RACE, ETHNICITY, AND LANGUAGE OF PATIENTS

Hospital Practices Regarding Collection of Information
to Address Disparities in Health Care

THE ROBERT WOOD JOHNSON FOUNDATION®

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National Public Health and Hospital Institute

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Donna Sickler, MPH

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WASHINGTON, DC

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The National Public Health and Hospital Institute (NPHHI) is a private, nonprofit organization established in 1988 to address major issues facing public hospitals and health systems, safety net organizations, underserved communities and populations, and related health policy issues of national importance. The NPHHI membership includes the hospitals and health systems that comprise the National Association of Public Hospitals and Health Systems (NAPH).

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Executive Summary

In 2003, the Institute of Medicine (IOM) formally declared war on health care disparities in the United States. Through its landmark report, *Unequal Treatment*, the IOM revealed disturbing truths about health care delivery, amassing an irrefutable body of evidence that showed patterns of disparate treatment for persons of racial and ethnic minorities — patterns that traditional indicators of access to care, such as health insurance coverage and income, could not fully explain.

The IOM report offered recommendations to mitigate or eliminate these disparities, including provisions to enhance data collection by health care organizations on the race and ethnicity of their patient populations. However, meeting the IOM's call for better data may be a challenge for the health care industry, which has not yet developed uniform metrics for identifying, quantifying, or analyzing health care disparities.

This report addresses the ability of health care organizations to describe their populations and assess the size and scope of health care disparities in-house. It provides information on the state of data collection in the U.S. hospital industry and also describes data collection practices at more than 60 safety net hospital systems across the country.

The findings in this report demonstrate that hospitals are currently equipped not only to collect this information from their patient populations but also to use it as another prism through which quality of care can be viewed and assessed. Despite their ability to collect and use this information, the findings also illustrate how uncommon it is for hospitals to look at quality across different dimensions of their patient populations. As a result, they miss important opportunities to ensure that they are providing the best possible care to each and every patient who comes through their doors.

Key Findings on Data Collection at Hospitals Nationwide

Researchers at the National Public Health and Hospital Institute (NPHHI) surveyed 500 hospitals that were representative of the non-federal acute care hospital industry in the U.S. on their practices regarding the collection of information on the race, ethnicity, and preferred language of their patients.

Collection of Race, Ethnicity, and Language Data

- More than three-quarters (78.4 percent) of non-federal acute care hospitals in the U.S. collect information on the race of their patients, and half collect information on patient ethnicity (50.4 percent) and language (50.2 percent). Teaching hospitals are most likely to collect such data: 85.8 percent of teaching hospitals indicate that they collect information on race and 59.2 percent collect information on ethnicity.
- Investor-owned hospitals are 68 percent more likely than government hospitals and 30 percent more likely than non-profit hospitals to collect information on at least some of their patients' primary or preferred languages. Likewise, teaching hospitals are 33 percent more likely than non-teaching hospitals to record patients' languages.
- Small hospitals (as measured by average daily census) are less likely to collect this data. Nevertheless, 71 percent of hospitals with an average daily census below 20 collected this data, compared to approximately 83 percent of hospitals with a census above 100. Over half of (non-federal) government-owned hospitals have a daily census less than 20; this may account for lower collection practices at these hospitals.
- Nearly all of the hospitals that collect race and ethnicity information do so at the point of registration for both inpatient (96.0 percent) and outpatient (93.5 percent) services provided at the hospital campus. The majority (89.1 percent) also collect this information in the emergency department and at affiliated same-day surgery centers (79.7 percent). Only about half (55.6 percent) of hospitals that collect this information do so at doctors' offices or clinics located away from the hospital campus.

Use of Race, Ethnicity, and Language Data

- NPHHI asked hospitals that collect race and ethnicity data whether they used it to assess and compare quality of care, utilization of health services, health outcomes, or patient satisfaction across their different patient populations. Overall, fewer than one in five hospitals that collects this information uses it for any of these purposes.
- Use of the information varies by governance and teaching status, with non-federal government hospitals far less likely to use the data, compared to non-profit and investor-owned hospitals. Teaching hospitals are much more likely than non-teaching hospitals to use this data. Still, only about one in four teaching hospitals uses the data to assess and compare utilization, quality, outcomes, or satisfaction for their patient populations. Investor-owned hospitals are more likely than non-profit hospitals to use this information.

Barriers to Data Collection

- Hospitals indicated that the most common barriers to data collection are staff and patient reluctance to ask or provide this information, confusion about race and ethnicity categories, and

a lack of need for this information. Hospitals were less likely to mention barriers related to limitations in information systems, staff time, legal issues, funding, or lack of commitment from executive leadership.

- For hospitals that do not collect data, the most common barrier by far is the sense that there is no need to collect the information. More than half of the hospitals that do not collect this information identified this as a barrier to collection — more than three times the rate seen among hospitals that do collect it. Hospitals that do not collect this information also are more likely to view information technology, funding, and legal limitations as barriers to data collection, while hospitals that already collect this information see these as much less significant barriers.

The findings demonstrate the importance of staff and patient education regarding the collection of race and ethnicity information. A significant percentage of hospitals — even those hospitals already engaged in these practices — seems to regard the practice with discomfort, indicating that staff may be reluctant to ask questions related to race and ethnicity, and patients may be uncomfortable providing this information without a clear understanding of how it may be used to enhance their overall health care experience.

Key Findings on Data Collection at NAPH Hospitals

Following the survey of U.S. hospitals, NPHHI surveyed public and other safety net hospitals to develop a deeper understanding of the ways that information on race, ethnicity, and preferred language of their patient populations is collected and used. Respondents in the second survey generally have diverse patient populations and were presumed to have experience collecting and recording information on patient race, ethnicity, and language. NPHHI used the membership of the National Association of Public Hospitals and Health Systems (NAPH) as the focus of the second survey; 64 hospitals and health systems participated.

Most of the hospitals (86 percent) that participated in the survey of safety net hospitals are public entities, and most (86 percent) have teaching programs. Approximately 38 percent of patients at these hospitals are white, 29 percent are black, 24 percent are Hispanic/Latino, and 3 percent are Asian or Pacific Islander.

Hospital Policies Regarding the Collection of Race, Ethnicity, and Language Information

- Although all of the responding hospitals routinely collect data on the race and ethnicity of patients, relatively few have formal policies regarding collection of the data. About one in five hospitals (20 percent) has such policies, and even fewer have specific policies that address

the categories or methods that should be used for data collection.

- Most respondents (59 percent) indicated that they generally ask patients to self-identify, some adhering to specific language and precise questions to solicit this information. One-quarter of respondents said that patient race and ethnicity is more often determined by clerks and other staff. Several of these respondents felt very strongly that this method is appropriate and less intrusive for patients than asking about race and ethnicity. Hospitals that "eyeball" patients indicated an awareness that this method could result in inaccurate data; nevertheless, some held a strong belief that the clerks and others who make such assessments know their patient populations extremely well and believed that errors are infrequent.

Data Collection

- All 64 respondents indicated that they have a field in their automated registration system to record race; in 84 percent of hospitals, this is a required field, meaning that registration clerks must enter a response to the question about race.
- Only 28 percent of responding hospitals have a field to record ethnicity; this is generally an optional field that can easily be skipped by the registration clerks.
- Eighty percent of respondents have a field for language although recording language information is highly variable across hospitals and is rarely a required field.
- Nearly three-quarters of the hospitals surveyed (70 percent) indicated that virtually all of their patients have information recorded about their race. An additional 19 percent have information for at least 95 percent of their patients. Relatively few of these patients are classified as "other," indicating that race information is recorded thoroughly for these patient populations.
- Respondents indicated that information on patient race is collected throughout the organization, including in emergency departments, inpatient registration, and at on-campus and off-site clinics. The majority of hospitals could share this information across sites of service, so that race information that is entered in the automated registration system at the first encounter is available at subsequent visits throughout the hospital or health system.
- Respondents reported a high degree of confidence in the data on race. Although they expressed the sentiment that the categories do not always capture information on their patient populations in as granular a fashion as they would like, they felt that the race information on their patients is extremely accurate.
- According to respondents, training staff appropriately and having required fields for recording race are important factors in comprehensive data collection.
- Responding hospitals generally do not separate race from ethnicity when soliciting and recording information about race/ethnicity. The most common practice is to use the following six categories as discrete racial categories: white, black, Hispanic/Latino, Asian/Pacific Islander,

Native American, and other. These categories are not consistent with the federal Office of Management and Budget (OMB) guidelines, which categorize race as white, black, American Indian or Alaska Native, Asian, or Native Hawaiian or Other Pacific Islander. According to OMB guidelines, patient ethnicity is classified as Hispanic/Latino, or non-Hispanic/non-Latino.

Discussion

The majority of U.S. hospitals are already actively engaged in data collection, at least for some segment of their patient populations. Nevertheless, despite its availability, very few hospitals are using the data in quality improvement efforts or even as a management or marketing tool.

We believe that the discussion about the use of the data is the most pressing one — and one that can be marginalized or obfuscated by discussions about the quality of the data.

It is our sense that the data on patient race and ethnicity is relatively accurate and generally reflects the racial and ethnic composition of patients who receive care at U.S. hospitals. Additional work needs to be done to develop systems to capture the most complete and accurate information on patients, but the field of disparities research can move forward using the data currently available.

Hospitals need not wait until the processes of collection are refined and perfected to begin recording patient race, ethnicity, and language data and using this information to support analyses of patient care. Hospitals should conduct appropriate training and provide adequate support to encourage registration clerks and others to ask patients for this information and to record the answers in a consistent fashion. Uniform collection methodologies that rely on patient self-reporting will go far toward developing valuable information that hospitals readily can use for quality improvement purposes.

Recommendations

1. The OMB categories may be a good starting point as guidance for hospitals. Over the long run, however, much more must be done to develop strategies for hospitals and health systems to identify the race and ethnicity of their patients accurately and appropriately. The OMB categories should be tested and evaluated in a set of hospitals with diverse patient populations to determine whether they are appropriate and practical.

   The OMB categories can provide hospitals with a way to record information in a uniform fashion. Hospitals that deviate from the OMB categories should make certain that they are recording the information uniformly across patients and across various access points in the hospital or health system. Hospitals should be encouraged to collect information in as granular a fashion as makes sense

for their community and their organization. This would serve local, state, and federal data collection purposes as well as organizational interests in the health and well-being of their particular patient populations.

2. Efforts to strengthen the accuracy and consistency of data collection should continue but should not take center stage in the struggle to identify and address health care disparities. The most significant and sustained efforts should focus on encouraging hospitals to use the information they currently collect. As their use of the information increases, their interest in making it as accurate as possible will also likely increase.
3. Health care organizations, hospital associations, and research groups should develop tools and templates to demonstrate to hospitals ways that they can use data on race and ethnicity to improve care for patients. Hospitals currently collect and report quality measures to the Centers for Medicare and Medicaid Services (CMS) through Hospital Compare, a publicly available, searchable database that allows the public to compare hospital performance on a number of evidenced-based quality measures. These and other public reporting requirements could evolve to enable health care organizations to determine whether their quality measures are consistent across various patient populations.

   Additional opportunities may exist for hospitals to routinely review quality and utilization data by the race and ethnicity of their patients. Voluntary efforts would have greater opportunities of success if organizations did not have to develop these reports on their own.
4. Hospitals and health systems should implement staff training that includes effective strategies to explain the relevance of the data to patient care. Such training may have a greater impact on data collection efforts than can improvements in information systems or other structural barriers. Some hospital staff are not yet convinced that data collection is necessary or even appropriate. Education about the value of the information for patient care, with clear examples of how using this information benefited the hospital and the patient, could increase the willingness of staff to pay attention to these important activities.

Introduction

In 2003, the Institute of Medicine formally declared war on health care disparities in the United States. Through its landmark report, *Unequal Treatment*[1], the IOM revealed disturbing truths about health care delivery, amassing an irrefutable body of evidence that showed patterns of disparate treatment for persons of racial and ethnic minorities — patterns that traditional indicators of access to care, such as health insurance coverage and income, could not fully explain. For reasons that were multi-dimensional and often unclear, the report indicated that health and health care delivery were not only different but generally much worse for persons of racial and ethnic minority groups than for patients who were white.

The IOM report offered a series of recommendations to mitigate or eliminate these disparities, including provisions to enhance data collection by health care organizations on the race and ethnicity of their patient populations. The IOM recognized that disparities cannot be addressed if they are not identified, and they cannot be identified without systematic mechanisms to link patient health and care delivery information with demographic details that include the patient's race and ethnicity.

Meeting the IOM's call for better data may be a challenge for the health care industry, which has not yet developed uniform metrics for identifying, quantifying, or analyzing health care disparities. Many provider organizations collect information on patient race and ethnicity, but few use this information to measure the extent to which patients of different races and ethnicities disparately use or benefit from the health services they receive. Health care organizations collectively accept the existence of health disparities, but most have not developed individual responses to eliminate them from their own organizations or communities.

Hospitals and health care organizations have been collecting demographic information on their patient populations for a long time. For at least 20 years, the federal government, primarily through the Office of Management and Budget (OMB), has provided a uniform set of standards for the collection of informa-

tion on race and ethnicity; such guidance has been used by the Bureau of the Census in its data collection activities and has been adopted by other organizations, including some hospitals and health care providers, as a means to capture data on their patient populations.

Over the years, the OMB classification schemes have been debated and revised to reflect concerns about the appropriateness of categories and data collection methodologies. Currently, the OMB (Revised) Standards for the Classification of Federal Data on Race and Ethnicity[2] include five categories for data on race and two on ethnicity. The race categories are American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The ethnicity categories are Hispanic/Latino and non-Hispanic/non-Latino.

This classification scheme distinguishes race from ethnicity and requires individuals to determine both. For example, a person of Hispanic or Latino ethnicity would first identify his or her race as white, black, American Indian or Alaska Native, Asian, or Native Hawaiian or Other Pacific Islander. Following identification of race, the person would identify either as Hispanic/Latino or non-Hispanic/non-Latino.

In 2005, the Health Research and Education Trust (HRET), a nonprofit research affiliate of the American Hospital Association, developed its own guidance for hospitals regarding the collection of data on patient race and ethnicity.[3] Like other organizations that studied the collection of such data,[4] HRET recommended using the OMB classifications for coding purposes but encouraged hospitals to record race data to reflect racial and ethnic groupings that were not recognized individually through the OMB categories. For example, a hospital could record "Korean" rather than "Asian" for the race of a patient. Under this scenario, hospitals could capture more complete information about their patient populations and still have the opportunity to aggregate the information to report according to the OMB categories.

HRET also recommended collecting information directly from the patient through open-ended questions about the individual's race and ethnicity. These questions should be preceded by a rationale for the need for the information — a practice that could reduce resistance from patients and increase trust in the data collection process.

Goals of the Report

This report addresses the first dimension of the war on disparities — the ability of health care organizations to describe their patient populations and assess the size and scope of health care disparities in-house. It focuses on hospitals and their practices concerning the collection of information on patient race and ethnicity. It is predicated on the notion that our battles against health care disparities cannot be fought and

ultimately won without clear and constant information about our patients' health, their utilization of health services, and their health outcomes.

