

Using patient-level demographic data to reduce health care disparities and reduce costs

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Introduction

The American Medical Association (AMA), Chicago Health Information Technology Regional Extension Center (CHITREC) and Alliance of Chicago Community Health Services (Alliance) are conducting a quality improvement (QI) project to improve the reliability of the collection, reporting and use of race and ethnicity data in the electronic health record (EHR) system of ambulatory care clinics.

Detection of disparities in health care requires collecting valid and reliable data on the demographic characteristics of patients receiving care and on the quality of the care delivered, then stratifying the quality performance data by the relevant demographic subgroups. However, evidence suggests that ambulatory care clinics often do not collect basic demographic information from their patients at all, or collect it in non-systematic and unreliable ways.

This poster describes the collaborative process and methods used to develop a toolkit aimed at improving the reliability of race and ethnicity data collection and use.

Estimated excess direct medical care expenditures due to health inequalities, 2003 to 2006, constant 2008 dollars (billions)[†]

	African Americans	Asians	Hispanics	Total
2003	35.2	3.6	17.6	56.3
2004	32.0	2.7	18.2	53.8
2005	32.8	2.9	22.4	58.2
2006	34.9	2.2	23.9	61.1
Total	135.9	11.4	82.0	229.4

LaVeist, T. A., Gaskin, D., & Richard, P. (2011). Estimating the economic burden of racial health inequalities in the United States. *International Journal of Health Services*, 41(2), 231-238.

Aim

Create a toolkit that assists ambulatory care clinics with improving the reliability of how they collect and use race and ethnicity data for QI purposes. This toolkit will teach practice staff best practices for race and ethnicity data collection. This patient demographic information will aid ambulatory care clinics that stratify their clinical performance measures by race and ethnicity to identify and reduce gaps in health care outcomes. Reducing these gaps in health outcomes may reduce excess direct medical care expenditures due to health inequalities.

Methods

Phase I (Completed)

- Review published recommendations and guidelines on race and ethnicity data collection
- Identify and partner with five ambulatory care clinics
- Observe process for race and ethnicity data collection and reporting in partner clinics
- Develop the business case for utilization of the toolkit



Registration staff often guess the race/ethnicity of their patients based on what they observe.

