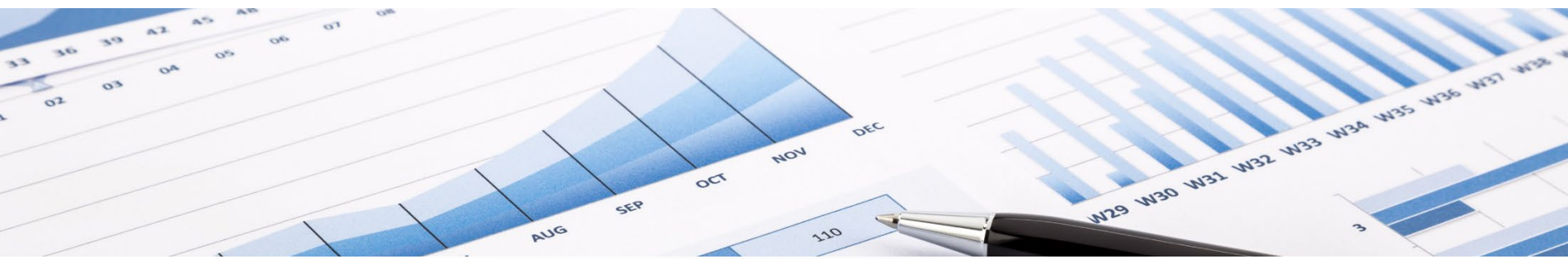# Health Equity Quickinar Series
Session 7

Culturally Competent Data Training

OBJECTIVES

- Identify the importance of culturally competent training for accuracy of REaL and social driver data collection.
- Discuss the importance of crucial conversations in engaging patients in reporting REaL data and social driver data.
- Identify points of data collection throughout the hospital stay process.

REaL = Race, ethnicity and language

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Equitable Data

- Make it the norm to break down data into detailed segments.
- Establish and use data-sharing partnerships for equity assessments.
- Build capacity for robust equity assessments.
- Promote diverse partnerships.
- Increase transparency.

Equitable Data Working Group. Recommendations from the Equitable Data Working Group. Available at www.whitehouse.gov/wp-content/uploads/2022/04/eo13985-vision-for-equitable-data.pdf.

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A Culturally Aware Healthcare System: Requirements

- Engaging leadership
- Engaging with the community
- Performing workforce training
- Conducting cultural assessments

- Identifying training topics
- Offering multiple training methods
- Measuring and tracking
- Implementing strategies

American Hospital Association Institute for Diversity and Health Equity (IFDHE). Health Equity Resource Series: Training and the Culture of Learning. Available at ifdhe.aha.org/system/files/media/file/2021/05/ifdhe_cultural_learning_toolkit_2.pdf.

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Accuracy of REal Data Collection: Proactive Approach

People of color are projected to make up over half of the U.S. population as of 2050.

Projected distribution of the United States population by race/ethnicity, 2020 and 2050

