Operationalizing Race & Ethnicity Data Collection

Birth Equity Initiative Monthly
Webinar 3 – January 16, 2024

Nebraska Perinatal Quality Improvement Collaborative
NPQIC

● NEBRASKA, WHERE A GREAT LIFE STARTS WITH HEALTHY MOMS AND HEALTHY BABIES. ●

Agenda

- NPQIC updates
- Equity Exercise
- Why focus on self-reporting race and ethnicity?
- Creating buy-in resources
- QI Data Collection Corner
- Team Talk
- BE next steps
- Appendix

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Introductions

- Name
- Role
- Institution

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NPQIC Updates

BE Virtual Office Hours

- Every 3rd Friday of the month from 12-1pm
- Starting in January 2024
- Join us virtually if you have questions to work through

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NPQIC Summit updates

- 2023 Summit Executive Summary available now on our website
- 2024 Summit
  - September 27, 2024 in Omaha @ The Highlander
  - ***Mark your calendar now!***

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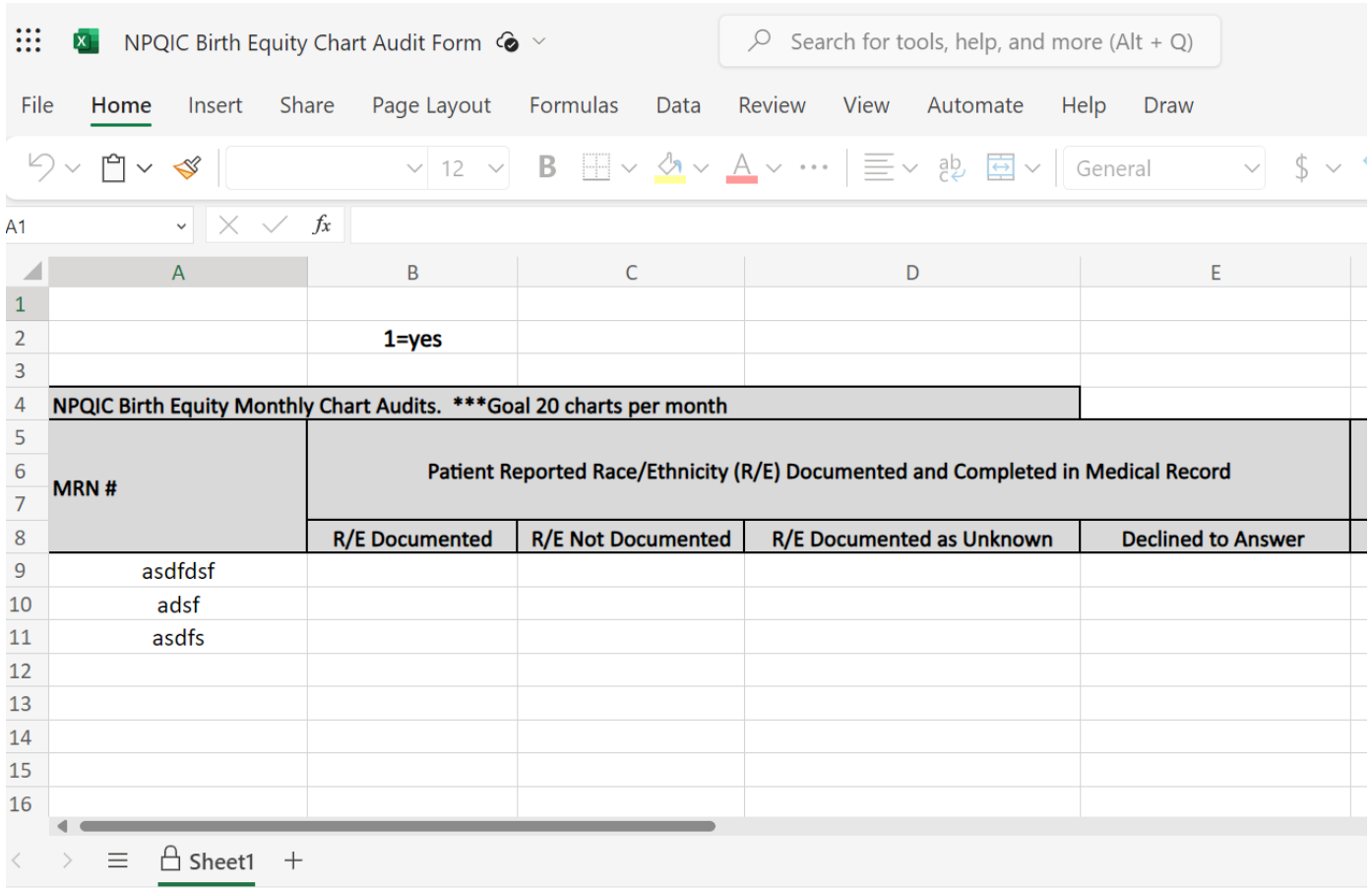
NEW: Monthly Chart Audit Form template



NPQIC Birth Equity Chart Audit Form

Search for tools, help, and more (Alt + Q)

File Home Insert Share Page Layout Formulas Data Review View Automate Help Draw

A1

	A	B	C	D	E
1					
2		1=yes			
3					
4	NPQIC Birth Equity Monthly Chart Audits. ***Goal 20 charts per month				
5	MRN #	Patient Reported Race/Ethnicity (R/E) Documented and Completed in Medical Record			
6					
7					
8		R/E Documented	R/E Not Documented	R/E Documented as Unknown	Declined to Answer
9	asdfdsf				
10	adsf				
11	asdfs				
12					
13					
14					
15					
16					