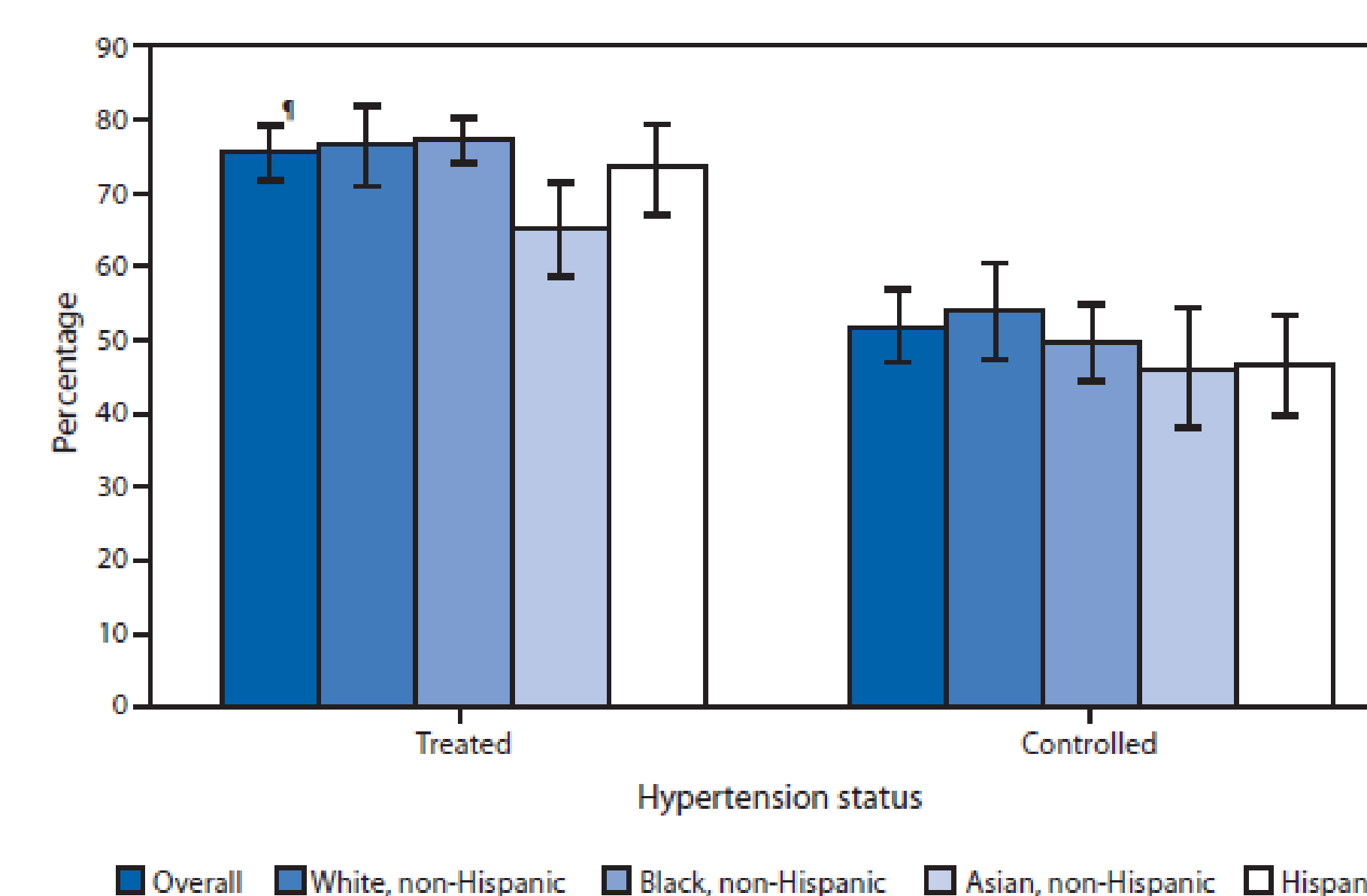


What would you choose if you had to identify the race and ethnicity of these four individuals?

Phase II (In progress)

- Design a toolkit that incorporates recommendations, guidelines and observations from real-world scenarios
- Conduct training and pilot testing of the toolkit in partner clinics to validate its efficacy
- Refine the toolkit based on feedback from partner clinics
- Develop a summary report of the process and outcomes of the pilot test
- Disseminate findings nationwide
- Identify strategies for widespread adoption of toolkit by ambulatory care practices and clinics, including policy and systems change

Percentage of Adults Aged ≥18 Years with Hypertension Reporting Treatment and Control of Their Condition, by Race/Ethnicity — United States, National Health and Nutrition Examination Survey, 2011–2012



During 2011–2012, 75.6% of adults aged ≥18 years with hypertension were taking medication to lower their blood pressure, and 51.8% had their blood pressure under control. **Non-Hispanic Asian adults with hypertension were less likely to be taking medication (65.2%) than were non-Hispanic black (77.4%) and non-Hispanic white (76.7%) adults with hypertension.**

By understanding how to stratify clinical performance measures by race and ethnicity, health care providers can examine if there are inequities in outcomes for specific population groups and develop focused, quality improvement interventions to improve these outcomes.

Anticipated results

Successful execution of this project will produce the following outcomes for ambulatory care clinics:

- A reliable performance measurement and reporting system within a practice
- Understanding of how to use race and ethnicity data in stratification of clinical performance reporting for a chronic medical condition
- Solutions to challenges that negatively affect equity of care within a practice
- Awareness of the business case for why health equity is valuable for a practice
- Development of a dissemination plan for spread of the patient-level demographic data collection toolkit

Discussion

This project strives to improve how ambulatory care clinics collect and use patient-level race and ethnicity data in EHRs. There are two main limitations for this project. Due to a small sample size, we will be unable to generalize our findings across ambulatory care clinics. Additionally, our definition of reliable data collection focuses on patient-self identification of race and ethnicity. Patients may not self-identify with the current Office of Management and Budget race and ethnicity categories.

Acknowledging these limitations, ambulatory care clinics can ensure reliability of race and ethnicity data collection by developing methods (e.g. patient intake forms that list the same race and ethnicity categories as the electronic health record template); understanding why this information is collected and training their staff on its value; and performing quality improvement assessments to reduce the number of patients who have their race and ethnicity identified as “unknown or don’t know.” Decreasing the number of patients with this information missing will allow for richer analysis of patient outcomes.

Conclusion

Ambulatory care clinics face many challenges in providing equitable care while working to sustain their business in a rapidly changing market. There are many advantages to reliably collecting race and ethnicity data, including, but not limited to, improved understanding of the diversity of an ambulatory care clinic’s existing patient panel, enhanced development of culturally-appropriate tailored services for patients and maximized revenue received from performance-based payment models.

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