Everyone in New Hampshire has a fair opportunity to live a long, healthy life.

Priority Workgroup: Race Ethnicity and Language (REaL) Data

New Hampshire Health & Equity Partnership

Increase the capacity in NH for the collection of high quality Race, Ethnicity and Language (REaL) data across all systems at the state and local level to identify disparities and promote utilization of data to inform improvements, policies and procedures.
WELCOME & INTRODUCTIONS

Your Name & Organization?
What Are You Hoping To Learn Today?

REaL Data: What is it?
Why is it important in NH?
Take Aways from this Section

- Understand why many of us come from a health perspective
- Understand what REaL Data is and how collecting it is important
  - ... it must be USED to disaggregate data to identify variation in quality or differences among groups in access, use or outcomes
  - ... then that information can be to DRIVE improvements in care and services
- This is true across domains
- Almost all domains influence health

Let’s start by talking about health

*(Almost) Everything relates to health!*
Social Determinants of Health

Environments where we live, learn, work, play and pray

Dahlgren & Whitehead, 1991

Greater focus on what creates health

Physical Environment
- Environmental Quality
- Built Environment

Clinical Care
- Access to Care
- Quality of Care

Social and Economic Factors
- Education
- Employment
- Income
- Family & Social Support
- Community Safety

Health Behaviors
- Tobacco use
- Diet & Exercise
- Alcohol Use
- Sexual Activity
Overall Rankings for New Hampshire 2016
Health Outcomes & Health Factors

http://www.countyhealthrankings.org/app/#!/new-hampshire/2016/overview
More Education, Longer Life

For both men and women, more education often means longer life.*

College graduates can expect to live at least five years longer than individuals who have not finished high school.

Years of School Completed
- 0-4 years
- 5-8 years
- 9-11 years
- 12 or more years

Overcoming Obstacles to Health, Feb 2008 RWJF

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Higher Income, Longer Life

Adult life expectancy increases with increasing income.

Men and women in the highest-income group can expect to live at least six and a half years longer than poor men and women.

Family Income
- Below 100% PPL
- 100-199% PPL
- 200-249% PPL
- 250-399% PPL
- 400% PPL or more

*Source: U.S. Census Bureau, American Community Survey.
Less Education, Worse Health

Figure 36. Less education is linked with worse health. Compared with college graduates, adults who have not finished high school are more than four times as likely to be in poor or fair health.

Educational Attainment:
- Less than high school
- High school graduate
- Some college
- College graduate

Lower Income, Worse Health

Figure 37. Lower income is linked with worse health. Compared with adults in the highest-income group, poor adults are nearly five times as likely to be in poor or fair health.

Family Income (Percent of Federal Poverty Level):
- <100%
- 100–185%
- 186–249%
- 250–399%
- ≥400%
Health Varies by Income and Across Racial or Ethnic Groups

Figure 7a: Lower income generally means worse health. Racial or ethnic differences in health status are also evident. Poorer health is much more common among black and Hispanic adults than among other adults.

Income Is Linked With Health Regardless of Racial or Ethnic Group

Figure 7b: Differences in health status by income do not simply reflect differences by race or ethnicity. Differences in health can be seen within each racial or ethnic group. Both income and racial or ethnic group matter.
Why does this matter?

We’re in New Hampshire!
New Hampshire is Changing

Racial/Ethnic Minorities produced 50% of NH's gain from 2000-2010

Minorities represent 7.7% in 2010 of NH's population (4.9% in 2000)


New Hampshire Population by Race and Hispanic Origin

Adults, 18 and over

Children, under 18

6.3% minority

12.2% minority

Source: 2010 Census
Analysis: K.M. Johnson, Carsey Institute, UNH

"Other" category includes individuals who report more than one race.
How Diverse are We?

