s needs and ensure that all patients get the best care possible. We’re going to ask you some questions so that we can provide our patients with appropriate and high quality care.

We will keep this information confidential and will update it in your medical record. The information you share will **not** be used to identify or determine your immigration status, and will **not** be reported to the authorities. You may choose not to answer any question(s).

You have been provided a list of Frequently Asked Questions and Definitions to help answer questions that you may have about this form, but our registration staff members are also happy to answer your questions.

1. **Ethnicity**

**Are you Hispanic, Latino/a, or Spanish origin?** (One or more categories may be selected)

- [ ] Mexican
- [ ] Mexican American
- [ ] Chicano/a
- [ ] Puerto Rican
- [ ] Cuban
- [ ] Unknown
- [ ] Another Hispanic, Latino/a, or Spanish Origin **(Please Choose from the list in Table One)**

2. **Race**

**What is your race?** (One or more categories may be selected)

- [ ] American Indian or Alaska Native
- [ ] Black or African American
- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Other Asian **(Please Choose From the List In Table Two)**
- [ ] White
- [ ] Other Race
- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Other Pacific Islander **(Please Choose from the List In Table Three)**
**Other Ethnicity Table**

**Table One: Other Hispanic, Latino/a, or Spanish Origin**

<table>
<thead>
<tr>
<th>Spanish Basque</th>
<th>La Raza</th>
<th>South American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andalusian</td>
<td>Mexican American Indian</td>
<td>Argentinean</td>
</tr>
<tr>
<td>Asturian</td>
<td>Central American</td>
<td>Bolivian</td>
</tr>
<tr>
<td>Castillian</td>
<td>Costa Rican</td>
<td>Chilean</td>
</tr>
<tr>
<td>Catalonian</td>
<td>Guatemalan</td>
<td>Colombian</td>
</tr>
<tr>
<td>Belearic Islander</td>
<td>Honduran</td>
<td>Ecuadorian</td>
</tr>
<tr>
<td>Gallego</td>
<td>Nicaraguan</td>
<td>Paraguayan</td>
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<tr>
<td>Valencian</td>
<td>Panamanian</td>
<td>Peruvian</td>
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<tr>
<td>Canarian</td>
<td>Salvadoran</td>
<td>Uruguayan</td>
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<tr>
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<td>Venezuelan</td>
</tr>
<tr>
<td></td>
<td>Canal Zone</td>
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</tr>
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</table>

**Other Race Tables**

**Table Two: Other Asian**

<table>
<thead>
<tr>
<th>Bangladeshi</th>
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</thead>
<tbody>
<tr>
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<td>Sri Lankan</td>
</tr>
<tr>
<td>Cambodian</td>
<td>Thai</td>
</tr>
<tr>
<td>Taiwanese</td>
<td>Iwo Jiman</td>
</tr>
<tr>
<td>Hmong</td>
<td>Maldivian</td>
</tr>
<tr>
<td>Indonesian</td>
<td>Nepalese</td>
</tr>
<tr>
<td>Loation</td>
<td>Singaporean</td>
</tr>
<tr>
<td>Malaysian</td>
<td>Madagascar</td>
</tr>
</tbody>
</table>

**Table Three: Other Pacific Islander**

<table>
<thead>
<tr>
<th>Polynesian</th>
<th>Micronesian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tahitian</td>
<td>Mariana Islander</td>
</tr>
<tr>
<td>Tongan</td>
<td>Saipanese</td>
</tr>
<tr>
<td>Tokelauan</td>
<td>Palauan</td>
</tr>
<tr>
<td>Guamanian</td>
<td>Carolinian</td>
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<tr>
<td></td>
<td>Kosraean</td>
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<tr>
<td></td>
<td>Kiribati</td>
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<td></td>
<td>Pohnpeian</td>
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<td></td>
<td>Chuukese</td>
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<td>Yapse</td>
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<td></td>
<td>Marchallese</td>
</tr>
<tr>
<td></td>
<td>Kribati</td>
</tr>
<tr>
<td></td>
<td>Other Micronesian</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Melanesian</th>
<th>Fijian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua New Guinean</td>
<td></td>
</tr>
<tr>
<td>Solomon Islander</td>
<td></td>
</tr>
<tr>
<td>New Hebrides</td>
<td></td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td></td>
</tr>
</tbody>
</table>
Definitions of Race and Ethnicity

**Ethnicity**

*Hispanic or Latino:* refers to a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.