The report provides information on the state of data collection in the U.S. hospital industry and also describes data collection practices at more than 60 safety net hospitals[5] across the country. It includes findings from two surveys conducted by the National Public Health and Hospital Institute (NPHHI), with support from The Robert Wood Johnson Foundation. The report provides information on the extent to which U.S. hospitals currently collect information on the race and ethnicity of their patient populations, as well as how this information is collected, recorded, and used.

The findings in this report demonstrate that hospitals are currently equipped not only to collect this information from their patient populations but also to use it as another prism through which quality of care can be viewed and assessed. Despite their ability to collect and use this information, the findings also illustrate how uncommon it is for hospitals to look at quality across different dimensions of their patient populations. As such, they miss important opportunities to make certain that they are providing the best possible care to each and every patient who comes through their doors.

This report is divided into three chapters. Chapter 1 presents the findings from a survey of hospitals that provides information on data collection practices common to the acute care hospital industry. Chapter 2 presents findings from a separate survey of safety net hospitals on specific and detailed data collection practices. All of the hospitals surveyed in Chapter 2 collect information on the race and ethnicity of their patients. Chapter 3 summarizes the key findings of the two surveys and offers recommendations, outlining ways that hospitals can improve their data collection efforts and their use of data on behalf of patient care.

1

Data Collection Practices in U.S. Acute Care Hospitals

Drawing upon previous surveys[6] and discussions with health care leaders in hospitals throughout the country, NPHHI researchers developed a short survey to determine the extent to which U.S. hospitals collected and used data on patient race, ethnicity, and preferred language. The survey also gathered information on the comprehensiveness of data collection across the many access points within a hospital system and addressed barriers to data collection. The U.S. hospital survey instrument is included in Appendix A.

Through conversations with senior leadership at large, public hospitals, we determined that the chief financial officer (CFO) was the best initial contact for the survey of data collection practices. NPHHI purchased a mailing list from the most current American Hospital Association annual survey of members, with names of CFOs and contact information for more than 3,000 acute care hospitals.[7] An initial sample of approximately 1,100 hospitals was drawn from this list, and researchers initiated contact to complete the survey. The survey was conducted from this initial sample and included 501 completed surveys for a response rate of 45.5 percent.

The survey findings were weighted to reflect the true distribution of non-federal acute care hospitals in the country in terms of governance and teaching status. Table 1 describes the characteristics of our hospital sample.

One-quarter of non-federal acute care hospitals are owned and operated by city, county, or state governments. Frequently, state-government-owned facilities are part of large state universities. Six out of 10 hospitals are non-profit organizations, and another 15 percent are for-profit, investor-owned entities.

Three-quarters of non-federal acute care hospitals with teaching programs are non-profit organizations. Even though they dominate the industry, only about 30 percent of non-profit hospitals in this country have teaching programs. In fact, the majority of hospitals, regardless of governance, are community hospitals that do not operate teaching programs. Approximately 16 percent of non-federal, government-owned hospitals have teaching programs. These tend to be larger hospitals that often play a significant safety net role in their communities. About 13 percent of investor-owned hospitals have teaching programs, although these programs tend to be smaller than those at more robust academic health centers with multiple residency programs.

TABLE 1	Characteristics of Hospitals
Governance	
Government, non-federal	25.0%
Non-profit	60.0%
Investor-owner	15.0%
Teaching Status	
Teaching	24.0%
No teaching	76.0%
Average Daily Census	
<20	31.5%
20–99	31.4%
100–249	23.4%
≥250	13.7%

SOURCES NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005; American Hospital Association Survey of Members, 2003.

The majority of hospitals are also relatively small, as measured in this survey by average daily census. Nearly one-third (31.5 percent) have fewer than 20 patients in beds on any given day, and nearly a third more (31.4 percent) have an average daily census between 20 and 99. Only 13.7 percent of hospitals treated an average of 250 patients or more on any given day.

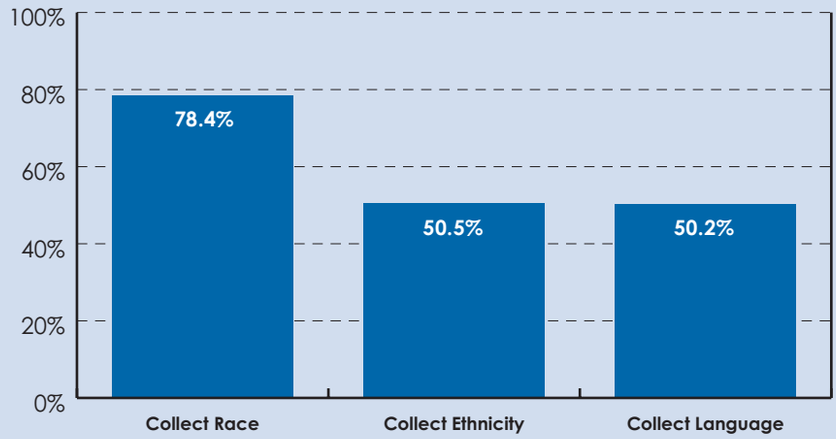
Non-federal, government-owned hospitals tend to be small; over half of them (52.7 percent) had an average daily census below 20, compared to 27.1 percent of non-profits and 12.1 percent of investor-owned hospitals. Teaching hospitals, on the other hand, tend to be large; 70 percent of teaching hospitals have an inpatient daily census of 100 or more, compared to 25 percent of non-teaching hospitals.

Survey Findings

The NPHHI survey confirms previous findings about data collection[8] and underscores the fact that the majority of acute care hospitals collect information on the race of at least a significant percentage of their patients. As Figure 1 illustrates, more than three-quarters of non-federal acute care hospitals in the U.S. collect information on the race of their patients, and half collect information on patient ethnicity (50.4 percent) and language (50.2 percent).

As can be seen in Figure 2, there is some variation in these practices by the governance and teaching status of the hospital. Teaching hospitals are most likely to collect data on patient race and ethnicity, with 85.8 percent of respondents indicating that they collect information on race and 59.2 percent

FIGURE 1 Percent of Hospitals Collecting Information on Patient Race, Ethnicity, and Language



SOURCE NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005.

collecting information on ethnicity. Even though teaching hospitals are ahead of others in this area, there is relatively little variation among hospitals, at least in terms of the collection of race and ethnicity data for some segment of their patient populations.

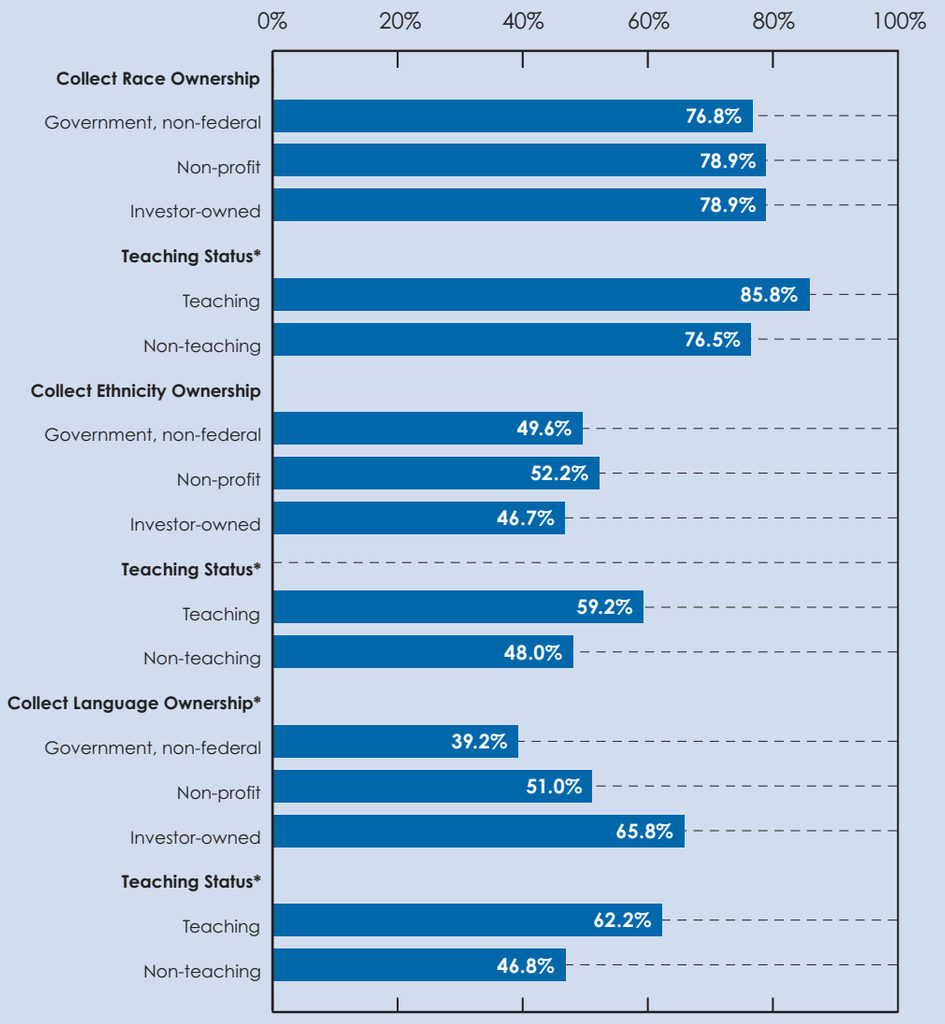
There appears to be greater variation in collection practices regarding patients' language, with investor-owned hospitals 68 percent more likely than government hospitals and 30 percent more likely than non-profit hospitals to indicate that they collect this information. Likewise, teaching hospitals are 33 percent more likely than non-teaching hospitals to record patient language, at least for some of their patients.

There appears to be a direct relationship between the size of the hospital and the likelihood that data on race and ethnicity is collected at that institution. Figure 3 demonstrates that, as the average daily census increases, the rate of data collection also increases. Once the hospital reaches an average daily census of 100, however, the effect seems to plateau. The hospitals with the lowest average daily census are the least likely to collect this data.

Data Collection Sites

Hospitals commonly collect information on patients at multiple access points, depending on the services that the patient seeks upon admission. For example, patients often enter a hospital through an emergency department, where clinical and administrative information is collected and recorded in an electronic database. Patients also may

FIGURE 2 Data Collection Practices by Governance and Teaching Status



SOURCES NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005.

* Indicates that the responses are significantly different ($p<.05$)

enter a hospital as an inpatient for voluntary procedures or may be referred by their primary or specialty care physicians, creating a separate registration procedure. Additionally patients may use hospital ambulatory services, such as same-day surgeries, on- or off-site clinics, or diagnostic and therapeutic

record and verify data on the race, ethnicity, and language of their patients. In some hospitals, all of these data collection processes interact and create opportunities to verify information previously entered into registration databases. In other hospitals, systems remain disjointed and require multiple entries for the same demographic data.

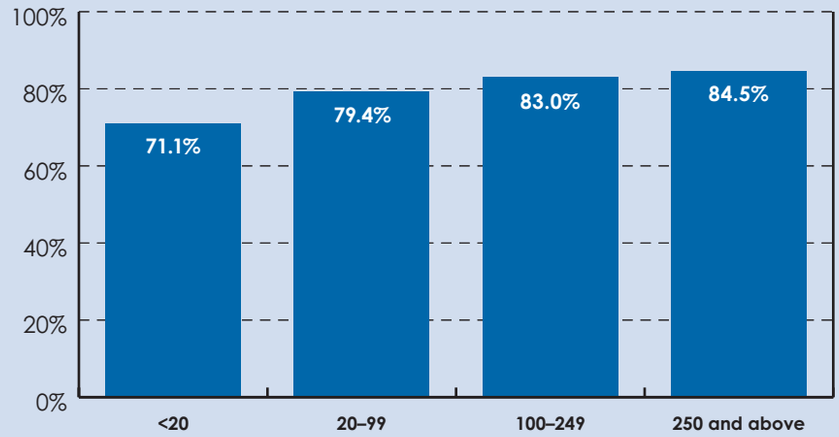
Figure 4 provides information on the sites of data collection for the 78.4 percent of hospitals indicating that they collect information on the race of their patient populations. Nearly all of the hospitals that collect this information do so at the point of registration both for inpatient and outpatient services provided at the hospital campus. The majority also collect this information in the emergency department and when patients present at affiliated same-day surgery centers. Only about half of hospitals that collect this information (55.6 percent) do so at doctors' offices or clinics located away from the hospital campus. The survey did not determine whether these separate collection points have the ability to share data electronically with each other, thereby eliminating the need to collect it on multiple occasions.

Hospital Use of Data on Patient Race and Ethnicity

Collection of data on race and ethnicity by so many of the nation's hospitals opens up opportunities to determine how well various patient populations fare in their institutions. In general, however, only a small proportion of hospitals use the data they collect for quality improvement purposes.

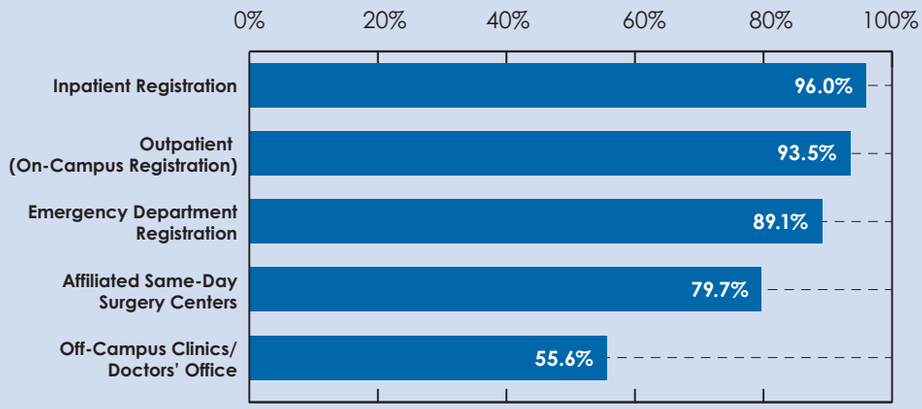
Table 2 illustrates the extent to which hospitals use race and ethnicity data to

FIGURE 3 Collection of Race Data, by Average Daily Census



SOURCE NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005.

FIGURE 4 Sites of Data Collection (Among Hospitals Indicating that They Collect Race Data)



SOURCE NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005.

assess or track various dimensions of quality. We asked hospitals that indicated they collect race and ethnicity data whether they used it to assess and compare quality of care, utilization of health services, health outcomes, or patient satisfaction across their different patient populations. Overall, fewer than one in five hospitals that collects this information uses it for any of these purposes.

Use of the information varies by governance and teaching status, with non-federal government hospitals far less likely to use the data, compared to non-profit and investor-owned hospitals. Teaching hospitals are much more likely than non-teaching hospitals to use this data; still, only about one in four uses it to assess and compare utilization, quality, outcomes, or satisfaction for patient populations. Perhaps surprisingly, investor-owned hospitals are more likely than non-profit hospitals to use this information. One possible explanation for this finding is that use of this information lends itself to more entrepreneurial organizations that are accustomed to looking at various patient demographics as part of their marketing and management functions. There appear to be other factors at play, however, since one would expect the percentages to be even higher among the investor-owned hospitals under this theory.

