Tuesday, October 11, 2022; 11:00am PT

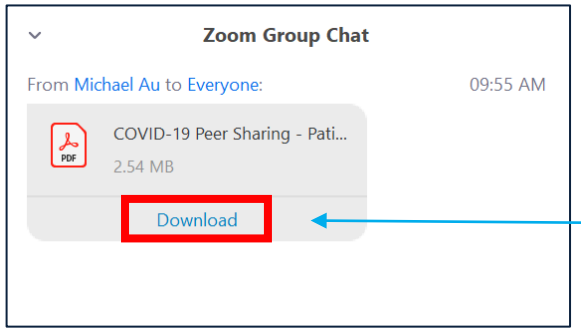
California Quality Collaborative

Improving the Collection and Use of Race, Ethnicity and Language Data

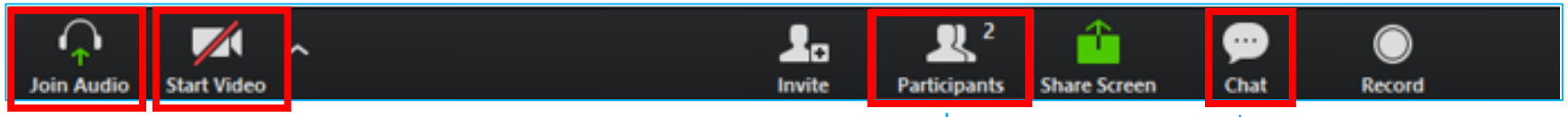
PBGH California Quality Collaborative

Tech Tips – Zoom Meetings

For polls, click the blue **submit button** to complete



Click Download in Chat for PDF of slide deck



Click to join or mute audio

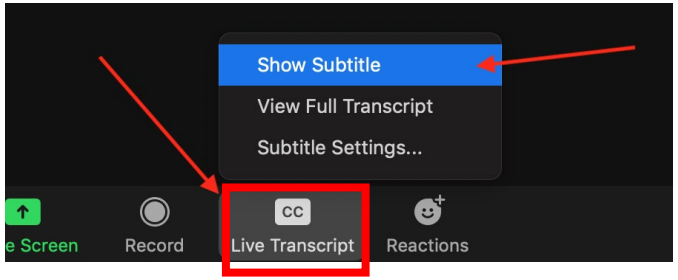
All attendees have video off upon entry

Click to see who else has joined

Ask questions and insert comments

Direct message Lydia Walker if you have any technical issues

Recording & deck will be shared with attendees



Request live closed captioning or view full meeting transcript

Poll: Who's in the (virtual) room?

Where are you dialing in from?

- Northern California
- Southern California
- Other West Coast
- East Coast
- Midwest
- Southwest

What type of organization do you represent?

- Patient
- Provider/Practice
- Health Plan
- Government Agency
- Technical Assistance Org
- Research Agency
- Other [Chat in]

California Quality Collaborative

Advancing the quality and efficiency
of the outpatient health care delivery system by
creating scalable, measurable improvement.

Launched in 2007, CQC is a **multi-stakeholder program.**
Core funding from health plans sharing a delivery system

Identifies and spreads best practices across outpatient delivery system in California

Trains 2,000 individuals from 250 organizations each year

CQC's track record includes **20% relative improvement** in clinical outcomes and **10:1 ROI**

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VHP Valley Health Plan

Today's Speakers

Rebecca Alcantar, MPA
Interim Population Care Manager,
Health Equity & Quality
Transformation Division,
Covered California

Teresa Ku-Borden, MD
Family Medicine Physician,
Family Care Specialists-Altais
Associate Program Director,
Adventist Health Residency Program

Cary Sanders, MPP
Senior Policy Director,
California Pan-Ethnic
Health Network

Michael Au
Senior Manager,
California Quality
Collaborative

Lindsay Petersen
Senior Manager,
Advanced Primary Care

Our Agenda

Today, we'll:

Review recommendations to improve REaL data collection and usage from a new issue brief published by CQC in partnership with the California Health Care Foundation.