Sheet1

Outstanding Launch Award

- Criteria:
  - Submitted Participation Roster
  - Completed Readiness Survey
  - Entered baseline data

Upcoming Resources & Tools

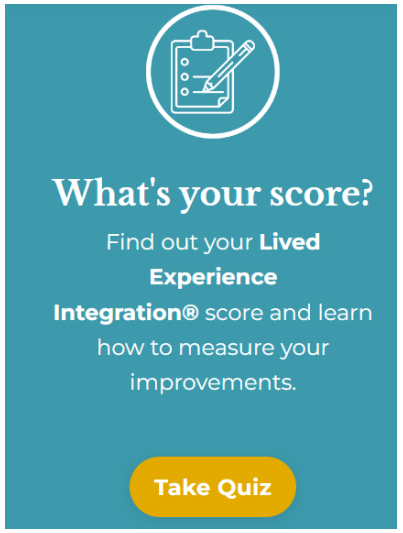
- Respectful Care Practices
- PREM Survey
- Engaging Patient Partners

Momma's Voices Community of Learning

- January COL
- March COL
- Patient Partner Locator

Participation highly encouraged to prepare teams for engaging patient partners this Spring!

https://www.mommasvoices.org/



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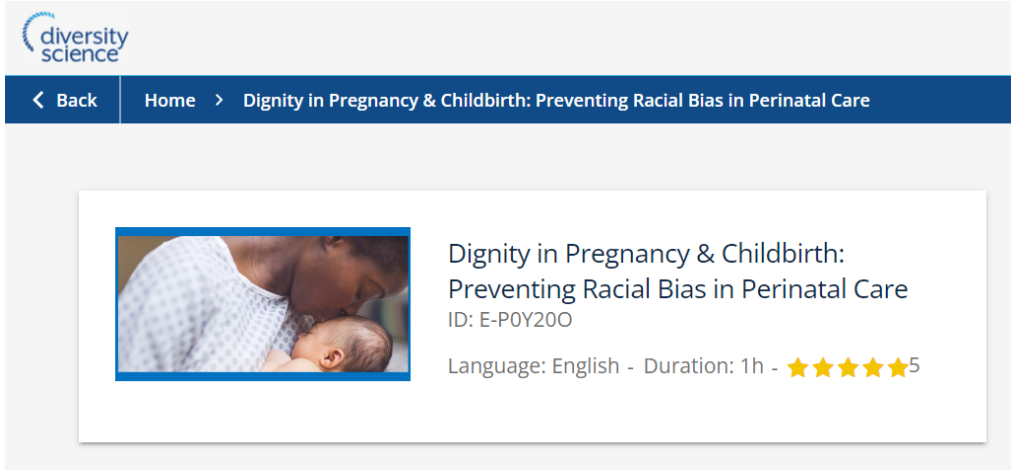
Key Strategy #8: Develop respectful care and bias education for providers, nurses, and staff

- Coming Soon: NPQIC has partnered with Diversity Science to provide simplified online access to the *Dignity in Pregnancy and Childbirth online e-module training*
- ***FREE**, 3-module program for perinatal providers, nurses, and staff*
- *Webpage link coming soon!*



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Monthly Webinar Topic Schedule

Title	Month
Kickoff	November 2023
Optimizing Race/Ethnicity Data Collection	December 2023
Operationalizing Race & Ethnicity Data Collection	January 2024
Equitable & Respectful Care Principles and PREM	February 2024
Engaging Patient Partners in QI/Birth Equity Work	March 2024
Implementing a comprehensive implicit bias training for provider/nurse education	April 2024

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Today: National Day of Racial Healing

A time to contemplate our shared values and create the blueprint together for #HowWeHeal from the effects of racism.

- Launched in 2017
- Opportunity to bring ALL people together in their common humanity and inspire collective action to create a more just and equitable world.

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National Day of Racial Healing

- Fundamental to this day is a clear understanding that racial healing is at the core of racial equity.

- This day is observed every year on the Tuesday following Martin Luther King, Jr. Day.

https://dayofracialhealing.org/

Equity Exercise

Teams are encouraged to complete the exercise with their Birth Equity teams

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Medical racism in 2024…

- **Last week**, an emergency physician with a large following (more than half a million people) asked on their social media platform:

“Why does it seem as though many African American patients often have people on their phones as a doctor enters the room?”

Think: What is your first reaction to this question?

- What emotions are coming up?
- What follow-up questions come to mind?

"Why does it seem as though many African American patients often have people on their phones as a doctor enters the room?"

- This question demonstrates a significant gap in conscious understanding of the history of medical racism and the ongoing impacts on patients today.
  - Medical experimentation
  - Crisis in caring for Black maternal patients
  - Not listening to patients, mistreatment, and stereotyping
  - Racism in medical education is pervasive
    - One recent study found that residents were **twice as likely** to underestimate Black patients' pain relative to other groups

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"Why does it seem as though many African American patients often have people on their phones as a doctor enters the room?"

- What might be the impacts of this public query on the Black population?
- What does this question reveal about the asking physician's personal understanding of historical and present-day medical racism?
- How could you respond to a colleague asking a similar question?
- What are some actions the asking physician could take after gaining an awareness of his/her own biases?

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Why focus on self-reporting race and ethnicity?

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Why focus on **patient-reported** race and ethnicity?

