

Moderator: Hello and welcome to Public Health Live, the third Thursday breakfast broadcast. I'm Benita Zahn and I'll be your moderator today. Before we get started, I'd like to ask that you please fill out your online evaluation at the end of the webcast. Continuing education credits are available after you take our short posttest, and your feedback is helpful in planning future programs. We encourage you to let us know what topics are of interest to you and how we can best serve your needs. As for today's program, we'll be taking your questions throughout the show by phone. The toll free number is 800-452-0662. Or you may send your written questions by e-mail. Please e-mail us at any time throughout the hour at phlive.ny@gmail.com. Today's program is *Collecting the Data, First Steps in Achieving Health Equity*. Our guests are Dr. David Zingmond, an Associate Professor In-Residence at The David Geffen School of Medicine at UCLA and Dr. Marcia J. Wilson, Associate Director of the Department of Health Policy at the School of Public Health and Health Services at George Washington University, and Dennis Whalen, President of the Healthcare Association of New York State. Thank you all so very much for being with us. Now, according to the Center for Disease Controls Office of Minority Health and Health Equity, minority health determines the health of the nation. Why is this so? The United States has become increasingly diverse in the last century. The 2010 U.S. Census documented approximately 36% of the population belongs to a racial or ethnic minority group. This proportion is expected to grow to over 50% within the next 30 years, and in this context, while health indicators such as life expectancy and infant mortality have improved for most Americans, some minorities continue to experience a disproportionate burden of preventable disease, death and disability compared with nonminorities. Therefore, it's clear, that as this segment of the population grows, the future health of the nation will be determined to a large extent by how effectively our society works with communities to eliminate health disparities among those populations. Today's web cast will discuss the important and leading role that our state's hospital systems play in meeting this challenge and in particular, the vital importance of creating a system for collecting standardized racial, ethnic and language patient data, as a critical first step in achieving our goal of health equity. Specifically, our panel of experts will address the rationale for data collection, including the challenges we face related to the design, implementation, and maintenance of a standardized data collection effort. In addition, they'll explain why hospitals, emergency rooms, diagnostic and outpatient surgical centers are logical places for data collection, and provide a road map for how to begin making the changes necessary to succeed. To begin our program, we're going to hear from Dr. Nirav Shah, Commissioner of the New York state Department of Health. He'll elaborate on why the issue of health disparities is so important.

Video- Dr. Nirav Shah: You know, despite all the advances we have made in the health care delivery system, health disparities are highly prevalent, and there's a lot of evidence to support that notion. If you look across almost every measure of well-being in the United States, there are large health disparities, and they're not going away. Health disparities have been defined by the Institute of Medicine as "racial or ethnic differences in the quality of health care that aren't due to access-related factors or clinical needs, preferences or the appropriateness of an intervention. " Research shows that racial and ethnic minorities tend to receive lower quality of health care, even after controlling for factors such as insurance status and income. And this evidence is consistent across a range of illness and health care services. The issue of health disparities is something that requires all of our attention. While we've seen significant improvements in health and longevity over the last century in the United States, these benefits have not been uniformly realized by all Americans. Life expectancy is actually improved by more than four years for Americans over the last 30 years, since 1980. But for black Americans, they still live four to six years fewer than whites. Factors that contribute to those disparities include income, education, environment and economic conditions, specific health behaviors, access to health care and the quality of that health care. You know, on the flip side, certain vulnerable populations actually get the wrong kind of care more often, in terms of amputation, in terms of getting their teeth pulled out rather than getting a root canal. These are things we want to avoid. And ultimately, these differences in health care between minorities and nonminorities are associated with higher mortality. If you look at age-adjusted death rates per 100,000 people for the four

leading causes of death in the United States, they are always much higher among blacks and African-Americans compared to whites. Heart disease, on average, 247 blacks die of heart disease versus 187 whites. For stroke, 60 blacks versus 40 whites. For cancer, 215 blacks versus 177 whites die. These kinds of statistics are borne out everywhere we look, that ultimately this bad care or inappropriate care or overutilization of the wrong kinds of services consistently leads to poor outcomes for our underserved minorities. So what do we do about this problem? We really need a broad approach that brings in all the players. And what we really need to start with is high-quality, reliable data to put boundaries around the problem. So we need data on the race, the ethnicity and the primary language of patients at almost every point of care. And once we improve the data collection, we can allow health care professionals to enhance their ability to interact with patients and provide real-time solutions. As we evaluate their work over time, we will finally start to address the challenges that we really face in every sector of health care today. I think we should start with our hospitals, for three reasons. First, there are many national organizations such as the American Hospital Association, the Association of American Medical Colleges, the American College of Healthcare Executives, and many others who have already started work in this area with their national call to action, to eliminate health care disparities. Second, New Yorkers recognize hospitals as leaders of health care in their communities. And finally, hospitals have an established history of experience with quality improvement and quality assessment. They, better than anyone else, have been doing this kind of work more than the outpatient setting, more than nursing homes, and so are equipped to help advance the goals that we all have. We are also looking to get support from state and federal funds and grants from organization such as the Robert wood Johnson Foundation. And unlike other efforts that have really been top-down, this has also been bottom-up and top-down and has resulted in collaborative efforts. So we're seeing substantial impetus coming from hospitals and hospital associations as well as from patient advocates and advocacy groups. And together we will find the right medium to advance our causes in improving minority health. What we're talking about today is really part of a broader historical effort to address disparities. And it goes all the way back to the civil rights act of 1964. Title VI of the act stipulated that no person in the United States shall on the basis of their race, color or national origin be excluded from participation, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. Now, Title VI didn't specifically mention health care, but subsequent judicial and congressional clarification has assured that it applies to most health care activities in the United States. And so today what this has done has created an environment for all hospitals and health care organizations to collect information on patients' race, ethnicity and spoken preferred language. This has expanded the role of federal programs and medical service mandates that health care agencies must collect this information and report on this information voluntarily and have training and technical assistance to optimize that. There are now standards being developed for data collection, and in 1999, a report of the U. S. Commission on Civil Rights criticized that those resource -- lack of resources and failure to collect and monitor data regarding enforcement related to that Title VI of the civil rights act has been a big problem. So our hope is that as we develop these standards, we will have a unified system of understanding the scope of the problem and then be able to address it. Some might ask if we're making progress. And I feel that we are actually making significant progress, and what's different today than in the past is that we're seeing convergence across all the areas, whether it's regulatory, payment, and other ways that the health care delivery system interacts with itself and with government. So, for example, the joint commission, the state health department, meaningful youth, all these initiatives coming down the pike, all say the same things. We need to collect high-quality data on race, ethnicity and language. And when we get consistent about these definitions, we need to improve the quality for the weakest links in the system. As we improve these quality failures of the health care delivery system, consistently they apply most to racial and ethnic minorities, we will see all boats rise. So I'm confident that as payment reform, the affordable care act, the mandates on meaningful use, additional surveillance measures, things coming from the patient-centered medical home movement, across the spectrum, all of these vectors are pointing in the same direction. And so our hope is

that in the near future we'll see rapid improvements in the health of minorities, and see that four to six-year longevity difference shrink to nothing.

Moderator: Well, Dr. Shah just kicked things off with a detailed look at the existence of health disparities and the health care disparities in this country. Also, the importance of addressing the problem. So, Dennis, I want to start with you and ask you to tell us from your perspective, why are health disparities the recognition of them, an important priority for hospitals?