Hear lessons learned from experts who have worked in the system to enhance quality and increase collection of REaL data.

Discuss how to support health equity initiatives.

Why Focus on Improving the Collection and Use of Race, Ethnicity and Language Data?

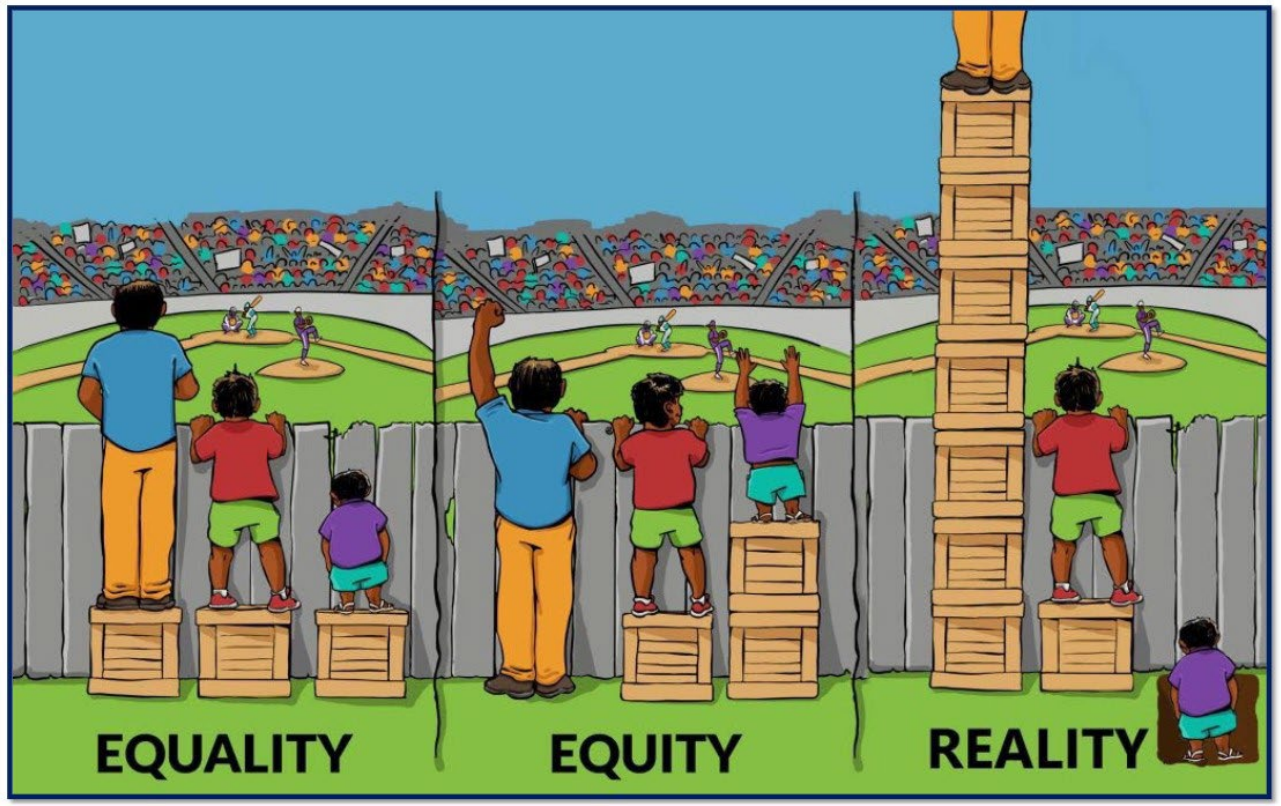
Long-standing systems of privilege and oppression impact the health of populations and communities.

Stratifying health quality data by race, ethnicity, language and other factors is crucial for understanding where health disparities exist and what they are.