1. Goal is to collect and use race, ethnicity and language (REaL) data in a meaningful way to understand and address health care disparities
2. Patient self-reporting of REaL data is the gold standard of data collection. Staff should never attempt to guess a patient's race, ethnicity or preferred language
3. Health care organizations should collect information on patients' race and ethnicity in order to measure disparities in care—and see if they exist in the organization.
   - Identifying and measuring disparities helps organizations initiate programs to improve quality of care

Source: American Hospital Association, 2013

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Why focus on **patient-reported** race and ethnicity?

4. Collecting accurate data helps evaluate trends and ensure disparities on the basis of race and national origin are addressed through identified opportunities for improvement
5. Organizations that collect accurate data can use this information to:
   - ensure they have sufficient language assistance services
   - develop appropriate patient education materials
   - track quality indicators and health outcomes for specific groups to inform improvements in quality of care

Source: American Hospital Association, 2013

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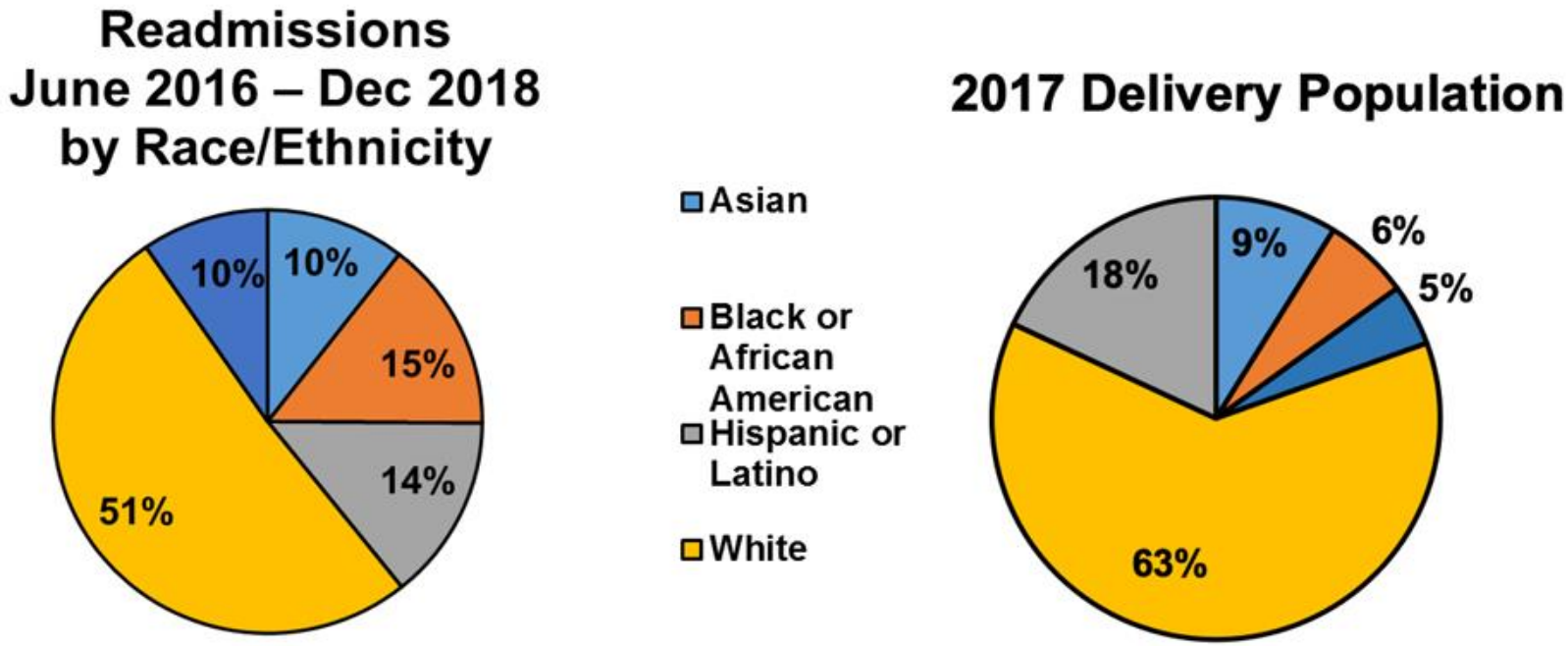
Equity:
Readmissions by Race/Ethnicity

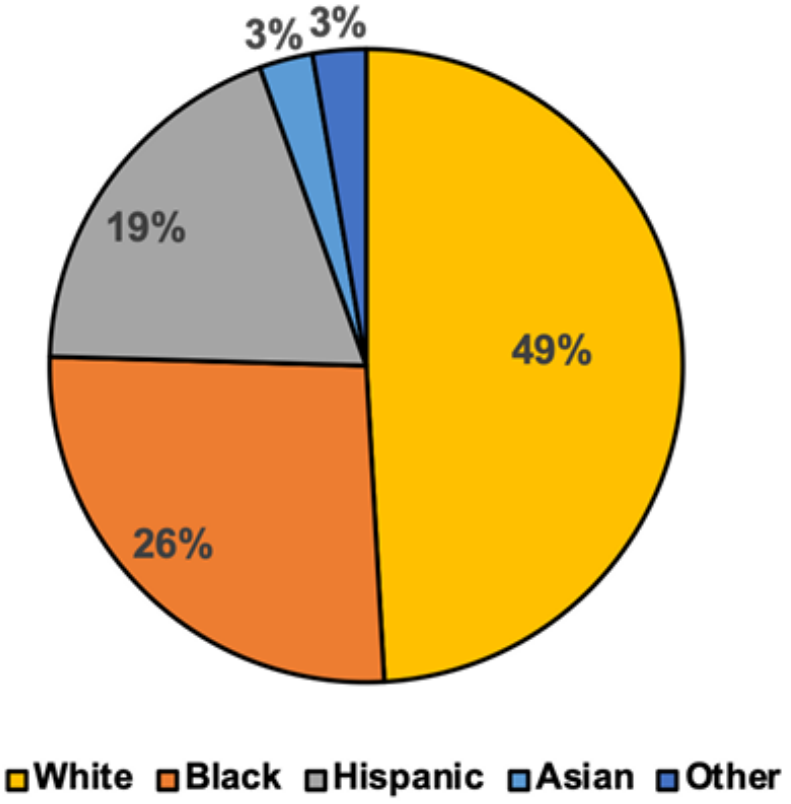
MASSACHUSETTS GENERAL HOSPITAL
OBSTETRICS & GYNECOLOGY



