

# Collecting and Analyzing Race and Ethnicity Data in Highly Diverse Communities: Challenges and Strategies for Healthcare Systems

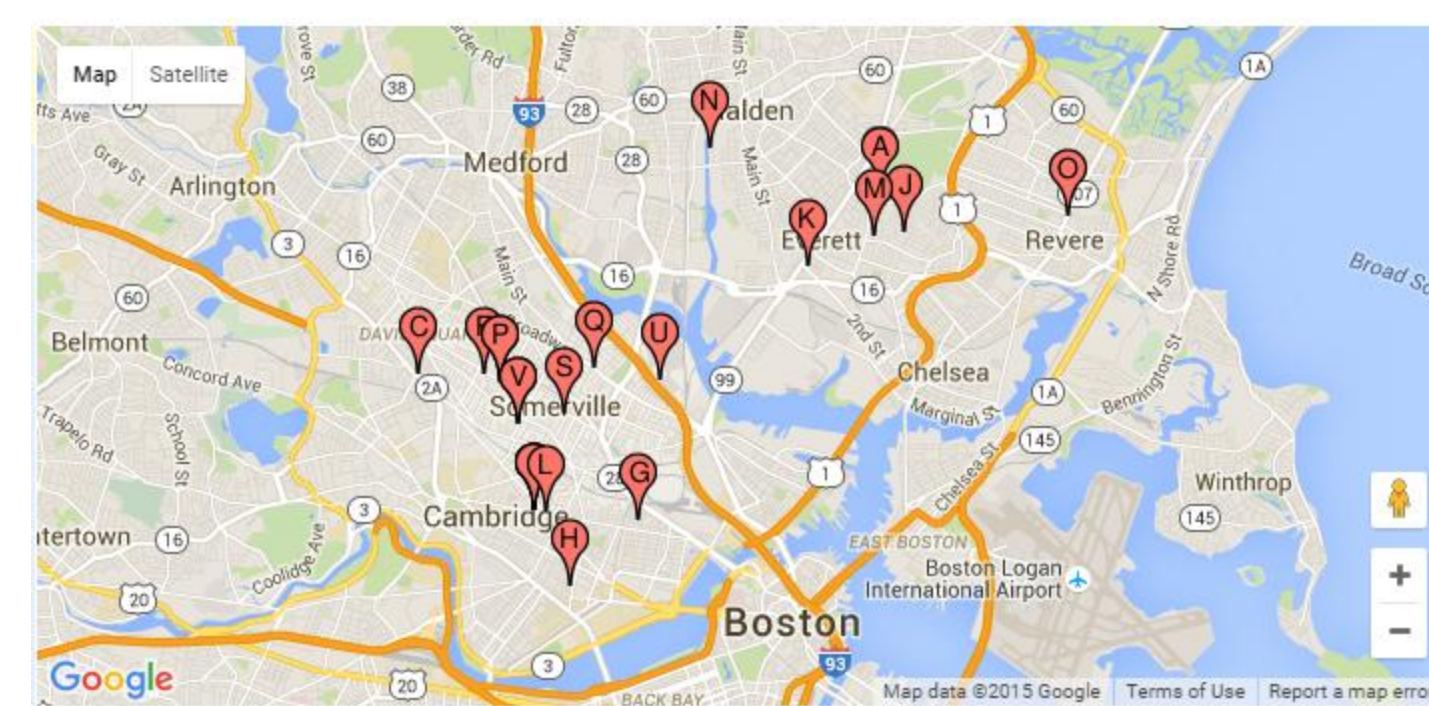
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## The Cambridge Health Alliance (CHA)

### Background

- Academic community health care system comprising 3 hospitals, 12 primary care clinics, and several other clinics and programs targeted at specific populations
- Robust community health programming led by the **Department of Community Health Improvement**
- Primarily serves the cities of Cambridge, Somerville, Everett, Malden, and Revere
- **Highly diverse patient population**
  - Many immigrant populations, particularly from Brazil, Haiti, Central America, and South Asia
  - Emerging populations from Nepal and Middle Eastern countries
  - 42% of primary care patients are Limited English Proficient
  - Over **65 languages** and over **125 ethnicities** represented in the primary care patient population



### Zero Disparities Committee

- Working group comprised primarily of members from the CHA Department of Community Health Improvement and the Institute for Community Health
- Works to ensure accurate and comprehensive race, ethnicity, and language (REL) data collection for CHA patients so that CHA can:
  - Understand the populations served and ensure that services are culturally and linguistically appropriate
  - Meet state and federal mandates
- Dedicated to using REL data to identify and promote awareness of **health disparities** at CHA