| Race/Ethnicity	2020	2050
White	60%	48%
Black	13%	13%
Hispanic	19%	26%
Asian	6%	8%
Other	2%	4%
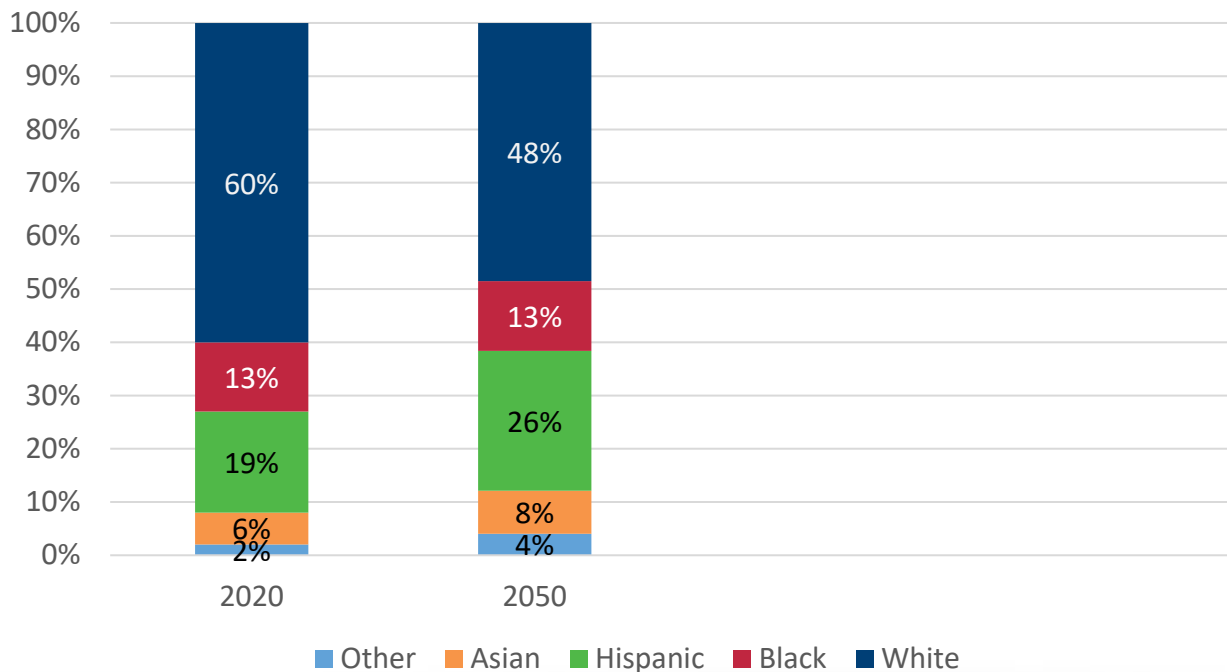
- **2020: 39% people of color**
- **2050: 52% people of color**

Note: All racial groups are non-Hispanic. Other includes Native Hawaiians and Pacific Islanders, American Indian and Alaska Natives, and individuals with 2 or more races. Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands.

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People of color fare worse than their White counterparts across many measures of health status.

