### Background

**Rationale for Reducing Health Care Disparities**

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### Topics Covered

- **Background** – why disparities in health care matter
- Improving Quality of Care and Reducing Disparities
- Standards for race, ethnicity, and language data
- Interventions and a road map forward

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### Health Care Should Be

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

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### Definitions

- **Health Disparities**: Differences in the:
  - Incidence,
  - Prevalence,
  - Mortality, and
  - Burden
  of diseases and other adverse health conditions that exist among specific population groups in the United States (NIH Definition)

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### Definitions

- **Health Care Disparities**: Differences in the quality of health care not due to access-related factors or clinical needs, preferences or appropriateness.
- Difference in treatment provided to members of different racial (or ethnic) groups that is not justified by the underlying health conditions or treatment preferences of patients.  
  – (Institute of Medicine definition)

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### Definitions

- Although disparities in health and health care can be inextricably tied to one another, distinguishing between them increases our understanding of the complexity of the problem.
Major Reports on Health Care Disparities

The Institute of Medicine (IOM) report, Unequal Treatment, identified 600+ studies. The IOM identified many areas of concern:
- Cardiovascular treatments and cerebrovascular disease
- HIV disease (HAART and PCP prophylaxis)
- Diabetes
- ESRD/Kidney failure
- Maternal and child health
- Cancer care
- Many surgical procedures

Racial and Ethnic Disparities in Health Care

In patients with insurance, disparities exist for:
- Primary Care
  - Mammography (Gornick et al., HSR 2004)
  - Influenza vaccination (Gornick et al., NEJM 1996)
- Heart disease
  - Cardiac catheterization & angioplasty (Harris et al, Ayanian et al.)
  - Coronary artery bypass graft (Peterson et al.)
  - Treatment of chest pain (Johnson et al.)
  - Referral to cardiology specialist care (Schulman et al.)
- Lung Ca Surgery (Bach et al.)
- Renal Transplantation (Ayanian et al.)
- Pain management (Todd et al.)
- Amputations (Gornick et al.)

The “Usual” Explanations

- Patient Level: Patient “preferences”
  - Treatment refusal
  - Clinical presentation of symptoms
  - Mistrust
  - Communication barriers
- Provider Level: Beliefs/Stereotypes re. patient health and behavior
  - Inadequate communication
  - Bias/prejudice
- Organizational Level
  - Structural and resource differences in where different groups receive care

IOM Health System Recommendations

1. Promote the consistency and equity of care through the use of evidence-based guidelines.
2. Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities.
3. Enhance patient-provided communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.
4. Support the use of interpretation services where community need exists.

Medical and Policy Literature Provide Extensive Data on Inequities in Care

Reducing Disparities Within the Health Care System

Detecting: Define health disparities and vulnerable populations. Measure disparities in vulnerable populations. Consider selection effects and confounding factors.

Understanding: Identify determinants of health disparities at the following levels: Patient/individual Provider Clinical encounter Health care system. Change policy.

Reducing Disparities Within the Health Care System

In order to make change, we need complete & accurate data.

Expecting Success: Ten Diverse Hospitals Across the Country

- Duke University Hospital, Durham, NC
- Mount Sinai Hospital, Chicago, IL
- Sinai-Grace Hospital, Detroit, MI
- Montefiore Medical Center, Bronx, NY
- Memorial Regional Hospital, Hollywood, FL
- University of Mississippi Medical Center, Jackson, MS
- Delta Regional Medical Center, Greenville, MS
- University Health System, San Antonio, TX
- Del Sol Medical Center, El Paso, TX
- Washington Hospital Center, Washington DC

Expecting Success Successes

- Memorial Regional Hospital, Broward County, Florida: Increased heart failure ideal measure from 72% to 97%.
- Del Sol Medical Center, El Paso, Texas: Ideal care measure increased from 15% to 94%.
- Washington Hospital Center, Washington DC: Complete discharge instructions for heart failure patients increased from 29% to 72%.

Aligning Forces for Quality?

- The Robert Wood Johnson Foundation’s signature effort to lift the overall quality of health care in 16 targeted communities across America.

Targeted Regions Will Improve and Sustain High-Quality, Patient-Centered, Equitable Care by 2015

AF4Q communities

- 16 communities
- 14 states
- 37 million people
- 271 counties
- 12% (>590) of U.S. hospitals
- More than 31,000 primary care physicians

AF4Q and Disparities

- AF4Q communities are working on disparities in the hospital and ambulatory settings
  - Initiatives across communities and within individual communities
- Hospital efforts based on Expecting Success
  - 10-hospital collaborative to address disparities in cardiac care (2005-2008)
  - Funded by the Robert Wood Johnson Foundation
Addressing Disparities: Three steps

- Collection of standardized race and ethnicity data
  - Categories are standardized
  - Patient self-reports
- Stratification and analysis of performance measures
  - Compare patients within an organization
  - Consolidate data to identify community-level trends
- Use of stratified data to identify disparities and develop QI interventions targeted to specific patient populations

Detecting and Understanding

- Quality improvement requires high-quality data.
  - Help hospitals gather data on race, ethnicity, primary language
  - Data provides complete/accurate information
- Hospital leaders need to be willing to discuss the possibility of disparities.
  - Physicians/leaders committed to doing right thing
  - Reluctance to consider gaps in care by demographics
  - Must gather data, examine evidence to provide quality, equitable care

Source: Robert Wood Johnson Foundation, Expecting Success: Excellence in Cardiac Care Program