Dennis Whalen: Well, this has been a significant problem of long-standing. So it's persistent, even as we recognize the importance of recognizing and dealing with disparities. When they are unrecognized and unaddressed, it blocks or interferes with the provision of good care and good outcome from that care. So it's tied directly to how effective hospitals are in providing treatment to individuals. Problems are missed or ignored or dealt with ineffectively. There's increased morbidity and mortality as a result. And there are poor outcomes, meaning poor health care is being provided. So disparities, despite this recognition of their importance, have continued over a number of years, and the landscape is getting a bit more complicated, because it's not as if disparities take place or occur in a vacuum. So while your introduction and Dr. Shah talked about the emergence of racial and ethnic minorities or individuals with disabilities, that's a continually changing dimension for hospitals to deal with, because it's evolving. And you can imagine how difficult it might be for hospitals situated in a community with a large influx of immigrants from other places and how do you sort of keep up and deal with it. So awareness is critical to this, because it's tied directly to how effective a hospital can be in dealing with its patients.

Moderator: So then the natural next question would be, how would data collection efforts improve the situation?

Dennis Whalen: Well, you know, Peter Drucker, the management expert, said "if you can't measure it, you can't improve it." And so, you know, hospitals have been collecting information for a very long time. And the issues have been standardization, consistency, objectivity and how that information is collected. So it's critical to ensure that we address those problems. It's also critical to ensure that hospitals and everyone collecting this information and using it understand how important it is. So at the same time as we press for, you know, resolving those issues of standardization and what elements are we collecting and how, it's important to continue to emphasize disparities as an issue that needs awareness. A better understanding of patients individually helps you better understand the community and the circumstances that patients are in. It helps you develop patient-centered interventions to deal with those problems. And you can then measure your success in reducing or eliminating it. And, you know, along the way you adjust and recalibrate when it looks like the particular interventions you've chosen to put in place are not getting the results you want.

Moderator: What about looking at population-level patterns? Will quality data give us more information in this area?

Dennis Whalen: It will. You know, public health has really been based on looking at the health of a community or a population. Hospitals more traditionally have been focused on dealing with that individual patient and providing the treatment and the cure. These ideas are blending more and more, as the way hospitals are evaluated, measured themselves, how reimbursement is being designed, how new models of care are evolving. You know, more and more now, hospitals are looking out at the community as part of what their responsibility is. You know, you can understand that if a hospital's reimbursement is partially measured on whether there are readmissions of patients into that hospital, you then understand why hospitals now are so concerned about what's the community environment that a patient is going back into. Do they have the necessary supports and connections to care? So it's understanding these health implications beyond just the individual patient. And that's leading to these

emphases that Dr. Shah talked about with population health and the prevention agenda and this shift that's taking place.

Moderator: That whole medical home model and you used the word reimbursement a few times so what's the business case? And that's really what we're starting to talk about here, for devoting time and effort to collecting the higher quality standardized demographic and language data.

Dennis Whalen: Yeah. Well, every health care provider, whether you're a hospital, physician, nurse, a social worker, wants to be effective. And wants to achieve good outcome for their patient or the population that they're responsible for. So, you know, understanding the circumstances of the individual patient and the community and the challenges that are embedded is now an essential ingredient to good care and good outcome. And we are moving as a system from one of volume to value, meaning that, you know, our whole system is now being designed not simply to produce a series of widgets, not to deliver a number of services that drives reimbursement, but to focus instead on outcome. And are we getting the value from health care that we should? And so this means that how effective you are is affecting your reimbursement. It will affect how payers choose whether or not to do business with you. It will affect how patients decide what institutions they're going to use. So the business case, really, is that better outcome from better and more effective care provides the return on investment.

Moderator: Now, one of the things that you mentioned was a willingness to conduct self-analysis in order to accurately understand a problem. We had the opportunity to speak Dr. Steven Safyer, the President and CEO of Montefiore Medical Center about the steps they have taken to collect better data and provide better patient treatment. Let's take a moment to hear what he had to say.

Video-Dr. Steven Sayfer: So I'm Dr. Steven Safyer, President and CEO of Montefiore Medical Center. Racial and ethnic data are critical for outcomes when you're dealing with diverse populations. In fact, they're probably critical when you're dealing with homogeneous populations. You really need to know you're -- the people you're caring for. What the community is about, who they are. I mean, it really is everything from what a population is susceptible to, what a population's experience is, which may change over time, and the different strategies you may use to treat different subpopulations that are all living in a wonderful state like ours, New York. I can't speak for all hospitals, but in general, people do collect race and gender. And Montefiore serves the Bronx and lower Westchester; these areas have 2 million people. And it is a majority/minority community. And we pride ourselves on really doing a good job of collecting important data, and using it. More and more for care management. To keep people well. And a few years ago, we were in a Robert Wood Johnson demonstration project that had to do with the impact of race on heart disease. And when we took a look at our own processes in terms of data collection, we actually saw that we were not doing a very good job so let me tell you what we found. When people come in to get care and they're new to the system, they register. And that's common, it happens, you know. There's a series of questions they ask you. They try to figure out what your insurance is, or if you don't have it, can we get you insurance and a series of questions have to do with your ethnic background, your religious background, and a whole series of other issues that we define. The community you come from. And just on the race issue alone, what we learned was that our people were eyeballing people and deciding what background they came from. But those eyeball impressions that are made upon people are often inaccurate. So we turned it around, and instead of eyeballing people, we have trained people that register individuals. If you're new to the system, just asking a question, you know, about your background. And it even surprised these experts at registering the answers they got, because people really describe themselves differently. And they know who they are. And they know where they came from.

Moderator: Okay. So as we build this, this morning, Dennis provided us with a solid framework for why we're having the conversation, why data collection efforts are so critical to improving the existing health care disparities. And then we heard from Dr. Safyer who gave us a great example of what his medical center is doing, and how it's benefited their practice. So David, you're going to be talking to us today about opportunities for New York to improve racial and ethnic data reporting. Give us a rundown of the topics you want to cover.

David Zingmond: So Benita, I'll be giving some information on background, why disparities matter in health care. How quality and disparities intersect. The -- how to perform race and language data collection. And interventions and the road forward.

Moderator: Okay. So why don't you start by talking to us about what health care should be. You know, in an ideal state, what are the characteristics of a good health care system?

David Zingmond: Well, the Institute of Medicine has a report called "Crossing the Quality Chasm." And they identified several key issues. Safe, effective patient-centered timely, efficient and equitable care. And when we talk about health care disparities, we're talking about gaps in or the inequities in it patient-centered care.

Moderator: Now, we've all heard the word "disparities." But what does it refer to in this context?

David Zingmond: Well, in this context, it refers to the differences in -- that exist between specific health care populations and the delivery of health care that they receive. And disparities in health, specifically, are related to patient social capital, their wealth, their education, their nutrition. And also the health care that they receive.

Moderator: Do we start looking at disparities in the incidence and prevalence of mortality and the burdens of disease, adverse outcomes, things like that as well?

David Zingmond: That's right. So those would be typical measures for health.

Moderator: How is it that different than health care disparities?

David Zingmond: Well, health care disparities refer to differences in the quality of health care that people actually receive. And that are not related to access or clinical needs, preferences or appropriateness. And on the flip side of that, it has to do with the differences in treatment provided to members of different racial or ethnic groups that's justified by their underlying health care conditions. So, for instance, that could include both under or overtreatment.

Moderator: So that if somebody is perhaps of a -- a minority, they may not be getting the aggressive care when it comes to -- we see sometimes with women and mammograms and breast cancer treatment.

David Zingmond: Or overaggressive treatment, because people don't understand what they really want.

Moderator: Now, the two definitions seem closely tied together in a number of ways. Why do we need to break apart of the definitions?

David Zingmond: Well, we need to break them apart, because from the standpoint of health and societal needs, they're both societal needs and medical needs. And these -- we need to be able to focus on these. So even in an ideal world, if we were to eliminate health care disparities, there would still be health differences. And so we in the health care profession need to do our part to reduce disparities.

