Section II

Hospital Leaders Role in Improving Health Equity

Hospital Leaders Role in Improving Health Equity

About this Section

Hospital leaders play a critical role in addressing health care disparities. Effectively addressing the issue of disparities in health care will require a two-fold approach from health care leaders. The first step—collecting data on patients' race and ethnicity is focused on gaining a complete understanding of the community served by the hospital and the characteristics of patient population. Data collection, if done properly, can facilitate the second step, which involves analyzing quality-of-care and health outcomes data using patient demographics to specifically identify disparities and implement actions to reduce such disparities. The goal of this section to provide the basic recommendations and tools for hospital leaders to ensure standardized data collection and developing systems to improve quality and address equity in care.

Tools in this Section

- Frequently Asked Questions for Hospital Leaders
- Recommendation Checklist
- Resources for Hospital Leaders

A. Hospital Leaders

Chief Executive Officer

Health care leaders are charged with advancing and managing individual organizational priorities. As hospitals and health care organizations work toward serving diverse populations, leaders must recognize the importance of understanding the unique characteristics of the communities they serve. Efforts to improve health care delivery require working with key staff. Leaders can be most effective by helping others develop the abilities and tools to create the best responses to problems and opportunities.

Improving the quality of care for all patients and eliminating health care disparities are central challenges facing our health care system. As emphasized by two reports from the Institute of Medicine (*Crossing the Quality Chasm and Unequal Treatment*), the need for better data about patients' race, ethnicity, and primary language is critical.

Legal Affairs Department

The law permits health care organizations to collect race and ethnicity information from patients for quality improvement purposes. For example, the collection of race, ethnicity, and primary language data is permitted under Title VI of the Civil Rights Act of 1964. Additionally, the collection and assessment of information about the communication access needs of individuals with a sensory disability promotes compliance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

Quality Improvement

The ultimate goal of collecting information about patient's race and ethnicity is to improve the quality of care for all patients. Evidence indicates that quality improvement efforts, when linked to demographic data such as race and ethnicity, can improve quality of care and reduce health care disparities. These data can be linked to assess technical quality (clinical measures) and service quality (wait times, patient experience of care) within your health care organization.

Clinicians

Doctors, nurses, and other health care practitioners are central to the functioning of health care systems and to societies as a whole. However, few societies have been as racially, ethnically, and culturally diverse as the United States, presenting challenges and opportunities. Each new wave of immigration provides a reminder of these challenges and opportunities.

In their individual encounters with patients, other clinical professionals who care for diverse populations need to incorporate knowledge about their patients' perceptions of illness and disease, belief systems, individual preferences, communication styles, and preferred language. In doing so, clinicians can provide the best possible care to their patients and equip them with appropriate resources. The need for accurate data is critical so hospitals can provide the resources clinicians need to provide quality health care to their patients.

B. Why Should Hospital Leaders Care?

Racial and ethnic disparities in health care have an impact on quality, safety, cost, and risk management. Disparities can lead to increased medical errors, prolonged length of stay, avoidable hospitalizations and readmissions, and over and under-utilization of procedures. Addressing disparities is no longer just a moral or ethical imperative – it has now taken on greater importance with significant bottom line implications, and has been acknowledged by ***Joint Commission and the National Quality Forum*** as an essential component of quality of care, and as part of community benefit principles.

Implications for Quality, Cost and Accreditation

Equity is the only pillar of quality that is seen as 'cross-cutting', meaning that it has implications for safety, effectiveness, patient-centeredness, timeliness, and efficiency.

Quality implications

Disparities in care can have a detrimental effect on the quality of care that is provided to patients. Patients who are racial and ethnic minorities may be more susceptible to being subject to medical errors; they may also have longer hospital stays and more frequent avoidable re-hospitalizations, and experience other adverse health outcomes. According to *the Institute of Medicine Report Unequal Treatment,* patients with the same insurance and socioeconomic status, and when comorbidities, stage of presentation and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts. Racial and ethnic minorities are also less likely to receive evidence-based care for certain conditions, which explains the disparities in health outcomes and management of patients with conditions such as diabetes, congestive heart failure, and community-acquired pneumonia.

Financial Implications

Disparities may increase the cost of care, through excessive tests to compensate for communication barriers, medical errors, increased length of hospital stay, and avoidable re-hospitalizations. The financial implication is further compounded in that payers are linking financial penalties to these outcomes.

Regulatory and Accreditation Implications

The Joint Commission has released new disparities and cultural competence accreditation standards, and the National Quality Forum has released cultural competence quality measures. Several provisions to reduce disparities were included in the Affordable Care Act. All these national efforts have further enhanced the need for providers to re-examine health care disparities in their organizations and identify solutions to provide more equitable care.

C. What Hospital Leaders Can Do

These recommendations are meant to provide an overall outline for how to move forward on this issue, and are in no way exhaustive.

Getting Started

Create a Disparities Committee or Task Force of individuals representing quality, operations, patient registration, social services, human resources, nursing and physician-leaders from several clinical services. This team should be charged with assessing what is being done to identify and address disparities, including whether patient's race and ethnicity data are being collected. Develop initial strategic plan. Educate leadership team on disparities, quality, equity via champion, local national expert.