Why Detecting/Understanding is Important

- B. Siegel et al. Journal of Health Care Quality (2007)
  - Did not believe that disparities existed in healthcare delivered to different populations
  - Perceived disparities as a function of social and economic factors beyond their control
  - Participating in a collaborative to reduce disparities would be considered an admission of inequitable care

  - 344 Cardiologists:
    - 34% agree disparities exist overall
    - 12% believe disparities exist in own hospital
    - 5% believe disparities exist in own practice

  - 208 Cardiovascular Surgeons:
    - 13% believe disparities occur often or very often
    - 5% believe disparities occur often or very often in own practice

  - 169 Primary Care Clinicians:
    - 88% acknowledged that disparities in diabetes care existed in U.S.
    - 40% acknowledged disparities in own practice

Discrepancy in Perceptions

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Quality of Care Framework

Health care disparities should be brought into the mainstream of quality assurance and continuous quality improvement discussions


Data are Key

HOW to collect relevant data to:
- Target specific groups to design appropriate programs and materials
- Evaluate which interventions are effective for different groups
- Meet reporting requirements

Data Collection is....
- Inconsistent
- Inaccurate
- Incomplete
- Fragmented
- In silos

HOSPITALS
- 82% collect race/ethnicity data nationally but....
- Categories vary within and across hospitals
- Staff mostly collect through observation
- Staff at some hospitals had been trained to “not ask.”
- The vast majority do not use data for quality improvement

Barriers to Collecting Data
- Legal concerns
- Privacy concerns
- Patients’ perceptions/culture
- System-level barriers
- Staff discomfort in explicitly asking patients to provide this information
- Validity, reliability, and utility of data
- Appropriate categories

Staff Anxiety
- Biggest challenge = concern about patient reactions
- Solutions:
  - Training, training, training
  - Health Research and Educational Trust toolkit
  - Reasons for collecting data
  - Feedback on findings
  - Monitoring quality of data collected
  -
Successful Data Collection and Quality Improvement Relies Upon Standardized Measures

Systematic Implementation

• Conduct education and feedback sessions with leadership and staff
• Define issues and concerns and identify how you will respond to them

• Training and education components should include
  — Policy context
  — Revised policies
  — New fields
  — Screens
  — Leadership-staff materials
  — Staff scripts
  — FAQs and potential answers
  — Specific scenarios
  — Staff questions
  — Monitoring

The Case for Standardization

Standardized race, ethnicity and language data:
• Support comparisons across organizations and regions and over time
• Support combination of data across organizations or regions to create pooled data sets (especially important for getting beyond small sample concerns)
• Support reporting of, and replication of, successful disparity-reduction initiatives

Institute of Medicine, 2009

Data Standards

1. REL must be self-reported
   — Or for parents to report for children and guardians to report for legally incapacitated adults
2. Federal statutes require reporting must comply with the Office of Management and Budget (OMB) standards
   — OMB standards for race and ethnicity must be used at a minimum

Prior Guidance

• OMB Directive – 1997
  — Hispanic/Latino Ethnicity
  — 5 Race Categories: White, Black, Native American, Asian, & Pacific Islander

• The OMB categories are insufficient to illuminate many disparities and to target QI efforts efficiently
Institute of Medicine Recommendations

1. Health Care organizations must have data on the race, ethnicity, and language of those they serve in order to identify disparities and to provide high quality care.

2. Detailed “granular ethnicity” and “language need” data, in addition to the OMB categories, can inform point of care services and resources and assist in improving overall quality and reducing disparities.

Mandated Standards for Race and Ethnicity Reporting in SPARCS

- Race and ethnicity categories per granular CDC categories, which can be “rolled up” to the main OMB categories
- Can report up to a combined ten granular race and ethnicity variables per patient

SPARCS Ethnicity Standards

<table>
<thead>
<tr>
<th>X12 Value</th>
<th>Ethnicity</th>
<th>Expanded Data Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>American Indian or Alaska Native</td>
<td>Additional Hispanic, Latino/a, or Spanish origin categories</td>
</tr>
<tr>
<td>E1.02</td>
<td>Mexican, Mexican American, Chicano/a</td>
<td>Additional Hispanic, Latino/a, or Spanish origin categories</td>
</tr>
<tr>
<td>E1.07</td>
<td>Cuban</td>
<td>Additional Hispanic, Latino/a, or Spanish origin categories</td>
</tr>
<tr>
<td>E1.08</td>
<td>Not of Hispanic, Latino/a, or Spanish origin</td>
<td></td>
</tr>
<tr>
<td>E1.09</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>X12 Value</th>
<th>Race</th>
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</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>Black or African American</td>
<td>Additional Pacific Islander categories</td>
</tr>
<tr>
<td>R1.01.001</td>
<td>Native Hawaiian</td>
<td>Additional Pacific Islander categories</td>
</tr>
<tr>
<td>R1.02.001</td>
<td>Guamanian or Chamorro</td>
<td>Additional Pacific Islander categories</td>
</tr>
<tr>
<td>R1.03.002</td>
<td>Samoan</td>
<td>Additional Pacific Islander categories</td>
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<td>R5</td>
<td>White</td>
<td></td>
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<tr>
<td>R9</td>
<td>Other Race</td>
<td></td>
</tr>
</tbody>
</table>

The Affordable Care Act: Section 4302

1. Establishes federal standards for REL data collection
   - Follow IOM recommendations for expanded granularity and multi-race reporting
2. Improves Data Collection and reporting
   - Required the DHHS Secretary to establish data collection standards
   - And to use of the standards in federal data collection
     - National Health Interview Survey (NHIS)
     - Current Population Survey (CPS)
     - American Community Survey and the analysis and reporting of these data
   - Instructing that the data be used for analyses and that the results be reported
   - Articulating some important language about funding