Manchester = 18%
Nashua = 21%
Concord = 10%
Berlin = 5%
Hanover = 26%

NH’s Growing Racial / Ethnic Diversity

Percent minority by census tract
Percent minority under 18 by census tract

Source: 2010 Census
Analysis: K.M. Johnson, Carsey Institute, UNH
Public School Enrollment

State-Wide
- American Indian or Alaskan Native
- Asian or Pacific Islander
- Hispanic
- Black, non-Hispanic
- White, non-Hispanic
- Multi-Race

Manchester
- American Indian or Alaskan Native
- Asian or Pacific Islander
- Hispanic
- Black, non-Hispanic
- White, non-Hispanic
- Multi-Race

ETHNICITY QUESTION:
- Do you consider yourself Hispanic or Latino?
  - Yes
  - No

RACE QUESTION:
- Which category(ies) best describes your race?
  (Select one or more)
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White

3 points to remember regarding these questions…

**ETHNICITY QUESTION:**
- **Do you consider yourself Hispanic/Latino?**
  - Yes
  - No

**RACE QUESTION:**
- **Which category(ies) best describes your race?**
  - American Indian/Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian/Other Pacific Islander
  - White

 Always ask ethnicity first

Individuals must self-identify

Individuals may check as many responses as they desire

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**Immigrants in NH**
Determined by response to a separate Census question

Foreign Born = 5.4%

Refugees comprise only ~6% of the foreign-born population in NH

Source: Carsey Institute, UNH
What are Disparities?

How do we know disparities even exist?
Diabetes Prevalence NH Adults

- Diabetes prevalence (adults)
  - Percent of adults who have diabetes: Both genders
  - State: New Hampshire
  - 95% CI
  - Year = 2010
  - Gender = All genders
  - Estimated percent of population = 7.89

BRFSS survey methodology changed in 2011.

Diabetes Prevalence NH Adults

- Diabetes prevalence (adults)
  - Percent of adults who have diabetes: 2010
  - State: New Hampshire
  - Both genders
  - Both genders, all ages
  - 95% CI

Estimated percent of population: 7.89
What if…
I want to know if there are differences by gender

Diabetes Prevalence NH Adults

Diabetes prevalence (adults)
Percent of adults who have diabetes: 2010
State: New Hampshire

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female, 18 to 24</th>
<th>Female, 25 to 34</th>
<th>Female, 35 to 44</th>
<th>Female, 45 to 64</th>
<th>Female, 65 or older</th>
<th>Male, 18 to 24</th>
<th>Male, 25 to 34</th>
<th>Male, 35 to 44</th>
<th>Male, 45 to 64</th>
<th>Male, 65 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated percent of population</td>
<td>5.0</td>
<td>6.0</td>
<td>7.0</td>
<td>8.0</td>
<td>9.0</td>
<td>5.0</td>
<td>6.0</td>
<td>7.0</td>
<td>8.0</td>
<td>9.0</td>
</tr>
</tbody>
</table>
What if…

I want to know if there are differences by race/ethnicity

Age-Adjusted Prevalence of Diagnosed Diabetes Among US Adults

2014

US Total = 8.5%

U.S. Prevalence Adults with Diabetes 2014 by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent %</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic White</td>
<td>7.3</td>
<td>1</td>
</tr>
<tr>
<td>Black / African American</td>
<td>13.4</td>
<td>1.8</td>
</tr>
<tr>
<td>American Indian / Native American</td>
<td>17.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Asian</td>
<td>7.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>12.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Native Hawaiian &amp; Pacific Islanders</td>
<td>17.6</td>
<td>2.4</td>
</tr>
</tbody>
</table>


Diabetes Prevalence NH Adults

Estimated percent of population = 9.15

80055 survey methodology changed in 2011.
What if there is no Race Ethnicity and Language (REaL) data?

...here in New Hampshire

Why Collect Data

“It is not the data, it is what you do with it.”

Maryland Hospital Indicator Project

“We can not manage what we can not measure.”

David Kindig, MD, MPH, University of Wisconsin School of Medicine
Percent of Mothers Breastfeeding
Massachusetts

- State: 70%
- Target: 75%

Percent of Mothers Breastfeeding
by Race/Ethnicity, Massachusetts

- Asian: 77%
- Hispanic: 71%
- State: 70%
- White, Non-Hispanic: 70%
- Black, Non-Hispanic: 68%