*Unknown:* Select this category if the patient is unable to physically respond, there is no available family member or caregiver to respond for the patient, or if for any reason, the demographic portion of the medical record cannot be completed.

**Race**

*Black or African American* refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicated their race(s) as “Black, African American, or Negro” or reported entries such as African American, Kenyan, Nigerian, or Haitian.

*White* refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as “White” or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

*Asian* refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as “Asian” or reported entries such as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” and “Other Asian” or provided other detailed Asian responses.

*American Indian/Alaska Native* refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicated their race(s) as “American Indian or Alaska Native” or reported their enrolled or principal tribe, such as Navajo, Blackfeet, Inupiat, Yup’ik, or Central American Indian groups or South American Indian groups.

*Native Hawaiian/Other Pacific Islander* refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race(s) as “Pacific Islander” or reported entries such as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” and “Other Pacific Islander” or provided other detailed Pacific Islander responses.

*Other Race* includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above or the lists provided.
Scripts for Collecting Race and Ethnicity

**Target Audience:** Hospital admissions/registration staff

*(Administered in person or over the phone)*

**Purpose:** This script is for hospital registration staff to use in asking a patient questions on his/her demographics. The script explains to the patient the importance of self-identification, the purpose of collecting this information, and ensures their confidentiality.

Self-identification is the preferred means of obtaining information about an individual’s race and ethnicity. The surveyor should not tell an individual who he or she is, or specify how an individual should classify himself or herself.

**Please note:** To provide flexibility and ensure data quality, separate questions for race and ethnicity should be used. Specifically, when self-reporting or other self-identification approaches are used, ethnicity should be asked first, and then race.

**Keep it simple.**

“We want to make sure that we identify and address each patients needs and ensure that all our patients get the best care possible. We’re going to ask you some questions about yourself such as: your name, your age, your address, your gender, your race, and your ethnicity. We’ll keep this information confidential and will update it in your medical record. This information will not be used for immigration purposes or reported to the authorities. The only people who see this information will be members of your care team and others who are authorized to see your medical record.”

Answers to Questions Patients Might Ask

Target Audience: Hospital admissions/registration staff

Purpose: This document provides answers to questions that are frequently asked by patients during the admission/registration process.

Q: What do my race and ethnicity have to do with my health?

A: Although we share similarities, our racial and ethnic backgrounds may place us at differing risks for some diseases. We can work to reduce these risks by making sure that everyone gets appropriate and high quality health care.

Q: Why am I being asked these questions?

A: We are collecting race and ethnicity information from all of our patients to help us get to know them better. By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your health needs.

Q: What will my information be used for?

A: Information you give us on your race and ethnicity will help us provide better services and programs to everyone.

Q: Who will see my information?

A: Your information is kept private and confidential and is protected by law (Health Insurance Portability and Accountability Act HIPAA 1996). The only people who will see your information are members of your health care team and others who are authorized to see your medical record.

Q: Who are you collecting this information from?

A: We are collecting this information from all our patients.

Q: What if I don’t want to answer these questions?

A: It is perfectly alright if you do not want to answer some or all of the questions. However, this information does help our hospital provide better care. Regardless of whether you answer these questions, we will provide you care.
Section IV: Tools/Resources Section

Answers to Questions Patients Might Ask

Q: What do you care? We’re all humans.

A: Information about your race and ethnicity helps us make sure we provide the highest quality of care for all patients. Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your health needs.

Q: Can’t you tell by looking at me?

A: Every person is different, so we do not make any assumptions based on how a person looks.

Q: I was born in _______ country, but I’ve lived here all my life. What should I choose?

A: It is really up to you. You can choose any term that you are most comfortable with.

Q: Are you trying to find out if I am a U.S. citizen?

A: No, definitely not. This information is confidential and used only to improve health care. No questions regarding citizenship or documentation are asked.

Q: Isn’t that an illegal question to ask?

A: No, it is not illegal to ask. Collecting and reporting race and ethnicity are legal under the federal Civil Rights Act of 1964. However, you may choose not to answer any question.

Q: What if I belong to more than one ethnicity?

A: You can check off all the ethnicities to which you belong.

Q: What if I belong to more than one race?

A: You can check off all the races to which you belong.

Q: What if I don’t know my race or ethnicity?