Moderator: Now, this is not a new area, because there have been -- there has been research done, significant reports have been published documenting the disparities in health care. Would you tell it us a little bit about that?

David Zingmond: Well, since the original reports that were done, there have been a number of reports by the IOM and the Agency for Health Research and Quality that have outlined disparities in health care by race and ethnicity.

Moderator: What are some of the major areas of concern that have been identified through studying the disparities that exist?

David Zingmond: Well, they extend across the full spectrum of health care. And these include both ambulatory care and institutional care, primary care and specialty care, covering just the whole range of health care.

Moderator: Would you talk to us a little bit about some examples of racial and ethnic health care disparities that exist for patients who have health insurance?

David Zingmond: Well, this is actually quite important, because we like to think that health insurance is a great equalizer and improves access to care. And, in fact, even for people with health insurance, there are still health care disparities. And they, again, cover the full spectrum of ambulatory and in-patient care and specialty and primary care. So insurance is not just the answer to reducing disparities.

Moderator: So what are some of the reasons given to the existence of these disparities?

David Zingmond: Well, patient and providers and organizations have all a role to play in this. So from the standpoint of the patients, we would like to think of them as having a patient-centered, equitable access and role in the governance of health care. So we would like them to be a part of health care decision-making. So when they don't have that, they -- so knowing what they're able to do is actually quite key. Providers are the agents for those patients. They provide them both in terms of how to communicate health care information and as well as how to guide the patients through towards specific decisions. And finally, the organizations are critical, because they facilitate the types of health care that are available to patients and providers. So the same doctor and patient in different settings will make different decisions. So, for instance, if I see a patient in my clinic, I may provide them different kinds of care than they might otherwise receive if I saw them in the emergency room or the hospital or county clinic. And so before we go ahead and try to design interventions, we have to better understand the problem that we're dealing with and collect better data.

Moderator: Because you would have a -- 360 of where they are in their life.

David Zingmond: Exactly.

Moderator: But let's talk a little. What would designing -- talk a little bit about an intervention. What would it look like?

David Zingmond: Well, from the standpoint of -- for reducing health care disparities, what we would like to know, is first of all, who our patients are. And then we would decide whether or not there are actually disparities existing for that particular type of care. We would like to be able to focus in and make an intervention, for instance, that would standardize care, regardless of whether a patient has a -- has any kind of background. So, for instance, making sure that they got a flu vaccine. Everybody should be approached in the same way.

Moderator: So there is a sort of blueprint that we're looking at on our screen right now.

David Zingmond: Right.

Moderator: That gives us a sense of that, where you go from detecting and then you go to understanding.

David Zingmond: Right.

Moderator: And then to redirecting.

David Zingmond: Right. So my colleague, Amy Killborn, has come up with a general framework for this, for detecting, understanding and reducing health care disparities. And this is based on the public health model. But in order to make it work, you actually really need good data.

Moderator: As we move along, what would be needed from hospital leaders to follow this kind of framework?

David Zingmond: Well, the first task that we need is high-quality data. And in order to affect change, what we need from health care administrators and hospital leaders is the -- is to be able to discuss whether or not there are disparities within their own institutions. So physicians and health care leaders are committed to doing the right thing. But they've been -- in the past, reluctant to consider that there are gaps in care at their institutions by demographics. So consider if a -- as Dennis had mentioned, if a hospital is trying to reduce readmissions, as mandated by Medicare for reimbursement and a certain group is disproportionately impacted by the -- by this, then shouldn't decision-makers focus in and clinicians focus in and be interested in reducing these disparities. And making this an area for them to -- to make as their focal area.

Moderator: You make the point that it's important that hospital leaders are willing to gather the data, number one, and then examine the evidence. Why is it so important they have an understanding of the data they have collected?

David Zingmond: Well, in order to make decisions, they have to -- they actually have to have the data to make an intervention and to measure the impact of the intervention.

Moderator: Robert Wood Johnson foundation took a look at this, didn't they?

David Zingmond: They funded a set of surveys that looked at attitudes towards and acknowledgment of disparities. And what they found among a set of health care providers, starting off with hospital and health care leaders is that when they asked them about their perceptions, many of the participants did not recognize that there was even a problem. So not in my backyard, is kind of how they put it. They didn't believe that disparities even existed within their own institutions. And if they did, that the disparities were actually beyond their control.

Moderator: Did they also have to acknowledge there may be disparities, and is that a problem, as well?

David Zingmond: Exactly. Well, I think from a marketing standpoint, you wouldn't want to tell your community that there are problems based on who you are rather than how sick you are. So in order to reduce disparities, there actually has to be recognition and admission that there is actually inequitable care, to start off with.

Moderator: Do you think, or does research show that different types of practitioners are likely to have different levels of awareness, regarding the disparities that exist in their own practices?

David Zingmond: Sure. So the Robert Wood Johnson Foundation funded and created and funded a set of surveys. And health care is like a pyramid. So primary care providers are closest to their -- closest to their patients. And they recognize that there are disparities. And as you go up the chain, up to surgeons, they're least likely to recognize there are health care disparities. They're the farthest away from actually -- actually seeing patients in the general population.

Moderator: So taking the next step, in that pyramid that you just talked about, primary care physicians would be the closest to the general population. Would that mean then that the hospital leaders are at the top, and subsequently, furthest removed?

David Zingmond: That's right. So in other work that was funded by the California endowment and working with the national quality forum, they found that hospital administrators were the least likely in the hospital to know about race, ethnicity and language data collection. And this is pretty important, because in order to make change, they actually have to know what the data that they're collecting. And since they're already collecting the data, they can actually identify and reduce disparities.

Moderator: Now, the disparities that exist, they have been well-documented. True?

David Zingmond: That's right. So in study after study, what we have seen is that there are racial and ethnic disparities in health care. So you can see that there are many different studies. And what our health care leadership needs to know, is that we're already tasked to collect these data, and so that allows us to identify and reduce disparities.

Moderator: So it would seem to me, if we already know the disparities exist, the time is at hand for the hospital leaders to start expanding the conversations, to talk about how to improve the quality of care to all patients.

David Zingmond: That's right. So race and ethnicity should be part of the general framework of quality initiative to improve quality at hospitals and other health care centers.

Moderator: But as you point out, you still have to recognize.

David Zingmond: Exactly.

Moderator: The research may be there. You've got to recognize it. And recognize that it exists in general. Our focus today, David, is on efforts in New York State. But when we look at the broader picture of hospitals across the country, what do the data collection efforts look like?

David Zingmond: Nationally, only 82% of hospitals are actually collecting race and ethnicity data. That includes everybody. Here in New York State and in California where I'm based, it's actually mandated and required. But nevertheless, there's a funnel effect between the data collection and data accuracy and subsequently the trust in that data and how those data are used for quality improvement purposes. So without standardized reliable data collection, the data can't be used for quality improvement. So sort of the don't ask, don't tell doesn't work for valid and reliable collection of data in this area.

Moderator: What do you find are some of the barriers that get in the way of collecting that data?

David Zingmond: The biggest barrier is actually staff reluctance to collect the data. So their hesitancy to actually address -- actually ask patients about this. The other issues that have been identified are much less important in the grand scheme of things, simply because data collection is mandated. And so legal patient concerns and legal concerns actually need to be addressed, and clarified. But they're actually not barriers for the data collection itself.

Moderator: Do you think that staffers know that it's mandated and so those other concerns shouldn't exist?

David Zingmond: That's what we're here to talk about today. And the state of New York is doing a great job in facilitating and providing resources to make that happen.

Moderator: And you also argue strongly for standardized measures, such as we've been talking about.

David Zingmond: That's right. That's part of the mandate. But the mandate isn't enough. So part of that is training and guidance and the state is doing a good job with that.