Breastfeeding among Mothers by Ethnicity, MA

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Indian</td>
<td></td>
<td>35%</td>
</tr>
<tr>
<td>Japanese</td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Pakistani</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Nigerian</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Salvadoran</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Colombian</td>
<td></td>
<td>40%</td>
</tr>
<tr>
<td>Barbadian</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Korean</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Cuban</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>MA TOTAL</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
<td>35%</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Afr-Amer</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Laotian</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Cambodian</td>
<td></td>
<td>40%</td>
</tr>
</tbody>
</table>

Data Collection Standards from ACA Section 4302

<table>
<thead>
<tr>
<th>Ethnicity Data Standard</th>
<th>Categories</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you Hispanic, Latino/a, or Spanish origin (One or more categories may be selected)</td>
<td></td>
<td>These categories roll-up to the Hispanic or Latino category of the OMB standard</td>
</tr>
<tr>
<td>a. No, not of Hispanic, Latino/a, or Spanish origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Yes, Mexican, Mexican American, Chican/o/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Yes, Puerto Rican</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Yes, Cuban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Yes, another Hispanic, Latino, or Spanish origin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race Data Standard</th>
<th>Categories</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your race? (One or more categories may be selected)</td>
<td></td>
<td>These categories are part of the current OMB standard</td>
</tr>
<tr>
<td>a. White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Black or African American</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. American Indian or Alaska Native</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Asian Indian</td>
<td></td>
<td>These categories roll-up to the Asian category of the OMB standard</td>
</tr>
<tr>
<td>e. Chinese</td>
<td></td>
<td>These categories roll-up to the Native Hawaiian or Other Pacific Islander category of the OMB standard</td>
</tr>
<tr>
<td>f. Filipino</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Japanese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Korean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Vietnamese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Other Asian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Native Hawaiian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Guamanian or Chamorro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Samoan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Other Pacific Islander</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What if there is no REaL data?

Race, Ethnicity and Language

Health & Equity Report Card

- Data to measure key health disparities among the state’s racial, ethnic, and linguistic minority populations
- Baseline measures for effective and efficient policy and program development
- Focused on Social Determinants of Health (what was available at the time)
- Long-term need for current data and accessibility (WISDOM)
Health & Equity Index Design

Ratio of the Minority Population to the White Population

- 1.0 or Less - No Disparity or Relative Advantage
- 1.0 to 1.4 - Small Disparity
- 1.5 to 2.1 Disparity Requires Attention
- Greater than 2.1 - More Attention is Needed.

Health & Equity Summary Index Across 10 Domains

Summary Health and Equity Index
In Table 8 we present a summary measure, based on ten independent indicators, of the social determinants of health for minority populations in New Hampshire. The summary includes an average equity index for each measure, weighted by the population represented in each racial and ethnic grouping.³

Table 8: Health and Equity Summary Index

<table>
<thead>
<tr>
<th>Area Source</th>
<th>Health &amp; Equity Summary Index</th>
<th>Average Over 10 Indicators American Community Survey, 2006 to 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Degree</td>
<td>Single Mother Household</td>
<td>Home Ownership</td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1.5</td>
<td>1.2</td>
</tr>
<tr>
<td>American Indian</td>
<td>2.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Asian</td>
<td>1.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Summary Index (weighted)</td>
<td>1.7</td>
<td>1.6</td>
</tr>
</tbody>
</table>

A disparity score greater than 1.0 indicates that minorities are doing worse than the white population. A disparity score less than 1.0 indicates that minorities are doing better than the white population. A disparity score equal to 1.0 indicates that minorities and the white population are doing the same.
2012 In-State Hospital Discharge Data Available in WISDOM
Thursday 11/17/16

Download the 2012 In-state hospital discharge data from your My WISDOM account.

Additional releases scheduled!

NH Health WISDOM is pleased to announce the availability of 2012 In-State Hospital Discharge Data. This is the first step in providing access to this valuable data source. The next steps will include the scheduled release of 2013, 2014 and 2015 data in early January. Currently, the data set is accessible as a downloaded file only. Updating the dashboards with the new data is expected to take several months and is scheduled to be completed by late Spring 2017.
Let’s look at other domains…

Study: Third Grade Reading Level Indicates Student’s Chances Of Graduating High School

Black children make up 18% of preschoolers, but make up nearly half of all out-of-school suspensions.
Implicit bias may help explain high preschool expulsion rates for black children

By Bill Hathaway
September 27, 2016

Track the eyes: Which students are teachers watching?