A: If you don’t know your race or ethnicity, you can leave these questions blank.

*Note for staff: If the patient does not self-identify with any of the race or ethnicity categories, registration staff may provide an explanation of the categories as needed to provide the patient with more information, however, staff should not pressure the patient to make a selection if the patient does not choose one.

Source: Health Research and Educational Trust Disparities Toolkit. hretdisparities.org, accessed on 10/11/13
Frequently Asked Questions about Standardizing the Collection of Race and Ethnicity Data

Target Audience: Hospital Admissions/Registration Staff

Purpose: This document provides answers to questions that are frequently asked about the collection of expanded race and ethnicity data.

FAQ 1: How is ethnicity defined and what is its relationship to a person’s race?
A: As stated in the 2009 Institute of Medicine Report Race, Ethnicity and Language Data Standardization for Health Care Quality Improvement, ethnicity is defined as a common ancestral heritage that gives social groups a shared sense of identity. A particular ethnic group may contain persons who self-identify with different race categories. This is why there is the convention now, as instituted by the U.S. government in 1997, to split race and ethnicity.

FAQ 2: Where can I find the list of race/ethnicity categories?
A: NYS uses the U.S. Centers for Disease Control and Prevention (CDC) code set, version 1.0. The CDC has prepared a code set for use in coding race and ethnicity data. This code set can be found at: http://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm

FAQ 3: What does SPARCS stand for?
A: The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for every patient admitted and discharged from the hospital or seen and discharged from an ambulatory surgery clinic or emergency department admission in New York State.

FAQ 4: Is there a standard to follow for reporting on persons with mixed or multiple races and ethnicities?
A: The SPARCS categories include the option for people to choose more than one race and more than one ethnicity. Refer to the link above or the example patient demographic form provided.
Frequently Asked Questions about Standardizing the Collection of Race and Ethnicity Data

FAQ 5: Do we need to collect all Race and Ethnicity Categories shown in Appendix RR including the more granular information or just the bolded levels?

A: Collect and report data as granular as possible. In the future, these more granular categories may be required.

FAQ 6: Is the patient required to sign the form that the intake staff person is using to collect race and ethnicity?

A: No the patient is not required to sign the form.

FAQ 7: Is it okay to record race and ethnicity by observation when it is obvious to the staff, especially if the person has been coming to the hospital for years?

A: No. All information on race and ethnicity needs to be captured through self-report by the patient or his/her caregiver.

FAQ 8: What should we do if our patients "refuse" or "decline" to answer the race, ethnicity and language questions?

A: Based on past experience with other hospitals, the percentage of refusals is small. SPARCS requires a race and ethnicity for every claim, there is not a recommendation for refuse or decline, the only options are to report "other" race and "unknown" ethnicity.

FAQ 9: My organization's Hispanic patients often have difficulty identifying with any of the standard race categories. What should registration staff do in this situation to help the patient self-identify?

A: Patients who identify themselves as Hispanic/Latino – which is their ethnicity – may have difficulty identifying with any of the standard race categories. If the patient does not self-identify with any of the race categories, registration staff may provide an explanation of the race categories as needed to provide the patient with more information, but should not put pressure on the patient to make a selection if the patient does not choose one.

FAQ 10: If a patient’s preferred language is Spanish, can registration staff assume the patient's ethnicity is Hispanic?

A: No, registration staff should not make any assumptions about a patient’s demographic information. The most accurate information is obtained when the patient provides his/her own response to the questions. The registration staff should ask the patient to self-identify his/her race and ethnicity.
Frequently Asked Questions about Standardizing the Collection of Race and Ethnicity Data

FAQ 11: Regarding the collection of patient race and ethnicity, how do we address patients’/family members concerns such as, "I have been coming here for a long time, don’t you have that information already?"

A: You can use the following response or a modification of it:

“We may have the information already but in some instances we do not. We want to make sure that we have the correct information for everyone so we can ensure that everyone is getting the best quality of care regardless of his/her race/ethnicity.”

FAQ 12: Should we ask patients for their race and ethnicity each time they come to the hospital?

A: We recommend that you develop a system that enables you to capture the information only once with periodic updates (e.g., every two years).

FAQ 13: How might our hospital address a patient concern about their immigration status when asked for their race and ethnicity?