Number of health status measures for which a group fared better, the same, or worse compared to White counterparts
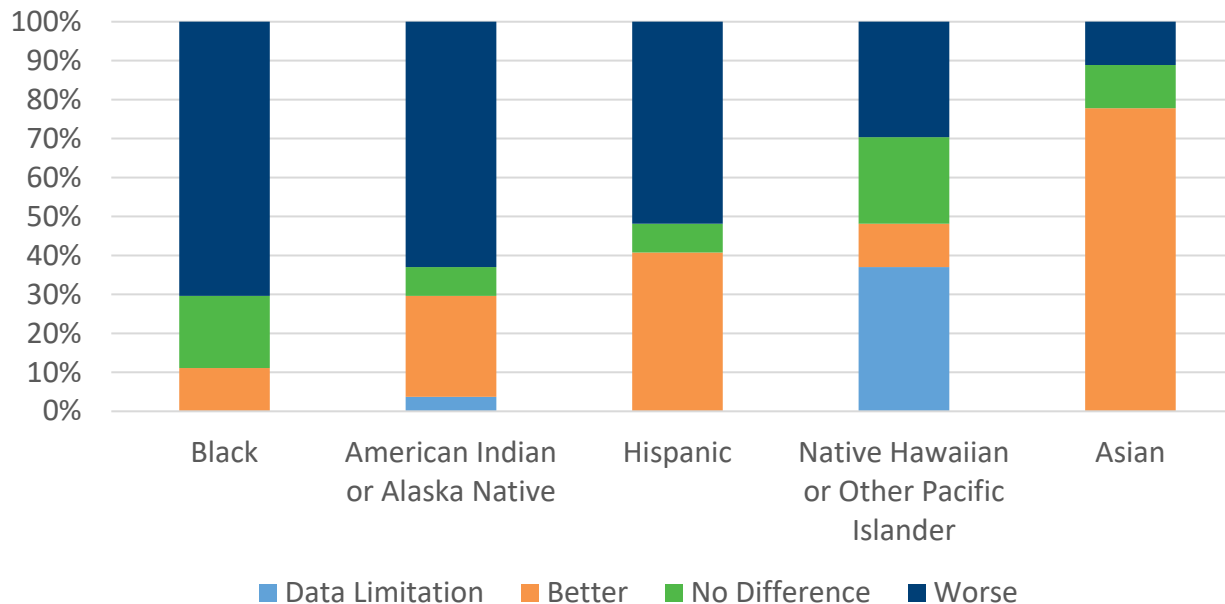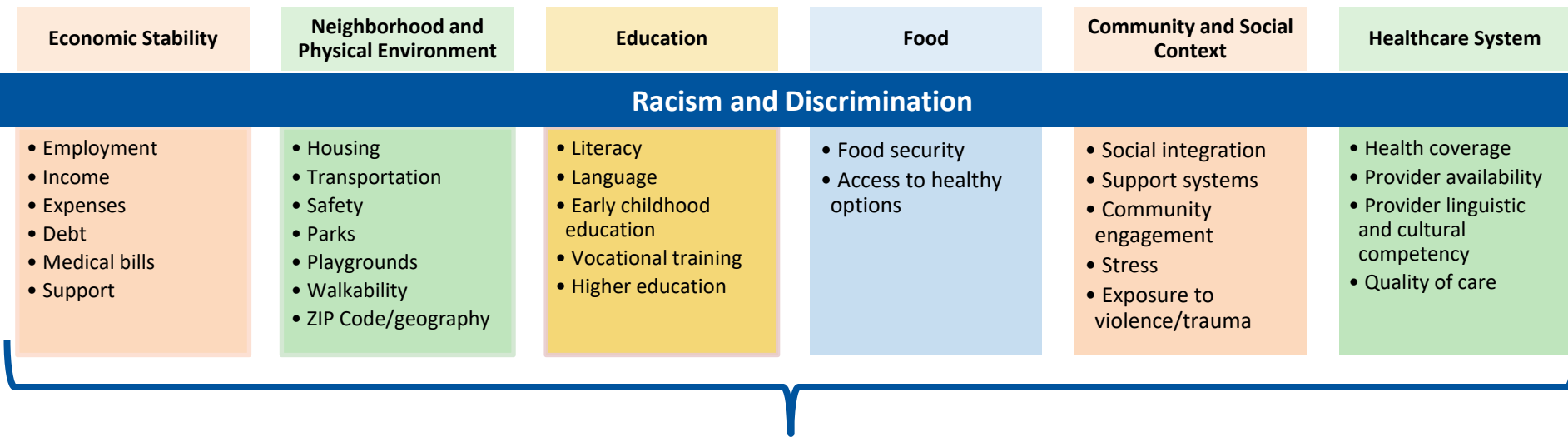
Note: Measures are for 2018 or the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from Whites at the $p<0.05$ level. No difference indicates no statistically significant difference. "Data limitation" indicates data are not separate for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

Legend: ■ Data Limitation ■ Better ■ No Difference ■ Worse

Categories: Black | American Indian or Alaska Native | Hispanic | Native Hawaiian or Other Pacific Islander | Asian

Artiga S. KFF. Health Disparities are a Symptom of Broader Social and Economic Inequities. June 1, 2020. Available at www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/#:~:text=These%20longstanding%20and%20persistent%20health,as%20underlying%20racism%20and%20discrimination.

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Social and Economic Factors Drive Health Outcomes

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Healthcare System
Racism and Discrimination					
• Employment • Income • Expenses • Debt • Medical bills • Support	• Housing • Transportation • Safety • Parks • Playgrounds • Walkability • ZIP Code/geography	• Literacy • Language • Early childhood education • Vocational training • Higher education	• Food security • Access to healthy options	• Social integration • Support systems • Community engagement • Stress • Exposure to violence/trauma	• Health coverage • Provider availability • Provider linguistic and cultural competency • Quality of care

Health Outcomes: Mortality, Morbidity, Life Expectancy, Healthcare Expenditures, Health Status, Functional Limitations

Artiga S. KFF. Health Disparities are a Symptom of Broader Social and Economic Inequities. June 1, 2020. Available at www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/#:~:text=These%20longstanding%20and%20persistent%20health,as%20underlying%20racism%20and%20discrimination.