Equity:
Readmissions by Race/Ethnicity

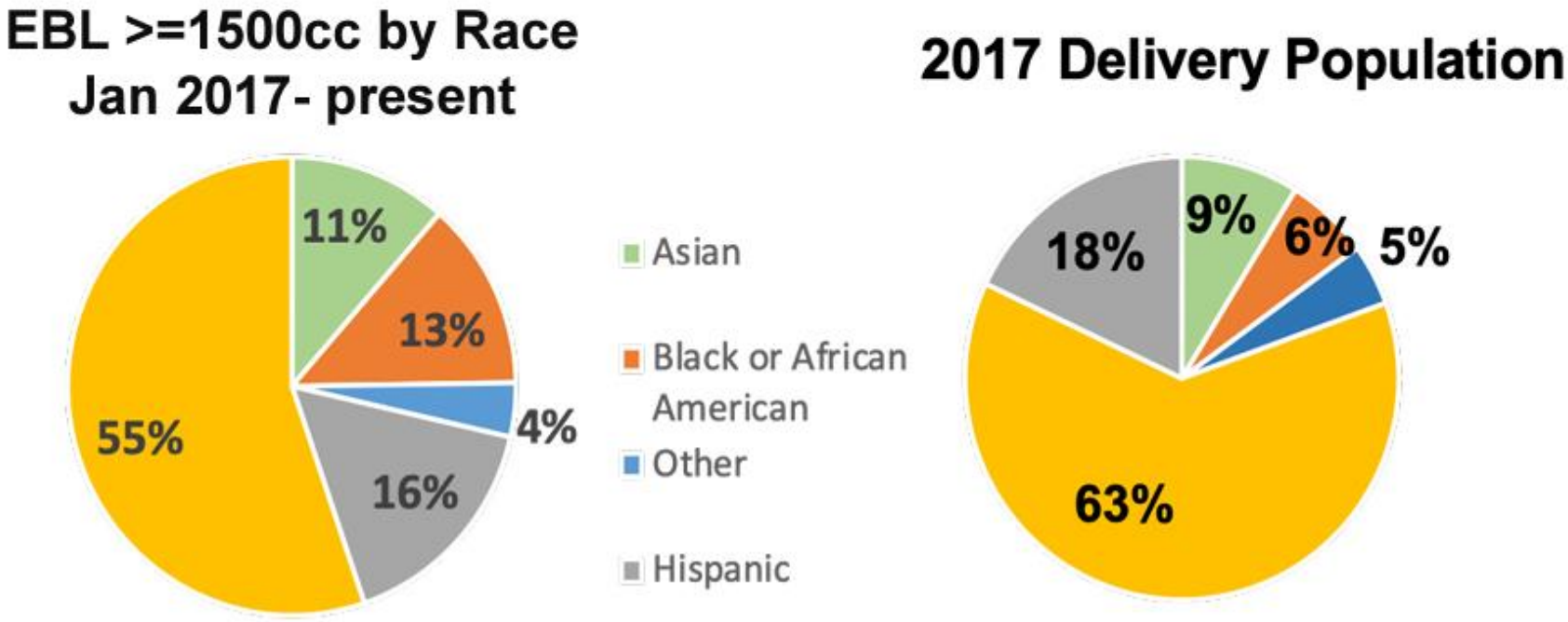
MASSACHUSETTS GENERAL HOSPITAL
OBSTETRICS & GYNECOLOGY

- Readmissions for hypertension
  - (AOR for black women 2.54 [1.06, 6.08])



Equity:
EBL >=1500cc by Race/Ethnicity

MASSACHUSETTS GENERAL HOSPITAL
OBSTETRICS & GYNECOLOGY



Review and Use the Data to Drive Quality Improvement

- Key questions for reviewing data include:

1. Is there a disparity in hospital outcomes between different groups?
2. What can we do to address identified disparities?
3. Are we improving outcomes and reducing disparity over time?
4. What more can we do?