- Black girls: 10%
- White girls: 13%
- Black boys: 42%
- White boys: 34%

Preschool teachers tend to more closely observe blacks than whites, especially black boys, when challenging behaviors are expected.

How are we doing in NH?

Carsey Research Issue Brief
Winter 2016
**Risk of experiencing high exclusionary discipline by student characteristics & circumstances**

**NH Middle and High Schools, 2010-2014**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>0.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2.1%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>5.4%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>10.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>34.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>51.7%</td>
</tr>
</tbody>
</table>

Source: New Hampshire Department of Education

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**ARCHIVED INFORMATION**

**U.S. Department of Education Announces Resolution of Manchester, N.H., School District Civil Rights Investigation**

*Agreement Provides Greater Access to College and Career Prep Courses for Black, Latino Students*

**APRIL 15, 2014**

Contact: Press Office, (202) 401-5778, press@ed.gov

The U.S. Department of Education’s Office for Civil Rights today announced a settlement with New Hampshire’s Manchester School District. The school district agreed to provide greater access to college and career preparation courses for black and Latino students.

OCR investigated whether the school district discriminated against black and Latino students on the basis of race or national origin by establishing policies and procedures that result in excluding these students from these programs and courses. The district’s advanced courses include honors and Advanced Placement (AP) courses and dual enrollment programs that offer college credit through local post-secondary institutions. Before OCR completed its review, the district expressed an interest in voluntarily resolving this case, resulting in the agreement announced today.
Disproportionate Enrollment in AP Courses

Manchester High Schools
Central, Memorial & West

2010-2011 School Year

<table>
<thead>
<tr>
<th></th>
<th>Student Enrollment</th>
<th>Student Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grades 9 – 12</td>
<td>AP Courses</td>
</tr>
<tr>
<td></td>
<td>#</td>
<td>#</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>5620</td>
<td>434</td>
</tr>
<tr>
<td>Black</td>
<td>381</td>
<td>17</td>
</tr>
<tr>
<td>Hispanic</td>
<td>596</td>
<td>9</td>
</tr>
<tr>
<td>White</td>
<td>4229</td>
<td>369</td>
</tr>
</tbody>
</table>

(Health) Disparities

Differences in health status, outcomes, and care services for population groups that are unnecessary, avoidable, and unjust.

- National Stakeholder Strategy, Healthy People 2020 and Health and Human Services (HHS) Plan
Culturally Effective Organizational Practices

- Improvement for diverse patients
- Utilization patterns
- Patient and family satisfaction
- Treatment adherence
- Levels of patient trust

Data – especially REaL Data

Really Matters!

- Need REaL Data to identify treatment variation and differences in patient outcomes and satisfaction across groups.
- Must monitor the impact of cultural effectiveness-related policies and activities on health equity and outcomes.
- This information must inform organizational strategic planning, and aid in tailoring service delivery to meet community needs.

http://iasp.brandeis.edu/pdfs/2015/CE.pdf
Real World Use of REaL Data
(from Healthcare)

REaL Data Barriers

System-level and patient-level barriers to collecting and using patient race, ethnicity, and primary language data include

• Lack of standardization of race, ethnicity, and language categories
• Lack of staff understanding of why data is collected
• Information technology limitations
• Staff discomfort about data collection
• Patient privacy concerns
### Racial and Ethnic Disparities among Enrollees in Medicare Advantage Plans

John Z. Ayanian, M.D., M.P.P., Bruce E. Landon, M.D., M.B.A., Joseph P. Newhouse, Ph.D., and Alan M. Zaslavsky, Ph.D.

NEJM 2014 Dec 11; 371(24): pp 2288-2297

#### Estimated Age-and-Sex-Adjusted Proportions of Black Enrollees and White Enrollees with Diabetes in Medicare Advantage HMOs in Whom Glycated Hemoglobin Was Controlled, Overall and According to Region

![Chart showing glycated hemoglobin levels for Black and White enrollees with diabetes in Medicare Advantage HMOs, divided by region: National, Northeast, Midwest, South, and West for 2006 and 2011.](chart.png)

### Disparities Index

CHCS has worked with participants in the BCAP Workgroup on *Improving Health Care Quality for Racially and Ethnically Diverse Populations* and others in the field to develop a disparities index for use within Medicaid populations.