A: If a patient has a concern related to immigration status, registration staff should make it clear to the patient that the race and ethnicity questions are not being asked to determine the patient’s immigration status and the patient’s responses to the questions will not be reported to the authorities. According to fieldwork with dozens of hospitals, including some in border states, most patients were comfortable with the above explanation. In a few instances, patients were still uncomfortable. SPARCS requires a race and ethnicity for every claim. There is not a category for refuse or decline, the only options are “other” race and “unknown” ethnicity.

FAQ 14: How should our registration staff obtain race and ethnicity for infants and children?

A: The reported race and ethnicity of infants and children should reflect the race(s) and ethnicity(ies) of both the infant’s mother and father. Previously, only one race and one ethnicity could be reported in SPARCS. Now up to a total of 10 different codes for race and ethnicity can be reported.
Frequently Asked Questions about Standardizing the Collection of Race and Ethnicity Data

FAQ 15: Should the script for asking questions about race and ethnicity be in paper or electronic format?

A: This decision is up to each hospital. It may be easier for staff if the script is on the patient registration screen, but some hospitals have indicated that there is not enough room on their screens to accommodate this option. When the script cannot be placed directly on the screen, it is best to have laminated cards, with script typed in large bold-faced font, at each registration station.

FAQ 16: When is the best time to start communicating to the community and our patient population about the changes to the registration process for collecting race and ethnicity information?

A: We suggest that you start communicating as soon as possible. You can use your hospital newsletter, community meetings, email, and other venues you have at your disposal. You may also want to display a poster or provide an informational flyer that registration staff can hand out to patients during registration.

We have developed flyer and poster tools to use and display in registration, waiting areas, cafeteria, and more in your hospital to let patients know that they will be asked for their race and ethnicity during registration. Each is available seven different languages. The poster and flyer files are available from http://improvepatientdatanys.org/

Reporting race and ethnicity in SPARCS for Newborn Infants

1. Hospitals that provide maternity care services should evaluate how they assess, collect and report the race and ethnicity of newborn infants.

2. In a 2013 survey of a sample of New York hospitals, a significant number reported that the race and ethnicity of newborn infants reflects ONLY the race and ethnicity of the mother.

3. The reported race and ethnicity of infants and children should reflect the race(s) and ethnicity(ies) of both the infant’s mother and father. Previously, only one race and one ethnicity could be reported in SPARCS. Now up to a total of 10 different codes for race or ethnicity can be reported. The specific data collection standard for race and ethnicity must be a valid code in accordance with the CDC Race and Ethnicity Code Set - Version 1.0 (See: http://www.health.ny.gov/statistics/sparcs/bulletin/jun13.pdf)

4. Hospitals need to ensure that the staff involved in accessing, collecting and reporting the race and ethnicity of newborn infants understand the importance of accurately collecting this information and how to communicate with and ask parents for this information. In addition, hospitals need to have processes and systems in place to report the race(s) and ethnicity(ies) of both the mother and the father and ensure that they are reflected in the race and ethnicity codes reported for their newborn infant.

5. As hospitals develop new processes, the Department will be interested in determining what the “Best Practices” are, and to share this information with other hospitals.
Target Audience: Trainers/Supervisors/Hospital Admissions/Registration Staff

Purpose: This document provides role play scenarios to be used as a training tool for training staff on collecting race and ethnicity data.
Section IV: Tools/Resources Section

Training Role Plays

**Trainer:** As part of training for registration staff on how to ask patients about their race and ethnicity, you explain how to ask patients for this information. Explain how you would like the staff member to ask the question, and respond to his/her concerns.

**Objective:** To help registration staff understand how to address patient concerns when being asked about race and ethnicity.

**Registration staff:** You are being trained to collect race and ethnicity data from patients. Perhaps in the past, when you asked this information, you found or heard that some patients were offended by the request, so you’re worried about asking for this information. Example: “I don’t think we should be asking for that – patients will be upset.”

**Trainer:** You are training registration staff on how to ask patients for information about their race and ethnicity. This is the third training you’ve run for your staff, and you keep having to explain why it’s important to collect these data.

**Objective:** Explain the importance of collecting these data to staff, and how long you expect this to add to the registration process.

**Registration staff:** You are being trained to collect race and ethnicity from patients. When you’re told about this new requirement, you’re frustrated that you already have too much information to get from patients, and don’t think this is important. Example: “We can barely collect all the information we have to. I don’t see why this is so important, and it will just take longer.”
Training Role Plays

**Trainer:** When training registration staff about how to collect information from patients, you explain the difference between race and ethnicity and why they’re asked about separately.