Source: CMQCC

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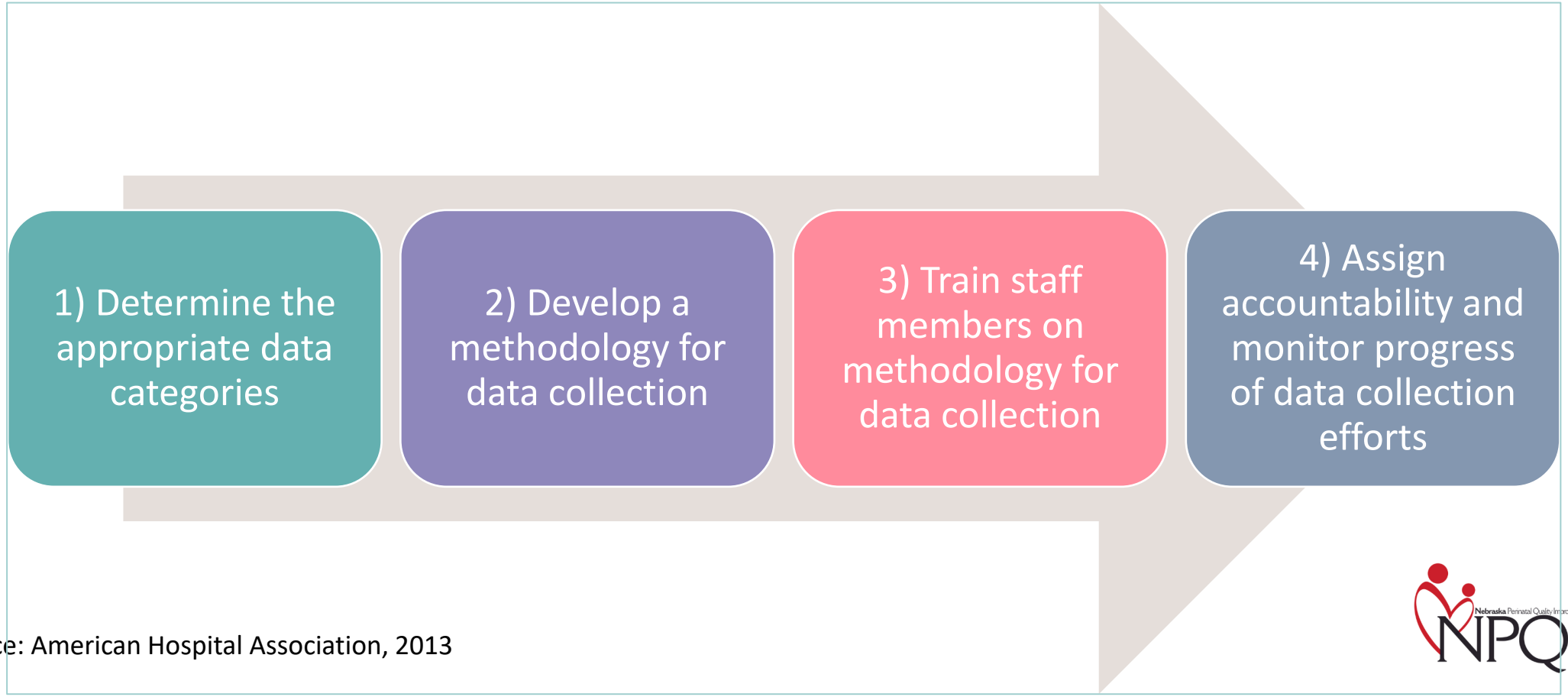
Optimizing REaL Data Collection

- Four-Step Approach to Ensure REaL Data Collection



Source: American Hospital Association, 2013

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Optimizing REaL Data Collection

- Step 1: Determine the appropriate data categories:
  - American Indian/Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian/Other Pacific Islander
  - White
  - Some other race
  - Declined
  - Unavailable/Unknown

Optimizing REaL Data Collection

- Step 2: Develop a methodology for data collection

Figure 3: Developing a Methodology for REAL Data Collection

Design Question	Options	Considerations / Suggested Method
Who should collect the data?	• Registration staff • Medical assistant • Registered nurse	• Using registration staff has been proven to increase collection rates, although one study found patients preferred being asked in the exam room by nursing staff.[8] Providers should assess staffing levels and determine who is best suited to collect the data. • **Suggested: Registration staff**
When should the data be collected?	• At time of check-in • Over the phone • Pre-exam	• Collecting preferred language data over the phone when a patient is scheduling an appointment can help in planning for interpretation services. • **Suggested: At check-in or over the phone**
What format should be used to collect the data?	• Paper format • Electronic kiosks / tablets • Verbal discussion	• Paper forms, kiosks and tablets allow for patient privacy, although one study has shown that collection rates are highest when patients have the option to also report REAL data verbally.[9] • Paper forms, kiosks and tablets may pose a challenge for patients with limited literacy. • Kiosks or tablets will eliminate the need for staff to transcribe data into the electronic medical record. • **Suggested: Provide options for a more private form of entry (paper form, kiosk or tablet) as well as verbal discussion**

Source: American Hospital Association, 2013.

Optimizing REaL Data Collection

Step 3: Train staff members on methodology for data collection:

- Once a methodology for data collection is defined, hospitals and care systems should provide training to appropriate staff members.
- Training on standardized processes and scripts on how best to ask patients for self-reported race/ethnicity/language can:
  - increase compliance
  - ensure data integrity
  - improve patient buy-in

Source: American Hospital Association, 2013

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Optimizing REaL Data Collection

Step 4: Assign accountability and monitor progress of data collection efforts:

- Hospital leadership should assign accountability and monitor data collection efforts to ensure processes are working as planned.
- For example, registration staff can be held accountable for achieving certain metrics against a baseline, such as a decrease in the number of patients reported as “unknown” for race or ethnicity.
- Leveraging existing processes can save time and resources

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Sample Language to Request Patient Race and Ethnicity Data

Sample 1: “We want to make sure all patients are getting the best care possible. Can you tell us what you consider your race, your ethnicity, and your preferred language?” (ILPQC Focus Groups)

Sample 2: “<Insert hospital name> is committed to giving you and all of our patients the best care possible. In order to do this, we ask you to tell us how you would describe your race, your ethnicity, and your preferred language.” (Health Partners)

Sample 3: “We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care.” (American Hospital Association)

Use PDSA cycles to test out a few versions to find the language that best fits your institution and patients' preferences.