Moderator: So talk to us a little about the importance of standardization.

David Zingmond: So standardized measures allow for comparison trending across institutions and regions. It allows us to actually pool data. So the state of New York SPARCS collects data for hospitals and surgery centers and emergency rooms. And allows us to actually make these sorts of comparisons, in fact not just in New York, but across the country.

Moderator: And how should this data be measured, how should it be obtained?

David Zingmond: Well, you know, one of the issues that we note is that there are a lot of objective data that we collect in health care. So patients' names and their ages, their birth dates are pretty straight forward. But race and ethnicity, in fact, language, are self-report. And so this is huge, because this is one of those things that you really actually have to ask the patient. What it is that their race, ethnicity and language are. So if a patient is unable to answer that question or they're a minor, if they're a baby, you need someone to answer for them. A care-giver or parent. And current law states that hospitals must collect race and ethnicity data that are actually consistent with OMB, Office of Management and Budget Standards. For race and ethnicity. The state of New York already does that.

Moderator: And the existing -- the current OMB standards for race and ethnicity would be what?

David Zingmond: They reflect two measures. Hispanic, Latino ethnicity and five category race measure which reflects White, Black, Native American, Asian and Pacific Islander. And progress has been made into incorporating into standard government data collections. But there is a lot of heterogeneity across local state and federal governments. And so, you know, the -- for quality improvement, the basic OMB categories are not really sufficient to illuminate disparities and target quality improvement efforts efficiently. So I'll give you an example. So if you're Hispanic, your health and health care issues may be different if you're from the Caribbean versus if you're from the Mexican -- the mountains of Mexico or Central America or South America.

Moderator: So you really have to get in a little further.

David Zingmond: For sure. And, of course, if you want to serve your community, you'll want to know who they are. So in California, most people who are Latino are Mexican in origin. Here in New York, it's mostly Puerto Rico and Cuban and Dominican. It's very different.

Moderator: David, if the OMB standards are insufficient, what's the recommended course of action?

David Zingmond: Well, the Institute of Medicine convened an expert panel, and what they did is they reviewed all of this information. And they hid it -- really hit it on the head. So what they said is that hospitals -- health care organizations, have to have data, granular data, on information, on race, ethnicity and language so they could serve and -- identify and serve disparities and provide high-quality of care to their patients. So what that means is that the -- the granular race, ethnicity and language data have to reflect the specific needs of the community. And it makes sense from an equity standpoint, because -- and it makes sense from a business stand point, because you really have to know the patients that you're serving in your community.

Moderator: So as you're crafting your data questions, you've got to be -- know your community, and delve in a little further than just stick with those five that OMB put out.

David Zingmond: That's right. Right. That's right.

Moderator: You've really got to put your hands around it.

David Zingmond: So if you live, like -- right. If you live in little Moscow, you want people who can speak Russian.

Moderator: How does the implementation of the Affordable Care Act affect the recommendations of the Institute of Medicine's recommendations?

David Zingmond: Well, everybody's -- everybody's familiar with the insurance exchanges and everything that's been going on currently. But the affordable care act has actually moved the bar in two ways. One is it's directed -- Department of Health and Human Services and the federal bureaucracy to collect to establish data collection standards that move beyond the basic OMB standards. And then secondly, it's -- furthermore, it's instructed them to disseminate these standards to federally funded national data collections and to use these standards in reporting out the results of these studies. So, you know where there are national data collections in place, we're actually implementing these standards.

Moderator: I was going to ask, what about for the areas where there are already these national data collections in place?

David Zingmond: Right. So we -- we're very fortunate here in the United States to have really good national surveys. So the National Health Interview Survey is implementing this, and then -- that's run by the Centers for Disease Control and other studies. So from the Census Bureau, the current population survey and the American Community Survey, which are well-used by demographers and others for establishing need and for planning purposes are also implementing these, as well.

Moderator: That's kind of macular. Let's look micro and what about reporting here in New York State.

David Zingmond: Well, here in New York State, the state is mandated a number of changes that embrace these standards. So what they have done is they have embraced the CDC categories, which are for more granular race and ethnicity measures and include patients' heritage, countries of origin. And they are allowing for the other major OMB recommendation, which is allowing for more than one response. So it recognizes our multiethnic heritage of many people, and so it allows people to self-identify up to ten race and ethnicity reflecting where their families come from. And it allows individuals to express mixed heritage.

Moderator: So what's the road going forward from here look like?

David Zingmond: Well, what I want to describe at this point is how race and language, ethnicity and language data are collected, and really how the hospitals are going to be able to make interventions along the way. And how the state of New York is going to be monitoring things.

Moderator: So if you could help explain the process of how the information then gets from the patient to SPARCS.

David Zingmond: So currently, the way this works is that the point of -- the point of entry for a patient is their registration with the clerk. And that's either clerk or registrar. And they actually collect all the demographic information. That information goes into the hospital registration system, and makes its way into the medical record. For the purposes of abstract and clinical information, health information technicians actually take that

step one further -- that one step further, and enter that in. And that data gets combined into a record abstract that gets reported on to SPARCS.

Moderator: Okay, I know we collect the information and you might say that's the first step but what would you say is the first step in all this?

David Zingmond: Well, the first step in actual data improvement is to -- what we have been talking about is to standardize race and ethnicity categories. And fortunately, here in New York State, it's already been mandated and there's a lot of guidance going forward, both for standardization materials and training.

Moderator: Once you have the standardization, what's the next step?

David Zingmond: Well, it's to optimize self-report of race and ethnicity. And as I mentioned, this includes the development and use of materials for training purposes, actually performing training, dissemination of materials, and other improvements. And those other improvements actually really move into the 21st century, so those include things like allowing patients to self-enter data, either in the hospital or via the internet via a secure portal to health information system. So New York State is embracing I think many of these -- this approach and is providing guidance in order to make this happen.

Moderator: Does that help with the reluctance of the front line staff that has, you know, served as a bit of a barrier as you pointed out earlier?

David Zingmond: Well, I think Marcia is going to talk a little bit about the training, but this has been the cumulative experience that training the staff can make a huge difference in improving the data collection.

Moderator: And then as you pointed out to the second step, how do we use this to improve feedback to hospitals?

David Zingmond: Well, the biggest challenge with insuring data quality is actually being able to audit the results themselves. And so it's very hard to get self-identified information for patients for self-report, race ethnicity. So some of the processes that we want to put in place are to identify and use standards for data audits and to improve the current data audits that are in place. This is pretty technical, but the other is to identify both as potential gold standards. So the hospitals themselves can do this kind of audit, both by sampling their patients, by asking the questions, again, when the patients come back to the hospital either readmission or in their outpatient clinics. From the standpoint of the state, the state collects a lot of self-report information, and they can leverage that information and use it to compare to the information that's already reporting by the hospitals on these same individuals.

Moderator: Start looking back and forth at it. What's the next step?

David Zingmond: Well, and the results of the information can be fed back to the state -- to the hospitals to let them know how well they're doing. That's important, because, again, as we mentioned before, that administrators tend not to know what the data that they're collecting or even less likely to know the quality of the data that they're reporting. And then finally, you know, essentially at this point, we're pretty much done. But there's always -- there's always gaps in information and incomplete data. And so supplemental sources of information as I mentioned before could be leveraged and used for improving the data quality that are reported and collected by the state. So the state itself can actually use data that it already has.

Moderator: A little redundancy is not so bad.

David Zingmond: Not so bad in this case, that's right.

Moderator: Yeah. And what are some examples of supplemental sources of self-reported data?