Fewer than one in five hospitals that collects this information uses it for any of these purposes.

Barriers to Data Collection

The survey included several questions designed to identify specific barriers to the collection of data on patient race and ethnicity. Even with the majority of hospitals actively engaged in data collection, anecdotal evidence indicates that collection practices are uneven and often

TABLE 2 Hospital Use of Race and Ethnicity Data, by Governance and Teaching Status

Uses data to assess and compare:	Non-Federal Government	Non-Profit	Investor-Owned	Teaching	Non-Teaching	All
Quality of Care	11.5%	15.3%	15.0%	21.4%	11.8%	13.5%
Utilization of Health Services	8.3%	20.8%	21.7%	28.2%	14.5%	17.5%
Health Outcomes	8.3%	16.1%	20.0%	23.3%	11.8%	14.6%
Satisfaction with Hospital Services	11.5%	16.5%	21.7%	21.4%	13.8%	15.5%

SOURCE NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005.

TABLE 3 Barriers to Hospital Collection of Race and Ethnicity Data

Barriers to Data Collection	Hospitals that Collect Data	Hospitals that Do Not Collect Data	All Hospitals
Reluctance of staff to ask this type of information	25.8%	22.3%	25.2%
Confusion about race/ethnicity categories	25.5%	16.1%	23.3%
No demonstrated need to collect this data	15.8%	51.6%	22.7%
Reluctance of patients to provide this type of information	24.3%	18.1%	22.7%
Limitations of health information technology systems to capture this type of data	8.7%	19.1%	10.7%
Lack of staff time to collect this data	8.9%	13.8%	9.5%
Concerns that collection of this data may expose the hospital to legal liability	7.9%	13.8%	8.9%
Lack of funding to support the collection of this data	4.3%	10.6%	5.8%
Lack of agreement of executive leadership on the need to collect this data	4.6%	6.4%	5.0%

SOURCE NPHHI Survey of Data Collection Practices of Acute Care Hospitals, 2005.

do not reflect the full patient population that receives care at a hospital or health system. Thus, we were very interested in learning about the barriers faced by hospitals that currently collect at least some of this information, and those experienced by hospitals that have not yet begun to collect such data.

Nine potential barriers to data collection were identified. Several address behavioral barriers — for example, reluctance of staff or patients to ask for or supply such information. Other barriers address structural or resource issues, such as limitations in information technology to record and process the data, or lack of funding or staff time to support the effort. Potential legal implications or leadership commitment to the effort also represented barriers.

Table 3 shows the responses to questions about barriers for the total sample and for hospitals that indicated that they do or do not collect race and ethnicity data. Clearly, there are interesting differences in the perception of data collection barriers between these two groups.

As a group, hospitals indicated that the most common barriers were staff and patient reluctance to ask or provide this information, confusion about race and ethnicity categories, and a lack of need for this information. Hospitals were less likely to mention barriers related to limitations in information systems, staff time, legal issues, funding, or executive leadership.

Large differences emerged, however, when looking at the data separately by hospitals that do or do not collect race and ethnicity data. For hospitals that do not collect data, the most common barrier by far was the sense that there was no need to collect the information. More than half of the hospitals that do not collect this information identified this as a barrier to collection – more than three times the rate seen among hospitals that collect this information. Hospitals that do not collect this information also were more likely to view information technology, funding, and legal limitations[9] as barriers to data collection, while hospitals that already collect this information saw these as much less significant barriers.

The findings demonstrate the importance of staff and patient education around the collection of race and ethnicity information. A significant percentage of hospitals — even those hospitals already engaged in these practices — seems to regard the practice with discomfort, indicating that staff may be reluctant to ask questions related to race and ethnicity, and patients may be uncomfortable providing this information without a clear understanding of how it may be used to enhance their overall health care experience.

For hospitals that do not collect data, the most common barrier by far was the sense that there was no need to collect the information.

Language Services

The survey included several questions about ways that respondents communicate with patients who have limited English proficiency. Half of the hospitals we surveyed collect information on

patient language although most of these collection practices are uneven and tend to relate to the need for an interpreter.

Over one-third of hospitals (38.5 percent) employ one or more interpreters to provide services to patients with limited English proficiency, and 42.6 percent use interpreters that are employed through contractual arrangements. Nearly two-thirds of hospitals (64.9 percent) use a telephone language line for patients who need interpretation services. Nearly a third of the hospitals use some combination of all of these services.

Patients who speak languages other than English often have difficulty communicating with health care providers and can have added problems with health literacy. The survey included questions about health literacy and the extent to which hospital staff viewed this as a concern for their health care organization.

Most respondents said that they do not consider inadequate health literacy to be a common problem for patients at their hospital. Only 27.5 percent of respondents indicated that this was a problem; nearly all of these hospitals indicated that they had some programs in place to assess the literacy levels of patients. Many more (41.8 percent) included some health education focused on low-literacy patients at their hospitals.

Key Findings: Data Collection Practices at Hospitals Nationwide

The NPHHI survey of hospitals provides evidence that the collection of data on the race of patients is a common occurrence at hospitals around the country. Although collection of race data is more common among large hospitals, even small hospitals with low utilization generally collect race data on at least some of their patients. Furthermore, hospitals are generally able to collect this information at multiple sites within their organizations and systems, and many are able to share the data to avoid the need to collect it repeatedly as patients use different services on different dates. Therefore, the issue is not whether hospitals collect this information but how they collect it, for whom they collect it, and for what purposes.

Relatively few hospitals are using information on the race of their patients in their quality improvement or ongoing management practices. As an industry, the practice is uncommon, with only about one in six hospitals that collects the information using it for any quality-related purposes. Teaching hospitals have a better record but nevertheless indicate that activity in this area is quite limited.

Barriers to data collection persist, with the survey findings indicating that many of the barriers relate to staff and patient education. The data indicate loud and clear that the biggest barrier to collection, among those who do not currently collect information on the race of patients, is they have not been convinced that there is a need for this information.

Future survey efforts might investigate barriers associated with the use

of the data and the ability to integrate information on the race of patients into routine quality improvement activities and inquiries. Clearly, this is the next hurdle to addressing racial and ethnic disparities and one that is only in its infancy at hospitals across the country.

2

Data Collection Practices at Safety Net Hospitals

Subsequent to the survey of acute care hospitals described in Chapter 1, NPHHI conducted a second telephone survey to develop a deeper understanding of the ways that information on race, ethnicity, and preferred language of patient populations is collected and used. This survey was not designed to produce findings that could be generalized to the acute care hospital industry. Rather, it focused on hospitals that were likely to be active in data collection efforts. The hospitals that participated in the national survey did not participate in the second telephone survey.

The goal of the second survey was to learn about data collection practices from a group of safety net hospitals with diverse patient populations and experience collecting and recording information on patient race, ethnicity, and language. NPHHI used the membership of the National Association of Public Hospitals and Health Systems (NAPH) as the focus of the second survey.[10] NPHHI contacted the CEOs of NAPH member hospitals and invited them to participate in the survey.[11] Sixty-four hospitals and health systems participated in the survey, for a response rate of 60 percent.

Interviews were held in the spring of 2005. Hospitals were asked to identify an individual familiar with the registration and data collection process who could serve as the principal respondent. Interviews were scheduled ahead of time and lasted approximately 45 minutes. Several hospitals included more than one individual on the telephone call; most often the patient registration manager was the principal contact. Additional participants included hospital CEOs, directors of patient relations, CFOs, medical directors, and many others. Completion of the survey frequently involved follow-up calls with additional hospital clinical or administrative staff. The safety net hospital survey instrument is included as Appendix B.

A central goal of the survey was to identify and describe processes and organizational factors that affect the collection of information about patient race, ethnicity, and language. While some research is available on the collection of this information in the hospital setting, little descriptive information is available to understand the processes involved in data collection and the practices com-

monly in place at hospitals with highly diverse patient populations.

We identified several areas of inquiry to be addressed in the in-depth interviews. These areas included:

- specific classifications or classification systems currently being used to collect information on race and ethnicity;
- availability of organizational policies regarding the collection of race and ethnicity data;
- sites of data collection across the hospital system;
- mechanisms for collecting, storing, sharing, and accessing the information;
- uses of the data, particularly to assess and compare health care quality, outcomes, utilization of services and patient satisfaction, across different patient populations;
- barriers to data collection and ways organizations can eliminate or mitigate such barriers;
- availability of training programs for line staff and others who collect and use this information;
- insights into the organizational commitment behind collection of the data and any organization-wide efforts to encourage consistent and accurate data collection.

Surveying safety net hospitals provided an opportunity to address these issues within hospital environments that were accustomed to treating highly diverse patients. For example, as a group, 26 percent of patients who receive care at NAPH member hospitals are black or African American, 23 percent are Hispanic or Latino, and 3 percent are Asian. These percentages mask an enormous amount of variation at the hospital level, where patient populations tend to reflect the racial and ethnic characteristics of their communities.

Characteristics of Responding Hospitals

Table 4 lists the 64 hospitals that participated in the safety net hospital survey and provides information on their governance, teaching status, bed size, and inpatient and outpatient service volumes. Most of the hospitals that participated in the survey are public entities, although there are various types of governance structures represented in the group. Some are under direct operation by local government — historically the most common type of governance structure for public hospitals. These hospitals are shown in Table 4 as "Public-1." Several hospitals are under direct operation by state governments, most commonly through state universities. These hospitals are shown as "Public-2." Many others have changed their governance and now operate as separate public entities. These are shown as "Public-3." Finally, one out of seven responding hospitals is a non-profit corporation and is shown as "Non-profit."

Eighty-six percent of the hospitals that participated in the survey have teaching programs that vary in size and scope. About a third of these are classified by

TABLE 4 Hospital Governance, Teaching Status, and Volume

Hospital	Location	Governance*	Teaching Hospital	Staffed Beds	Discharges	Clinic Visits
		Public-1=25% Public-2=17% Public-3=44% Non-profit= 14%	Yes=86% No=14%	Average Staffed Beds	Average Discharges	Average Clinic Visits
64 Responding Hospitals				**373**	**19,090**	**392,185**
Arrowhead Regional Medical Center	Colton, CA	Public-1	Yes	353	20,641	332,662
Bellevue Hospital Center	New York, NY	Public-3	Yes	774	27,000	550,000
Bogalusa Medical Center	Bogalusa, LA	Public-2	No	83	2,364	54,097
Boston Medical Center	Boston, MA	Non-profit	Yes	506	28,000	877,000
Broadlawns Medical Center	Des Moines, IA	Public-3	Yes	89	5,000	157,000
Broward General Medical Center	Fort Lauderdale, FL	Public-3	No	560	24,633	263,556
Cambridge Health Alliance	Cambridge, MA	Public-3	Yes	386	18,500	714,049
Central Georgia Health System	Macon, GA	Non-profit	Yes	495	28,378	438,285
Coney Island Hospital	Brooklyn, NY	Public-3	Yes	364	15,705	325,161
Contra Costa Regional Medical Center	Martinez, CA	Public-1	Yes	124	11,300	381,000
Cooper Green Hospital	Birmingham, AL	Public-1	Yes	141	6,700	160,000
Coral Springs Medical Center	Coral Springs, FL	Public-3	No	182	11,790	91,577
Denver Health	Denver, CO	Public-3	Yes	336	22,000	600,000
Elmhurst Hospital Center	Elmhurst, NY	Public-3	Yes	525	27,668	705,743
Erlanger Health System	Chattanooga, TN	Public-3	Yes	528	30,756	315,956
Gouverneur Nursing and Diagnostic and Treatment Center	New York, NY	Public-3	Yes	210	N/A	275,000
Grady Health System	Atlanta, GA	Public-1	Yes	748	31,103	863,202
Hale Ho' ola Kamaku Hospital	Honokaa, HI	Public-2	No	98	142	1,024
Harbor/UCLA Medical Center	Torrance, CA	Public-1	Yes	321	22,525	272,932
Harborview Medical Center	Seattle, WA	Public-3	Yes	368	16,000	300,000
Harlem Hospital Center	New York, NY	Public-3	Yes	257	12,670	382,466
Hennepin County Medical Center	Minneapolis, MN	Public-1	Yes	422	24,787	460,287
Howard University Hospital	Washington, DC	Non-profit	Yes	319	13,558	90,252
Hurley Medical Center	Flint, MI	Public-3	Yes	463	23,699	464,687
Imperial Point Medical Center	Imperial Point, FL	Public-3	No	180	6,544	55,258
JPS Health Network	Fort Worth, TX	Public-3	Yes	328	19,500	683,000
Kauai Veterans Memorial Hospital	Waimea, HI	Public-3	No	45	1,041	N/A
Kona Hospital	Kealakekua, HI	Public-2	No	94	3,580	22,104
LAC+USC Healthcare Network	Los Angeles, CA	Public-1	Yes	736	41,458	1,175,003
Laguna Honda Hospital & Rehabilitation Center	San Francisco, CA	Public-1	Yes	1100	N/A	4,000
Lallie Kemp Regional Medical Center	Independence, LA	Public-2	No	28	1,382	107,206
LSU Health Care Services Division	Baton Rouge, LA	Public-2	Yes	101	52,611	1,306,021
Maricopa Integrated Health System	Phoenix, AZ	Public-3	Yes	481	31,524	446,825
Marlborough-UMass Memorial Healthcare System	Worcester, MA	Non-profit	Yes	65	2,500	40,000
Medical Center of Louisiana at New Orleans	New Orleans, LA	Public-2	Yes	565	25,806	455,150
Memorial Hospital Pembroke	Pembroke Pines, FL	Public-3	Yes	149	6,550	123,266
Memorial Hospital West	Pembroke Pines, FL	Public-3	Yes	236	18,955	241,414
Memorial Regional Hospital	Hollywood, FL	Public-3	Yes	684	33,329	317,397
The MetroHealth System	Cleveland, OH	Non-profit	Yes	545	27,000	680,000
Metropolitan Hospital Center	New York, NY	Public-3	Yes	359	14,900	377,000
North Broward Medical Center	Pompano Beach, FL	Public-3	No	337	26,976	153,069
The Ohio State University Hospital	Columbus, OH	Public-2	Yes	559	7,000	148,000
Olive View-UCLA Medical Center	Sylmar, CA	Public-1	Yes	238	12,947	205,556