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Staff Training and Script Examples

Remember to *ask* the patient or designated caregiver to self-identify their race and ethnic background:

"We want to make sure that all our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

Then ask:

Ethnicity Question

"Are you Hispanic, Latino, or Spanish origin?"

(OMB recommends asking ethnicity before race.)

- Yes, Hispanic, Latino, or Spanish origin
- No, not of Hispanic, Latino, or Spanish origin
- Declined
- Unavailable/Unknown

Race Question

"Which category best describes your race? (One or more categories may be marked)"

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Other Pacific Islander
- White
- Some other race
- Declined
- Unavailable/Unknown

Source: American Hospital Association, 2021

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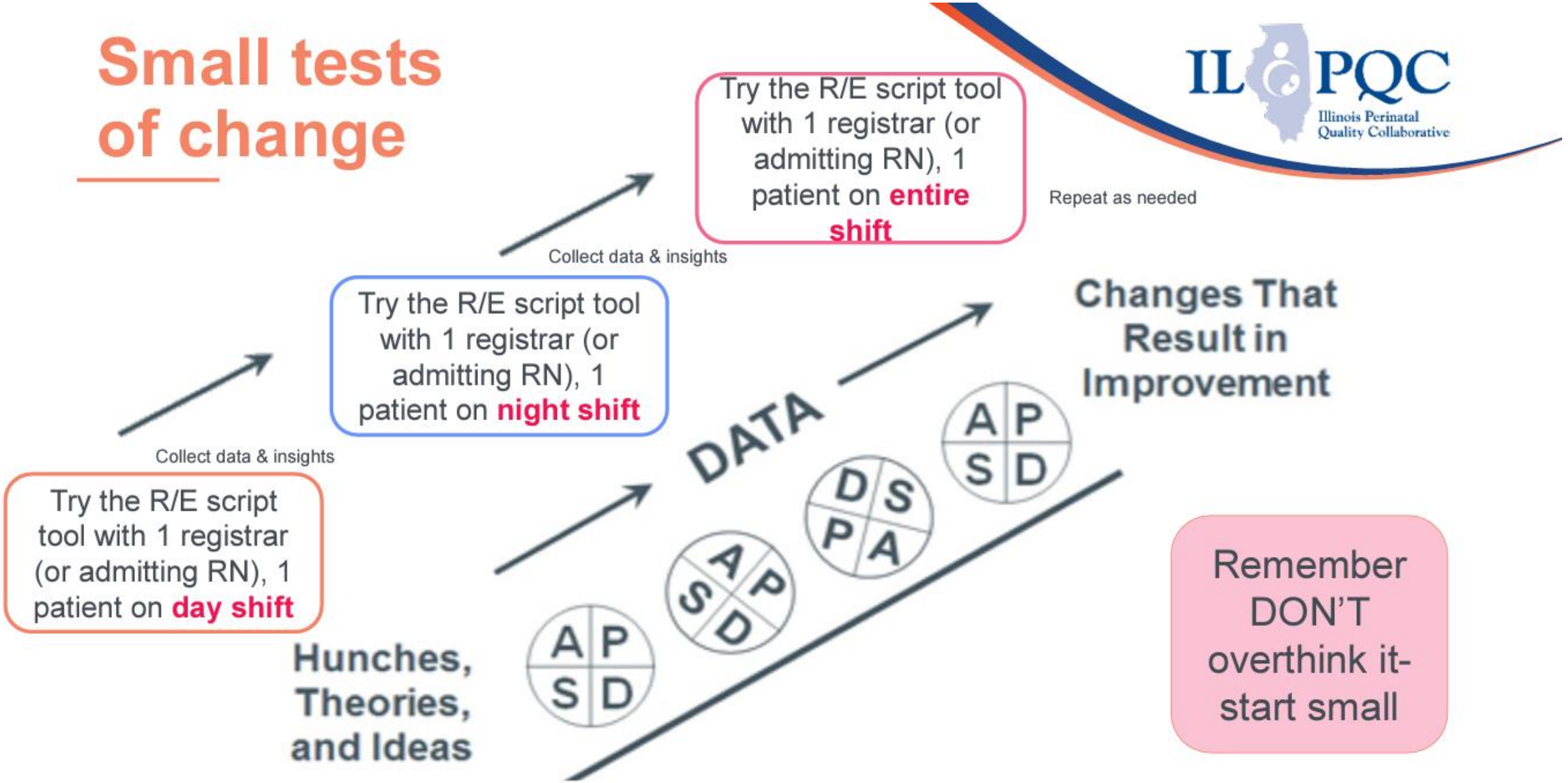
Small tests of change



Remember DON'T overthink it- start small

Addressing Concerns from Patients regarding race/ethnicity

- When you explain why you are asking people to report their race/ethnicity/sex/primary language and do so in a nonthreatening and polite manner, resistance to providing this information is minimized.

- There may be individuals who do not understand the question or do not want to respond to it.
  - It is very important to remember that if someone does not want to answer these questions, simply record "declined" and move on with the registration process.

Source: American Hospital Association, 2021

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Addressing Concerns from Patients Regarding Race/Ethnicity

- If people express concern about confidentiality or who will see this information, state the following:
  - "The only people who see this information are registration staff, your clinical care team, administrators for the hospital, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law."

