Capturing Race/Ethnicity/Language Data for Interoperability

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Issue

Health Equity has become front and center when considering factors that affect patient health outcomes.

Disparities in healthcare and outcomes have been attributed to differences in REaL (Race, Ethnicity, and Language) even after adjusting for varied characteristics such as education, income, insurance, access to care, and health status.

It is estimated racial and ethnic disparities in health and healthcare cost the United States $1.24 trillion between 2003-2006.

To improve health outcomes related to REaL, organizations must first know their population. This can be achieved with accurate data collection within the Electronic Health Record.

Translating data into actionable information allows stakeholders to not only understand disparities but to develop reports to compare trends across groups, develop targeted strategies, and progress of interventions.

An increasing number of federal policies emphasize the need for obtaining REaL data, among other types of data.

According to KHA, most hospitals collect (82%) data for Race and Ethnicity, but the data are not collected in a systematic or standard manner that is conducive for sharing and interoperability.

Project

KONZA Kansas Health Information Network recognized it is in a unique position to observe and quantify the level of REaL data it receives from its contributing organizations.

REaL data from an organization is transmitted to the KHIN Health Information Exchange via the HL7v2 ADT interface (one of the most common interfaces used in registration practices). If the HL7v2 message does not include REaL then we can deduce there may be an issue with this data collection and/or transmission from the site.

If the data is not interoperable to KHIN HIE, it most likely will not be shareable to quality programs, reporting databases, payers, etc.

The KHIN team identified 1000 ADT messages from each Kansas hospital that had a functioning ADT Interface with the HIE during the designated time frame in Q2 2023. Messages may have contained duplicate patients.

Each message was reviewed manually for presence of Race/Ethnicity/Language completed data segments.

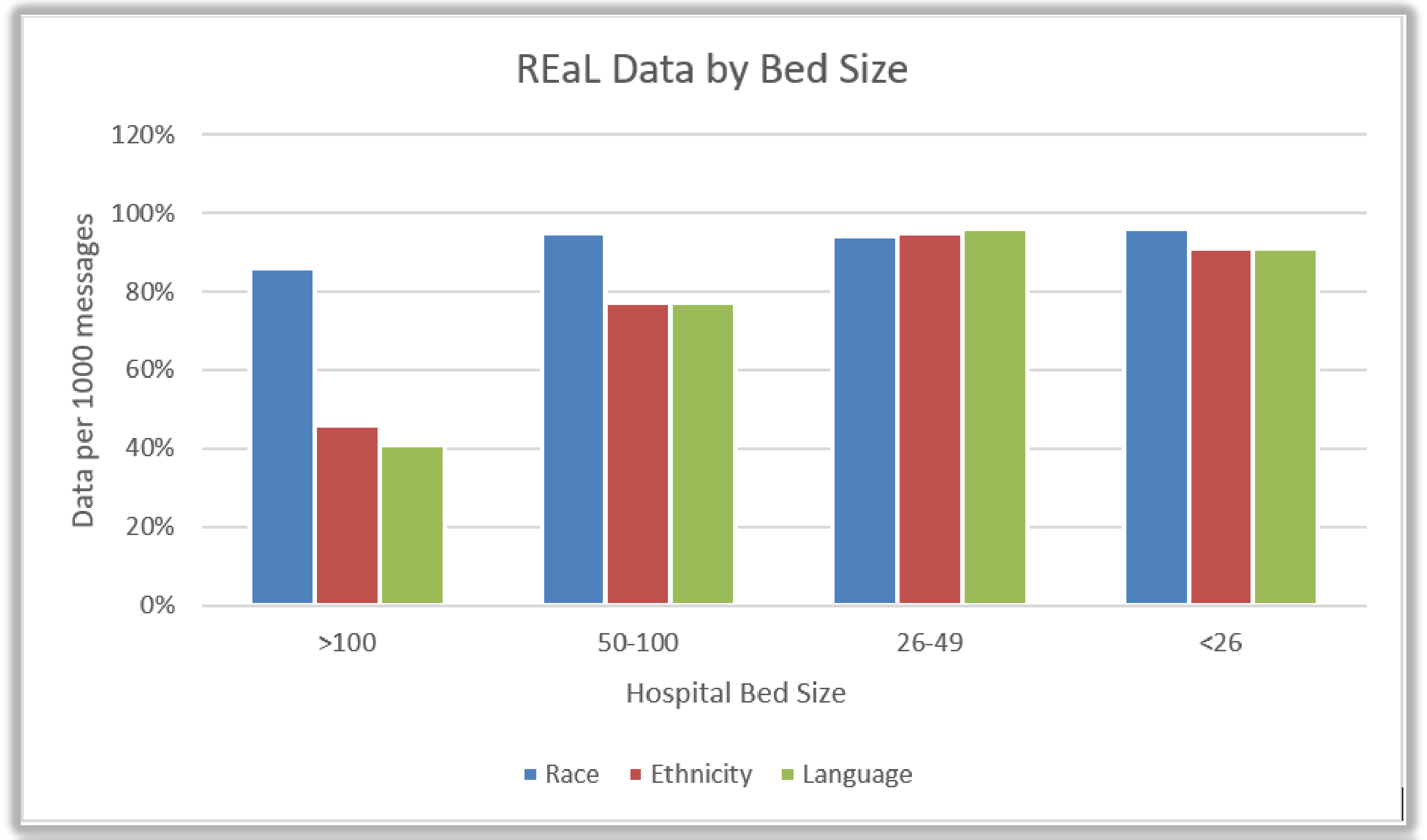
Once data was collected, the percentages of completed data types were calculated. This data was presented in two distinct ways:

- Presented to individual organizations who met <80% for any data type to assist in improving data capture.
- Deidentified cohorts based on Bed Size, EMR, and Kansas Hospital Association Region

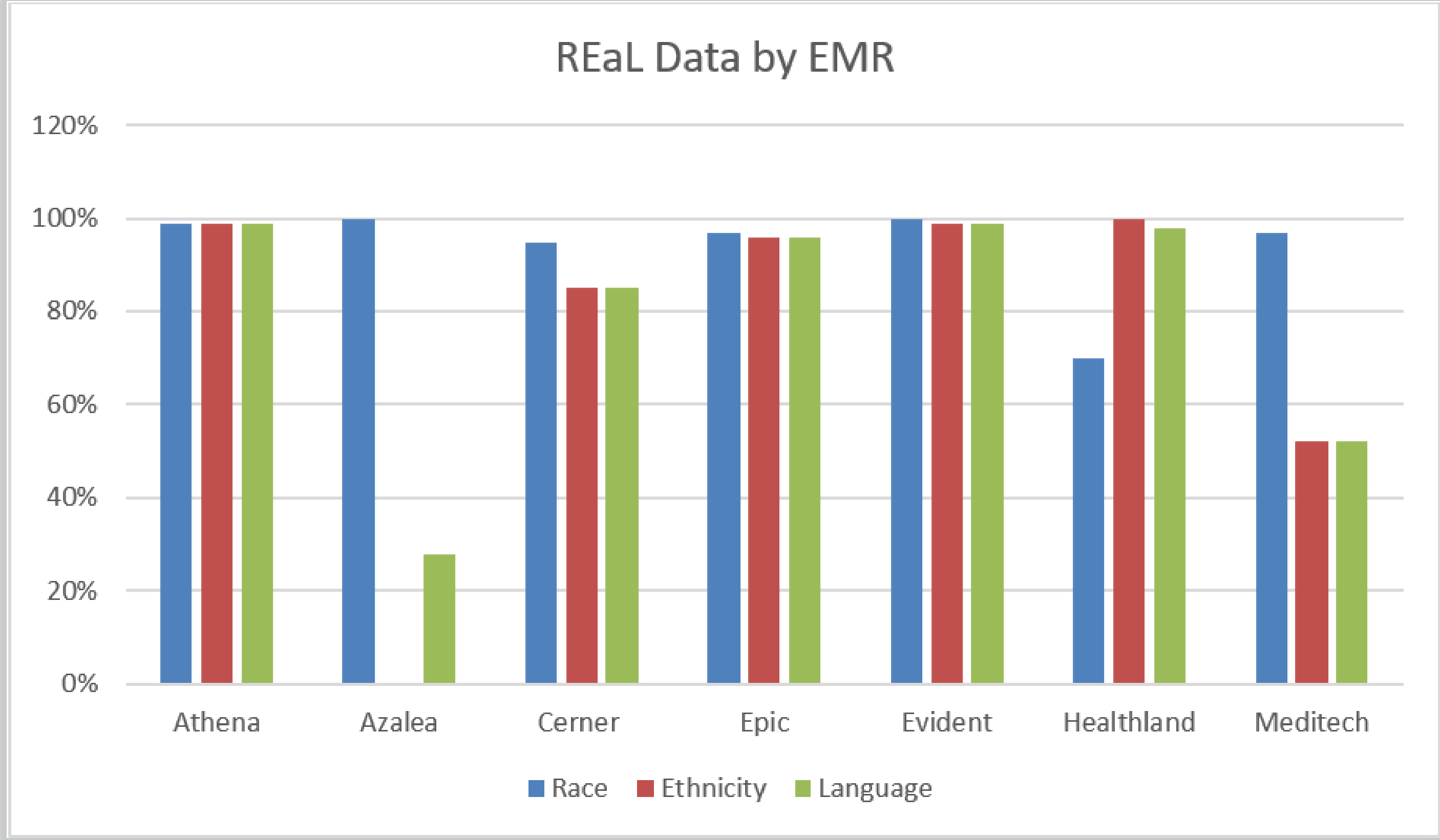
Results

63% of sites receiving outreach from KHIN rectified the root cause of their REaL data capture issues within three months. Multiple sites were able to improve SHIP grant funding as well.