Cultural Competency Training: Addressing the Framework

Age and generational influence

Disability status (developmental disability)

Disability status (acquired physical/cognitive/psychological disability)

Religion and spiritual orientation

Ethnicity and race

Socioeconomic status

Sexual orientation

Indigenous heritage

National origin

Gender identity

Cultural Competency: Authur Kleinman's Eight Questions

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?

Kleinman A., Eisenberg L., Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Annals of internal medicine. 1978. 88(2): 251–258. Available at the U.S. Department of Health and Human Services Office of Minority Health Think Cultural Health webpage: www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.

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Collecting REal Data to Reduce Disparities

- Ensure sufficient language assistance services.

- Develop appropriate patient education materials.

- Track quality indicators and health outcomes.

Evaluating and Elevating Health Equity

Health Equity Accreditation

- Building an internal culture
- Collecting data
- Identifying opportunities to reduce health inequities

Health Equity Accreditation Plus

- Collecting data
- Establishing mutually beneficial partnerships
- Building meaningful opportunities
- Identifying opportunities to improve the referral process

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Staff Training

- Appropriate staff should be trained on the collection of REaL and SDOH data.

- Training in collection of REaL data is available from the American Hospital Association at ifdhe.aha.org/hretdisparities/staff-training.

  - Discusses why these data are being collected

  - Reviews common patient questions and appropriate answers

SODH = Social determinants of health
American Hospital Association Institute for Diversity and Health Equity (IFDHE). Why Collect Race, Ethnicity, and Primary Language. Available at ifdhe.aha.org/hretdisparities/why-collect-race-ehtnicity-language.

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Why Collect REaL Data? Handout

HSAG's PFAC developed an FAQ handout for patient education about collection of REaL data.

Frequently Asked Questions
About the Collection of Patient Race, Ethnicity, and Language Information

HSAG HQIC

Q: What if I don't want to answer these questions?
A: It is perfectly alright if you do not want to answer these questions. We will provide you care no matter how you choose to answer. However, knowing the answers to these questions helps our hospital provide more personalized care.

Q: What do my race and ethnicity have to do with my health?
A: Your race and ethnic backgrounds may place you at different risks for some diseases. By knowing more about you, the hospital will be better able to meet your health needs.

Q: Who are you collecting this information from?
A: This hospital collects this information from all patients.

Q: Why am I being asked these questions?
A: This hospital collects information on race, ethnic backgrounds, and the language you speak from all our patients to make sure that everyone receives personalized care. By knowing more about you, we will be better able to meet your health needs.

Q: What will my information be used for at the hospital?
A: Your answers to these questions can help us to offer more personalized services and programs to you and others like you. Hospitals can also use your answers to make sure that all patients are getting the same quality of care no matter their race or ethnicity.

Q: Who will see my information?
A: Your information will be kept private and safe. The only people who will see your race and ethnicity information are members of your care team.

Q: What if I belong to more than one race?
A: You can check off all the races you belong to.

Q: What if I don't know my race or ethnicity?
A: If you don't know your race or ethnicity, you can talk to hospital registration staff and they can help you decide the best way to answer.

Q: Who can I ask questions about this?
A: The hospital registration staff and their supervisors are happy to answer any questions [you] may have.

This was prepared by Health Services Advisory Group (HSAG), a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. XS-HQIC-DIS-06242021-01

Created by Patients for Patients

PFAC = Patient and Family Advisory Committee
HSAG. Frequently Asked Questions About the Collection of Patient Race, Ethnicity, and Language Information. Available at www.hsag.com/globalassets/hqic/hqic-ptedwhycollectrealdata.pdf.