David Zingmond: Well, you know, you would be surprised, but there's quite a bit. So the state, as I mentioned before, collects data going through to the hospitals. But then the cancer -- there's cancer registrar collects data. Most cancers are identified in the hospital, so there's a lot of duplication among those patients. Patients who die, they -- they have death certificates submitted. Births also are reported out to the Department of Public Health and in fact, for moms, this is really important because they are the ones who are filling out the birth certificates, and we can compare what's on the birth certificate for what the mom reports for her race, ethnicity to what the hospitals report at the time of birth in the deliveries. So we have a lot of information. In fact, there's other information that's not health care information that we could even leverage, as well. So there's a lot that could be done that would help for data accuracy.

Moderator: What's the final step in all of this?

David Zingmond: Well, you know, there's -- once we have self-reported information, there's actually also indirect methods that we can use for improvement. This is very technical, but there's statistical methods for projecting out race and ethnicity based on patient's name and granular coded data. This is an approach that even Medicare has used, as well as private insurers who in the past haven't collected information on race and ethnicity. But this is actually a -- sort of a last step. And it doesn't replace the actual collection of data. So the current efforts in New York state are the gold standard, and I believe that what they're doing is consistent with towards achieving actually good results.

Moderator: Where do you see us going from here?

David Zingmond: Well, the road forward is actually pretty clear. And we have a lot of -- the state of New York is providing a lot of guidance in the implementation and there is substantial experience and information on making the implementation a success. So nationally there are good materials for training, and both through the tool kit and what work we have done in California. And so there is a lot of information that can be used and employed here in New York State. So I think the information that's collected is going to be really good quality and can be leveraged for making health care better and disparities decrease here in the empire state.

Moderator: David, thank you. Wonderful information for us to contemplate, look at today. Marcia, you're up. Your turn. You're going to be talking about efforts made by the Robert Wood Johnson foundation. Correct?

Marcia Wilson: Yes, that's correct, Benita. I'm going to highlight some work that we have been doing in disparities, but one program is aligning forces for quality. We call it AF4Q and the Robert Wood Johnson foundation signature effort to improve the overall quality of health care, reduce racial and ethnic disparities and provide models for national reform in 16 targeted communities across the nation.

Moderator: Okay. Let's take a more in depth look at that.

Marcia Wilson: Okay. Well, health care quality is a national problem. Health care is delivered locally. And then that means it needs to be fixed locally. And in each of these 16 communities, there is an organization that brings together people who give care, physicians and hospitals. Those who pay for care, employers and health plans. And those that get care, patients or consumers. And all these stakeholders work together to improve the quality of health care in their community. Now, the AF4Q communities are quite diverse. Some are actually entire states, like Maine or Minnesota. Some are single counties like Humboldt county in northern California. And others lie

somewhere in between, like here in western New York, where there are eight counties that come oh together as a community that includes the city of Buffalo. And while they're all working on overall health care quality, I really want to talk a little bit more about their disparities work today.

Moderator: When you talk about these communities and how they can be so diverse or not, are you talking only about the disparities in hospitals?

Marcia Wilson: No, actually, they're looking at disparities in several settings, including hospitals and in the ambulatory setting, as well. We had a lot of efforts that did focus on hospitals. At the national program office, we have led a number of collaboratives that included hospitals across all 16 of the communities, and each of those hospitals was expected to standardize the way they collect race and ethnicity data. Now some of the efforts in hospitals are local, like the greater Cincinnati health council, which is working on disparities in their hospitals in southern Ohio, and across into northern Kentucky. Now, over the years, the national program office has worked with over 200 hospitals in the standardized collection of race and ethnicity data, but the beginning, the really foundation was a program called expecting success, also funded by the Robert Wood Johnson Foundation, and it was a ten-hospital collaborative to address disparities in cardiac care, and it was so good to hear from Dr. Safyer today, because Montefiore medical center was one of those hospitals.

Moderator: Who needed -- who needs to get involved to address these disparities in a significant way?

Marcia Wilson: Senior leadership is key. They have to be engaged. And that's because they can do three things. First of all, they determine organizational priorities. The CEO can say, disparities is going to be a priority in our organization. Once they declare that it's a priority, they can allocate the necessary resources. For example, the time and money to appropriately train the staff. The registration staff. And the third thing they can do, they can remove barriers. So now that new York hospitals are going to have to be collecting more granular categories, they are probably going to have to make some changes to their information technology, their IT systems, to capture this data. The CEO can say to the IT department, this is a priority, this change needs to go to the top of the to do list. The other thing that needs to happen is, we've got to get provider-level data. Say, for example, the State of New York says we have disparities, and they show state-level data. Well, who owns that problem? As David said, you've got to be able to push that data down to the level of the provider. Because if not, you run into a problem we call "assumed equity." And that's when hospital leaders or health care leaders think the disparities exist, but not in their organization. And because they believe they treat all their patients the same, they assume the care is equitable. Once you have provider-level data, you can have the difficult discussions about potential disparities, and should you find a disparity, it can move you to action.

Moderator: And where action has been taken, Marcia? Were there specific steps followed in the process?

Marcia Wilson: Absolutely. We use a three-step framework from the Institute of Medicine and it mirrors exactly the framework that David mentioned before by Killborn. You collect the data, you stratify and analyze the data, and should you find a disparity, then you can act on that difference.

Moderator: As with any change.

Marcia Wilson: Uh-huh.

Moderator: I'm sure there were challenges.

Marcia Wilson: Yes.

Moderator: People don't like change.

Marcia Wilson: Very difficult.

Moderator: We want to talk about some of the challenges you faced.

Marcia Wilson: Sure. Across this three-step framework, we found eight challenges. In the first step, the standardized data collection, the number-one challenge was staff anxiety. Staff are uncomfortable asking these questions. The second challenge was, which standardized categories should we use? Now, the hospitals in New York are fortunate. They're not going to have this problem, because they have been given the set of categories to collect. And then the final challenge is making the necessary change to the IT system to collect the new demographics, and, again, this is where you need to have that CEO leadership who can remove that barrier.

Moderator: Were there challenges regarding the stratification and the analysis of the data?

Marcia Wilson: Absolutely. And one of them has to do with data collection versus data analysis versus data reporting. And let me explain what I mean by that. In New York, the hospitals are now being asked to collect more granular categories. Some hospitals may elect to even collect more granular than what's required. So they collect all these granular categories, then they collapse some of them and report those categories to the State of New York. And then the State of New York in doing analysis may need to collapse categories a little further. And this is the issue with granular -- collecting more granular data. We're big advocates of collecting more granular data, because we think it's more patient-centered. That patient has more choices. Plus it gives the organization much more accurate information about its patients. But when you have granular sub categories, you can get into some pretty small numbers in some of those categories. So when you go to do the analysis and compare different groups, sometimes you have to roll up to broader categories. So that's the challenge there.

David Zingmond: I would just say that granular categories may be a -- I mean, for the audience, maybe a weird thing to say. And what -- what we're really trying to say is, you know, know your patients and where they're from. And so what's good for one hospital organization may be a very specific subgroup of people from a specific part of the world and so it's good for them to know who they are.

Moderator: We started talking about this and you started using the term granular, all I could think of is sand. Sand may look like the same thing, until you start looking at each individual pebble. And it can be quite different. And the makeup of that. And that's what you're talking about. Not just looking at the broad brush. But really understanding, as Marcia said, the patient that you are dealing with.

David Zingmond: Right. The State of New York is creating guidance and the categories that they're providing are general categories and even very -- and pretty specific sub categories. But what's good for a specific provider may not exactly be in what they say you have to collect. So you can go beyond what they're saying.

Moderator: And then I have to wonder, even then, Marcia, were there challenges regarding -- I'm sorry, once you have identified the disparity, what were the challenges then?