Hospital	Location	Governance	Teaching Hospital	Staffed Beds	Discharges	Clinic Visits
Parkland Health & Hospital System	Dallas, TX	Public-3	Yes	735	44,000	1,161,500
Phoebe Putney Memorial Hospital	Albany, GA	Non-profit	Yes	424	23,407	537,123
Queens Hospital Center	Jamaica, NY	Public-3	Yes	208	11,863	357,074
Ranchos Los Amigos National Rehabilitation Center	Downey, CA	Public-1	Yes	150	2,262	60,000
Regional Medical Center at Memphis	Memphis, TN	Non-profit	Yes	376	16,913	295,982
Riverside County Regional Medical Center	Riverside, CA	Public-1	Yes	359	21,500	182,000
San Joaquin General Hospital	Stockton, CA	Public-1	Yes	146	11,617	184,834
San Mateo Medical Center	San Mateo, CA	Public-1	Yes	181	4,030	215,917
Santa Clara Valley Health & Hospital System	San Jose, CA	Public-1	Yes	506	26,449	689,013
San Francisco General Hospital	San Francisco, CA	Public-1	Yes	547	17,144	730,976
Thomason Hospital	El Paso, TX	Public-3	Yes	232	19,859	240,442
Truman Medical Centers	Kansas City, MO	Non-profit	Yes	501	16,979	579,959
UMass Memorial Healthcare System	Worcester, MA	Non-profit	Yes	640	42,099	807,906
UMDNJ-University Hospital	Newark, NJ	Public-3	Yes	448	20,000	205,000
University Hospital, The University of New Mexico Health Sciences Center	Albuquerque, NM	Public-2	Yes	320	18,293	408,366
The University of Texas Medical Branch at Galveston	Galveston, TX	Public-2	Yes	670	37,307	55,575
The University of Texas M.D. Anderson Cancer Center	Houston, TX	Public-2	Yes	456	20,600	605,000
The University of Texas Health Center at Tyler	Tyler, TX	Public-2	Yes	119	3,383	49,068
VCU Health System	Richmond, VA	Public-3	Yes	678	30,394	421,885
Wishard Health Services	Indianapolis, IN	Public-1	Yes	296	17,947	953,800
Woodhull Medical and Mental Health Center	Brooklyn, NY	Public-3	Yes	385	19,000	350,000

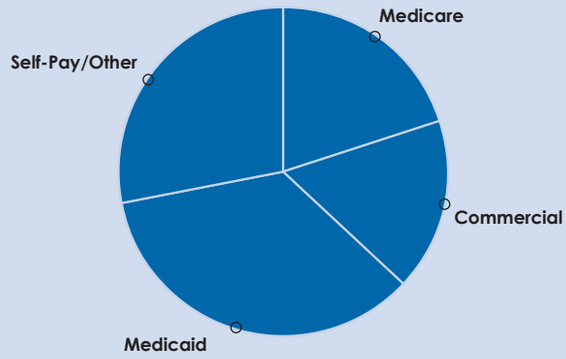
SOURCE **NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005, and the 2003 AHA Annual Survey of Members.**

NOTE **Hale Ho'ola Kamaku, Laguna Honda, and Rancho Los Amigos are primarily long-term care facilities.**

Public-1=Direct Operation by Local Government, Public-2=Direct Operation by State Government, Public-3=Separate Public Entity

FIGURE 5 | **Average Payer Mix for Patients at Responding Hospitals**

Medicare	20%
Commercial	17%
Medicaid	35%
Self-Pay/Other	28%



SOURCE NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.

the American Hospital Association as academic medical centers and serve as the principal teaching program for one or more medical schools.[12] Others offer multiple residency programs and are classified as teaching or major teaching hospitals. Nine survey participants do not operate teaching programs.

NAPH member hospitals tend to be large, a fact that is reflected in the average bed size of 373 for responding hospitals. Volumes at these hospitals are high, both for discharges and outpatient clinic visits. In 2004, responding hospitals had an average of 19,090 discharges and 392,185 outpatient visits.

Despite variations in their governance and size, NAPH member hospitals share a common mission to provide care to everyone in their communities, regardless of health insurance coverage or ability to pay. Most NAPH member hospitals have disproportionately high numbers of uninsured, underinsured, and publicly insured individuals — and the payer mix of responding hospitals is no different. As can be seen in Figure 5, over one-quarter (28 percent) of patients at these hospitals are uninsured, and an additional one-third are covered by Medicaid. Safety net hospital margins are chronically low, making investment in capital such as information technology and data collection systems and enhancements extremely challenging.

Diversity of the Patient Populations at Responding Hospitals

Hospitals were asked about the racial composition of their patient populations according to the most common categories, which include white, black/African American, Hispanic/Latino, Asian/Pacific Islander, American Indian/Alaskan Native/Native American, other,

and unknown. These categories differ from the OMB categories and do not separate race from ethnicity, as OMB guidance indicates. This issue will be discussed in greater detail in Chapter 3.

As Table 5 illustrates, NAPH member hospitals treat an extremely diverse patient population, with significant variation across individual hospitals. Across respondent hospitals, 38 percent of patients were white, 29 percent were black, 24 percent were Hispanic/Latino, and 3 percent were Asian or Pacific Islander.

Hospital Policies Regarding the Collection of Data on Race, Ethnicity, and Language

The NPHHI survey of NAPH member hospitals included questions designed to identify the existence of policies regarding the collection of data on race, ethnicity, and language. These questions were intended to determine whether formal policies were in place that specifically addressed the collection of this information and also whether hospitals had policies that addressed the ways that this information was sought. Specifically, hospitals were asked whether they required registration staff to use standard questions designed to allow patients to self-identify race, ethnicity, and language or whether they allowed (or encouraged) the registration staff to make a visual determination. The latter practice is often referred to as "eyeballing" and may be common in health care organizations and other sites that record race and ethnicity information.

Table 6 presents information on the availability of policies on the collection of data and also describes the most common method of identifying patient race and ethnicity, regardless of whether the hospital has formal policies that address the practice. The first column, "Policies for Collection," indicates whether the hospital has a formal policy that addresses the practice of collecting data on race and ethnicity, irrespective of details concerning data collection. The second and third columns, "Policies Specifying Race" and "Policies Specifying Ethnicity," address whether the hospital has formal policies that identify the specific categories of race or ethnicity for data collection purposes. The fourth column, "Policies Specifying Solicitation of Information," indicates whether the hospital has a formal policy on the ways race and ethnicity information may be collected from the patient. The last column, "Solicitation Method," identifies how the hospital, regardless of the existence of organizational policy, generally gathers this information.

Although all of the responding hospitals routinely collect data on the race and ethnicity of patients, relatively few have formal policies regarding the collection of the data. About one in five hospitals (22 percent) have such policies, and even fewer have specific policies that address the categories or methods that should be used for data collection.

TABLE 5 Racial Composition of Patient Population

Hospital	White	Black	Latino	Asian	American Indian/ Native American/ Alaskan Native	Other	Don't Know
62 Hospital Respondents	**38%**	**29%**	**24%**	**3%**	**<1%**	**4%**	**2%**
Arrowhead Regional Medical Center	33%	14%	42%	2%	0%	4%	5%
Bellevue Hospital Center	18%	27%	38%	11%		7%	0%
Bogalusa Medical Center	67%	32%	0%	0%	0%	0%	0%
Boston Medical Center	28%	32%	14%	3%	0%	4%	19%
Broadlawns Medical Center	76%	13%	9%	1%		1%	0%
Broward General Medical Center	39%	43%	13%	0%		5%	0%
Cambridge Health Alliance	72%	9%	9%	1%		4%	5%
Central Georgia Health System	55%	39%	1%	0%		0%	5%
Coney Island Hospital	54%	18%	15%	8%		4%	0%
Contra Costa Regional Medical Center	42%	16%	32%	6%		4%	0%
Cooper Green Hospital	25%	65%	10%	0%	0%	0%	0%
Coral Springs Medical Center	63%	18%	13%	1%		5%	0%
Denver Health	26%	13%	54%	1%	3%	3%	0%
Elmhurst Hospital Center	14%	10%	54%	17%	0%	4%	0%
Erlanger Health System	74%	20%	2%	2%	0%	0%	2%
Gouverneur Nursing and Diagnostic and Treatment Center	10%	5%	45%	40%	0%	0%	0%
Grady Health System	12%	79%	3%	1%	0%	5%	0%
Hale Ho' ola Kamaku Hospital	50%	0%	0%	50%	0%	0%	0%
Harbor/UCLA Medical Center	16%	20%	51%	8%		4%	0%
Harborview Medical Center	51%	26%	6%	9%	2%	6%	0%
Harlem Hospital Center	7%	56%	33%	2%	0%	2%	0%
Hennepin County Medical Center	41%	29%	15%	3%		9%	4%
Howard University Hospital	15%	70%	15%	0%	0%	0%	0%
Hurley Medical Center	52%	45%	1%	0%		2%	0%
Imperial Point Medical Center	77%	17%	4%	0%		2%	0%
JPS Health Network	46%	13%	23%	4%		14%	0%
Kona Hospital	53%	1%	2%	42%		2%	0%
LAC+USC Healthcare Network	11%	13%	66%	6%	0%	2%	2%
Laguna Honda Hospital & Rehabilitation Center	40%	25%	12%	16%	0%	7%	0%
Lallie Kemp Regional Medical Center	57&	42%	0%	0%		0%	0%
LSU Health Care Services Division	41%	56%	2%	1%	0%	0%	0%
Marlborough-UMass Memorial Healthcare System	88%	2%	8%	1%	0%	1%	0%
Medical Center of Louisiana at New Orleans	24%	71%	3%	1%	0%	1%	0%
Memorial Hospital Pembroke	62%	15%	18%	0%		3%	2%
Memorial Hospital West	49%	19%	24%	1%		4%	4%
Memorial Regional Hospital	59%	20%	15%	0%		4%	3%
The MetroHealth System	48%	35%	8%	1%	1%	4%	3%
Metropolitan Hospital Center	5%	28%	64%	1%		2%	0%
North Broward Medical Center	39%	43%	13%	0%		5%	0%
The Ohio State University Hospital	71%	22%	1%	1%		3%	2%
Olive View-UCLA Medical Center	24%	7%	61%	6%		2%	0%
Parkland Health & Hospital System	16%	31%	49%	2%	0%	2%	0%
Phoebe Putney Memorial Hospital	50%	48%	1%	0%		1%	0%
Queens Hospital Center	9%	47%	14%	4%		26%	0%
Ranchos Los Amigos National Rehabilitation Center	11%	16%	61%	4%	0%	8%	0%

Hospital	White	Black	Latino	Asian	American Indian/ Native American/ Alaskan Native	Other	Don't Know
Regional Medical Center at Memphis	21%	75%	2%	0%	0%	2%	0%
Riverside County Regional Medical Center	50%	15%	31%	1%		2%	0%
San Joaquin General Hospital	30%	13%	42%	12%	0%	2%	1%
San Mateo Medical Center	15%	6%	59%	10%	1%	9%	0%
Santa Clara Valley Health & Hospital System	26%	6%	56%	5%	0%	4%	3%
San Francisco General Hospital	25%	21%	29%	20%	0%	5%	0%
Thomason Hospital	5%	1%	93%	0%	0%	0%	0%
Truman Medical Centers	53%	33%	7%	1%	0%	6%	0%
UMass Memorial Healthcare	85%	4%	8%	2%		1%	0%
UMDNJ-University Hospital	12%	56%	31%	1%	0%	0%	0%
University Hospital, The University of New Mexico Health Sciences Center	24%	2%	39%	1%		10%	23%
The University of Texas Medical Branch at Galveston	42%	21%	34%	1%		0%	1%
The University of Texas M.D. Anderson Cancer Center	64%	8%	13%	0%	0%	15%	0%
The University of Texas Health Center at Tyler	76%	20%	4%	0%	0%	0%	0%
VCU Health System	44%	41%	2%	1%	0%	3%	9%
Wishard Health Services	37%	38%	11%	1%	0%	1%	12%
Woodhull Medical and Mental Health Center	7%	37%	52%	1%	1%	1%	1%

SOURCE NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.

TABLE 6 Policies Regarding the Collection of Patient Race and Ethnicity Data

Hospital	Policies for Collection	Policies Specifying Race	Policies Specifying Ethnicity	Policies Specifying Solicitation of Information	Solicitation Method
64 Responding Hospitals	**Yes=22%**	**Yes=16%**	**Yes=13%**	**Yes=13%**	**Self-Identify=61% Eyeball=23% Mixed=16%**
Arrowhead Regional Medical Center	Yes	Yes	Yes	No	Self-Identify
Bellevue Hospital Center	Yes	No	No	Yes	Mixed
Bogalusa Medical Center	No	No	No	No	Self-Identify
Boston Medical Center	No	No	No	No	Self-Identify
Broadlawns Medical Center	No	No	No	No	Self-Identify
Broward General Medical Center	No	No	No	No	Mixed
Cambridge Health Alliance	No	No	No	No	Eyeball
Central Georgia Health System	No	No	No	Yes	Self-Identify
Coney Island Hospital	No	No	No	No	Eyeball
Contra Costa Regional Medical Center	No	No	No	No	Self-Identify
Cooper Green Hospital	No	No	No	No	Self-Identify
Coral Springs Medical Center	No	No	No	No	Mixed
Denver Health	No	No	No	Yes	Self-Identify
Elmhurst Hospital Center	Yes	No	No	No	Eyeball
Erlanger Health System	No	No	No	No	Self-Identify
Gouverneur Nursing and Diagnostic and Treatment Center	No	No	No	No	Self-Identify
Grady Health System	No	No	No	No	Self-Identify
Hale Ho' ola Kamaku Hospital	No	No	No	No	Eyeball
Harbor/UCLA Medical Center	No	No	No	Yes	Self-Identify
Harborview Medical Center	Yes	Yes	Yes	No	Self-Identify
Harlem Hospital Center	No	No	No	No	Self-Identify
Hennepin County Medical Center	No	No	No	No	Self-Identify
Howard University Hospital	No	No	No	No	Eyeball
Hurley Medical Center	No	No	No	No	Eyeball
Imperial Point Medical Center	No	No	No	No	Mixed
JPS Health Network	No	No	No	No	Self-Identify
Kauai Veterans Memorial Hospital	No	No	No	No	Self-Identify
Kona Hospital	No	No	No	No	Eyeball
LAC+USC Healthcare Network	No	No	No	No	Self-Identify
Laguna Honda Hospital & Rehabilitation Center	No	No	No	No	Self-Identify
Lallie Kemp Regional Medical Center	No	No	No	No	Self-Identify
LSU Health Care Services Division	No	No	No	No	Mixed
Maricopa Integrated Health System	No	No	No	No	Mixed
Marlborough-UMass Memorial Healthcare System	Yes	Yes	No	No	Self-Identify
Medical Center of Louisiana at New Orleans	No	No	No	No	Eyeball
Memorial Hospital Pembroke	No	No	No	No	Self-Identify
Memorial Hospital West	No	No	No	No	Self-Identify
Memorial Regional Hospital	No	No	No	No	Self-Identify
The MetroHealth System	No	No	No	No	Self-Identify
Metropolitan Hospital Center	No	No	No	No	Self-Identify
North Broward Medical Center	No	No	No	No	Mixed
The Ohio State University Hospital	Yes	Yes	Yes	No	Self-Identify
Olive View-UCLA Medical Center	No	No	No	No	Eyeball
Parkland Health & Hospital System	Yes	Yes	Yes	No	Eyeball

Hospital	Policies for Collection	Policies Specifying Race	Policies Specifying Ethnicity	Policies Specifying Solicitation of Information	Solicitation Method
Phoebe Putney Memorial Hospital	No	No	No	No	Mixed
Queens Hospital Center	Yes	No	No	No	Eyeball
Ranchos Los Amigos National Rehabilitation Center*	Yes	Yes	Yes	Yes	Self-Identify
Regional Medical Center at Memphis	No	No	No	No	Eyeball
Riverside County Regional Medical Center	Yes	Yes	Yes	Yes	Eyeball
San Joaquin General Hospital	Yes	No	Yes	No	Self-Identify
San Mateo Medical Center	Yes	Yes	No	No	Self-Identify
Santa Clara Valley Health & Hospital System	No	No	No	No	Self-Identify
San Francisco General Hospital	No	No	No	No	Eyeball
Thomason Hospital	No	No	No	No	Eyeball
Truman Medical Centers	Yes	Yes	Yes	Yes	Self-Identify
UMass Memorial Healthcare System	No	No	No	No	Self-Identify
UMDNJ-University Hospital	No	No	No	No	Self-Identify
University Hospital, The University of New Mexico Health Sciences Center	No	No	No	No	Mixed
The University of Texas Medical Branch at Galveston	No	No	No	No	Self-Identify
The University of Texas M.D. Anderson Cancer Center	No	No	No	No	Self-Identify
The University of Texas Health Center at Tyler	No	No	No	No	Self-Identify
VCU Health System	No	No	No	No	Self-Identify
Wishard Health Services	No	No	No	No	Mixed
Woodhull Medical and Mental Health Center	Yes	Yes	No	Yes	Self-Identify

SOURCE **NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.**

Rancho Los Amigos has practices for the collection of data as well as practices specifying race and ethnicity.

