Reviewer's report

Title: Responses of Massachusetts Hospitals to a State Mandate to Collect Race, Ethnicity and Language Data from Patients: A Qualitative Study

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Reviewer: Cindy Brach

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This is a very timely piece of policy research. Currently 12 states require the collection of race/ethnicity data, yet little is known about the impact of state requirements. The study would be more instructive if more information about the “intervention.” Exactly what did the state require, and what guidance did they give, and what assistance was available? I’m also sure that readers would appreciate knowing how they could obtain the training materials used in Massachusetts.

Minor Essential Revisions

The authors claim that although their study, “included only 28 of the 78 acute-care hospitals in Massachusetts, it was reasonably representative of all hospitals subject to the regulation.” However, my reading of Table 1 is that there was a non-response bias. Non-respondents were less likely to be from the Boston and Metrowest region, from a small hospital, have a residency training program, or be a disproportionate share hospital. Furthermore, 7 of the 28 responding hospitals were involved in efforts to develop the regulation. I think the authors need to discuss this limitation further. It would also be helpful to know what follow-up efforts were made to try to increase the response rate.

Discretionary Revisions

The article states that prior to the regulation, all the hospitals were collecting race and language data per OMB standards. It would be helpful to put this into context, i.e., to know if most acute-care hospitals in the U.S. already collect race and ethnicity data, albeit not in a standardized fashion. Also, I am not aware of any OMB guidance on collection of language data.

The big change required by the hospitals was to collect self-reported race and ethnicity data in an expanded number of categories, and to collect data on preferred language. The major impact of the regulations, however, was in the use of racial, ethnic, and language data by the hospitals to identify disparities and engage in quality improvement. The article does not make it clear how a regulation on data collection had a substantial impact on data use. Was it merely that the data were now more reliable, or was assistance available to the hospitals on using the data? Were there other drivers for disparity reduction in Massachusetts at that time? Readers would also like to know if expanding the ethnic categories to 144 ethnicities created any benefits, i.e., whether hospitals
thought the more refined data were useful.

In sum, I think the article is very useful to allay concerns about collecting self-report race, ethnicity, and language data, and encouraging that regulatory action can prompt standardized collection and use of such data. More elaboration on “the intervention” and what kind of direction hospitals would have liked from the State would be helpful to states considering replicating the regulations.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.