**Objective:** Clarify the difference between race and ethnicity, and reinforce the need to ask both questions.

**Registration staff:** You are being trained to collect race and ethnicity data from patients. Your trainer has told you about the difference between race and ethnicity, but you still don’t understand why there are two questions and don’t think it’s important for you to ask both of them.

**Registration:** It is 4:30 p.m. on a Friday afternoon. The clinic is very busy today and you have registered a lot of patients. It has been a long week and you are feeling pretty tired. You are hoping that not many people come in during your last half hour.

**Objective:** How do you answer questions in a way that calms patient fears about immigration status?

**Patient:** You recently came to the US from Guatemala and you are going to the clinic for the first time in this country. You don’t have health insurance, but you have heard that people without it can still get care at this clinic. You have had a bad cough for many weeks and are afraid that you are very ill. Your English is still not very good, so you brought along your niece. You are worried that people will think that you don’t have your papers and hope that your niece can help you communicate.
Section IV: Tools/Resources Section

Training Role Plays

**Registration:** You are feeling good today. Things have been going well at work and everything at home is great. Your friend just stopped by the clinic to say hello and it put you in an even better mood. This morning, your boss told you that you are doing a great job with the patients.

**Objective:** How do you ask questions when patient’s first language is not one that you speak?

**Patient:** You have traveled from Iran to visit your family in New York City. Your daughter is a professor at Columbia University. You like coming to America to see how she is living. Unfortunately, you fell down the stairs this morning. Your daughter took you to the doctor on her way to a big conference that she couldn’t miss. You know some English, but she told you that there were people who speak Farsi here at the hospital who will help you.

**Registration:** Today has been an okay day. You are a little stressed because the clinic had a JCAHO evaluation yesterday. You weren’t working yesterday, but your boss says that staff in the clinic has to do a better job at working with patients. You aren’t really sure what this means, but you are trying to be more helpful today.

**Objective:** How do you address patient questions about what ethnicity means and assist them to identify theirs?

**Patient:** You notice a sign posted in the clinic while you are waiting in line to register. It says that the Rochester Health Alliance is going to be collecting race and ethnicity information from all patients. You aren’t sure what this means and you are worried that you won’t know how to answer the questions.
Section IV: Tools/Resources Section

Training Role Plays

**Registration**: It is hard for you to ask the new questions about race and ethnicity during registration. You aren’t really sure why the hospital needs this information anyway and it really slows down your process.

**Objective**: How do you assist a patient with self-identification of all of his/her races and ethnicities?

**Patient**: It has been all over the news about how hospitals need to ask all patients for their race and ethnicity. You really dislike these questions because they force you to pick a category. You almost always say “Other” because you are Black and White and Hispanic. Sometimes you say that you are “Multiracial” but most of the time they try to make you pick and you really don’t think that describes who you are.

**Registration**: You just finished a very long registration process with a patient that was asking a lot of questions. Normally, you take the time to answer them and have a lot of patience, but your line is three people long! You are really hoping that the next guy is easy so that you can get rid of the line.

**Objective**: How do you handle a situation when a patient gets upset and doesn’t want to answer the questions?

**Patient**: You are surprised to hear that the person in front of you in line at the clinic has to tell the registration staff what their race and ethnicity are. You wonder if this information is being collected for the government or to discriminate against minorities. You know that you have the right to not answer these questions and you aren’t going to tell anybody about your heritage. What does it matter to your health anyway?
Registration: It has been a busy day in the emergency room. You have had a line since you started and it is only 12 o’clock. You see a woman that you know because she comes in a lot is next in line. You wonder how she is going to respond to the new questions you have to ask about her race and ethnicity, especially since you know her pretty well.

Objective: How do you handle a situation when you are very familiar with a patient?

Patient: You are going to the emergency room for a sore throat. You come in pretty often for yourself and family members and you know the registration staff pretty well. You had to wait almost a half hour to register, but you are happy to see your friend working behind the desk.

Registration: It is 4:00 am and you are having a rough and busy shift. You didn’t get much sleep because your children are sick and stayed home from school. You are irritable, tired, hungry, and worried about your kids. You have been asking the race and ethnicity questions for a few weeks now and you realize that you can almost always guess the patient’s answers before they say it. Your manager isn’t around and more and more patients are coming into the emergency room.