Primary care, the doorway to our health system, is uniquely positioned to help identify and alleviate disparate care and outcomes.

However, that potential is inhibited by inadequate demographic data collection and loss of potential to connect it with data on quality, outcomes and patient experience.

Definitions



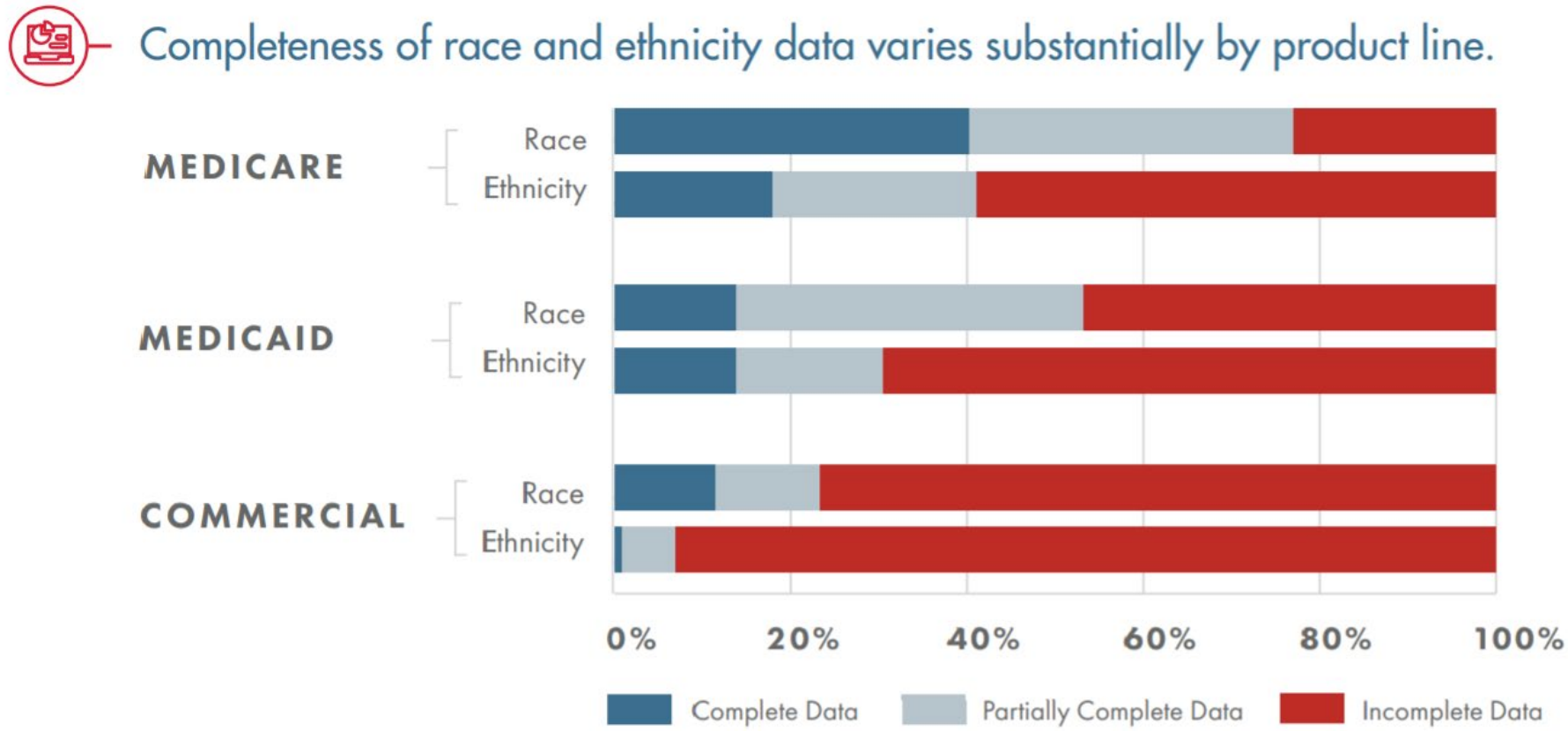
Health equity: Everyone has a fair and just opportunity to be healthy. Equity is not the same as equality. Equity often requires additional efforts and investments for those who currently experience worse health and fewer opportunities.