Marcia Wilson: Right. Well, not surprisingly, once you find a disparity, what surprises a lot of people, Benita, the data give you a lot more questions than they do answers. Once you find a disparity, that's when the real work begins, digging through the data and talking to your patients to find out why those differences exist. Almost doing a root cause analysis. And then figuring out the intervention that's going to reduce that disparity. Now, David talked about the big body of evidence we have documenting disparities. Unfortunately, the body of evidence on the interventions to reduce disparities is much smaller. There is some good work going on. One program in

particular, Finding Answers, also funded by the Robert Wood Johnson Foundation, is actually looking at which interventions can reduce a disparity. But let's just say, that's a work in progress. And then the last challenge is one that Dennis mentioned earlier. In health care organizations, they can only do so much to reduce disparities if they stay within their four walls. And at some point, they've got to reach out to the community. They've got to develop partnerships with community organizations, because that patient's health moves into the community. And I think under the Affordable Care Act, for example, the Community Health Needs Assessments the hospitals are going to do, is going to help them build and strengthen those relationships with the community. So that's a great first step.

Moderator: I have a feeling we're all going to suspect the answer to this. I'm going to ask you the question anyway. Of all the challenges, which would you say was the greatest?

Marcia Wilson: Number one, staff anxiety. It's just a difficult set of questions to ask. Now, the solution to that is you've got to take the time to train your staff properly, even if it takes you months to get through all the staff training. Now, the good news is, there is a great tool kit out there, and David mentioned it earlier, it's by the Health Research and Educational Trust. HRET is the research arm of the hospital organization, and a wealth of resources that hospitals can use. Another thing we recommend is tell your staff why -- the reasons for collecting the data. Let them know this is important. It's not just one more thing they have to do. Secondly, if you learn something about your patients, tell your staff. Because then they understand why it's so important to collect the data. And finally, monitor staff. Don't just train them and walk away, make it part of their annual review, where you monitor and make sure they're following the policy of actually asking the question.

Moderator: Marcia, is there evidence supporting the idea we're getting closer to closing the gap and eliminating certain disparities?

Marcia Wilson: There has been some progress in some hospitals. And we believe that some of the keys are not just looking at performance measures in the aggregate for all patients. But having the ability to stratify or break down those performance measures by race and ethnicity and compare different populations. One of our hospitals, in expecting success, learned they had a disparity between Hispanic and non-Hispanic heart failure patients receiving discharge instructions. They had no idea that there was such a difference. They were able to close that gap, eliminate the disparity, because they could see where there was a problem, figure out what was causing it, and then make sure that all their patients were receiving the same quality of care.

Moderator: Do you have examples for here in New York State?

Marcia Wilson: Actually, we have a great example here in New York State. It's in western New York. It's called the p² collaborative, and they are working with ten safety net clinics. These clinics serve very diverse patient populations, high number of Medicaid patients. And what they have done is, they have drilled down to three clinics, and in those clinics, they're improving the quality of race and ethnicity data that they're actually collecting to make sure that they don't have disparities. And in the meantime, they're also trying to develop what we call a culture of equity in those clinics. And this means that disparities isn't something you do in addition to regular quality improvement. Disparities has to fall under the quality improvement umbrella. And when you have got leaders who recognize that -- providers who recognize that disparities represent a failure in quality, then you have taken an important first step towards moving towards a culture of equity.

Moderator: Which brings me to ask, once the hospitals have the data, what can they do with it?

Marcia Wilson: Anything they want. And that's the great part about this. No matter the reason for collecting race and ethnicity data, once you have data on your patients that you can trust, you can look at anything, and any

group -- any different groups of patients. So, for example, one hospital looked at 30-day readmission rates across four different conditions. And then they broke it down by patient race, ethnicity and preferred language. And this hospital saw some interesting differences between groups of patients, and they learned a lot about the readmission patterns in their hospital. This data gave them a whole new set of questions to look at in terms of quality of care, and that's powerful information.

Moderator: Once staff, hospital administration recognizes and they don't say not in my backyard, they say, okay, maybe we do have the problem and we're going to mine and get this data. Does the hospital then have to say, okay, but now I've got to put on a whole another staff in order to best evaluate this data so we can figure out what to do with it? Is the staff already in place to do this?

Marcia Wilson: That depends on the institution. If they're already looking at disparities, they may have staff whose job is to do the analysis. But that's -- that goes back to what I said about senior leadership buying in. They then need to allocate the resources to make this happen. Besides training your front line staff, it can be allocating the full-time equivalents or employees to do the analysis, and then to actually figure out what the problem is, which, as I said before, involves digging through the data, hold focus groups with your patients and ask them what the problems are in them not getting this care. So they -- there are -- resources that have to be allocated once the senior leadership make this commitment.

Moderator: And then I want to go back to when you talked about, and you've all touched on staff involvement and staff pushback, in that once you bring the staff in, this starts to really -- you get the information, it starts to flow. Does the staff then feel empowered to explain to the patient why they're asking these questions? Because we have a culture where being asked these questions sometimes becomes off-putting.

Marcia Wilson: Yes. The important thing is that should be a part of staff training and the HRET tool kit has suggested language. There is research that suggests what language might resonate with the patients. But more importantly, each hospital should take these training materials, take these scripts, and make it work for their organization so for example, it may be part of this admission. So when registration staff talk to patients, they should be talking in the language of their hospital or their clinic where they work. So you could -- you take the tools, you make the scripts match what your mission is. And what staff are comfortable with. And that becomes part of their training in asking the question.

Moderator: And then I want to bring Dennis back into the conversation here. Because this really speaks to what you said in the beginning in terms of the business model and how we have shifted and patient satisfaction is so key.

Dennis Whalen: Yeah. I mean, you know, we're now in the age of technology. People are used to using Amazon and Yelp to make decisions. And more and more information is available to individuals through that mechanism that speak to the quality. We've got measures of patient satisfaction being used to measure and evaluate effectiveness of institutions. So all of these things blend together. Now, I don't minimize the challenge for institutions to do this. Because it's not only about training your staff, there needs to be some emphasis in the community about this. Because when individuals are asked these questions, they themselves have some resistance to the idea of providing this information. So it's a complex -- it sounds simple and straightforward. But it has a lot of complexities. And, you know, resource allocation is always a challenge. But I think more and more the fact that we're doing big data analysis that we're moving more to outcome-based, that patient satisfaction is part of the equation, that this becomes more possible as a legitimate business case for hospitals to pursue.

Moderator: Before we move on, I know we've got some questions that you've all sent in to us. Marcia, I wonder if you would summarize some of the key points here, the case for addressing disparities, why it's so essential.

Marcia Wilson: There's a number of reasons why organizations are moving towards addressing disparities. The first reason has been around for a long time and that is fulfilling your mission. If you see a diverse patient population, then addressing disparities should be woven into the fabric of what your organization does. But there's some other external factors influencing hospitals. And I think Dr. Shah used the word "convergence" during his remarks. And this is really exactly what's happening. It might be because you need to meet a mandate. New York State now has an enhanced mandate. Joint Commission has changed their standards on race ethnicity and language data collection. We have meaningful use that came out of the American Recovery and Reinvestment Act of 2009. And then also in improving quality, and we heard Dr. Safyer address this earlier. If you collect data where you accurately know your patients, that allows you to improve quality by doing the comparisons, identifying the gaps. And without that information, improving quality, you could only get so far when you look at aggregate data. And then finally, as Dennis said, the reimbursement methods are changing, Medicare is changing how they pay for readmissions. Accountable care organizations are being asked to be held accountable for the health of a patient population. And as public and private sector move towards paying for quality, paying for value, every hospital is going to have to have this kind of data in order to respond to that.

Moderator: We're going to move to your questions. So this comes to us from Maryland. For you, Marcia. How can hospital-collected data on health disparities be used to represent the community? Since the clients that are served by the hospital may be from only certain areas of a community?