## Standards for race/ethnicity data collection

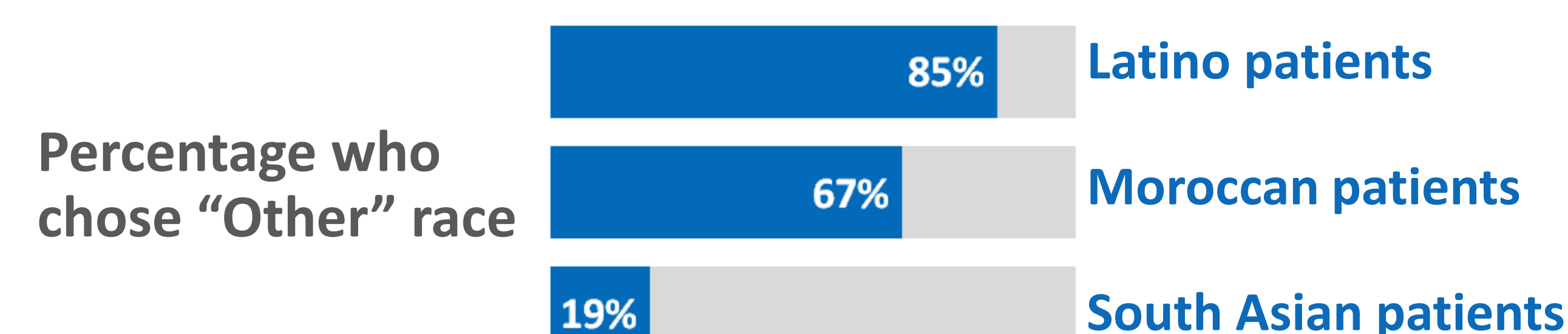
### National Standards

- The Office of Management and Budget (OMB) sets the **minimum standards** for race/ethnicity data collection and federal reporting
- Preferred format is to ask race and ethnicity questions **separately** with ethnicity asked first
- Race and ethnicity should be **self-identified** whenever possible
- OMB standards have two categories for ethnicity and five for race
- A person may choose more than one race category

| ETHNICITY   | RACE   |
|---|--|
| <ul style="list-style-type: none"> <li>• Hispanic or Latino</li> <li>• Not Hispanic or Latino</li> </ul> <p><i>Definition: "A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race."</i></p> | <ul style="list-style-type: none"> <li>• American Indian or Alaska Native</li> <li>• Asian</li> <li>• Black or African American</li> <li>• Native Hawaiian or Other Pacific Islander</li> <li>• White</li> </ul> |

## Challenges with national standards

- Broad categories don't capture **cultural diversity within groups**
  - Example: a black patient could be African American, Haitian, Ethiopian, Jamaican → these are very different cultures with different factors that may affect health
- Looking at broad categories alone can **mask disparities**
  - Example: Overweight/obesity rate for CHA adult primary care patients is 65%
  - Rate for Asian patients: 50%
  - **Rate for Pakistani patients: 73%**
- Some populations do not identify with any of the standard race categories, leading to a **high percentage choosing "Other" race**. The resulting data is not useful for identifying disparities or improving services to better meet patients' needs.



Data for FY14 CHA primary care patients

## CHA's approach to data collection and analysis

### Data collection

- CHA collects race and Hispanic/Latino ethnicity according to OMB standards
- CHA also collects **detailed ethnicity** from all patients
  - The electronic medical record (EMR) has more than 130 options for detailed ethnicity, and this list is periodically updated
  - Detailed ethnicity is a required field in the CHA's EMR (must be populated)
  - Patients can choose more than one ethnicity
- All registration staff are trained on how to collect REL data and how to respond to common questions/concerns

Afghanistani  
African American  
African  
Albanian  
Algerian  
American  
American  
Angolan  
Argentinean  
Armenian  
Asian Indian  
Assyrian  
Austrian  
Azorean  
Bahamian  
Bangladeshi  
Barbadian  
Belize  
Bhutanese  
Bolivian  
Botswanan  
Brazilian  
Bulgarian  
Burmese  
Cambodian  
Cameroon  
Canadian

### Benefits to this approach

- More inclusive
- More nuanced information about populations served
- Deeper understanding of health disparities

### Challenges to this approach

- Detailed data collection requires resources and extensive staff training
- Sample sizes for some ethnicities are very small; some level of rolling up is necessary
- Categorizing patients with multiple ethnicities

### Data analysis

- The Zero Disparities Committee developed a tiered categorization system that enables drilling down and rolling up of ethnicities.



- This framework is used to identify disparities **within and across ethnicity categories** for key clinical and quality measures.

African American, Haitian, Latino, and Portuguese/Azorean patients were most likely to be overweight or obese (ages 18+)