Health disparities: Inequitable differences in health outcomes closely linked with social conditions. Both individuals and populations as a whole can experience health disparities. Health disparities are often associated with historical and current unequal distribution of social, political, economic and environmental resources, as well as structural racism and other discriminatory conditions.

Social determinants of health: The conditions in which people are born, grow, work, live and age. They are a wide set of forces and systems shaping conditions of daily life, including economic, political and social policies and systems.

https://cpehn.org/assets/uploads/2021/10/CPEHN.HPIReport.FINAL_-1.pdf

Completeness of Race and Ethnicity Data Varies Substantially by Health Insurance Product Line



76% of race data and 94% of ethnicity data are incomplete

in health plan commercial products as of 2019

https://www.ncqa.org/wp-content/uploads/2021/06/20210622_NCQA_Health_Equity_Social_Determinants_of_Health_in_HEDIS.pdf

We Must Do Better

For any health program assessing outcomes, quality, and/or patient experience, a massive piece of the picture is missing without incorporating REaL data

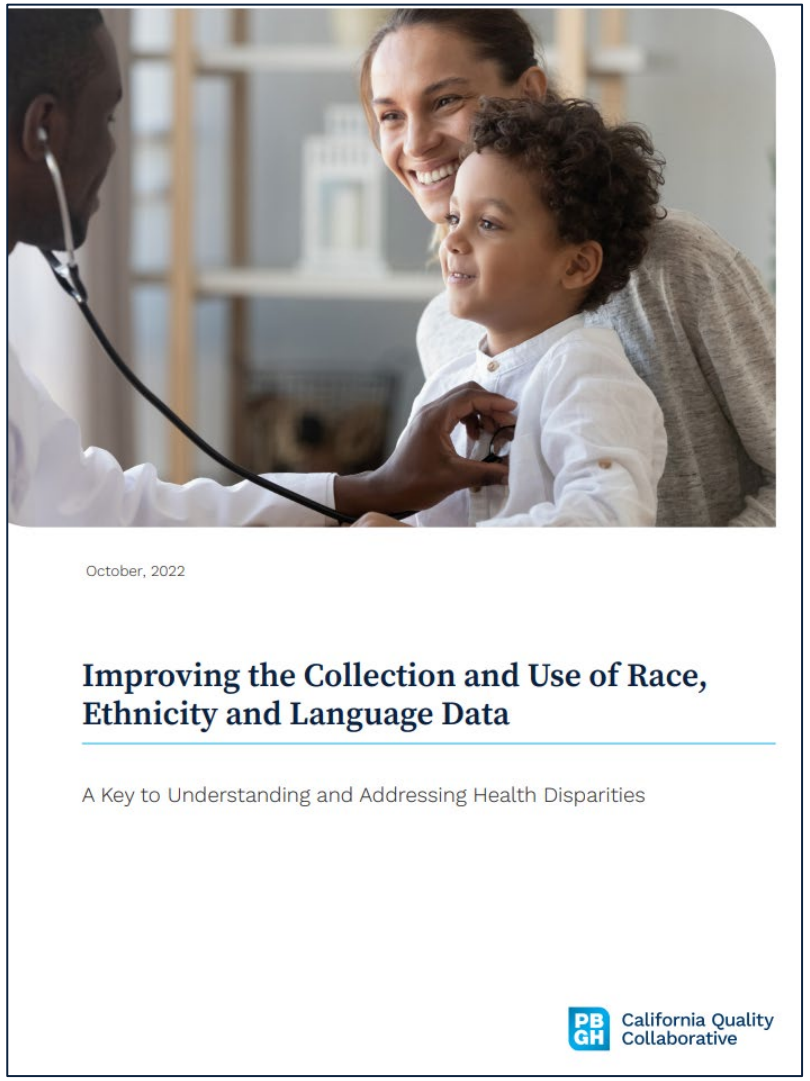
We need to be able to measure across populations and communities in order to know if interventions are working

