American Hospital Association

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July 23, 2004

Dennis O'Leary, M.D.
President
Joint Commission on Accreditation for
Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Re: Proposed Standard Requiring the Collection of Information on Race, Ethnicity, and Primary Language – Request for Field Review

Dear Dr. O'Leary:

On behalf of the American Hospital Association (AHA), its 4,700 member hospitals and health care systems, and 31,000 individual members, we appreciate the opportunity to respond to the June 30, 2004 request for field review of the proposed new language that would be added to standard IM.620 requiring that all accredited organizations collect information on race, ethnicity, and primary language in patient clinical records.

General Comment
The AHA supports the growing national focus on eliminating racial and ethnic disparities in health care treatment and outcomes. There is a growing body of evidence documenting these disparities in treatment and outcomes. To understand and address disparities effectively, all health care partners – hospitals, physicians, other providers, government, insurers, employers and others – need to work collaboratively and on many fronts. And to do so, we need sound data and information to guide our activities. **We believe, however, that the proposed standard is premature because we do not yet know what data will best support activities to reduce disparities and research is currently underway that will help inform how a constructive standard might be fashioned. Consequently, we urge that the proposal be tabled.** In the meantime, AHA believes it is essential to continue efforts to raise awareness on these issues and encourage providers to take action.

Specific Comments
There are several critical issues regarding data collection and each of them is currently being addressed by research, including a major project underway at our Health Research and

Educational Trust (HRET) working with six major health care systems across the country with funding from the Commonwealth Fund. We believe the critical issues are:

- **Selecting the right set of racial and ethnic categories**. While the Office of Management and Budget categories referenced in the proposed standard may be one of the better classification schemes currently available, we also know that it does not provide a sufficient level of granularity to address quality of care issues. To be able to make a difference in the quality of care at the bedside, more detailed information on race and ethnicity – beyond African-American or Hispanic – is needed. Hospitals and others need to experiment and test current data categories in practical contexts before any particular approach is locked into place. This is currently underway in HRET's work on the development of a uniform framework for collecting information on patient race, ethnicity, and primary language data.

- **Adopting an appropriate and consistent process for collecting the data.** We know from HRET's work that most hospitals are collecting racial, ethnic, and primary language data but there is little consistency in how the data are collected. One of the most important issues in the collection of race and ethnicity data, for example, is whether the information is self-reported or determined secondhand by an admitting nurse or physician. As a result, the reliability of some data and the comparability of data across facilities are limited. The development of a framework to collect information on patient race, ethnicity, and primary language is a first step and lays the foundation for a long-term effort to improve quality of care and reduce disparities. This work is currently underway and should be completed before any one approach is adopted in JCAHO standards.

- **Determining how the data will be used.** One of the most important steps that needs to inform the development of any standard regarding data collection is to have a firm understanding of what data will be useful and how it will be used. Again, this issue is being addressed by the work being done by HRET. Once Phase 1 (developing and testing a uniform framework for collecting racial, ethnic, and primary language data) is completed, Phase 2 will use the framework for improving quality of care and reducing disparities by selecting a set of clinical conditions and a core set of indicators to track over time. By linking clinical information with race, ethnicity, and primary language information about patients, participants in this research will monitor the care process and where it breaks down or has the potential to break down, and develop interventions that seek to improve the quality of care for different population groups. This process will help refine the identification of what data is useful to the process of improving quality and reducing disparities.

The sources of racial and ethnic differences and disparities are many: differences in socioeconomic factors such as income and education level; differences in the health behaviors of consumers in both seeking care and adhering to treatment regimens; lack of multi-cultural knowledge and sensitivity on the part of providers; actual discrimination and stereotyping by

health care providers; language barriers; lack of diversity in the health care workforce; and payment and coverage differences, to name just a few.

The AHA is steadfast in its commitment to reducing racial and ethnic disparities in health care. To that end, we are working with hospitals to better understand both the patient-related and health-system-related factors that contribute to disparities, and to marshal the talent and commitment of hospitals to determine how best to work with others to eliminate health care disparities in the United States.

Specifically, the AHA:

- Continues to convene a group of health care leaders on this issue to guide the AHA's efforts and assess the most effective means of stimulating and supporting community-level action to address and eliminate health care disparities.

- Develops communications to share best practices and insights, including current research on the sources and causes of disparities as well as alternative approaches to reducing disparities.

- Hosts a series of member conference calls, providing first-hand accounts of best practices and highlighting how other hospitals and health care organizations are working to erase disparities in health care outcomes within their communities.

- Created a clearinghouse of case examples, research, data, evaluation tools, and expertise to help hospitals understand the diversity of the people who live and work in their communities, the nature and causes of particular disparities within specific populations in their communities, and ways others have dealt with these critical issues to provide culturally-sensitive and medically-appropriate care. The resources can be found at www.aha.org, under "Racial and Ethnic Disparities."

- Created *A Diversity and Cultural Proficiency Assessment Tool for Leaders*, as part of the AHA's Strategies for Leadership series. A collaborative effort among the AHA, the National Center for Health Care Leadership, the Institute for Diversity in Health Management and the American College of Healthcare Executives, the tool provides health care leaders with a self-assessment and follow-up action steps to ensure that they have a diverse and culturally proficient workforce to deliver appropriate care. The tool also profiles seven hospitals and health systems and their steps to diversify their health care workforce while providing care to an increasingly diverse patient population.

- Continues to sponsor the Institute for Diversity in Health Management, which is committed to expanding the health care leadership opportunities for racially and ethnically diverse individuals in health care management.

- Supports Health Research and Educational Trust research projects, including the one described above.

We ask that the Joint Commission postpone its consideration of this standard to provide more time for these efforts to bear fruit.

Again, thank you for the opportunity to comment on the proposed standard. If you have any questions or wish to discuss these comments, please contact Don Nielsen, M.D., AHA's Senior Vice President for Clinical Leadership at (312) 422-2708 or by email at dnielsen@aha.org.

Sincerely

Rick Pollack
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