Objective: How do you record this information from all patients in a standardized way?

Patient: You were working the night shift at Shaw’s and cut your hand very deeply on the deli slicer. You have heard from family members about the new questions that they are asking at the hospital. Your family members told you that it was uncomfortable and frightening. You had a discussion together about your family’s heritage and you now know that you are Brazilian, Black, and Hispanic. You will be able to answer the hospital’s questions confidently.
Training Role Plays

**Registration:** A patient has come to register before seeing her doctor. You must collect race and ethnicity information from her. She is offended when asked about her race.

**Objective:** To address the patient’s concerns about being asked about race and ethnicity.

**Patient:** You are the patient and were told to go to patient registration before seeing your doctor. You are offended when asked about your race and ethnicity. You do not immediately provide the information, but instead express your feelings to the staff person who requested the information. Example: “That’s none of your business.”

**Registration:** A patient must register before being admitted for a biopsy. You must collect race and ethnicity information from the patient. He is concerned about his privacy.

**Objective:** To address the patient’s concerns about the privacy of his information.

**Patient:** You are the patient and were told to go to patient registration before being admitted for a biopsy. When asked about your ethnicity, you do not immediately provide the information because you are worried about who will see it and how it will be used. Example: “What is going to happen to the information if I give it to you?”
Training Resources

The following links are for further staff training resources:


This site contains resources/toolkit and activities to improve the reliability and completeness of race and ethnicity data collected and reported; and promote use of these data to identify and target health care disparities and improve health equity in New York.

**Race and Ethnicity Data Collection Training Module for Physician Practice Staff Registration Staff:**


This online tool from the Greater Cincinnati Health Council has been created for physician practice registration staff training on standardized race, ethnicity and language (REL) data collection practices. The module includes the following:

- **Implementation guide:** Provides an easy, step-by-step process office managers can use to implement race and ethnicity data collection in practice sites; explains how and why standardized categories and patient self-reporting are critical elements.
- **E-learning module:** Trains managers and registration staff in primary care settings to collect self-reported data from patients. Training only takes about 15 minutes to complete!


This toolkit is a web-based tool that provides hospitals, health systems, clinics, and health plans information and resources for systematically collecting race, ethnicity, and primary language data from patients. The Toolkit is useful for educating and informing your staff about the importance of data collection, how to implement a framework to collect race, ethnicity, and primary language data at your organization, and ultimately how to use these data to improve quality of care for all populations.
Training Resources

Standardizing the Collection of Race, Ethnicity, and Language Data


The standardization of patient race, ethnicity and language (R/E/L) data collection is a cornerstone of the Aligning Forces for Quality Hospital Quality Network. This webpage provides guidance and resources necessary for participating hospitals to implement this change within their institution.

Data Collection Role Plays for Registration/Admission Staff Training


The Massachusetts Hospital Association developed these role plays to use as part of training for registration staff on how ask patients race and ethnicity data and address patient concerns.

Race and Ethnicity Data Collection Resources

http://www.mhalink.org/Content/ NavigationMenu/ MyMHA/ Resources/ RaceEthnicityData/ defaul t.htm

This collection of material was developed by the Massachusetts Hospital Association to assist hospitals to comply with state regulations regarding the collection of patient’s race and ethnicity.
Section V

SPARCS Coordinators and Information Technology Staff
SPARCS Coordinators and Information Technology Staff

About this Section:

SPARCS Coordinators and IT Staff are key in implementing the collection and reporting of expanded race and ethnicity data in NYS. Standardized data collection is critical to understanding and eliminating racial and ethnic disparities in health care. The goal of this section is to provide a brief overview of expanded race and ethnicity data collection for SPARCS.

Tools in this Section:

- Frequently Asked Questions for SPARCS Coordinators
A. Information Technology IT Staff

The IT department and staff are key in implementing the framework for collecting patient race and ethnicity data within a hospital or health system. IT staff can identify infrastructure capacity and needs and are best able to integrate the necessary elements of the framework (codes, fields, etc.) into existing systems or in modifying the systems that exist, if necessary. Points of clarification for IT staff to consider include:

- Incorporate the actual script (for asking the questions) on the registration screen so front-line staff can explain or provide the rationale for why they are asking patients to provide information about their race and ethnicity. It is easier for staff if the script is on the patient registration screen, but some facilities have indicated that there is not enough room on their screens to accommodate this option. When the script cannot be placed directly on the screen, it is best to have laminated cards, with the script typed in large bold-faced font, at each registration station.