Most respondents (61 percent) indicated that they generally ask patients to self-identify, some with very specific language about the precise questions that should be used to solicit this information. Nearly one-quarter of respondents said that clerks and other staff more often determine patient race and ethnicity. Several of these respondents felt strongly that this method was appropriate and less intrusive for patients than asking about race and ethnicity. Hospitals that eyeball patients indicated an awareness that this method could result in inaccurate data; nevertheless, some held a strong belief that the clerks and others who make such assessments know the patient populations extremely well and believed that errors are infrequent.

Collection of Race Data

The NPHHI survey included questions about operational aspects associated with recording race information as well as estimates of the percentage of patients for whom race data was available. These findings are presented in Table 7.

Hospitals were asked whether their automated registration process included a field to record race and whether it was a required field. All 64 respondents indicated that they had a field to record race; in 81 percent of hospitals, this is a required field, meaning that registration clerks must enter a response to the question about race.

Nearly three-quarters of the hospitals surveyed (70 percent) indicated that virtually all of their patients had information recorded about their race. An additional 19 percent had information for at least 95 percent of their patients. These high percentages are consistent with prior research on the ability of public hospitals to collect information on the race of their patient populations. In a recent study on public hospital experiences with managing diabetes for their patients, six of the seven hospitals that participated in the project were able to provide race information for more than 98 percent of their patients.[13] The remaining patients were generally classified as unknown. Furthermore, relatively few of the patients with race classifications were categorized as "other," indicating that race information was recorded thoroughly for these patient populations.

Respondents indicated that race information was collected throughout the organization, including in emergency departments, inpatient registration, and at on-campus and off-site clinics. The majority of hospitals indicated that the patient information data could be shared across sites of service, so that race information entered in the automated registration at the first encounter would be available at subsequent visits throughout the hospital or health system.

The NPHHI survey does not provide information on the accuracy of the data. The findings identified no standard mechanisms at any of the hospitals to verify the accuracy of information on the race of patients,

other than checking race and ethnicity at subsequent hospital visits. By far, however, the respondents indicated a high degree of confidence in the data on race. Although they expressed the sentiment that the categories did not always capture information on their patient populations in as granular a fashion as they would like, they felt that the race information on their patients was extremely accurate.

During interviews with the hospitals, several respondents stressed the importance of making the collection of data on race a required field. Some considered this the single most important factor in terms of comprehensive data collection. Without such a requirement, staff who are reluctant to ask this type of information may neglect to identify the race of patients. On the other hand, requiring this information from staff who are uncomfortable with the process may result in staff preferring to gather this information through eyeballing rather than asking about race.

In many of the interviews, respondents discussed the importance of appropriate training for the staff responsible for collecting this type of information. At the Central Georgia Health System, part of the staff orientation involves education on ways to appropriately interact with patients who are uncomfortable providing information regarding their race or ethnicity. Boston Medical Center trains staff who are involved in data collection on the importance of allowing patients to self-report. An additional component of the training emphasizes the importance of explaining the value of this information.

Harborview Medical Center in Seattle performs quality review for each person in the registration department to determine whether they are recording race and ethnicity information correctly. Registration managers identify clerks who record larger numbers of blanks or "unknowns" in their race fields.

Categories of Classification for Race

Responding hospitals were asked about the categories used in their patient registration systems to identify the race of their patients. The most common practice was to use the following six categories: white, black, Hispanic/Latino, Asian/Pacific Islander, Native American, and other.

These categories are not consistent with those recommended by OMB and subsequently by HRET and others. In practice, ethnicity — as defined by the category Hispanic/Latino — is commonly included as a race category instead of being separately identified following the identification of race.

Table 8 identifies the conventions used to identify race at responding hospitals. Hospitals that have a "Yes" in the column "Common Race Categories" are using the following categories: white, black, Hispanic/Latino, Asian/Pacific Islander, Native American, and other to identify patient race. The next column, "Additions/Deletions/Differences,"

TABLE 7 Collection Practices of Patient Race Information

Hospital	Is there a Field for Race?	Is it a Required Field?	Estimated % of Patients with Race Information
64 Responding Hospitals	**Yes=100%**	**Yes=81%**	**Percent with 95% or more=89%**
Arrowhead Regional Medical Center	Yes	Yes	95%
Bellevue Hospital Center	Yes	No	100%
Bogalusa Medical Center	Yes	Yes	100%
Boston Medical Center	Yes	Yes	85%
Broadlawns Medical Center	Yes	Yes	100%
Broward General Medical Center	Yes	Yes	100%
Cambridge Health Alliance	Yes	Yes	100%
Central Georgia Health System	Yes	Yes	100%
Coney Island Hospital	Yes	Yes	100%
Contra Costa Regional Medical Center	Yes	Yes	100%
Cooper Green Hospital	Yes	Yes	100%
Coral Springs Medical Center	Yes	Yes	100%
Denver Health	Yes	Yes	100%
Elmhurst Hospital Center	Yes	Yes	100%
Erlanger Health System	Yes	Yes	100%
Gouverneur Nursing and Diagnostic and Treatment Center	Yes	No	95%
Grady Health System	Yes	Yes	100%
Hale Ho' ola Kamaku Hospital	Yes	No	95%
Harbor/UCLA Medical Center	Yes	Yes	98%
Harborview Medical Center	Yes	Yes	100%
Harlem Hospital Center	Yes	No	75%
Hennepin County Medical Center	Yes	No	80%
Howard University Hospital	Yes	Yes	100%
Hurley Medical Center	Yes	Yes	100%
Imperial Point Medical Center	Yes	Yes	100%
JPS Health Network	Yes	Yes	98%
Kauai Veterans Memorial Hospital	Yes	Yes	100%
Kona Hospital	Yes	No	95%
LAC+USC Healthcare Network	Yes	No	95%
Laguna Honda Hospital & Rehabilitation Center	Yes	No	90%
Lallie Kemp Regional Medical Center	Yes	Yes	100%
LSU Health Care Services Division	Yes	Yes	100%
Maricopa Integrated Health System	Yes	Yes	95%
Marlborough-UMass Memorial Healthcare System	Yes	Yes	80%
Medical Center of Louisiana at New Orleans	Yes	Yes	100%
Memorial Hospital Pembroke	Yes	Yes	100%
Memorial Hospital West	Yes	Yes	100%
Memorial Regional Hospital	Yes	Yes	100%
The MetroHealth System	Yes	Yes	97%
Metropolitan Hospital Center	Yes	Yes	100%
North Broward Medical Center	Yes	Yes	100%
The Ohio State University Hospital	Yes	Yes	100%
Olive View-UCLA Medical Center	Yes	Yes	100%

Hospital	Is there a Field for Race?	Is it a Required Field?	Estimated % of Patients with Race Information
Parkland Health & Hospital System	Yes	Yes	100%
Phoebe Putney Memorial Hospital	Yes	Yes	100%
Queens Hospital Center	Yes	Yes	100%
Ranchos Los Amigos National Rehabilitation Center	Yes	Yes	100%
Regional Medical Center at Memphis	Yes	Yes	100%
Riverside County Regional Medical Center	Yes	No	95%
San Joaquin General Hospital	Yes	Yes	100%
San Mateo Medical Center	Yes	Yes	100%
Santa Clara Valley Health & Hospital System	Yes	Yes	95%
San Francisco General Hospital	Yes	Yes	100%
Thomason Hospital	Yes	Yes	100%
Truman Medical Centers	Yes	Yes	100%
UMass Memorial Healthcare System	Yes	Yes	100%
UMDNJ-University Hospital	Yes	No	93%
University Hospital, The University of New Mexico Health Sciences Center	Yes	No	<50%
The University of Texas Medical Branch at Galveston	Yes	Yes	100%
The University of Texas M.D. Anderson Cancer Center	Yes	Yes	100%
The University of Texas Health Center at Tyler	Yes	Yes	100%
VCU Health System	Yes	Yes	100%
Wishard Health Services	Yes	No	99%
Woodhull Medical and Mental Health Center	Yes	Yes	100%

SOURCE NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.

TABLE 8 | Race Classifications at Respondent Hospitals

Hospital	Common Race Categories	Additions/Deletions/Differences
Arrowhead Regional Medical Center	Yes	
Bellevue Hospital Center	No	Categories are: Black, White, Asian, South Asian, Native American, Pacific Islander, Hispanic, Black Hispanic, Other, Unknown
Bogalusa Medical Center	Yes	
Boston Medical Center	Yes	Middle Eastern, Declined
Broadlawns Medical Center	Yes	
Broward General Medical Center	No	Categories are: Hispanic White, Hispanic Black, Indian/Eskimo, Asian/Pacific Islander, White, Black, Other
Cambridge Health Alliance	Yes	Pacific Islander not collected
Central Georgia Health System	No	Categories are: African American, Hispanic/Latino, Asian, Unknown, Caucasian, Other, American Indian, Multi-racial, Pacific Islander, Non-white Hispanic, Refusal
Coney Island Hospital	Yes	Categories are: American Indian, Black Non-Hispanic,
Contra Costa Regional Medical Center	No	Chinese, Eskimo, White Hispanic, East Indian, Japanese, Black Hispanic, Other Hispanic, Iran-Iraq-Middle Eastern, Other, Pacific Islander, Refused to state, SE Asian, Unknown, White Non-Hispanic, Filipino
Cooper Green Hospital	No	Categories are: African American, Caucasian, Hispanic/Latino, Other
Coral Springs Medical Center	No	Categories are: Hispanic White, Hispanic Black, Indian/Eskimo, Asian/Pacific Islander, White, Black, Other
Denver Health	Yes	
Elmhurst Hospital Center	No	Categories are: Asian, Black, Hispanic, American Indian/Alaskan, Hispanic White, Hispanic Black, Hispanic Other, Other, Native Hawaiian/Pacific Islander, South Asian/Middle Eastern, Unknown, White
Erlanger Health System	Yes	
Gouverneur Nursing and Diagnostic and Treatment Center	Yes	
Grady Health System	No	Categories are: White, Black, Other, Hispanic, Asian, Arabic, Asian/Indian, Native American, Middle Eastern, African
Hale Ho' ola Kamaku Hospital	No	Categories are: Black, Caucasian, Chinese, Samoan, Hawaiian, Japanese, Filipino
Harbor/UCLA Medical Center	No	Categories are: Asian, Black, White, Other Filipino, Indian, Pacific Islander
Harborview Medical Center	Yes	Multi-racial
Harlem Hospital Center	No	Categories are: Asian, Black, Hispanic, American Indian/Alaskan Native, Hispanic White, Hispanic Black, Hispanic Other, Native Hawaiian/Other, South Asian/Middle Eastern, Unknown, White
Hennepin County Medical Center	Yes	Asian and Pacific Islander are recorded as separate categories.
Howard University Hospital	Yes	
Hurley Medical Center	Yes	
Imperial Point Medical Center	No	Categories are: Hispanic White, Hispanic Black, Indian/Eskimo, Asian/Pacific Islander, White, Black, Other
JPS Health Network	Yes	
Kauai Veterans Memorial Hospital	No	Categories are: Chinese, Filipino, Hawaiian, Japanese, Korean, Mixed, Part Hawaiian, Polynesian, Caucasian, Cosmopolitan, Other
Kona Hospital	No	Categories are: American Indian/Eskimo, Black, Chinese, Filipino, Hawaiian, Japanese, Korean, Other Asian, Part Hawaiian, Polynesian, Caucasian, Hispanic, Other
LAC+USC Healthcare Network	No	Native American/Unknown, Other/Hispanic, Other/Non-Hispanic, Other/Unknown, Unknown/Hispanic, Unknown/Non-Hispanic, Unknown/Unknown, White/Hispanic, White/Non-Hispanic, White/Unknown, Asian/Hispanic, Asian/Non-Hispanic, Asian/Unknown, Black/Hispanic, Black/Non-Hispanic, Black/Unknown, Native American/Hispanic, Native American/Non-Hispanic