Source: American Hospital Association, 2021

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Creating Buy-in Resources

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Resources for Buy-in

Key Driver #2: Utilize race/ethnicity from medical record and quality data to improve birth equity

1) Improve patient-reported race/ethnicity data collection for EMR
   - HPOE -Reducing health care disparities: collection and use of race, ethnicity and language data
   - AHA: Disparities Toolkit
   - AHA: How to Ask the Questions Regarding Race/Ethnicity
   - AHA: Staff Training and Scripts Examples
   - AHA: Optimizing Real Data Collection
   - AHA: Develop a Methodology for Data Collection
   - NPQIC: Process Flow for Race & Ethnicity Data Collection with Staff Responses

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Resources for Buy-in

Key Driver #2: Utilize race/ethnicity from medical record and quality data to improve birth equity

2) Resources to assist review of hospital maternal health quality data by race, ethnicity, and Medicaid status

- AHA: Framework for Stratifying Race, Ethnicity, and Language Data
- Mass.gov: Racial Equity Data Road Map

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QI Data Collection Corner

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Birth Equity Structure Measures

Structure Measures	
% of facilities that have implemented a doula policy which was informed by doulas and providers	% of facilities that have a standardized system to provide all patients the recommended postpartum patient education materials prior to hospital discharge including education on urgent maternal warning signs postpartum safety and tools to improve communication between patients and their healthcare providers
% of facilities that have engaged patients and/or community members to provide input on quality improvement efforts	
% of facilities that have adopted the principles of a doula-friendly hospital	
% of facilities that have implemented a protocol for improving the collection and accuracy of patient-reported race/ethnicity data	% of facilities that have developed a process to review maternal health quality data stratified by race/ethnicity and Medicaid status
% of facilities that have implemented a Patient Reported Experience Measure (PREM) survey to obtain feedback from postpartum patients and a process to review and share results	% of facilities that have a strategy for sharing expected respectful care practices with delivery/postpartum staff and patients (i.e. posting in L&D rooms) including appropriately engaging support partners and/or doulas

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Birth Equity Process & Outcome Measures

Process Measures	
% of patients responding to the PREM survey (Data provided by NPQIC)	% of providers, nurses, and staff completing education on the importance of listening to patients, providing respectful care and addressing implicit bias
Outcome Measures	
% of sample patient charts with self-reported race/ethnicity documented	% of patients completing PREM survey who reported always or often feeling heard on PREM- data provided by NPQIC
% of sample patient charts with documentation of receiving education on urgent maternal warning signs/ postpartum safety and tools to improve communication between patients and their healthcare providers prior to delivery discharge	

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How Will We Show Improvement?

- By tracking system changes (Structure Measures)
  - Haven't started | working on it | in place
- By tracking clinical culture change (Process and Outcome Measures)
  - Random sample of 20 delivery records per month to track progress on key strategies
  - Report progress on educating providers, nurses, and staff

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Team Talk

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Tips for monthly data entry

- When collecting monthly maternal data, be sure to only count moms of multiples one time
- For patients who declined to share race or race was unavailable/unknown, please add to the "Other" category in REDCap
- Nebraska Medicaid plans in 2024:
  - Molina Healthcare
  - Nebraska Total Care
  - United Healthcare Community Plan

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BE Next Steps

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Preparation	Getting Started	Early Implementation	Throughout Year 1	Year 2
Meet with colleagues to establish buy-in and determine co-leads	Schedule regular meetings with team to review data and PDSAs and make improvements	Work with IT and data team to make system changes	Establish stakeholder group including doulas and patients	Continue reviewing PDSAs
Complete participation agreement	Attend the data call	Collect baseline data (Jan, Feb, March 2024)	Implement strategy for sharing REC practices in L&D	Continue reviewing PREM data
Complete Readiness Survey (Microsoft Forms)	Attend Kickoff Call	Create a draft 30-60-90 day plan	Implement doula-friendly policies	Continue reviewing equity data
Review your hospital's data and identify opportunities for improvement	Review Data Collection Form with your team; identify needed systems changes in order to collect equity variables	Plan first PDSA cycle to address 30-60-90 day plan	Standardize system for sharing urgent maternal warning signs	Additional equity trainings for providers (film screening, modules, etc)
	Review Birth Equity Toolkit	Schedule kickoff meeting/grand rounds	Implement implicit bias training	Continue meeting with provider/ doula/patient group
		Create plan for implicit bias training	Implement PREM survey and regularly review PREM data	

10 Steps for Getting Started with BE

1. Submit your BE Participation Agreement and complete the NPQIC BE Teams Readiness Survey to identify team opportunities for improvement. Please work together as a team to complete the survey and choose one team member to fill out the survey. Remember, there are no correct answers. It's ok to start with lots of opportunities for improvement!
2. Schedule regular, at least monthly, BE QI team meetings to review your data and make improvement plans and identify PDSAs cycles for the coming month.
3. Review the NPQIC BE Data Collection Form with your team and discuss strategies for data collection and attend the BE Data Call on December 12, 2023. After reviewing the data form, start conducting baseline data collection (Jan, Feb, March 2024).
4. Review your hospital's baseline data and identify opportunities for improvement. Reference the BE Key Strategies and Drivers Diagram to identify possible interventions. Consider how your team will use the monthly data to monitor initiative progress and provide feedback to clinical teams.
5. Review the NPQIC Birth Equity Toolkit (online) for nationally vetted resources to support your improvement goals.