Marcia Wilson: Well, I think that's a great question. I think it becomes increasingly more important as we move, as we have all moved to population health. One of the advantages is -- in New York is being able to access data across providers. A single provider can look at his or her data within their organization. And certainly, as we said today, we expect them to act on it. But in order to look at the population across the community, you've got to be able to combine data sources. That's one reason that standardized categories are so key. If you don't have standardized categories, can you imagine in a state where the categories aren't mandated everybody collects different categories. So New York is really ahead of the game, and David talked about this with different data sources. The categories are standardized. Data can be combined across provider, and then that becomes much more powerful in looking at the population in a community.

Moderator: And you've all used that word about standardized. And that's so important, because otherwise you're collecting apples and oranges and grapefruits and you don't really know ultimately what you've got. And I want to say thank you at the outset for everybody who did send in or call in a question for us. David, this is for you. Do you think that the public should be better educated about the need to collect race and ethnicity data, and how it's used? This question also coming from Maryland. Many immigrants, that the concept of race/ethnicity is not common.

David Zingmond: That's actually quite true. And, in fact, when folks have their first encounter with the health care system and other institutions and they're asked about race and ethnicity, they have no idea what they're talking about. So in some places, as I've been told by some of my colleagues, where in the Caribbean they are -- they don't talk about that they might be -- would be considered African-American. They go by their shade of color. Instead of calling themselves a specific thing. So we do have to educate the -- the community in general about race and ethnicity, and language collection. We ask those questions on the Census and the American Community Survey. It's not something that's just out there that isn't being collected. But we also have to alert people to know what we're using this information for. And so this has to do with -- we're using this information not to identify

people for, like, what their genetics are or anything like that. We're trying to understand what their preferences are, their cultural identification, where they're from, so that we can better serve their needs. And better address what might be happening to them, both when we see them in the health care setting and when they're not in the health care setting. Because frankly, much of what -- much what happens with a person's health doesn't happen when they see their doctor.

Moderator: I'm smiling, because I'm seeing a very large group of other being checked

David Zingmond: Well, I should say, in the California -- so if you asked the question to someone who is Latino what their race is, 95% of them say "other. " And that's because they're mestizo, they're mixed race. They're indigenous people. They have indigenous background. They have European background. They have Asian background, a lot of Chinese immigrants built railroads in Mexico too.

Marcia Wilson: I wanted to go back to a point that Dennis made about the community being involved. And I think it speaks, Benita, to the question that just came in. In a couple of our AF4Q communities, they have actually had public campaigns to make everyone aware that when you go to see your doctor, when you go to the hospital, you're going to be asked these questions. So what they're trying to do from the community side is make this the norm. Make this the expectation. So no matter where you go, Dennis, you know you'll be asked these questions. And I think that's a great complement to what the hospitals are now being asked to do. Because I was -- we were in Detroit, we were doing some training, and a woman came up to me, and she said, I went to my doctor the other day, and they didn't ask me about my race and ethnicity and they're supposed to and I asked them -- so this is a changing mind shift, a changing culture, if you will. So hopefully, if -- through these companion community campaigns, there can be an increased awareness among everyone about why this is so important.

Moderator: Dennis?

Dennis Whalen: You know, I think both of these questions speak to the importance of something that Marcia said about combining data sets. So there are a number of sets of providers and organizations that are out there looking at these community questions. And they all have a different perspective. But by bringing those together, we get a much more enriched view of what's going on. And, you know, the Department of Health here in New York, for several years now, has been encouraging and providing incentives for hospitals to work with their county health departments on doing community health assessment. So you have the more traditional role of a county health department in doing public health assessments, you know, relying on different methods of collecting information, CDC does behavioral health surveys. So lots of sources of information can come together. And then be enriched by the experience of providers who are interacting with specific patients. So it really is this idea of bringing together a number of sources.

Moderator: I'm also hearing an underlying issue here of health literacy, and language in general with diverse populations, you will have issues over language. You may even have a child being the interpreter. Not a good situation for the parent and having to get this ethnicity issue on the table in a language that is -- I want to use the word understandable, but one that makes sense in someone's native tongue to know really what you're asking.

David Zingmond: Right. Well the question about language has to do with what's the -- what is the language that you're most comfortable with discussing medical issues. And so that may not be the same thing as what you speak at home. I just would like to add that we're talking about this in the context of a rollout from New York State and for alerting hospitals and helping them to implement these changes. But, you know, front line staff, there's a lot of turnover. And so my expectation is that this is going to be an ongoing training process, and so hospitals really have to be invested, not just in this initial setup, but they need to be prepared to train and retrain their clerks to do this

and registrars to do this so that the data quality stay good over time. You know, three months from now, after the initial wave of people understand this, then the next group is going to have to go through the same process.

Moderator: Which, Dennis, raises the next question we were sent. How will HANYS support hospitals in making these changes?

Dennis Whalen: We have been working closely with the Department of Health and Dr. Shah in this rollout, both in terms of data collection and in terms of his larger Prevention Agenda and population health agendas. And Marcia mentioned resources that the American Hospital Association and HRET have put together, and we are, of course, a close partner with them. So we have been sponsoring a series of educational programs through our organization, and working with our membership along these same lines to reinforce and expand upon the effort we're talking about today.

Moderator: Marcia, in your work with hospitals, were there any unexpected partners or community groups that helped support implementation and hospitals?

Marcia Wilson: That's an excellent question. I would say that for the most part, where we saw the stronger community relationships were in the outpatient setting, some of which were part of health systems. So it wasn't as much the hospitals themselves, but as those patients transition to the outpatient setting, I think there were more community partners. Now, I -- I think that has shifted. I think since we have been working in this field for about seven years, we definitely have seen a real shift where hospitals now are more willing to engage more -- with community partners. But I think historically, it's been a little more prevalent in the ambulatory setting.

David Zingmond: You know, hospitals are independent entities, even when they're hospital chains. So I would expect that -- because of the way their leadership in a particular hospital may be more successful in implementing this type of system, within their own facility, as opposed to over a whole system. Although I would say that the system heads then would be the ones who would need to make the implementation a success across their entire system.

Moderator: That was going to be a question that I was going to jump in with. Once you get this information collected and a system going in the hospital and you're utilizing it in the hospital, that's great. But it's great insofar as the hospital. You still have to get it out into the community. And how do you -- how do you make that happen in a time -- does it mean partnering, Dennis, with your county health departments?

Dennis Whalen: Well, you know, partnership with hospitals is sort of an increasingly common characteristic these days, because of some of the ideas we have talked about as there's now an increased focus on population health, on health in the community. And, you know, hospitals were designed to sort of treat the immediate urgent situation. And it really has been for many years focused on the patient appearing at the door in an ambulance, and getting that urgent care and treatment and being discharged. And then that's sort of been the limitation of the responsibility. So, you know, if you're going to get paid, for example, under one of these reimbursement models, where you're capitated for the care of a population, then your incentives are all different. It's not just about that. It's about preventing occurrences of people coming into the hospital in the first place, preventing readmission to the hospital, ensuring you have the best outcome to ensure that that happens. That they have connections in the community to provide support and other care. And so increasingly, it is about partnerships. And some models in New York, for example, health homes, are designed specifically for this purpose of bringing different types of providers together. And so I think it's an increasingly common event now for hospitals to be thinking about and acting in terms of partnerships with community members.

Moderator: I think I'm also hearing that there is room, and I think Marcia, you touched on it, for innovative ways to get this information out there and how to best share it. But New York being established for at least the collection at this point. I love this question. And it's from the Office of Medicaid Inspector General. Doesn't say which state so we don't know. Okay. Would data collection see less disparity if entered into systems by medical staff or thus trained? Example, first or second-year medical students.