Hospital	Common Race Categories	Additions/Deletions/Differences
Laguna Honda Hospital & Rehabilitation Center	No	Categories are: African American, Non-Hispanic White, Other Asian, Chinese, Filipino, Latino, Other
Lallie-Kemp Regional Medical Center	Yes	Do not record Pacific Islander
LSU Health Care Services Division	Yes	Do not record Pacific Islander
Maricopa Integrated Health System	Yes	Do not record Pacific Islander
Marlborough-UMass Memorial Healthcare System	No	Categories are: White, Black, Hispanic, American Indian, Asian, Hispanic-Black, Hispanic-White, American Indian-White, Black-Asian, Black-White, African American, White-Black, Refused
Medical Center of Louisiana at New Orleans	Yes	
Memorial Hospital Pembroke	Yes	Also record Haitian and refusal/no response.
Memorial Hospital West	Yes	Also record Haitian and refusal/no response.
Memorial Regional Hospital	Yes	Also record Haitian and refusal/no response.
The MetroHealth System	Yes	Also record Multi-racial
Metropolitan Hospital Center	No	Categories are: Asian, Black, Hispanic, American Indian, Hispanic-White, Hispanic-Black, Hispanic-Other, Other, Native Hawaiian, Southern Asian, Unknown, White
North Broward Medical Center	No	Categories are: Hispanic White, Hispanic Black, Indian/Eskimo, Asian/Pacific Islander, White, Black, Other
The Ohio State University Hospital	No	African American, Asian/Chinese, Asian/Cambodian, Middle Eastern, African Other, Native Hawaiian, Asian/Japanese, Asian/Korean, Asian/Laotian, More than 1 race, American Indian/ Alaskan, Asian/Indian/Pakistani, Asian/Vietnamese, White, Somali, Asian/Other, Refuse to answer, Unknown
Olive View-UCLA Medical Center	No	Categories are: Other-Unknown, Other-referral, Other Hispanic, Other non-Hispanic, Other, Native American Non-Hispanic, Native American Hispanic, Native American Unknown, Hispanic, Non-Hispanic, Filipino Hispanic, Filipino Non-Hispanic, Filipino Unknown, American Indian Unknown, American Indian Non-Hispanic, American Indian Hispanic, American Indian/Alaskan, Unknown Hispanic, Unknown Non-Hispanic, Unknown Unknown, Russian, Armenian, Asian/Pacific Islander, Black, Filipino, Native American, White, White Hispanic, White Non-Hispanic, White Unknown, Black/African American, Black Non-Hispanic, Black Hispanic, Black Unknown, Asian Hispanic, Asian Non-Hispanic, Asian Unknown
Parkland Health & Hospital System	Yes	
Phoebe Putney Memorial Hospital	Yes	
Queens Hospital Center	No	Categories are: Asian, Black, Hispanic, American Indian/Alaskan, Hispanic White, Hispanic Black, Hispanic Other, Other, Native Hawaiian/Pacific Islander, South Asian/Middle Eastern, Unknown, White
Ranchos Los Amigos National Rehabilitation Center	Yes	Also record Filipino
Regional Medical Center at Memphis	Yes	Also record African
Riverside County Regional Medical Center	Yes	
San Joaquin General Hospital	No	Categories are: Asian/Pacific Islander, Black, Native American-Hispanic, Black-Hispanic, Asian-Hispanic, Native American/Eskimo, Unknown, White, Other, Other-Hispanic, White-Hispanic
San Mateo Medical Center	No	Categories are: Black, White, Chinese, Filipino, Indian, Japanese, Korean, Native American, Pacific Islander/Other, Vietnamese, Cambodian, Hawaiian, Other
Santa Clara Valley Health & Hospital System	No	Filipino, Endo-Chinese, Pacific Islander, Vietnamese, White, Black, Asian, Hispanic, American Indian, Arab, Other, Unknown
San Francisco General Hospital	Yes	

TABLE 8 Race Classifications at Respondent Hospitals (Continued)

Hospital	Common Race Categories	Additions/Deletions/Differences
Thomason Hospital	No	Categories are: White Non-Hispanic, Black Hispanic, Black Non-Hispanic, American Indian Hispanic, American Indian Non-Hispanic, Asian Hispanic, Asian Non-Hispanic, Other Hispanic, Other Non-Hispanic, White Hispanic
Truman Medical Centers	Yes	Also record Multi-racial
UMass Memorial Healthcare System	No	Categories are: White, Black, Hispanic, American Indian/Eskimo, Asian, Hispanic-Black, Hispanic-White, American Indian-Black, American Indian-White, Native Hawaiian/Pacific Islander, Asian-Black, African American-White-Black, Unknown
UMDNJ-University Hospital	No	Categories are: Black, Chinese, Filipino, American Indian, Japanese, Hawaiian, Other Asian-Pacific Islander, White, Other, Unknown
University Hospital, The University of New Mexico Health Sciences Center	No	Categories are: White Anglo, Hispanic, Vietnamese, Native American, Other, African American Native Hawaiian and Pacific Islander are recorded as separate categories
The University of Texas Medical Branch at Galveston	Yes	
The University of Texas M.D. Anderson Cancer Center	Yes	
The University of Texas Health Center at Tyler	Yes	
VCU Health System	Yes	
Wishard Health Services	Yes	Also record Multi-racial
Woodhull Medical and Mental Health Center	No	Categories are: White, Asian, Black, Other

SOURCE NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.

identifies categories that are used to record race at the hospital in cases where the common convention is not used. Generally, these hospitals have drop-down menus in their automated registration systems that allow easy recording of these specific categories.

Overall, 34 hospitals (53 percent) used the common race classifications. As can be seen in Table 8, there is wide variation in the race classifications at each hospital. Some hospitals indicated in interviews that they had tailored their categories to respond to their particular patient populations. Others indicated that their practices resulted from the categories available through their registration system software.

Clearly, many hospitals combined race and ethnicity into one question at their organization. For example, at the LAC+USC Healthcare Network, race and ethnicity are included in a required field at the point of registration. In the case of LAC+USC, the patient can self-identify specific categories that then can be included in the patient record. Hispanic/Latino patients can be classified in several different categories, depending on the patient's assessment.

Collection Practices Related to Ethnicity and Language

Hospitals were also asked about collection practices regarding the ethnicity and preferred language of patients. As can be seen in Table 9, only 28 percent of responding hospitals have a field to record ethnicity, which is generally an optional field that can easily be skipped by the registration clerks.

Many more hospitals have a field for language in their registration systems, although few respondents indicated that they routinely complete the language field. Several hospitals indicated that the collection of language information was a required field, but even these hospitals said they did not have a high degree of confidence that the process accurately captured language data for the majority of patients. In practice, language information is most often recorded for patients who require the services of an interpreter.

The collection of language information typically occurs at registration but also can happen during scheduling or during the clinic visit. Information about language is often stored in the "notes" section of the patient's medical record, which can be difficult to access if a hospital does not have an electronic medical record.

Many respondents indicated that they struggle with the most appropriate way to ask patients about their language. Some hospitals ask patients, "What is your preferred language?" or "What language would you prefer your health care in?" Other respondents asked patients, "What language do you speak at home?" Many hospitals use language identification cards that allow the patient to point to their language prior to arranging for an interpreter to assist them with their communication needs.

The amount of detail that hospitals collect on language varies greatly. For example, Cambridge Health Alliance asks their patients three questions: What is the primary language you speak? What is the primary language you write? What is the primary language you prefer for your health care?

Table 10 provides information on the collection of patient ethnicity by the 28 percent of hospitals that have separate fields for this information. As can be seen from the survey findings, ethnicity information is most commonly collected in a manner inconsistent with OMB guidelines. Eight of the 18 hospitals that collect ethnicity specifically identify patients as Hispanic/Latino (or Non-Hispanic/Non-Latino). The others include many different ethnicities as potential categories. Again, these categories appear as part of a drop-down menu during the registration process to allow easy selection of a particular category.

Some hospitals include the same categories in both race and ethnicity fields. For example, Woodhull Medical Center, which is part of the New York City Health and Hospitals Corporation, includes Hispanic and Native American in its race categories as well as in its ethnicity categories. This practice indicates that several of these hospitals may rely on the ethnicity category only when the race category does not allow for sufficient explanation of the patient's classification. For example, this would enable hospitals to identify patients who classify themselves as multi-racial.

Even for hospitals with the ability to separately identify patient ethnicity, respondents indicated that the collection of this information is infrequent. In most cases, the ethnicity field is not a required one and is skipped more often than not. It is important to note that again, there is great diversity with regards to the types of ethnic categories hospitals use. Similar to race, this can be due to the capabilities of the information technology system or it can be driven by the diversity department/interpreter services of the hospital and expanded to capture information on a wide variety of ethnicities.

Several respondents described their feelings about the OMB question on ethnicity, questioning why Hispanic/Latino and Non-Hispanic/Non-Latino were the only classifications of interest to policymakers. While the structure of the race question was identified as problematic for many Hispanic and Latino patients, the ethnicity question was also considered inappropriate, given the diversity of the country. In the words of one of the respondents during an interview: "What does it mean for my ethnicity to be non-Hispanic? Is that what I am? A non-something?"

Like ethnicity, the categories of language that are recorded vary greatly across hospitals. For example, some organizations only capture information on English, Spanish, and "Other Languages." Ranchos Los Amigos, on the other hand, has over 200 languages from which to choose in its registration menu.

Hospital Use of Data on Patient Race and Ethnicity

Several of the respondents indicated that they were using the data that they collect to examine quality of care, health outcomes, utilization of services, and patient satisfaction. Even though data collection practices are common, use of the data for any type of analysis is not widespread. In general, we identified several purposes for which race, ethnicity, and language data are currently being used. For example, hospitals look at this data to develop marketing materials for their communities, especially targeting segments of their patient populations for specific services. Hospitals also are beginning to look broadly across their patient populations to determine whether their patients, in the aggregate as well as in the subcategory, are receiving appropriate and effective services. At times, they use the data to target specific groups for interventions designed to improve access or quality of care. Specific examples of the use of race, ethnicity, and language data include the following:

- Harlem Hospital uses race, ethnicity, and language data when determining whether its staff adequately reflects its community and populations.
- Coney Island Hospital uses the data when developing planning and marketing activities.
- Bellevue Hospital has used the data on the race of its patients to target specific populations to improve use of important health services. As examples, Bellevue has targeted breast-feeding rates in Chinese patients and developmental issues in Hispanic/Latino children.
- Broadlawns Medical Center uses information on languages to determine whether it has the appropriate number and mix of interpreters on staff.
- Cambridge Health Alliance examines utilization of services by different departments, stratified by the race of the patient. It has added clinics for Portuguese and Haitian patients based on these assessments.
- Contra Costa currently collaborates with Kaiser Permanente to examine quality of care among diabetes patients of different racial/ethnic backgrounds. In addition, Contra Costa examines prevalence of conditions and procedures by patient race to determine quality of care. Based on the results of these analyses, it tests various interventions to reduce disparities.
- Denver Health looks at utilization of services and health outcomes by race and ethnicity. Among these are utilization of preventive services such as pap smears, tests for glycemic control for persons with diabetes, mammograms, and management of lipid levels and hypertension.
- Elmhurst and Queens Hospital Centers are beginning to look at race and ethnicity with respect to quality and health outcomes in the chronic disease patient population, including asthma, diabetes, depression, and congestive heart failure.

TABLE 9 Availability of Automated System Fields to Collect Ethnicity and Language

Hospital	Is there a Field for Ethnicity?	Is there a Field for Language?
64 Responding Hospitals	**Yes=28%**	**Yes=80%**
Arrowhead Regional Medical Center	Yes	Yes
Bellevue Hospital Center	No	Yes
Bogalusa Medical Center	No	No
Boston Medical Center	No	Yes
Broadlawns Medical Center	No	Yes
Broward General Medical Center	No	Yes
Cambridge Health Alliance	No	Yes
Central Georgia Health System	No	Yes
Coney Island Hospital	No	Yes
Contra Costa Regional Medical Center	No	Yes
Cooper Green Hospital	No	Yes
Coral Springs Medical Center	No	Yes
Denver Health	No	Yes
Elmhurst Hospital Center	No	Yes
Erlanger Health System	No	No
Gouverneur Nursing and Diagnostic and Treatment Center	No	Yes
Grady Health System	No	Yes
Hale Ho' ola Kamaku Hospital	No	Yes
Harbor/UCLA Medical Center	Yes	Yes
Harborview Medical Center	Yes	Yes
Harlem Hospital Center	No	Yes
Hennepin County Medical Center	No	Yes
Howard University Hospital	No	No
Hurley Medical Center	No	No
Imperial Point Medical Center	No	Yes
JPS Health Network	No	Yes
Kauai Veterans Memorial Hospital	No	No
Kona Hospital	No	No
LAC+USC Healthcare Network	No	Yes
Laguna Honda Hospital & Rehabilitation Center	No	Yes
Lallie Kemp Regional Medical Center	No	No
LSU Health Care Services Division	No	No
Maricopa Integrated Health System	No	Yes
Marlborough-UMass Memorial Healthcare System	No	Yes
Medical Center of Louisiana at New Orleans	No	No
Memorial Hospital Pembroke	Yes	Yes
Memorial Hospital West	Yes	Yes
Memorial Regional Hospital	Yes	Yes
The MetroHealth System	No	Yes
Metropolitan Hospital Center	No	Yes
North Broward Medical Center	No	Yes
The Ohio State University Hospital	Yes	No
Olive View-UCLA Medical Center	No	Yes
Parkland Health & Hospital System	Yes	Yes
Phoebe Putney Memorial Hospital	Yes	Yes
Queens Hospital Center	No	Yes

Hospital	Is there a Field for Ethnicity?	Is there a Field for Language?
Ranchos Los Amigos National Rehabilitation Center	Yes	Yes
Regional Medical Center at Memphis	No	Yes
Riverside County Regional Medical Center	Yes	Yes
San Joaquin General Hospital	No	Yes
San Mateo Medical Center	Yes	Yes
Santa Clara Valley Health & Hospital System	Yes	Yes
San Francisco General Hospital	Yes	No
Thomason Hospital	No	Yes
Truman Medical Centers	Yes	Yes
UMass Memorial Healthcare System	No	Yes
UMDNJ-University Hospital	Yes	Yes
University Hospital-The university of New Mexico Health Sciences Center	No	Yes
The University of Texas Medical Branch at Galveston	Yes	No
The University of Texas M.D. Anderson Cancer Center	No	Yes
The University of Texas Health Center at Tyler	No	Yes
VCU Health System	No	No
Wishard Health Services	No	Yes
Woodhull Medical and Mental Health Center	Yes	Yes

SOURCE NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.

TABLE 10 Collection Practices Related to Patient Ethnicity

Hospital	Ethnicity Categories
Arrowhead Regional Medical Center	Unknown, Hispanic, Non-Hispanic, Other
Harbor/UCLA Medical Center	Hispanic/Non-Hispanic
Harborview Medical Center	Vietnamese, White/Caucasian, Not Hawaiian, Not reported, Unknown, Cuban, Mexican/Mexican American, Filipino, Guaminian/Chamarro, Multiple, American Indian/Alaskan, Asian Indian, Black/African American, Cambodian, Thai, Chinese, Samoan, Not Spanish/Unknown, Other Asian, Other Pacific Islander, Other Spanish/Hispanic, Puerto Rican
Memorial Hospital Pembroke	American Indian, Canadian, Chinese, Eastern European, Hispanic, Polish, Eskimo, Caribbean Islander, Haitian, Hispanic, Cuban, Mexican, Nicaraguan, Puerto Rican, Indo Asian, Japan, Korean, Middle Eastern, North African, American, South Pacific, Portuguese, Russian, South African, SE Asian, Cambodian, Laotian, Vietnamese, Sub-Saharan African, Western European
Memorial Hospital West	American Indian, Canadian, Chinese, Eastern European, Hispanic, Polish, Eskimo, Caribbean Islander, Haitian, Hispanic, Cuban, Mexican, Nicaraguan, Puerto Rican, Indo Asian, Japan, Korean, Middle Eastern, North African, American, South Pacific, Portuguese, Russian, South African, SE Asian, Cambodian, Laotian, Vietnamese, Sub-Saharan African, Western European
Memorial Regional Hospital	American Indian, Canadian, Chinese, Eastern European, Hispanic, Polish, Eskimo, Caribbean Islander, Haitian, Hispanic, Cuban, Mexican, Nicaraguan, Puerto Rican, Indo Asian, Japan, Korean, Middle Eastern, North African, American, South Pacific, Portuguese, Russian, South African, SE Asian, Cambodian, Laotian, Vietnamese, Sub-Saharan African, Western European
The Ohio State University Hospital	Hispanic/Latino
Parkland Health & Hospital System	Hispanic, Non-Hispanic, Unknown
Phoebe Putney Memorial Hospital	American, Australian, Canadian, Chinese, Cuban, English, French, German, Irish, Mexican, Vietnamese
Ranchos Los Amigos National Rehabilitation Center	Hispanic, Non-Hispanic, Unknown
Riverside County Regional Medical Center	Hispanic, Non-Hispanic, Unknown
San Mateo Medical Center	Hispanic, Non-Hispanic
Santa Clara Valley Health & Hospital System	Hispanic, Non-Hispanic, Unknown
San Francisco General Hospital	Cambodian, Central American, Chinese, Cuban, Middle Eastern, Filipino, Guamanian, Hawaiian, Indian, Japanese, Korean, Laotian, Mexican, Mexican-American/Chicano, Other Non-White, Puerto Rican, Other Asian, Russian, Samoan, Other European, Other Hispanic/Latino, Vietnamese, Other Southeast Asian, Russian Jew, White/Caucasian, African American/Black, Hispanic/Latin American, Native American/Eskimo/Aleut, Asian, Other, Asian/Pacific Islander, Unknown/Undeclared
Truman Medical Centers	African, American, Arab, Canadian, Chinese, Columbian, Cuban, Eastern Indian, Ethiopian, French, German, Greek, Haitian, Iranian, Israeli, Italian, Jamaican, Japanese, Kenyan, Korean, Lebanese, Mexican, Nigerian, Other Filipino, Polish, Russian, Scandanavian, Spanish, United Kingdom, Vietnamese
UMDNJ-University Hospital	Central/South American, Cuban, Mexican, Puerto Rican, Other/unknown/Hispanic, Non-Hispanic, Unknown
The University of Texas Medical Branch at Galveston	Arabic, Chinese, Czech, Danish, Dutch, English, French, German, Hebrew, Hungarian, Indian, Italian, Japanese, Korean, Malaysian, Neo-Malaysian, Nigerian, Norwegian, Pakistani, Persian, Filipino, Polish, Portuguese, Russian, Spanish, Sweden, Thai, Turkey, Vietnamese, Yiddish
Woodhull Medical and Mental Health Center	Hispanic, Native Hawaiian/PI, South Asian/Middle Eastern, American Indian, Alaskan

SOURCE NPHHI Survey of NAPH Member Hospitals on Collection of Race/Ethnicity/Language Data, 2005.

