HRET Fellowship Program Summary
Racial and Ethnic Data Collection in Rural Hospitals

Background

As a national advocate for America's hospitals, the American Hospital Association (AHA) encourages and supports efforts towards creating health equity through the elimination of racial and ethnic disparities in health care. It is through the collection of data on admission and discharge that significant progress can be made towards addressing disparities.

This report is a summary of an Action Learning Project (ALP) for a 2007-2008 fellowship program on Cultural Competency sponsored by the AHA affiliate, The Hospital Research and Educational Trust (HRET).

Background/Project Overview

Research by the Institute of Medicine, the Kaiser Family Foundation and The Commonwealth Fund suggests that differences in treatment and health care outcomes exist and persist based on race and ethnicity. 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 among 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 growing body of evidence documenting these disparities has led to a national goal of eliminating racial and ethnic disparities in treatment and outcomes. To understand and address disparities effectively, all health care

stakeholders – patients, hospitals, physicians, other providers, government, insurers, employers and others – need to work collaboratively and on many fronts. Data collection is an important key to addressing disparities.

Without proper data collection activities, hospitals are unable to determine what services to provide to its community. This is especially true as communities become more racially and culturally diverse and hospitals try to identify service gaps to eliminate disparities. Who's in the community; what languages do they speak; what religious and medical beliefs do they hold; and what are their dietary restrictions? Will their differences prevent them from seeking care at the hospital?

Rural community hospitals are vital in ensuring access to health care services by vulnerable populations. These hospitals face numerous challenges: low volume, inadequate reimbursement, and travel distances. Traditionally, many of these communities have been primarily white. The influx of new racial and ethnic groups presents even more challenges. Lack of staffing, non-integrated data systems and inadequate reimbursement are obstacles to collecting the data that is needed to develop programs and services for new populations. How are these hospitals responding to the need for data collection?

Providing interpreter services and printed instructions in different languages have been the predominant ways in which many hospitals have attempted to bridge one disparity gap-- language barriers. In order to effect change, initiatives must be expanded throughout the hospital. Services should be all inclusive for cultural differences as well as language differences. The board of directors provides direction for initiatives on change, and senior management implements plans for change, Change should be embraced by staff at all levels within the hospital..

Action Learning Project

Each fellowship team had to develop a year-long project, the Action Learning Project (ALP). The initial focus of the AHA fellows' ALP was to partner with HRET to develop a peer training program for rural hospital CEOs and senior executives. These executives would participate in train-the-trainer and peer-learning projects at various AHA sponsored meetings, such as Health Forum's Leadership Conference and the Rural Health Care Leadership Conference. Once trainers were identified and equipped with a curriculum, a series of conference calls targeted towards smaller hospitals were to be designed and conducted, using these trained hospital CEOs. Part of the proposal included the development of a compendium of resources and initiatives developed by the AHA and its affiliates around the issue of eliminating disparities in health care to provide members with a tangible and single, point-of-reference document that could be easily updated and available for distribution.

In reevaluating the focus of the ALP, it was determined that this project would present a number of challenges. Primarily, a train-the-trainer program would require rural CEOs to invest a great amount of time and resources, both of which would be difficult. The ALP team decided that the most productive project would be to shift to a data collection focus. The team wanted to find out how many rural hospitals are collecting racial, ethnic and language data; where the data is being collected; and how the hospital plans to use the data. Health care providers are not prohibited from collecting data by race and ethnicity if done for the purposes of quality improvement and not for discriminatory purposes.

Information Gathering

The ALP included member interviews, a focus group session, discussions at two governance meetings, and a survey tool.

Member Interviews

During conversations with several rural CEOs, the key points identified were (1) the limited diversity in rural communities (2) the primary reason for disparity in care is due to economic circumstances rather than racial bias and (3) some hospitals are collecting general census data but not using it to determine service needs, etc. While there may be limited diversity in rural areas, one incentive for rural hospitals to address cultural gaps may be litigation if diverse community members do not receive adequate care.

In addition to providing input on the AHA's draft survey on data collection, several rural rural hospital CEOs were willing to share information by telephone about their communities and their efforts to bridge service gaps. In one Midwestern hospital, data was being captured for inpatient and outpatient visits. The community is over 90 percent White with a small Hispanic population. Three new ethnic groups--Cambodians, Czech, and Indonesians—have moved into the community to work in the meat processing plant that opened. Another hospital in the West that was primarily White and Hispanic was experiencing a growth of workers from Guatemala in an agricultural economy based on alfalfa and potatoes.

Governing Council Discussions

Constituency section governing councils are AHA governance bodies that represent and support membership groups. In September 2007, the senior director for the

Section for Small or Rural Hospitals and the director for the Section for Long-Term Care and Rehabilitation Care presented the ALP project to their respective council members. They solicited their assistance on behalf of the CCL fellows by engaging them in a discussion on challenges in their community due to immigration and migration. They asked members to share strategies or best practices they had found helpful. Several members indicated their willingness to talk with the fellows regarding data collection and its relevance to eliminating health care disparities.