David Zingmond: I would just say, it's all -- again, it's the same thing as the staff. They have to ask the question. And, in fact, in current medical training, our trainees are focused less on the social history and asking about the patient. They're still drilling down on the clinical conditions. And frankly, as a primary care provider and a professor, my statement is you need to know who your patients are. And where they're coming from. Because your treatments are going to be totally unsuccessful once they leave your office if you don't know who they are. So they would have to go through the same training.

Marcia Wilson: And I think that's -- you make a great point, David. Because so often you have the registration staff who are well-trained. The patient self-reports their race and ethnicity and then a clinician who may dictate a history and physical and looks at the patient and decides what that race and ethnicity are. So we had one health system where the physicians agreed they would not look at the patient and decide race and ethnicity. They would actually go back and use the demographics that had been collected at registration. So that was great. It prevented that disconnect from different pieces of information.

Moderator: I'm going to use the analogy to the television show "The Voice." Don't look at them, just ask them.

David Zingmond: And I would add to that, that there's -- it doesn't matter who asks the question. You actually have to ask the question. So, for instance, if you don't ask a patient about what language they prefer, you may get -- the clinician will quickly find out the patient doesn't speak English well.

Moderator: You just get a lot of this.

David Zingmond: You get a lot of that. But if you look at the registration form, you know, they may just be interested in where the -- the patient's name, birth date, where they live, and what insurance they have.

Moderator: Right. Question came in or -- for clarification, David. Health care providers need to know their patients so they can provide proper care for them. The race and ethnicity may affect the way they were treated or previously treated. Can you comment on the fact that homogeneous race is declining-- wouldn't their place of origin be more important to decipher the previous care they had?

David Zingmond: Well, you know, there's -- again, the collection of race and ethnicity is a -- is quite a challenge in a country that has -- that's a melting pot. But how we self-identify with regard to race and ethnicity reflect our preferences and our -- and our behaviors. So -- and that -- to that -- that speaks to many things. So, you know, there may be a generation ago, if you were Hispanic, you might have just answered that you were White. Whereas now, if you're younger, you might actually be responding that you're Hispanic. And that will reflect what you eat, where you go, and so on. So it's -- and you can answer in more than one way. And since it's self-reported, in fact, you could report more than one way differently each time you encounter the health care system over your lifetime. And so --

Moderator: So then how do we know how to best treat?

David Zingmond: Well, in this case, it's in terms of the encounter that you see them. It's how they self-identify at that time.

Moderator: But you may be missing something important.

David Zingmond: You might. But this is -- this isn't rocket science. Right? This is trying to get at how patients behave. We're trying to help them.

Moderator: Right. Overall I guess the confusion is how the data is collected for those of multiple ethnicities.

David Zingmond: For multiple race and ethnicity, we allow for them -- first of all, to identify, even to order their preference on their background. And then there are -- in terms of the CDC and the OMB and Institute of Medicine have created a general framework for rolling up categories for reporting out to these bureaucratic institutions.

Moderator: Marica, did you want to jump in?

Marcia Wilson: No, nothing.

Moderator: And I find this whole multiethnicity, and I'm sure many of the people who are sitting in the audience and listening today may identify with one particular, you know, racial or ethnic group. But as the conversation goes on, you start to think, well, Gram was really Russian and my Great Grandfather was Greek and my other Great Gram was Hispanic. So I may appear White, but what am I? And how should I be answering these questions as they are asked of me in the future.

Marcia Wilson: Well, I think in part, one of the important things going forward is having the ability for a patient to report more than one choice. And historically, when we had much more limited information technology systems, you could only pick one. And then you couldn't be more than one. And I think as we move forward in the technology and being able to collect multiple -- you can make multiple choices, which is that -- that is what is happening in America, you need to be able to make multiple choices. I think that's important. The way we're going to have to start doing some work on the other side is then when we go to do analysis. How do we handle those kind of data.

Moderator: You may have more than you know what to do with.

Marcia Wilson: Right.

Moderator: And have to decide at some point -- right, as you say, what to do with it. David, in California, we had a question. Were hospital leaders surprised at the disparities in health care at their institutions or hospitals?

David Zingmond: I would say here in New York state, the quality of the data potentially are more granular and even perhaps more accurate. Even now. So the answer to that -- I don't even think they know in my home state. And we're still in the process going through the same process that New York State is. That implementing and improving the actual collection. It's a -- this is not -- this is not a New York State-centered issue. This is a national issue that, frankly, we're only really barely scratching the surface.

Moderator: And I have to also wonder, what the world of electronic medical records will play in this discussion. As your healthcare, your health records are more easily accessed. More seamlessly, as you may travel across the country.

David Zingmond: well, I think Medicare is a great example. When they first came up with race, ethnicity categories for Medicare, it was really Black/not Black. That was the categorization. And so they have spent a lot of time trying to move over and actually use data that they collect through satisfaction surveys to correct that

information. But they themselves have a big, big barrier to overcome, because they don't even on a national standpoint, they don't have good data. So we're trying to move ahead.

Moderator: Yeah. And we've got about a minute. But somebody wanted to know if you would comment on health care in Canada and Europe. Are their health disparities as great as in the U.S. and should we just switch to Canada's system to health care and that's a whole another program.

David Zingmond: There is a white paper in England that looked at disparities and addressed sort of -- the recognizing and how socioeconomic status and the built environment impact health. So they had not only a white paper, but a policy paper on how to do this.

Moderator: And they did take a look. And we have another question. Can you please provide the source to access the HRET tool kit?

Marcia Wilson: If you just google it, if you go out and google HRET tool kit and get to their website, but it's fabulous. Wonderful resources. But if you just google it, you will be able to get to that tool kit.

Moderator: And very briefly in New York, is there a best practice for working with the racial community that may experience a health or health care disparity?

Dennis Whalen: Lots of great examples. We heard from Steve Safyer at Montefiore, which has done a great job over a number of years in mounting community programs that address disparities. So a wealth of these that I think probably health department would be the best source to get a set of examples across different kinds of providers.

Moderator: And I should point out that if you want to ask a question and you were not able to get to that question in during the program, you can ask it and the staff will get you answers. Because sometimes it's as the doors are closing that we realize that we had something that wasn't addressed and want to make sure that everybody is able to get that information. For more information about this webcast, as well as how New York State is working to eliminate health care disparities, you can visit the link that is up on your screen, we'll leave it up there for a moment so that you have an opportunity to jot that down. It's www.improvepatientdatanys.org so you can get more info. Because this is a good jumping off point. It's one to get the conversation going. And there is obviously a lot of work that has to be done to make sure that it's done smoothly, that it's done effectively, that everybody feels that they have a buy-in to it. As I think you all pointed out. That the staff understands the value of this, that it's not merely being inquisitive, and not, as I think you said, Marcia, just one more thing to add to an already busy day, and to understand that this really makes better patient experience. And you are on the step to getting to the point of better care for the patients. I want to thank you very much for joining us today. Of course, our thanks to our panel participants. Please remember to fill out your evaluations online. As we mentioned, your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain your continuing education hours, CME and CHES credits, learners must visit the www.phlive.org, and complete an evaluation and posttest for today's offering. Additional information on upcoming broadcasts and public health topics can also be found on our Facebook page. Don't forget to like us on Facebook and to stay up to date. As a reminder, you can also download the companion guide to this broadcast on our website, www.phlive.org. The companion guide will provide you with learning activities to help you further your knowledge and understanding of topics covered in today's program. This web cast will be available and on demand on our website within two weeks and DVDs of any of our broadcasts can be ordered from our websites, as well. Please join us for our next broadcast November 21st as we address human trafficking. I'm Benita Zahn and thanks for joining us on Public Health Live.