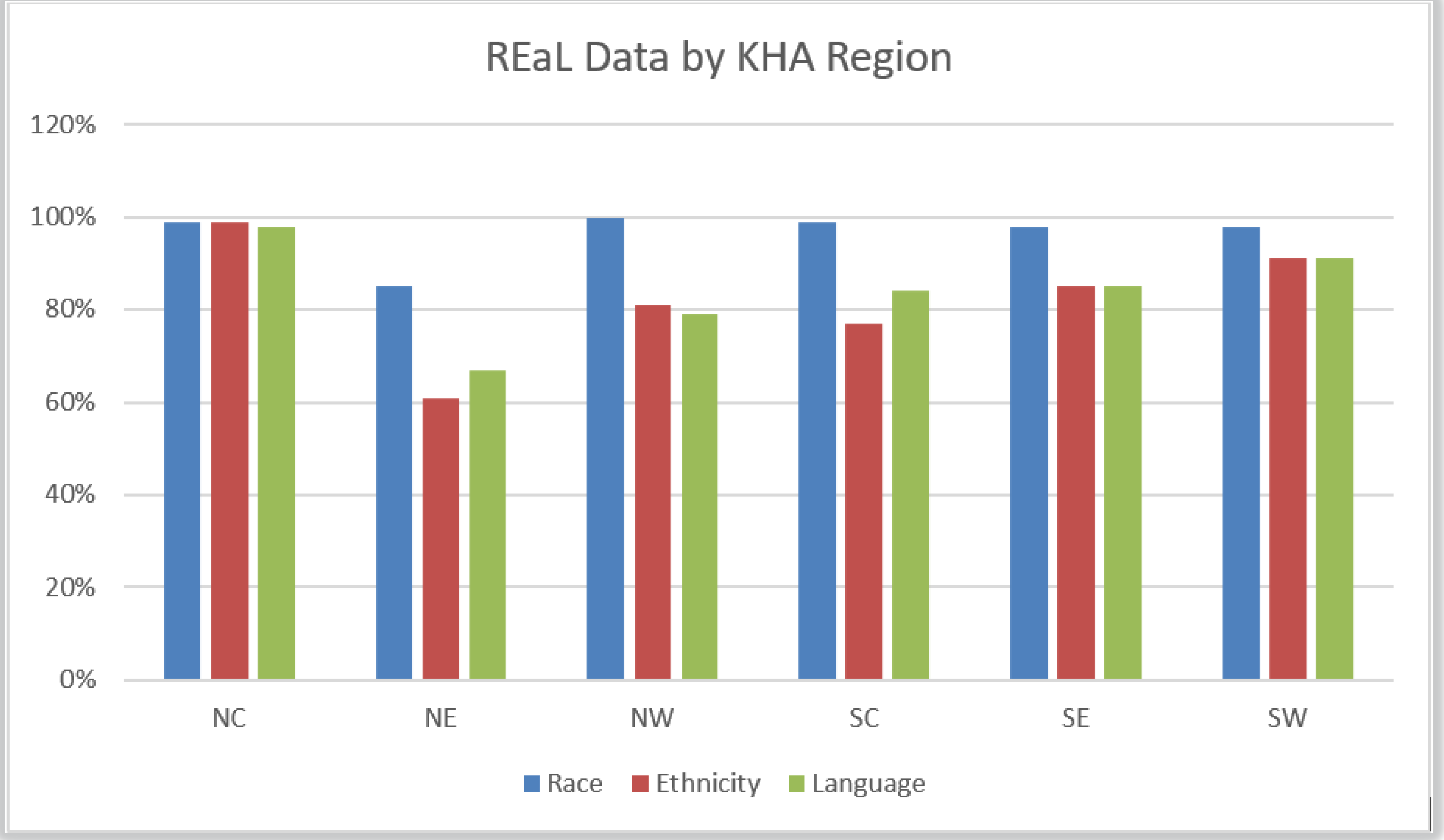
REaL Data by Bed Size



REaL Data by EMR



REaL Data by KHA Region



Lessons Learned

What are roadblocks to REaL data collection?

Three identified areas to address

- Staff Education and Workflow
- EMR Data Entry
- EMR Interoperability Parameters

Organization Information

KONZA National Network (KHIN) advances health information sharing, enabling better care management, transformative value-based payment models and actionable data analytics that improve patient outcomes. KONZA's suite of products and services integrate with clinical workflows to provide seamless sharing of health data across networks and systems. With a growing portfolio of connected sites from across the nation, KONZA provides centralized access to data, delivery of data and analytic tools for healthcare optimization. KONZA is transforming access to comprehensive patient data as one of the first organizations to onboard as a Qualified Health Information Network (QHIN) under Trusted Exchange Framework and Common Agreement (TEFCA).

Contact

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