

## Collection of Data on Race and Ethnic Group by Physician Practices

**TO THE EDITOR:** We support the principle that Wynia et al. (March 4 issue)<sup>1</sup> outline on the collection of data on patients' race and ethnic group. It is critical, however, to link that information to the delivery of care.

Comparative feedback and public reporting of outcomes according to race and ethnic group are necessary to lessen the gap in results between these groups. These efforts also will increase awareness about the unique health challenges faced by specific populations.<sup>2</sup>

HealthPartners Medical Group reports key clinical outcomes of more than 400,000 patients. These outcomes are classified according to socioeconomic status and race and ethnic group. Since 2004, more than 90% of patients have willingly shared their race and ethnic group, country of origin, and preferred language. We are using the information to improve care.

Where we have identified gaps in the care of minority patients, we have implemented targeted interventions. We established a structured approach to improve rates of mammographic screening among minority women (Fig. 1). We also changed our metrics, and we now report rates of colonoscopic screening among blacks starting at 45 years of age.<sup>3</sup>

Our work remains focused on developing additional usable quality measurements. Our future goal is even more customized, individualized information resulting in better outcomes for our patients.<sup>4</sup>

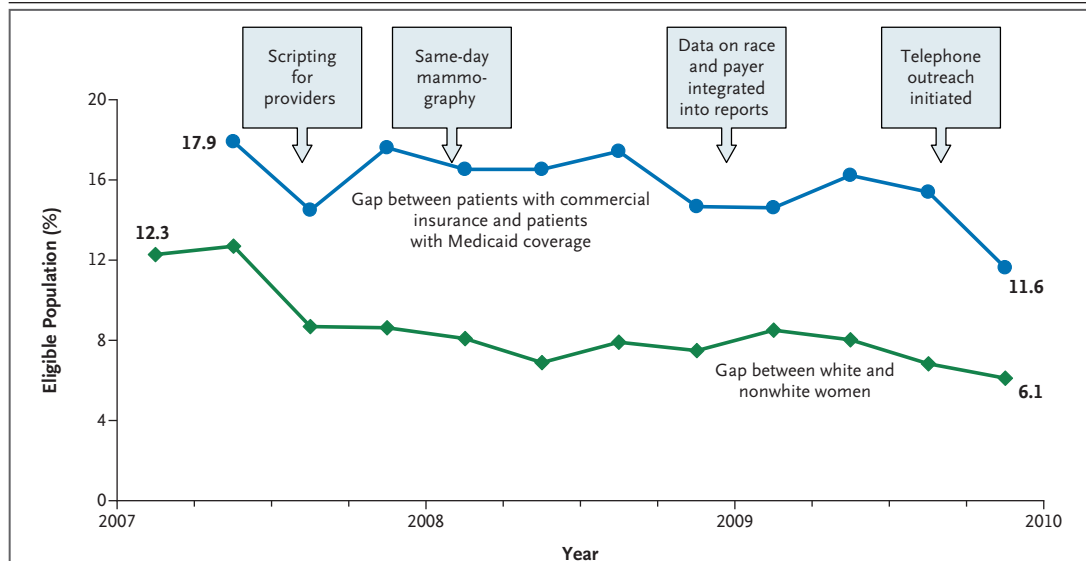
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No potential conflict of interest relevant to this letter was reported.

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**TO THE EDITOR:** The article by Wynia et al. is a timely reminder of the importance of collecting self-reported data on race and ethnic group in primary care. The development of reliable methods of recording data on race, ethnic group, and



**Figure 1. Disparity in Mammographic Screening in Primary Care, According to Payer and Patient's Race.**

The rate of mammographic screening is the proportion of the eligible population that underwent screening in the previous 18 months. The eligible population included women 50 to 75 years of age who were seen by a primary care physician or by an obstetrician-gynecologist during the reporting period. Women who had undergone bilateral mastectomy were excluded. Race was determined by self-report at a clinic appointment.

language is an essential first stage in the identification of inequalities. The information can support the development of local health policy and responsive local services, and it can be used to assess the provision of services to ethnically diverse populations by provider organizations.

Examples from the United Kingdom (Table 1) show that barriers can be overcome. The key includes training, financial reward to local practices, and evidence that collected data are put to good use by the local health care community.

Such data are invaluable in informing clinicians about the epidemiologic characteristics of their patient populations. For example, among South Asian persons who are older than 65 years of age in the United Kingdom, the risk of diabetes approaches 50%.<sup>1</sup>

Without such data collection, these differences would remain hidden. Revealing them allows targeted intervention within practices to raise the overall quality of care and diminish the unequal burden of poor health among many ethnic minority groups.

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No potential conflict of interest relevant to this letter was reported.

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**THE AUTHORS REPLY:** Von Sternberg et al. and Hull et al. add to the examples of organizations that have developed systems to collect accurate demographic data from patients and have used these data to improve health care quality. Their letters also illustrate that the collection of basic demographic data is only the first of three necessary steps in detecting subgroups of patients who are receiving a lower quality of care; for these patients, quality-improvement interventions are especially powerful. The other steps are the collection of reliable data on quality of care and then stratification of these quality measures according to demographic groups. Each step poses challenges. A recent report of the High-Value Health Care Project, a program of the Robert Wood Johnson Foundation and the Engelberg

**Table 1. Progress in Recording of Data on Patients' Race and Ethnic Group in 139 General Practices in East London, United Kingdom.**

Local Registry	2005	2006	2007	2008	2009
	<i>percent with data recorded</i>				
Total primary care population*	38	48	62	70	78
Heart disease	79	85	91	96	97
Chronic obstructive lung disease	74	84	99	96	98
Diabetes	83	88	94	98	98

\* The total population was 843,720 in 2009.

Center for Health Care Reform at the Brookings Institution, emphasized both the importance and the difficulty of developing systems to accomplish all three steps.<sup>1</sup>

In an era of increasing adoption of electronic health records, health care organizations and individual physician practices should not shoulder the burden of developing homegrown systems and the analytic capacity necessary to collect and use demographic and quality data. Instead, at a minimum, all systems of electronic health records should provide demographic fields that can be standardized and that include some basic guidance to facilitate data collection, such as answers to frequently asked questions. It is also reasonable to expect electronic health records to provide simple, two-click access to reports of performance data stratified according to any key demographic group. The Commission to End Health Care Disparities<sup>2</sup> has recently begun the "Two Clicks to Equity" project, which will encourage vendors of electronic health records to offer this basic set of tools that is necessary for detecting and addressing disparities.

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Since publication of their article, the authors report no further potential conflict of interest.

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