Discussion and Recommendations

3

The NPHHI surveys offer insights into data collection practices at U.S. hospitals and provide important lessons to hospital leadership, clinicians, researchers, and policymakers about the potential to develop more systematic mechanisms to understand and address health disparities. The findings reflect hospital practices, but there are lessons here for other sectors of the health care industry as well.

The findings portray a classic "good news, bad news" scenario. The good news is that most hospitals are already actively engaged in data collection, at least for some segment of their patient populations. They have the technological wherewithal to collect information on the race, ethnicity, and language of their patient populations at the access points that are most important in their health care environments. For the majority of hospitals, they also have the means to record the information such that it resides in a database that is accessible at multiple access points, thereby obviating the need for redundant data collection.

The bad news is that, despite the availability of the data, very few hospitals are using it in quality improvement efforts or even as a management or marketing tool. Hospitals generally do not use the data to determine whether various subpopulations are satisfied with the care they receive; to measure utilization of various services; or to make certain that all patients are receiving a standard of care that is determined to be necessary for high-quality health care.

Ironically, respondents to both surveys demonstrated a high degree of awareness regarding the subject of health care disparities. This awareness, however, related more to health disparities outside of their hospitals than potential disparities within. Although we did not ask survey respondents whether they believed there were disparities within the four walls of their hospitals or health systems, many respondents voiced the opinion that their institutions were disparity free. For this reason, they believed that analysis of health outcomes, satisfaction, and quality measures by race and ethnicity would be an empty exercise.

The interviews with NAPH respondents were particularly interesting, since safety net hospitals are on the front lines of health care delivery for diverse patient populations and are confronted every day with the challenges of delivering high-quality health care in a culturally and linguistically appropriate manner. Several respondents described disparities in terms of utilization of health services, primarily as a result of cultural differences and expectations that originate

with the patients and their families. NAPH member hospitals have gone to great lengths to identify and understand these differences and customize their services to better meet the needs of their patient populations. Nevertheless, the recognition of differences in culture, language, and background does not necessarily create an interest in developing empirical tools and measurements to address the potential for disparities within the health system.

Interestingly, the hospitals that have looked at satisfaction, utilization, health outcomes and quality of care by the race, ethnicity, and/or language of their patients reported that they gained important information that was of immediate and practical use to their efforts to provide the best possible care for their patients. Hospitals have redesigned services, developed outreach efforts, reassigned clinical and front-line staff, and altered communication strategies based on the ability to stratify information by race, ethnicity, and language.

We believe that the discussion about the use of the data is the most pressing one — and one that can be marginalized or obfuscated by discussions about the *quality* of the data. As is clear from the survey findings, data collection on race, ethnicity, and language in the hospital setting is a home-grown endeavor that is often messy, uneven, and incomplete. Race and ethnicity are determined by patients, in their own words; by registration clerks asking carefully scripted questions; and by other registration clerks, after eyeballing the patient or identifying the patient's last name. Clearly, the process has the potential for errors.

After discussions with 64 hospitals in this study, review of the survey findings of the U.S. hospital industry, and extensive work with public hospitals prior to this study, we conclude that the data on the race and ethnicity of patients is relatively accurate and generally reflects the racial and ethnic composition of patients who receive care at U.S. hospitals. Additional work needs to be done to develop systems to capture the most complete and accurate information on patients, but the field of disparities research can move forward using the data that currently exists on patient use of hospital care.

Hospitals need not wait until the processes of collection are refined and perfected to begin recording race, ethnicity, and language of their patients and using this information to support analyses of patient care. Hospitals should conduct appropriate training and provide adequate support to encourage registration clerks and others to ask patients about their race, ethnicity, and language and to record this information in a consistent fashion. Uniform collection methodologies that rely on patient self-reporting will go far toward developing valuable information that hospitals can readily use for quality improvement purposes.

Hospital practices in terms of classification of race and ethnicity are highly variable and, for the most part, do not

follow OMB guidelines. For several reasons, few hospitals separate the questions regarding race and ethnicity. First, about half of the hospitals in the NAPH survey reported that they do not have a field for ethnicity and generally include a category for Hispanic/Latino in their race field. Second, there is resistance to lengthening the registration process with additional questions; consequently, most respondents preferred a one-step process for race and ethnicity. Third, and perhaps most importantly, for the majority of respondents, separating race from ethnicity creates discomfort for staff and patients and forces an artificial categorization that most respondents said they prefer to avoid.

Widespread use of the OMB categories will require targeted training that provides information to hospital staff and patients alike. The OMB categories involve identification of race that is, for many individuals, inconsistent with their own self-categorization. Many Hispanic and Latino individuals do not consider themselves white, black, or American Indian. They consider themselves Cuban, Mexican, Puerto Rican, Honduran, or many other ethnicities that reflect countries of origin with a common Spanish language. Without adequate training, staff may be reluctant to ask Hispanic or Latino patients to classify themselves according to one of the OMB racial categories. Patients may be unwilling to do so and may select "other" for their race if the option is available to them. Or, staff may try to avoid the question by eyeballing and making the identification on their own.

For some hospitals, the OMB categories may not be the best construct for recording race and ethnicity, in part because the categories do not fully capture the granularity of information that is most meaningful for their patient populations. For other hospitals, these categories are the gold standard, and registration departments work hard to make certain that their practices conform to this standard.

What became clear throughout conversations with hospital staff was the importance of raising awareness about methods for data collection and the need to respect the terminology and categories that patients were most comfortable providing. NPHHI strongly supports efforts to have patients self-identify, when possible, and this self-identification process should embrace the race and ethnicity of the patient, as determined by the patient.

Recommendations

Hospitals are well on their way to incorporating data collection on the race and ethnicity of patients into their routine registration process, but much more needs to be done to move data collection to data use. We offer four recommendations to move the field toward more meaningful use of this information.

1. The OMB categories may be a good starting point as guidance for hospitals. Over the long run, however, much

more must be done to develop strategies for hospitals and health systems to identify the race and ethnicity of their patients accurately and appropriately. The OMB categories should be tested and evaluated in a set of hospitals with diverse patient populations to determine whether they are appropriate and practical.

The OMB categories can provide hospitals with a way to record information in a uniform fashion. Hospitals that deviate from the OMB categories should make certain that they are recording the information uniformly across patients and across various access points in the hospital or health system. Hospitals should be encouraged to collect information in as granular a fashion as makes sense for their community and their organization. This would serve local, state, and federal data collection purposes as well as organizational interests in the health and well-being of their particular patient populations.

2. Efforts to strengthen the accuracy and consistency of data collection should continue but should not take center stage in the struggle to identify and address health care disparities. The most significant and sustained efforts should focus on encouraging hospitals to use the information they currently collect. As their use of the information increases, their interest in making it as accurate as possible will also likely increase.
3. Health care organizations, hospital associations, and research groups should develop tools and templates to demonstrate to hospitals ways that they can use data on race, ethnicity and language to improve care for patients. Hospitals currently collect and report quality measures to the Centers for Medicare and Medicaid Services (CMS) through Hospital Compare, a publicly available, searchable database that allows the public to compare hospital performance on a number of evidenced-based quality measures.[14] These and other public reporting requirements could evolve to enable health care organizations to determine whether their quality measures are consistent across various patient populations.

   Additional opportunities may exist for hospitals to routinely review quality and utilization data by the race, ethnicity and language of their patients. Voluntary efforts would have greater opportunities of success if organizations did not have to develop these reports on their own.
4. Hospitals should implement staff training that includes effective strategies to explain the relevance of the data to patient care. Such training can have a greater impact on data collection than can improvements in information systems or other structural barriers. Some hospital staff are not yet convinced that data collection is necessary or even appropriate. Education about the value of the

information for patient care, with clear examples of how using this information benefited the hospital and the patient, could increase the willingness of staff to pay attention to these important activities.

Appendix A

Phase I Survey: RWJ Project on Data Collection

This survey is intended to gather information about the collection of race and ethnicity data for patients in U.S. hospitals. Please answer the following questions as accurately as possible for your organization. If you do not know the answer to any of the questions, or if the question is not applicable to your hospital, please indicate so on the survey. (Include contact information of staff person at NPHHI for questions.)

RESPONDENT INFORMATION

Hospital

Name of person completing survey

Position/title of person completing survey

Telephone/Fax E-mail

HOSPITAL INFORMATION

1. Please indicate your hospital ownership status:
   a. Non-government, not-for-profit
   b. Investor-owned/for-profit
   c. Government, nonfederal (city, county or state)
   d. Other (please specify) _____

2. How would you describe your hospital?
   a. Community Hospital (no medical residents or fellows)
   b. Teaching Hospital (up to 25 medical residents and fellows per 100 beds)
   c. Major Teaching Hospital (25 or more medical residents and fellows per 100 beds)
   d. Academic Medical Center (Hospital serves as primary teaching hospital or medical school)

3. Please estimate the percentage of gross charges for the following categories of patients: (Please include managed care and fee-for-service charges together in the appropriate category.) The total should come as close to 100 percent as possible. If you don't have patients in any one of the following categories, please indicate by placing a '0' in the appropriate category.
   a. Medicare _____%
   b. Commercial Insurance _____%
   c. Medicaid and SCHIP _____%
   d. Uninsured/Self pay _____%
   e. Other _____%
      (specify): _____
   f. Do not know

4. What is your average daily inpatient census?

_____

_____

RACE, ETHNICITY, AND PRIMARY LANGUAGE DATA COLLECTION

5. Does your hospital collect information on the race of patients (this would generally involve classifying patients as white, black/African American, American Indian or Alaska Native, Asian and Native Hawaiian or other Pacific Islander, etc)?
a. Yes
b. No
c. Do not know

6. Does your hospital collect information on the ethnicity of patients (this would involve classifying patients as Hispanic/Latino, or non-Hispanic/non-Latino)?
a. Yes
b. No
c. Do not know

7. Is patient race/ethnicity typically collected at the point of patient registration for inpatient care?
a. Yes
b. No
c. Do not know
d. N/A

8. Is patient race/ethnicity typically collected at the point of patient registration for outpatient care at the hospital campus?
a. Yes
b. No
c. Do not know
d. N/A

9. Is patient race/ethnicity typically collected at the point of patient registration for outpatient care at clinics or doctors' offices that are affiliated with the hospital but located off the hospital campus?
a. Yes
b. No
c. Do not know
d. N/A

10. Is patient race/ethnicity typically collected at the point of patient registration for care at the emergency department?
a. Yes
b. No
c. Do not know
d. N/A

11. Is patient race/ethnicity typically collected at the point of patient registration for ambulatory or same-day surgery centers that are affiliated with the hospital?
a. Yes
b. No
c. Do not know
d. N/A

12. Does your hospital use race/ethnicity data to assess and compare quality of care among different patients?
a. Yes
b. No
c. Don't know

13. Does your hospital use race/ethnicity data to assess and compare utilization of health services among different patients?
a. Yes
b. No
c. Don't know

Appendix A

Phase I Survey: RWJ Project on Data Collection

14. Does your hospital use race/ethnicity data to assess and compare health outcomes across different patients?
- a. Yes
- b. No
- c. Don't know

15. Does your hospital use race/ethnicity data to assess and compare satisfaction with hospital services among different patients?
- a. Yes
- b. No
- c. Don't know

16. Please indicate whether any of the following represent a barrier to the collection of race/ethnicity data at your organization:
- a. Confusion about race/ethnicity categories
  1. Yes
  2. No
  3. Do not know
- b. Reluctance of staff to ask this type of information
  1. Yes
  2. No
  3. Do not know
- c. Reluctance of patients to provide this type of information
  1. Yes
  2. No
  3. Do not know
- d. Concerns that collection of this data may expose the hospital to legal liability
  1. Yes
  2. No
  3. Do not know
- e. Lack of funding to support the collection of this data
  1. Yes
  2. No
  3. Do not know
- f. Limitations of health information technology system to capture this type of data
  1. Yes
  2. No
  3. Do not know
- g. No demonstrated need to collect this data
  1. Yes
  2. No
  3. Do not know
- h. Lack of agreement of executive leadership on the need to collect this data
  1. Yes
  2. No
  3. Do not know
- i. Lack of staff time to collect this data
  1. Yes
  2. No
  3. Do not know

INTERPRETER SERVICES

17. Does your hospital collect information on patients' primary language if it is other than English (such as Spanish, Chinese, German, Haitian Creole, etc.)?
- a. Yes
- b. No
- c. Do not know
- d. N/A

18. Does your hospital employ interpreters (either full-time or part-time)?
- a. Yes
  1. If yes, what would the annual FTE (full-time equivalent) equal? _____
- b. No
- c. Do not know

19. Does your hospital use contract interpreters for in-person interpretation?
- a. Yes
- b. No
- c. Do not know

20. Does your hospital use a telephone language interpreter service?
- a. Yes
- b. No
- c. Do not know

21. What is the total annual budget for interpreter services? (Including employed interpreters, translation services, telephone language interpreter service, contracted services, etc.)
- a. $_____
- b. Do not know
- c. N/A

LITERACY LEVEL

Health literacy has been defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

22. Do you believe that inadequate health literacy is a common problem with patients at your hospital?
- a. Yes
- b. No
- c. Do not know

23. Do you have programs in your hospital to assess the literacy levels of patients?
- a. Yes
- b. No
- c. Do not know

24. Do you have health education focused on low literacy patients?
- a. Yes
- b. No
- c. Do not know

Appendix B

Phase II Survey: RWJ Project on Data Collection

RESPONDENT INFORMATION

Hospital

Name of person completing survey

Position/title of person completing survey

Telephone/Fax E-mail

HOSPITAL INFORMATION

1. Your hospital is listed as a (separate public entity, non-profit corporation, direct operation by state or local government, investor owned) organization. Is this correct?

