

WHY SHOULD HOSPITALS COLLECT PATIENT RACE, ETHNICITY, AND LANGUAGE?

Target Audience: Hospital Executives and Upper and Middle Managers

Purpose: This document outlines the purposes and legal justification for collecting patient race, ethnicity, and language and details initiatives and legislation (both enacted and proposed) that aim to promote and standardize data collection.

WHY SHOULD HOSPITALS COLLECT PATIENT RACE, ETHNICITY, AND LANGUAGE?

California is the nation's most populous and diverse state. Almost 60% of Californians belong to a racial and/or ethnic minority group and nearly 1 in 5 are limited English proficient. Because race, ethnicity, and language affect health beliefs, risks, behaviors, and outcomes, it is critical to collect this information.

Collecting patient race, ethnicity, and language is part of a process by which hospital staff can identify and address unique patient needs. Although there is concern that this information will be used to discriminate against patients or will adversely affect clinical decisions, when collected systematically and used responsibly, these data can help identify and reduce disparities and improve health care for all patients. Collecting patient information allows hospitals to provide culturally competent care, improve health care quality, and fulfill legal and regulatory mandates.

CULTURALLY COMPETENT CARE

Collecting patient race, ethnicity, and language is part of a process promoting effective communication, cultural competence, and patient and family-centered care. By collecting these types of data, hospitals can better serve patients by:

- Enhancing availability of interpreters and translated written materials for patients
- Developing health promotion outreach strategies and targeted interventions for populations with higher risk of disease or hospitalizations
- Adapting existing services to meet the health and cultural needs of patients
- Providing culturally concordant care
- Improving community relations

QUALITY IMPROVEMENT

One of the most significant barriers health systems face in improving quality and reducing disparities is systematically characterizing the populations they serve, addressing their needs, and monitoring outcomes. Evidence shows that when quality improvement efforts are linked to race and ethnicity data, quality of care is improved and health care disparities are reduced. Collecting patients' race, ethnicity, and language allows hospitals to:

- Improve patient-provider communication
- Better understand the patient population
- Identify and address disparities in health status, quality of care, and outcomes
- Leverage funding for programs
- Improve patient satisfaction

FULFILLING LEGAL/REGULATORY REQUIREMENTS

The law permits health care organizations to collect race, and ethnicity from patients. Many laws require reporting of race and ethnicity. There is no known law stating that it is illegal to ask patients for information on their race and/or ethnicity. The 1964 Civil Rights Act allows hospitals and health care organizations to collect information on patients' race, ethnicity, and spoken language to improve health care quality, and many health care agencies are mandated to collect this information. There are state and national efforts to standardize and integrate collection of race, ethnicity, and language data into models of patient-centered care.

WHY SHOULD HOSPITALS COLLECT PATIENT RACE, ETHNICITY, AND LANGUAGE?

- The California Health and Safety Code Division 107, Part 5 requires health care institutions to report patients' race, ethnicity, and principal language.
- California's Language Assistance Policy (Senate Bill 853) mandates that all health plans conduct a needs assessment to understand the race, ethnicity, and preferred spoken and written language of all enrollees and requires that essential documents be translated into the most widely spoken languages.
- The National Standards on Culturally and Linguistically Appropriate Services (CLAS) mandate that all health care organizations receiving federal funding provide both verbal and written language assistance, including interpreter services, and post the availability of, and the right to access language assistance to patients.
- California State Assembly Bill 1088 (signed into law in October 2011) requires that starting on July 1, 2012, state agencies, boards, and commissions that collect demographic information to include the full spectrum of Asian American, Native Hawaiian and Other Pacific Islander ethnicities in data collection, consistent with the US Census.
- In September 2011, the Congressional Tri-Caucus introduced The Health Equity and Accountability Act, which includes steps to improve cultural and linguistic competency of care and promotes enhancements to collection and analysis of data about health disparities.

CURRENT AND PAST INITIATIVES TO IMPROVE COLLECTION AND REPORTING OF PATIENT DATA

- With funding from the Agency for Health Care Research and Quality, in 2009, the Institute of Medicine published a report with recommendations to standardize data collection of race, ethnicity, and language, consistent with categories recommended by the Office of Management and Budget.
- The Joint Commission includes the collection of patient race, ethnicity, and language as part of its Patient-Centered Standards for Hospitals.
- The US Department of Health and Human Services is advancing the standardization and collection of race and ethnicity, as mandated by Section 4302 of the Affordable Care Act.
- Hospital systems and payers have started efforts to collect these data from patients and beneficiaries.
- The Office of Statewide Health Planning and Development requires reporting of race, ethnicity, and principal language for all patients discharged from the hospital, seen in the Emergency Department, or undergoing a procedure in the hospital-based ambulatory surgery center.