Self-reported data is the best to use, though other methods of gathering and stratifying data exist

New Issue Brief Provides A Deep Dive and Recommendations

"Improving the Collection and Use of Race, Ethnicity and Language Data: A Key to Understanding and Addressing Health Disparities"

- Describes availability of (REaL) data in the health system
- Presents two proxy options for stratifying if self-reported data is unavailable (imputation and geographic retrofitting)
- Assesses pros and cons for stratification methods based on variables
- Considers case example from the Advanced Primary Care measurement pilot
- Suggests improvements for self-reported REaL data collection and reporting systemwide



https://www.pbgh.org/wp-content/uploads/2022/10/Improving-the-Collection-and-Use-of-Race-Ethnicity-and-Language-Data.pdf

Recommendations for Increasing REaL Data Collection

Change Lever	Benefits	Limitations	Actors
Legislation, policy and regulation	Enables national or statewide standardized change.	High level, must have accountably mechanism & resources.	Lawmakers, decision makers at health agencies.
Contracting and business relationships	Can be directly tied to payment, market share, and other incentives.	Optional. Unlikely to be standard across systems. Relies on organizations to act.	Purchasers, health plans, provider groups.
Organizational leadership, culture, internal systems	Most immediate way to increase data collection, reporting and sharing.	Optional. Unlikely to be standard across systems. Requires change management.	Purchasers, health plans, provider groups.
Certification requirements	Required for participating member organizations. Standardized. Reputational component. Can be tied to contracting.	Accreditation may be optional.	National accrediting bodies.
Advocacy and Education	*Cross cutting, and a crucial element to all change levers above*		

Poll: Collection of ReAL Data

How is your organization collecting and using race, ethnicity and language (REaL) data? (Answer all that apply)

- Not collecting
- Collecting REaL data (*e.g.* patient online account, enrollment counselor, case manager)
- Working to increase patient self reporting of REaL data (*e.g.* staff trainings to ask the questions)
- Combining REaL data with quality measures to illuminate disparities
- Using disparity information to inform strategy (e.g. wellness campaigns)
- Rewarding improvements in REaL data collection and/or reduction of disparities (*e.g.* financial incentives)
- Not applicable to my organization

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Panel Discussion

Panelists

Rebecca Alcantar, MPA
Interim Population Care Manager, Health Equity & Quality Transformation Division, Covered California

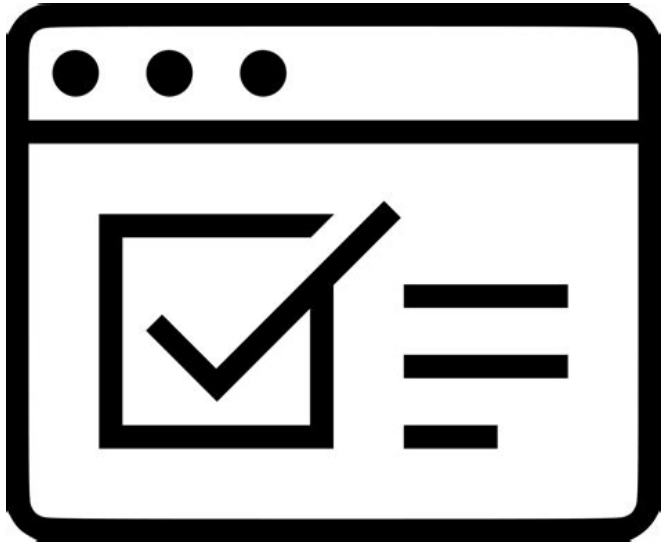
Teresa Ku-Borden, MD
Family Medicine Physician, Family Care Specialists-Altais Associate Program Director, Adventist Health Residency Program