Rural Liaison Conference Call

The Section for Small or Rural Hospitals sponsors a regular conference call with rural liaisons from state hospital associations. In a November 2007, information was shared about the project and contact information given.

In January 2008, 13 CEOs and trustees convened as a focus group at the AHA's Rural Hospital Leadership Conference. These CEOs and hospital trustees from across the country discussed activities within their communities. Participants offered examples of current and emerging diversity in their communities. Several hospitals located in the Midwest and West include communal religious groups such as the Amish, Mennonites and Hutterrites. A hospital on the East coast with predominantly White and Hispanic populations was in the midst of hiring a Muslim staff member, and another hospital in the Pacific Northwest was hiring a Black surgeon.

The group also reviewed and commented on the draft survey that was to be mailed to rural hospitals.

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Survey Results

The survey with ten questions was developed and distributed to rural hospital members using the SurveyMonkey tool. There was a total of 136 responses received but 75% of survey respondents indicated that they were collecting racial and ethnic data. Most of the data that hospitals reported collecting was on race, followed by religion, ethnicity, and language.

Hospitals indicated that data is being used primarily for reporting and compliance purposes. Data are also being used for demographics analyses and to monitor utilization of services. Overall, access to care rather than legal concerns was the reason given for collection.

Those who reported collecting data indicated that the reason for this was related to the demographic makeup of many communities—mainly white and/or Hispanic. Also, other than fulfilling loan compliance requirements, a number of hospitals believe that they are collecting enough patient data without adding more information.

The primary point of collection for data is at admissions rather than at discharge. This distinction is important because collection at discharge may yield more quality information that will be extremely useful.

SUVEY QUESTIONS ON RACIAL AND ETHNIC DATA COLLECTION IN RURAL HOSPITALS

1. Demographic data
2. Are you a critical access hospital?
3. What is your hospital bed size?
4. Please indicate type of ownership/control
5. Does your hospital collect racial and ethnic data
6. What data is collected?
7. Where is the data collected?
8. How is this data being used?
9. Who within your hospital is responsible for disparities/diversity initiatives?
10. What do you believe are the incentives for hospitals to collect racial and ethnic data?

Barriers and Challenges

The biggest challenge to the revised ALP on data collection was the low response rate to the survey. . Many of the communities are fairly homogenous communities, with populations, in many cases, that are approximately 90% white. While disappointing, the results provide a baseline for future research.

The most unanticipated surprise was that CEOs and trustees would take time during a national program to attend a small focus group to share their experiences.

Post Fellowship

Fellows were asked to evaluate the impact of their ALP on their respective organizations using three priorities: raising the awareness of rural hospital CEOs about health care inequities; engaging and equipping rural CEOs so they can become change agents in their hospitals; and providing resources for rural hospitals as they address disparities.

As a national membership organization, the AHA recognizes the importance of health equity and will be one of the national organizations out front on this issue. The fellowship project allowed staff to reach out to the rural hospital leadership on an issue that will become increasingly important in the very near future.

Opportunities may exist beyond the CCL fellowship period to delve more deeply into what the survey has yielded that can be useful to the field. The collection of a number of case examples would add to the project. Further contact with selected CEOs and other hospital staff will be helpful in looking specifically at the different kinds of data that can be gathered at discharge as opposed to admissions.

AHA Resources and Tools

Through the development of toolkits for data collection, an information-sharing program, trustee education, and a comprehensive Web site, the AHA and its affiliates are working to equip members to bridge disparities gaps and create health equity.

. The HRET toolkit facilitates the collection of patient data pertaining to race, ethnicity and language preference. This toolkit gives hospitals, health systems, clinics and resources needed for collecting race, ethnicity, and primary language data from patients. It can be used to educate and inform hospital staff about the importance of data collection, how to implement a framework to collect race, ethnicity, and primary language data, and how to use the data to improve quality of care for all populations.

The AHA's Center for Healthcare Governance http://www.americangovernance.com/americangovernance_app/index.jsp and the Institute for Diversity in Health Management (IFD) http://www.diversityconnection.org/, have developed the Trustee Professionalism Training program to identify and recruit minority community leaders interested in hospital governance, and provide them with one-day training on governance duties and responsibilities. This innovative pilot program offers a new tool to help hospitals diversify their boards of directors.

IFD has developed a first-of-its-kind data collection and information sharing program that will take a snapshot of the current state of diversity in the health care field. "The State of Healthcare Diversity and Disparities: A Benchmark Study of U.S. Hospitals" will allow hospitals to see how their programs compare with one another, while sharing the strategies of high-performing organizations.

PLEASE SHARE YOUR CASE EXAMPLES

We want our rural hospital members to be able to learn from each other about plans, projects and outreach efforts to address health are disparities. Please share information about your hospital and community's efforts to bridge service gaps. Forward cases to the AHA's Section for Small or Rural Hospitals at dcobbs@aha.org 312-422-3317.

2007-2008 HRET Cultural Competency Fellows
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Visit the AHA's Web site on

"Eliminating Racial and Ethnic Disparities."

http://www.aha.org/aha_app/issues/Disparities/index.jsp