- The CHCS Disparities Index measures changes in racial and ethnic health disparities, as well as overall changes in quality of care.
- The DI measures each health plan’s progress toward eliminating disparities by comparing the difference between each racial and ethnic subgroup’s rate on a measure and the “best” performing subgroup’s rate for the same measure.
- The quality component of the Disparities Index measures each subgroup’s performance against an external norm such as the HEDIS 75th percentile (the national Medicaid rate per measure).
- The index can potentially be used as part of a needs assessment, to identify an overall pattern of disparities at the plan level, to evaluate ongoing disease management programs, and to determine whether the disparities experienced by racial/ethnic groups are increasing or decreasing.
Quality Improvement Efforts using REaL Data

- Molina Healthcare of Michigan Shots for Shorties – Increasing Immunizations among African American Children and Adolescents in Michigan
- Monroe Plan for Medical Care - Healthy Beginnings for African American Pregnant Teens
- Manchester Community Health Center Diabetes QI Initiative
- Impact of Race/Ethnicity and Socioeconomic Status on Risk-Adjusted Hospital Readmission Rates Following Hip and Knee Arthroplasty

Molina Healthcare of Michigan Shots for Shorties
Increasing Immunizations among African American Children and Adolescents in Michigan

- Molina reviewed its 2004 HEDIS rates by ethnicity and determined that childhood and adolescent immunizations were the areas of greatest disparity between African Americans and whites.
- The plan added a field to store the pertinent data in the plan’s internal immunization database. Molina Healthcare is now able to determine whether the targeted children have completed their immunization series
- Molina surveyed the parents of children age 12-24 months and 12-13 years who were overdue for immunizations to identify barriers to getting timely immunizations.
- The childhood immunization rate for African American members increased from 38.3% in 2004 to 58.4% in 2006. Despite the increase, the plan has still not reached its goal of 68% and a disparity still exists: Molina’s immunization rate for African American children is below the 76.8% for whites and the 84.4% for Hispanics in 2006. Nonetheless, the intervention increased the childhood immunization rates in six of the eight pilot sites.

Monroe Plan for Medical Care
Healthy Beginnings for African American Pregnant Teens

- The Monroe Plan set a goal of addressing high neonatal intensive care unit (NICU) utilization and low prenatal care rates among African American pregnant teenagers and their babies.

- Monroe Plan hired one additional outreach worker and one part-time social worker to manage up to 30 pregnant African American teenagers under age 18 through their pregnancies and during the postpartum period, until their infants reached six months.

- The program offered home visits, facilitation of transportation to services (either by arrangement or direct transport), and opportunities for health education.

- Since implementing this outreach effort in 2005, the Monroe Plan has documented a decrease in NICU admission rates for the babies of the targeted population. The initial goal was to decrease the difference in NICU admission rates between African American and white teenagers by at least 50%. The intervention contributed to a decrease from 11% to 4.9% in the disparity between rates of NICU admissions among babies of African American teen mothers and babies of white teen mothers in 2005.


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Manchester Community Health Center QI Initiative

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>% DM Pts with HbA1c &gt;9</th>
<th>% DM Pts with HBA1c value</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>75.23%</td>
<td>69.28%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0.00%</td>
<td>0.24%</td>
</tr>
<tr>
<td>Asian</td>
<td>4.59%</td>
<td>10.60%</td>
</tr>
<tr>
<td>Black</td>
<td>9.17%</td>
<td>10.48%</td>
</tr>
<tr>
<td>Multiple</td>
<td>3.67%</td>
<td>2.17%</td>
</tr>
<tr>
<td>Undetermined/Other</td>
<td>7.34%</td>
<td>6.02%</td>
</tr>
<tr>
<td>American Indian/Alaskan</td>
<td>0.00%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>HISPANIC</td>
<td>25.00%</td>
<td>10.00%</td>
</tr>
<tr>
<td>NON-HISPANIC</td>
<td>75.00%</td>
<td>90.00%</td>
</tr>
</tbody>
</table>
Impact of Race/Ethnicity and Socioeconomic Status on Risk-Adjusted Hospital Readmission Rates Following Hip and Knee Arthroplasty

- Calculated 2 sets of risk-adjusted readmission rates
  - used the Centers for Medicare & Medicaid Services standard risk-adjustment algorithm that incorporates patient age, sex, comorbidities, and hospital effects
  - added race/ethnicity and socioeconomic status to the model.
  - Using data from the Healthcare Cost and Utilization Project, 2011 State Inpatient Databases, compared the relative performances of 1,194 hospitals across the 2 methods.