- There is no “declined” response; the only options are “unknown” ethnicity” and “other” race.

- Ethnicity should be listed and asked before race question.

- Separate fields for race and ethnicity are needed and there should be 10 total fields.

Computer-supported solutions can make the approach of collecting the race and ethnicity data useable on a large scale while helping registrars quickly enter the data. The set of categories that NYS is using is the Center for Disease Control and Prevention Code set, version 1.0 to support this approach.
B. What Data to Collect

The passage of the Patient Protection and Affordable Care Act (PPACA) includes requirements on the enhanced collection and reporting of data on race and ethnicity. The PPACA revised standards includes separate race and ethnicity questions. The OMB Standards for Data on Race and Ethnicity are the base minimum standard.

NYS is using the CDC Race and Ethnicity Code set, version 1.0 and definitions of race and ethnicity. This code set is based on current federal standards for classifying data on race and ethnicity. Hospitals are encouraged to track more detailed data (granular sub-categories), however, these subcategories must roll up into the following categories for reporting


C. New York State required race and ethnicity categories for reporting SPARCS data.

Data Collection: Enhanced Reporting Requirements (Race and Ethnicity)

On May 31, 2013, a letter of notification was sent to Article 28 facilities that submit data to SPARCS that the inpatient and outpatient data elements for reporting race and ethnicity are being expanded to align with Affordable Care Act (ACA) Section 4302 data collection standards. Providers will need to ensure that their electronic medical health records collect, in structured fields, race and ethnicity according to the expanded data standards.

The standards for collection and reporting of data on race and ethnicity have been revised to include additional categories among Hispanic, Asian and Native Hawaiian or Pacific Islander populations. In addition, the NYSDOH will now allow the reporting of up to ten selections of race and/or ethnicity. Expanded data reporting standards are being implemented to improve hospitals’ and researchers ability to monitor and understand health disparities, and to develop more effective strategies for reducing or eliminating disparities.

If hospitals’ have any questions on the expanded race and ethnicity data standards, or the time frame for data collection, they should contact SPARCS Operations at: SPARCS@health.state.ny.us.
D. Complying with Civil Rights Laws

Routine monitoring of access, use of services, and outcomes of care by race and ethnicity helps ensure compliance with civil rights laws. Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and related statutes and their implementing regulations require that patients from different racial and ethnic groups and patients with disabilities have equal opportunity to access quality care.
Section V
SPARCS Tools
Section V: Tools

Frequently Asked Questions for SPARCS Coordinators

1. Q: What guidelines should be used for assigning the codes? For example, if a patient is White and Korean, how should the race be reported?

   A: The expanded race and ethnicity reporting standards will allow for both the collection of greater granularity of the race or ethnicity, as well as up to ten different race and ethnicity selections. In the above example, both would be reported. Please follow the guidelines included in Appendix RR - Race and Ethnicity Codes and the Input Data Specifications.

2. Q: Will the new values replace the older, high-level ones? For example, will the current data standard X12 value of R2, Asian race, be replaced with a new value, or will the general "Asian" value remain, in addition to the new values?

   A: One of the goals of the Affordable Care Act (ACA) is to be able to recognize and eliminate disparities by establishing data collection standards (refer to Section 4302, Understanding Health Disparities: Data Collection and Analysis). To accomplish this, the categories R2, R4, and E1 have been enhanced to include more granular levels of race and ethnicity. Although we will continue to allow the general "Asian", "Native Hawaiian or Pacific Islander" values, we encourage the reporting of more detailed information. SPARCS will be performing quality checks to ensure that more detailed data are reported over time.

3. Q: If a patient has previously answered this question using the current data standard, should he/she be re-questioned regarding his/her race/ethnicity using the new expanded data standard?

   A: Yes, the patient should be prompted to answer these questions using the new expanded standard. However, it is not necessary to collect this information at every visit, unless your database does not retain the data (e.g., this information is purged every three months) or if your system does not allow for flagging.