2. How would you describe your hospital?
   a. Community Hospital (no medical residents or fellows)
   b. Teaching Hospital (up to 25 medical residents and fellows per 100 beds)
   c. Major Teaching Hospital (25 or more medical residents and fellows per 100 beds)
   d. Academic Medical Center (Hospital serves as primary teaching hospital or medical school)

3. Please estimate the percent of patients that are covered by:
   a. Medicare _____%
   b. Commercial Insurance _____%
   c. Medicaid and SCHIP _____%
   d. Uninsured/Self pay _____%
   e. Other (specify): _____ _____%

4. In 2004, about how many inpatient admissions did your hospital have?

5. In 2004, about how many outpatient visits did your hospital have (include off-site clinics, school-based clinics, etc.)?

I would like you to tell me about how you classify patients by race/ethnicity at your hospital.

6. Do you have organizational policies that specifically address the collection of patient race? (If so, can you please send us a copy?)
   a. Do they specify the categories of race?
   b. Do they specify the categories of ethnicity?
   c. Do they specify the method used to solicit race/ethnicity data from the patient? (For example, development of standard questions, patient self-report, "eye-balling the patient," other.)

7. What racial categories do you use to classify patients by race? (Please be specific)

8. What ethnic categories do you use to classify patients by ethnicity? (Please be specific)

9. Clarification question: Are Hispanic individuals categorized as Hispanic only or are they categorized as white, black, or other and also Hispanic or non-Hispanic?

10. For about what percentage of patients do you estimate you have race/ethnicity data?
   a. Can you describe in more detail the method used for soliciting race/ethnicity data?
   b. How well do you think these racial/ethnic categories works in terms of capturing accurate and complete data?

11. Do you classify patients as multi-racial? If yes, how is this captured?

12. Using your classification systems, can you estimate what the racial and ethnic composition of your patient population?

13. What categories, if any, do you use to classify patients by language?

14. Can you tell me where within your organization patient race/ethnicity is recorded:
   Potential sites: Emergency Department, inpatient admission, outpatient registration, clinics or physician offices associated with the hospital, ambulatory care or same-day surgery centers associated with the hospital.

15. Is information on patient race/ethnicity accessible at all of these sites? Where information is available, describe how consistent it is across sites.

16. Describe the process related to recording and/or verifying this data.

17. What is the process involved in changing or updating categories for collecting data on patient race/ethnicity?

18. Describe how the process of identifying the need for an interpreter fits into the patient registration process.

I would like to ask you some questions regarding the community surrounding your organization.

19. Please describe how closely your race/ethnicity categories reflect the specific racial/ethnic composition of your community (for example, different Hispanic groups, recent immigrant populations, etc.).

20. What role if any do community boards or other community organizations have regarding the collection of race/ethnicity?

I would like to ask you about how you use this data.

21. Please provide examples of how your organization uses race/ethnicity data to assess and compare quality of care among different patients.

22. Please provide examples of how your organization uses race/ethnicity data to assess and compare utilization of health services among different patients.

23. Please provide examples of how your organization uses race/ethnicity data to assess and compare health outcomes across different patients.

24. Please provide examples of how your organization uses race/ethnicity data to assess and compare satisfaction with hospital services among different patients.

Appendix B

Phase II Survey: RWJ Project on Data Collection

BARRIERS TO DATA COLLECTION

25. The following list identifies potential barriers to the collection of race/ethnicity data. Can you provide information on which ones affect you?

a. Confusion about race/ethnicity categories
b. Reluctance of staff to ask this type of information
c. Reluctance of patients to provide this type of information
d. Concerns that collection of this data may expose the hospital to legal liability
e. Lack of funding to support the collection of this data
f. Limitations of health information technology system to capture this type of data
g. No demonstrated need to collect this data
h. Lack of agreement of executive leadership on the need to collect this data
i. Lack of staff time to collect this data

26. If you have an EMR, describe the extent to which race/ethnicity data is available system-wide.

27. Describe the extent to which race/ethnicity data can be linked to clinical and encounter data, utilization data, and outcome data. For example, can you determine if diabetic African-American patients are more likely to get an eye exam than white patients?

28. Describe the extent to which language data can be linked to clinical and encounter data, utilization data, and outcome data. For example, can you determine if patients who speak a language other than English are more likely to have a C-section when they deliver their babies than white patients?

I would like to ask you some questions about your workforce and training.

29. About what proportion of your workforce is:

a. White _____%
b. African American _____%
c. Hispanic/Latino _____%
d. Asian/Pacific Islander _____%
e. Other _____%

30. Describe current training practices associated with the collection or analysis of patient race/ethnicity data.

31. Is there any mechanism to review the completion rate and accuracy of race/ethnicity data collection by hospital staff?

LESSONS LEARNED

32. What lessons do you think your organization has learned over the years on how to best collect this information? Are there practices or processes that have changed that work better now, and can you describe some of these?

33. What areas do you still consider not to be working as well as you would like, and what are some of the options you will try to improve the collection of the data?

Notes

1. Brian Smedley, Adrienne Stith, Alan Nelson, editors, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, (Washington, DC: National Academy of Sciences, 2003).

2. See the OMB Statistical Policy Directive No. 15, *Race and Ethnic Standards for Federal Statistics and Administrative Reporting*, October 30, 1997.

3. Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman, *Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals*, (New York, NY: The Commonwealth Fund, May 2004).

4. Michele Ver Ploeg and Edward Perrin, editors, *Eliminating Health Disparities: Measurement and Data Needs,* (Washington, DC: National Academies Press, 2004).

5. Throughout this report, the term "safety net hospitals" is used to refer to NAPH member hospitals and health systems, which may include health care providers owned and operated by cities, counties, states, universities, nonprofit organizations, or other entities. They share a common safety net mission of providing health care to all, regardless of ability to pay.

6. Hasnain-Wynia, et al, 2004; also JCAHO survey.

7. AHA lists approximately 4,829 non-federal acute care hospitals in the U.S. NPHHI used a subset of this list to draw a sample for the national survey so that researchers could initiate contact with hospitals by directing correspondence to those individuals named as CFOs in the AHA mailing list. Thus, the sample was drawn from a list of approximately 3,800 non-federal acute care hospitals. The group of hospitals with CFOs listed was compared to the group of hospitals in the AHA database without CFOs listed; no significant differences of interest were found between the two groups.

8. Hasnain-Wynia, et al, 2004.

9. For a discussion about the potential for legal barriers to use of the data, see: S. Rosenbaum, P. Borzi, L. Repasch, T. Burke, J. Benevelli, *Charting the Legal Environment of Health Information*, (Washington, DC: The George Washington University School of Public Health and Health Services, May 2005).

10. All hospital systems that were members of NAPH were invited to participate in the survey. Many NAPH member systems include multiple hospitals, and some of these hospitals participated individually in the survey. In some cases, all hospitals within a system were not included in our sample. For example, the Hawaii Health Systems Corporation is comprised of 11 hospitals, most of which are extremely small and operate primarily as outpatient clinics. NPHHI invited the three largest hospitals and three of the other hospitals to participate in the survey.

11. Hospitals within health systems were contacted to participate in the study. NPHHI excluded several NAPH members that were not focused on general acute care and several of the smaller community hospitals.

12. American Hospital Association Hospital Statistics, 2003 Edition.

13. Marsha Regenstein, Jennifer Huang, et al. *Diabetes in Safety Net Hospitals and Health Systems*. (New York: The Commonwealth Fund, June 2005). The seventh hospital also collects race information but did not provide it for the project.

14. For information on Hospital Compare, see: www.hospitalcompare.hhs.gov.

NAPH Members

Alameda County Medical Center Oakland CA

Arrowhead Regional Medical Center Colton CA

Boston Medical Center Boston MA

Broadlawns Medical Center Des Moines IA

Cambridge Health Alliance Cambridge MA

Carolinas HealthCare System Charlotte NC

Central Georgia Health System Inc. Macon GA

Community Health Network of San Francisco San Francisco CA

- **Laguna Honda Hospital & Rehabilitation Center** San Francisco CA
- **San Francisco General Hospital** San Francisco CA

Contra Costa Regional Medical Center Martinez CA

Cook County Bureau of Health Services Chicago IL

- **The John H. Stroger, Jr. Hospital of Cook County** Chicago IL
- **Oak Forest Hospital** Oak Forest IL
- **Provident Hospital of Cook County** Chicago IL

Cooper Green Hospital Birmingham AL

Denver Health Denver CO

Erlanger Health System Chattanooga TN

Governor Juan F. Luis Hospital and Medical Center St. Croix VI

Grady Health System Atlanta GA

Halifax Community Health System Daytona Beach FL

Harborview Medical Center Seattle WA

Harris County Hospital District Houston TX

- **Ben Taub General Hospital** Houston TX
- **Lyndon B. Johnson Hospital** Houston TX

Hawaii Health Systems Corporation Honolulu HI

- **Hale Ho'ola Kamaku Hospital** Honokaa HI
- **Hilo Medical Center** Hilo HI
- **Ka'u Hospital** Pahala HI
- **Kauai Veterans Memorial Hospital** Waimea HI
- **Kohala Hospital** Kapaau HI
- **Kona Hospital** Kealakekua HI
- **Kula Hospital** Kula HI
- **Lana'i Community Hospital** Lanai City HI
- **Leahi Hospital** Honolulu HI
- **Maluhia** Honolulu HI
- **Maui Memorial Hospital** Wailuku HI
- **Samuel Mahelona Memorial Hospital** Kapaa HI
- **West Kauai Medical Center** Kauai HI

Health Care District of Palm Beach County West Palm Beach FL

- **Glades General Hospital** Belle Glade FL

The Health and Hospital Corporation of Marion County Indianapolis IN

- **Wishard Health Services** Indianapolis IN

Hennepin County Medical Center Minneapolis MN

Howard University Hospital Washington DC

Hurley Medical Center Flint MI

Jackson Memorial Hospital Miami FL

JPS Health Network Fort Worth TX

Kern Medical Center Bakersfield CA

Los Angeles County Department of Health Services Los Angeles CA

- **Harbor/UCLA Medical Center** Torrance CA
- **Martin Luther King/Drew Medical Center** Los Angeles CA
- **LAC+USC Healthcare Network** Los Angeles CA
- **Olive View-UCLA Medical Center** Sylmar CA
- **Rancho Los Amigos National Rehabilitation Center** Downey CA

LSU Health Sciences Center Health Care Services Division Baton Rouge LA

- **Bogalusa Medical Center** Bogalusa LA
- **Earl K. Long Medical Center** Baton Rouge LA
- **Huey P. Long Medical Center** Pineville LA
- **Lallie Kemp Regional Medical Center** Independence LA
- **Leonard J. Chabert Medical Center** Houma LA
- **Medical Center of Louisiana at New Orleans** New Orleans LA
- **University Medical Center** Lafayette LA
- **Dr. Walter O. Moss Regional Medical Center** Lake Charles LA

Maricopa Integrated Health System Phoenix AZ

Memorial Healthcare System Hollywood FL

- **Joe DiMaggio Children's Hospital at Memorial** Hollywood FL

NAPH Members

Memorial Hospital Miramar Miramar FL

Memorial Hospital Pembroke Pembroke Pines FL

Memorial Hospital West Pembroke Pines FL

Memorial Regional Hospital Hollywood FL

Memorial Hospital at Gulfport Gulfport MS

The MetroHealth System Cleveland OH

Natividad Medical Center Salinas CA

New York City Health and Hospitals Corporation New York NY

Bellevue Hospital Center New York NY

Coler-Goldwater Memorial Hospital Roosevelt Island NY

Coney Island Hospital Brooklyn NY

Cumberland Diagnostics & Treatment Center Brooklyn NY

Dr. Susan Smith McKinney Nursing and Rehabilitation Center Brooklyn NY

East New York Diagnostics & Treatment Center Brooklyn NY

Elmhurst Hospital Center Elmhurst NY

Gouverneur Nursing and Diagnostic & Treatment Center New York NY

Harlem Hospital Center New York NY

Jacobi Medical Center Bronx NY

Kings County Hospital Brooklyn NY

Lincoln Medical and Mental Health Center Bronx NY

Metropolitan Hospital Center New York NY

Morrisania Diagnostics & Treatment Center Bronx NY

North Central Bronx Hospital Bronx NY

Queens Hospital Center Jamaica NY

Renaissance Health Care Network Diagnostics & Treatment Center New York NY

Sea View Hospital Rehabilitation Center & Home Staten Island NY

Segundo Ruiz Belvis Diagnostic & Treatment Center Bronx NY

Woodhull Medical and Mental Health Center Brooklyn NY

North Broward Hospital District Fort Lauderdale FL

Broward General Medical Center Fort Lauderdale FL

Coral Springs Medical Center Coral Springs FL

Imperial Point Medical Center Imperial Point FL

North Broward Medical Center Pompano Beach FL

The Ohio State University Hospital Columbus OH

Parkland Health & Hospital System Dallas TX

Regional Medical Center at Memphis Memphis TN

Riverside County Regional Medical Center Riverside CA

San Joaquin General Hospital Stockton CA

San Mateo Medical Center San Mateo CA

Santa Clara Valley Health & Hospital System San Jose CA

Schneider Regional Medical Center St. Thomas VI

Roy Lester Schneider Hospital St. Thomas VI

Myrah Keating Smith Community Health Center St. John VI

Stony Brook University Hospital Stony Brook NY

Thomason Hospital El Paso TX

Truman Medical Centers Kansas City MO

TMC Hospital Hill Kansas City MO

TMC Lakewood Kansas City MO

TMC Behavioral Health Kansas City MO

UMass Memorial Healthcare System Worcester MA

UMDNJ-University Hospital Newark NJ

University Health System San Antonio TX

University HealthSystem Consortium Oak Brook IL

University Hospital, The University of New Mexico Health Sciences Center Albuquerque NM

University Medical Center of Southern Nevada Las Vegas NV

University of Arkansas for Medical Sciences Little Rock AR

University of Chicago Hospitals & Health System Chicago IL

University of Colorado Hospital Denver CO

The University of Kansas Hospital Kansas City KS

University of Texas System Austin TX

The University of Texas Health Center at Tyler Tyler TX

The University of Texas M.D. Anderson Cancer Center Houston TX

The University of Texas Medical Branch at Galveston Galveston TX

VCU Health System Authority Richmond VA

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