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10 Steps for Getting Started with BE

6. Meet with your QI team to create a draft **30-60-90 day plan**. This plan helps your team decide where to start and identify what you want to accomplish in the first 3 months. Consider focusing on the BE Key Strategies using your baseline data and readiness survey results to give input on where your hospital should start.
7. Plan your first PDSA Cycle with your team to address your 30-60-90-day plan. These small tests of change help your hospital test process/system changes to reach initiative goals. Please see linked worksheet for more details on planning your first small test of change. Focus on BE key strategies for improvement, start small and test a change/ improvement with one nurse, one provider, one patient, or one day or one week. Review results, make improvements and implement if successful, repeat the cycle if adaptations are needed.
8. Consider scheduling a BE kick-off meeting and /or grand rounds to officially announce the launch of your hospital BE initiative work. This should include sharing an overview of the BE initiative, BE Key Strategies, and your team goals for the initiative with OB clinical staff to facilitate OB provider, nurse, and staff buy-in. Assistance from NPQIC will be available.
9. Review implicit bias training resources and create a plan for implementation and completion of implicit bias training by L&D OB providers and nursing staff, process to review results and plan for using feedback to drive improvement.
10. **Reach out to NPQIC with any questions or for clarification – we are here to help!**

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Who Should Be on Your Birth Equity Team?

- Required
  - Provider leader
  - Nursing leader
  - Senior leader

- Suggested
  - Prenatal/outpatient representative
  - Patient advisor and/or community liaison
  - Midwife and/or doula
  - QI professional
  - Health IT representative
  - Equity officer
  - Medical Informatics
  - Social Worker
  - L&D nurse(s)/postpartum nurse(s)
  - Emergency Room representative
  - Resident/fellow (if have trainees)

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Schedule your coaching calls with NPQIC!

- In addition to monthly office hours, we are here to support you with one-on-one coaching calls.
- Occur every other month
- Send 2-3 options that meet your team's availability to Kara

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Birth Equity Timeline- Next 3 months

January	February	March
Monthly Webinar January 16, 12-1pm Office hours begin: third Friday of each month January 19, 12-1pm Momma's Voices COL begins Begin Q1 Data Collection	**Monthly Webinar: Equitable & Respectful Care** February 20, 12-1pm Office Hours February 16, 12-1pm Schedule bi-monthly coaching calls with NPQIC	**Monthly Webinar: Engaging Patient & Community Partners** March 19, 12-1pm Office Hours March 15, 12-1pm Q1 Data due by April 15

Appendix

Recap from the last two months' focus on data

Step 1: Assemble a working group that is focused on health care disparities data

- The working group will move forward all of steps on the following slides
- Include staff from the following hospital areas on the working group:

  - Diversity and inclusion
  - Quality and safety
  - Information and technology
  - Data analytics
  - Language services
  - Admitting and registration
  - Compliance
  - Community outreach
  - Data source stakeholders (e.g. birth certificate clerk)

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Step 2. Identify sources of race, ethnicity, and insurance status data

Determine how / where race/ethnicity is collected in the medical record

- Consider how these data were collected
- Are there protocols for data collection available to review?
- Are they available in the EMR?
- Is there an opportunity to confirm self-reported race/ethnicity is documented during the delivery admission?

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Step 3: Identify the highest priority maternal quality measures to track by race/ethnicity and insurance status

Look at OB measures currently collected at your hospital, including measures collected for Leapfrog, Joint Commission, CMS Hospital-acquired condition (HAC), National Quality Forum, Healthcare Effectiveness Data and Information Set (HEDIS), and Agency for Healthcare Research and Quality Patient Safety Indicators (AHRQ-PSI).

- Measures used by other PQCs and hospitals doing equity work include:
  - Severe maternal morbidity (SMM)
  - Nulliparous, Term, Singleton, Vertex (NTSV) cesarean birth
  - Total preterm birth
  - Maternal ICU admissions rate
  - Timely treatment for severe hypertension
  - Breastfeeding

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Step 4: Determine if possible to stratify data by race/ethnicity

- If there is insufficient data to stratify results so that disparities can be identified Hospitals may need to address small group sizes by aggregating metrics to obtain larger groups or look across time (ie. review data quarterly or every 6 months)
- CMQCC recommends that racial/ethnic group sizes less than 20 are insufficient for meaningful group comparisons.
- To achieve larger group sizes for comparison, consider aggregating units of time for analysis (e.g. 6 months, 12 months) or consider comparing one group (e.g. black race) to all other groups (e.g. all nonblack races) or stratifying by insurance status (public vs private).

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Step 5: Stratify the data

Stratify data by: Race/Ethnicity : consider Black, White, Hispanic, Asian, Other
Insurance status: Private vs. Public (Medicaid, Medicare)

- Other data options Language preference: track outcomes for patients whose primary language is not English
- Resources on race and ethnicity categories: Census approach to race and ethnicity categories. Office of Management and Budget Minimum Standards for Data Collection

Use your stratified data to create reports/dashboards that display data trends and health care disparities.

Incorporating these dashboards into regularly scheduled quality meetings in order to identify and address health care disparities

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Step 6: Review and use the data to drive quality improvement

Review data with a lens of equity to identify differences by race/ethnicity or insurance status

Develop potential strategies to address these differences in care provided or outcomes

Provide opportunities to focus your quality improvement efforts on these issues at your hospital or outpatient perinatal care locations

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Step 6: Review and use the data to drive quality improvement

- Key questions for reviewing data include:
  - Is there a disparity in hospital outcomes between different groups?
  - What can we do to address identified disparities?
  - Are we improving outcomes and reducing disparity over time?
  - What more can we do?

Source: CMQCC

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Questions?

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