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Evaluation of Social Needs

- Staff should be trained on the importance of collecting social needs data.
  - Improves buy-in from the staff
  - Allows staff to communicate effectively with patients
- Staff should be able to communicate to patients about why social needs are being collected.
  - Helps understand the patients and their needs better and provides higher quality of care
  - Allows for facilitation of services
  - Gives context to some of the challenges patients may be facing

National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association, Institute for Alternative Futures. Protocol for Responding to an Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Implementation and Action Toolkit. Available at prapare.org/wp-content/uploads/2022/09/Full-Toolkit_June-2022_Final.pdf.

Staff Training (cont.)

- Staff should be trained to have sensitive conversations with patients.

  - Social needs can be sensitive to discuss.

  - Staff should be empathetic and supportive when having these discussions.

- Oregon Primary Care Association has a Patient-Centered SDOH Conversation Guide:

  - www.orpca.org/files/11%20Empathic%20Inquiry%20Conversation%20Guide.pdf

Oregon Primary Care Association (OPCA). Patient-Centered Social Determinants of Health Screening Conversation Guide. Available at https://www.orpca.org/files/11%20Empathic%20Inquiry%20Conversation%20Guide.pdf.

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PRAPARE Implementation and Action Toolkit

- Standardized risk-assessment tool for SDOH
- Includes resources for training staff on the use of PRAPARE and collection of SDOH data
- [PRAPARE Toolkit](#)
- [PRAPARE introduction script](#)

National Association of Community Health Centers

PRAPARE. Implementation and Action Toolkit. Available at https://prapare.org/prapare-toolkit/.
National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association, Institute for Alternative Futures. Protocol for Responding to an Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Introduction script. Available at http://www.nachc.org/wp-content/uploads/2019/01/PRAPARE-script-Venice-Family-Clinic.docx.

SDOH Screening Statement Example

Example statement from PRAPARE:

"We would now like to ask you some non-medical questions to better understand you as a person and any needs you may have. We want to make sure that we provide the best care and services possible to meet your needs. This information will help us determine if we need to add new services or programs to better care for our patients. This information will be kept private and secure. Only clinic staff will have access to this information. Your decision to answer or to refuse to answer will NOT impact your ability to receive care. In many cases, this information will help us determine if you are eligible for any additional benefits, programs, or services. Please let us know if you have any questions, concerns, or suggestions."

Collection Opportunities

- Data can be collected by different staff members.
  - Registration staff or clinical staff, such as medical assistants or nurses, may perform data collection.
  - Best option can be dependent on staffing levels.
- Hospitals have multiple options for time of collection:
  - Over the phone when appointment is made, at time of check-in, or pre-exam.
  - In emergent settings, data can be collected at different times depending on patient.

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Key Concepts

- Collection of REaL and SDOH data should be done in a culturally competent, sensitive manner.

- Collection of this data is critical to reducing disparities and addressing social needs.

- Staff should understand why the data are being collected and be able to discuss this with patients, if necessary.

- Social needs can be a sensitive topic; staff should be trained to have difficult conversations with patients.

Join Us for the Entire Series

Recordings, slides, and resource links will be posted for on-demand access after every session.

8. Analysis and Stratification of Health Equity Data

8. Analysis and Stratification of Health Equity Data

Thursday, April 27, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Discuss the role of the HSAG HQIC data dashboard in stratifying disparities in health outcomes.
- Identify how hospitals can use internal data to stratify disparities in health outcomes.
- Review the importance of transparency of identified disparities throughout the organization.

1. Health Equity, Hospitals, and CMS Reporting	2. Engaging Leadership in Health Equity
3. Health Equity as a Strategic Priority	4. Collection and Validating REaL Data
5. Social Determinants and Social Drivers of Health	6. Screening for Social Drivers
7. Culturally Competent Data Training	8. Analysis and Stratification of Health Equity Data
9. Health Equity Interventions	10. Best Practices in Health Equity Interventions
11. Community Paramedicine	12. Identifying Community Health Disparities
13. Community Engagement—Health Equity	

www.hsag.com/health-equity-quickinars

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Thank you!

hospitalquality@hsag.com