- Results
  - Addition of race/ethnicity and socioeconomic status to the risk-adjustment algorithm resulted in
    1) little or no change in the risk-adjusted readmission rates at nearly all hospitals
    2) no change in the designation of the readmission rate as better, worse, or not different from the population mean at >99% of the hospitals
    3) no change in the excess readmission ratio at >97% of the hospitals.

Leading Practices for Using Patient REaL Data

1. Use an equity scorecard or dashboard to report organizational performance
2. Inform and customize the language translation services you provide
3. Review performance indicators such as length of stay, admissions, and avoidable readmissions
4. Review process of care measures
5. Review outcomes of care
6. Analyze provision of certain preventive care
Key Strategies for Collecting Patient REaL Data

1. Engage senior leadership
2. Define goals for data collection
3. Combine disparities data collection with existing reporting requirements
4. Track and report progress on an organization-wide basis
5. Build data collection into quality improvement initiatives
6. Utilize national, regional, and state resources available
7. Review, revise, and refine process and categories constantly

What the H&EP Data Work Group has been doing
In the Beginning...

**2004-2010 MIAB Data Committee**
- **11/19/2004 MIAB Data Committee Kickoff Meeting**
- Funded by Endowment for Health
- Coordinated by NH Minority Health Coalition

http://www.healthyNH.com/images/nhhep/AssessmentREaLDataCollectionNHPublicHealthDataSets.pdf
In the Beginning...

• 2004-2010 MIAB Data Committee

• 2010: Phase I Assessment
  REaL Data Collection in NH Public Health Data Sets

2011: Plan to Address
Health Disparities and
Promote Health Equity in New Hampshire

The Plan

Priorities for action
to work towards
health and equity
for racial, ethnic
and language
minorities in
New Hampshire
The Plan: Data Recommendations

• Establish NH DHHS guidelines and policy for the collection of race, ethnicity and language data as a model for other agencies and organizations
• Identify resources for electronic data system improvements and quality assurance
• Train collectors and submitters of race, ethnicity and language data to use NH DHHS policy
• Educate the public about the collection of race, ethnicity and language data
• Work with data stewards to stratify their data to identify disparities
• Develop an equity index reflecting data from health and other sectors

Review of current best practices for collection of REaL Data

ACA Section 4302
October 2011
### Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status

With an LGBT Plan


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### Spring 2012

**H&EP Issue Brief #1**

- Improving Health Care Quality: Racial, Ethnic and Language Data
Dashboard of Indicators on health and equity for racial, ethnic, and linguistic minority population groups in NH


Qualitative Assessment

October 2014

- When do you collect data?
- Does your organization look at any quality data stratified by any Racial, Ethnic, Language group?

- What database do you use to collect data?
- How does your organization access the quality of data collection efforts in relation to Racial, Ethnic, Language group?

- What does your infrastructure to collect data look like?
- Who within your organization is responsible for the quality of Racial, Ethnic, Language data?

- How does data collection change across various programs within your organization?
- What does your organization do to ensure or improve the quality of Racial, Ethnic, Language data collection?

- What is the purpose of your data collection efforts?
- If your organization was to make a change regarding what Racial, Ethnic, Language demographic questions were asked (or how they are asked) who would make that decision? How would that decision most likely happen?

- What are your barriers to data collection?
- Is there any concern in your organization about current or future payment being tied to the ability of your organization to address disparities?

- How do your funding sources require you to submit data?
- What are the current incentives or regulations for your organization to collect this data?