Cary Sanders, MPP
Senior Policy Director, California Pan-Ethnic Health Network

Poll: Webinar feedback

The content of this webinar was helpful

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree



Stay Connected to CQC

Issue Brief:

Improving the Collection and Use of Race, Ethnicity and Language Data: A Key to Understanding and Addressing Health Disparities

Additional Resources

- California Quality Collaborative
- Resilient Primary Care Webinar Series

Sign up for our newsletter

For questions, email us cqcinfo@pbgh.org

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Thank you!

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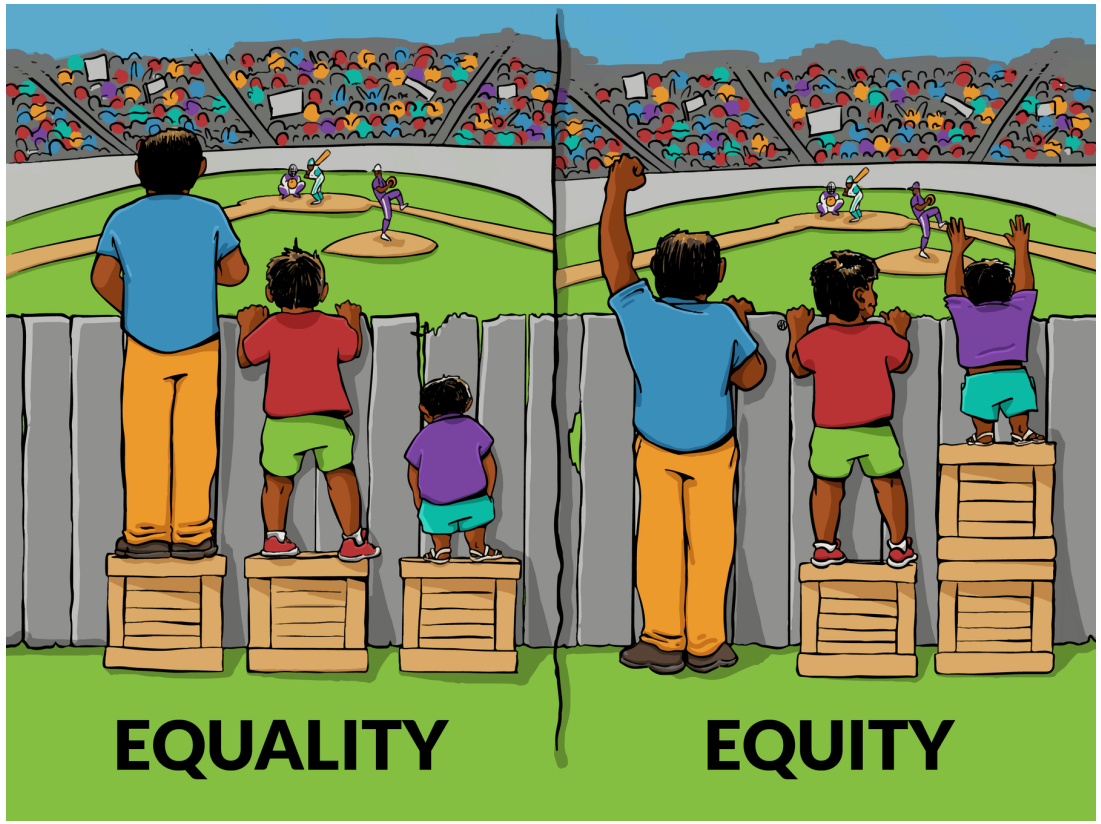
Appendix

Definitions



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