4. Q: Are these race and ethnicity categories nationally recognized?

   A: The Affordable Care Act (ACA), a United States Federal Statue, Section 4302, requires a new minimum data collection standard for race and ethnicity. The codes used to report these standards are the CDC's Race and Ethnicity Code Set, version 1.0. This code set has long been a part of the X12/837 list of codes in the DMG segment. The difference is that now, with the implementation of the ACA, instead of collecting the first portion of the code, we will be collecting the full three sections of the code.
Section V: Tools

Frequently Asked Questions for SPARCS Coordinators

5. Q: The 837 SPARCS specification uses the "*" character as an element separator. Can we use a different character other than the "*"?

   A: The "*" was meant to indicate that additional values not displayed on the list, but included in Appendix RR-Race and Ethnicity Codes (http://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm), should be entered. We understand the confusion this has caused and have replaced the "*" with a "?" in subsequent communications. Regarding the use of the codes, you may find it helpful to use Appendix RR-Race and Ethnicity Codes for these additional values when a patient states that his/her race or ethnicity is not included on the form.

6. Q: Can you provide an example of what the DMG segment should look like if there are multiple races and/or ethnicity values submitted for a patient?

   A: Examples of how to report multiple race and/or ethnicity codes can be found in the Input Data Specifications at http://www.health.ny.gov/statistics/sparcs/sysdoc/elements_837/index.htm

7. Q: The current DMG fields are defined as alpha fields of 2 characters. How would you like us to report races and ethnicities greater than two characters (e.g., R4.01.001)?

   A: The fields for the required expanded race and ethnicity have been increased to hold nine characters (including the "."). Additional information can be found in the http://www.health.ny.gov/statistics/sparcs/sysdoc/elements_837/index.htm

8. Q: Does it matter what order race and ethnicity questions are asked?

   A: Yes. To improve data quality, separate questions should be used to assess race and ethnicity; individuals should be asked to self-report, and questions about ethnicity should be asked first, and then race.
Frequently Asked Questions for SPARCS Coordinators

9. **Q:** Can we collect even more granular data (i.e., more categories of race and/or ethnicity) than required, or capture a race and/or ethnicity not included on the list?

   **A:** Yes. The data standards required by New York State SPARCS represent minimum standards and are not intended to limit the collection of needed data. Facilities desiring more granularity are permitted and encouraged to collect additional data as needed, provided they are valid codes as listed in the CDC Race and Ethnicity Code Set, version 1.0, and pass the SPARCS edits.

10. **Q:** If the patient's specific race or ethnicity is not present in the new expanded data standards, how should this be captured?

    **A:** Facilities should make every attempt to include a patient's reported race and/or ethnicity. Appendix RR-Race and Ethnicity Codes lists other codes not included on the form.

11. **Q:** Are other states expanding the race and ethnicity categories in their hospital datasets?

    **A:** Yes. A number of states have expanded their race and ethnicity categories to collect more detailed and specific race and/or ethnicity categories. In addition, a number of states (including Massachusetts, New Jersey, California, Idaho, Oregon, and Washington) have been working to improve the accuracy and quality of the race/ethnicity data they collect and report as part of their statewide hospital discharge dataset.

12. **Q:** Why do the new race and ethnicity standards matter?

    **A:** According to the Institute of Medicine, standardized data collection is critical to understanding and eliminating racial and ethnic disparities in health care. A critical barrier to eliminating disparities and improving the quality of patient care is the frequent lack of even the most basic data on race and ethnicity of patients within health care organizations. The methods for collecting these data are disparate and, for the most part, incompatible across organizations and institutions in the health care sector.
Frequently Asked Questions for SPARCS Coordinators

13. Q: Should the script for asking race/ethnicity/language questions be in paper or electronic format?

A: This decision is up to each facility. It is easier for staff if the script is on the patient registration screen, but some facilities have indicated that there is not enough room on their screens to accommodate this option. When the script cannot be placed directly on the screen, it is best to have laminated cards, with the script typed in large bold-faced font, at each registration station.

14. Q: Is it okay to record race and ethnicity by observation when it is obvious to the staff and especially if the person has been coming to the facility for years?

A: No. All information on race and ethnicity needs to be captured through self-report of the patient or his/her caregiver.

15. Q: Do the expanded data standards apply only to electronic medical health records?

A: The expanded data standards apply not only to electronic medical health records, but also to paper and claim based medical records. Providers will need to ensure that their medical health records collect, in structured fields, race and ethnicity according to the expanded data standards.
Bibliography


Bibliography


Bibliography