- If you were to guess, without having data, what disparities might you anticipate Racial, Ethnic, Language minority patients of your organization experience? (utilization of services and outcomes)

- 15 key informant interviews
- Hospitals, FQHCs, Social Services, Mental Health Centers
Quantitative Assessment
2015-2016

**Organization response to patient/client not answering race/ethnicity question**

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>We enter it as refused/unreported</td>
<td>64.3%</td>
<td>(9)</td>
</tr>
<tr>
<td>We leave it blank</td>
<td>14.3%</td>
<td>(2)</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>14.3%</td>
<td>(3)</td>
</tr>
</tbody>
</table>

*How do you handle....?*
# Quantitative Assessment 2015-2016

## Current process/ability to extract (report on) demographic data points

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Cannot extract/report on any data</th>
<th>Can only manually extract/report</th>
<th>Can extract data from one software</th>
<th>Can extract data across multiple</th>
<th>Can extract for some of our programs</th>
<th>Can extract for all of our programs</th>
<th>I do not know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Language</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Language for Services</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Needs Interpreter</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Gender (male/female)</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transgender</td>
<td>1</td>
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<td>Address</td>
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<td>1</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Income or Poverty Level</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
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<td>Health Insurance</td>
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<td>4</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Education Level</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Living Arrangements (Home Owner, Renter, Homeless, etc)</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

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## Framework for a Culturally Effective Organization

[http://iasp.brandeis.edu/pdfs/2015/CE.pdf](http://iasp.brandeis.edu/pdfs/2015/CE.pdf)
Let’s begin to determine our course forward!

Increase the capacity in NH for the collection of high quality Race, Ethnicity and Language (REaL) data across all systems at the state and local level to identify disparities and promote utilization of data to inform improvements, policies and procedures.
Introductions/who we are

Collective Impact primer

Envisioning goals, strategies, & resources

AUNE’s Center for Behavioral Health Innovation (BHI)
Infusing science with practice to improve the lives of underserved populations, shoulder to shoulder with community partners

Integration of behavioral health

Knowledge translation

Evaluation & Monitoring

Facilitation and technical assistance

We’re heavily involved in children’s behavioral health work

Infusing science & practice to improve the lives of underserved populations, shoulder to shoulder with community partners

BHI’s work accelerates over time

Large variety of projects, partners, and populations

BHI project timeline, medium & large projects only

Behavioral Health Integration; Evaluation

Develop integrated primary care in Suffolk County

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Develop integrated primary care in Suffolk County

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care

Evaluate integrated primary care
2. Aligned portfolio of interventions and outcomes for collective change

**Collective Impact**
- A group working towards the same outcome,
- Looking at the same data,
- To continuously improve practices over time

**Coordinated Impact**
- A group working on the same issue,
- Sharing information about what they do
- To better coordinate efforts

**Individual Impact**
- Individual practitioners working on specific issues
- Collecting qualitative and quantitative data
- To demonstrate impact with individual students

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2. The 5 Conditions of Collective Impact

1. **Common Agenda**
   - Common understanding of the problem
   - Shared vision for change

2. **Shared Measurement**
   - Collecting data and measuring results
   - Focus on performance management
   - Shared accountability

3. **Mutually Reinforcing Activities**
   - Differentiated approaches
   - Coordination through joint plan of action

4. **Continuous Communication**
   - Consistent and open communication
   - Focus on building trust

5. **Backbone Support**
   - Separate organization(s) with staff
   - Resources and skills to convene and coordinate participating organizations
Seeking for all a fair opportunity to live a long, healthy life

Individual reflection

What needs to change with REaL data for H&EP to succeed?

3 minutes – brainstorm

2 minutes – select single most important change
Seeking for all a fair opportunity to live a long, healthy life

Small Groups (~4 people each)

**Which change is most important for the H&EP to succeed**

5 minutes – hear each person’s most important change

5 minutes – discuss, reach consensus on single most important change and why

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Large Group

**List of most important changes:**

1. Uniform Real data collection (from social service providers) that are consistent across organizations and understood by all that are comparable to national standards

2. Need to educate data collectors why collection is important—not just more work!

3. Ensure people know why we are asking REAL data questions before asking. Feed results back to respondents

4. Educate informants about the importance of asking REAL data questions with use of a standardized data set (see 1)

5. Legislation to require universal collection of REAL data (with identifier)