Creating the Foundation

Develop a plan to **collect patient race/ethnicity data** (if not already done) and create medical policies to support this work. Assign an organizational leader as the key report for this work and engage in efforts to raise awareness of the issue among faculty and staff. Ensure all staff are trained. Solidify community partnership and relationships in anticipation of future interventions.

Moving to Action

Create a **"disparities dashboard"** composed of key quality measures stratified by race and ethnicity (e.g. National Hospital Quality Measures, HEDIS outpatient measures, patient satisfaction, etc.) that can be routinely presented to leadership and monitored. If disparities are found, create pilot programs to address them (examples include disease management programs with health coaches, navigators, or community health workers).

Evaluate, Disseminate, Reengineer

Evaluate pilot studies and develop a dissemination strategy to post results; chart a new course and reengineer strategies from lessons learned. Embed successful practices into standard programs of care.

Source: : Betancourt JR, Green AR, King RR, Tan-McGrory A, Cervantes M, and Renfrew M. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders. Boston, Mass:* The Disparities Solution Center at Massachusetts General Hospital, Institute for Health Policy; *www2.massgeneral.org/disparitiessolutions/guide.*accessed on 10/04/13

Section II.

Tools/Resources

Frequently Asked Questions on Collecting Expanded Race and Ethnicity Data for Hospital Leaders

Q: Why is equity an important component of quality?

A: The Institute of Medicine Report *Crossing the Quality Chasm* suggests health care systems must focus on six key elements: efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity. Equity is achieved by providing care that does not vary in quality by personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Q: Given all the competing interests and priorities our hospital is facing, why should we focus on equity?

A: Research has shown that racial and ethnic disparities in health care, and their root causes, have an impact on quality, safety, cost, and risk management. For example, patients with limited-English proficiency suffer from more medical errors with greater clinical consequences than their English proficient counterparts; have longer lengths of stay for the same clinical condition; may undergo more high-priced diagnostic tests due to challenges related to communication; and have higher rates of readmission for chronic conditions and more avoidable hospitalizations. All of these situations may pose significant risk management issues as well. Furthermore, addressing disparities will likely soon become a key part of the Joint Commission's Accreditation Standards, the National Quality Forum's quality measures, a key aspect of pay-for-performance contracts, and amore central component of community benefit principles that are now under close federal scrutiny.

Q: Is there evidence that hospitals may be providing care that is not equitable?

A: The Institute of Medicine Report *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation, and other confounders are controlled for, minorities often receive a lower quality of health care than do their non-minority counterparts.

Racial and ethnic disparities have been found in the quality of hospital care delivered to patients with cardiovascular disease (including acute myocardial infarction and congestive heart failure), diabetes, and cancer screening and management. **Health-system level factors** (related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for minority patients or those with limited-English proficiency), **care-process variables** (related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication), and **patient-level variables** (patient's mistrust, poor adherence to treatment, and delays in seeking care) all contribute to disparities.

Frequently Asked Questions on Collecting Expanded Race and Ethnicity Data for Hospital Leaders

Q: How do disparities apply to our hospital? We treat all patients the same regardless of race/ethnicity?

A: While most health care professionals and hospitals strive to provide the same level of quality of care to all patients, evidence shows this may not be the case. Research highlights racial/ethnic disparities in care across a wide range of institutions, geographic regions and services. The bottom line is that if you have not looked at your hospital's quality data stratified by race and ethnicity, you cannot assume that your hospital does not have disparities.

Another key point is that treating everyone the same may not be enough. Patients may respond differently when presented with the same information from a clinician. Ensuring the highest quality of care possible to all patients requires understanding and adapting care to the patient's unique needs and perspectives, which are often influenced by their social and cultural backgrounds. Only then can high-quality care be achieved in a patient-centered manner.

Q: Aren't racial and ethnic disparities in health mainly due to socioeconomic factors like poverty, poor education, and lack of insurance?

A: There is no doubt that socioeconomic status, educational attainment, and the environment – social determinants of health – as well as access to care, contribute to racial and ethnic disparities in health. However, the Institute of Medicine Report *Unequal Treatment* reviewed hundreds of articles that controlled for these factors and still found differences in quality of care based solely on the race and ethnicity of the patient.

These are termed racial and ethnic disparities in health care. Efforts to improve quality and achieve equity should focus on the root causes of racial and ethnic disparities in health care.

Q: New studies suggest that racial and ethnic disparities in health care are primarily due to where and by whom patients are seen. Shouldn't disparities efforts focus on improving quality at institutions predominately serving minorities?

A: Research, including those studies presented in *Unequal Treatment,* shows that racial and ethnic disparities in health care can happen anywhere, and among patients cared for by any provider. Efforts to address disparities should include quality improvement strategies in predominately minority-serving institutions, as well as institutions that serve a diverse patient population. The bottom line is that in order to assure equity, all hospitals need to collect data on patient race and ethnicity and stratify quality measures accordingly to determine if disparities exist – regardless of the size of the minority population being served.

Frequently Asked Questions on Collecting Expanded Race and Ethnicity Data for Hospital Leaders

Q: Are there hospitals actively engaged in disparities work across the country?

A: Many hospitals in New York State and across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity. Activities have included the development of a strategic plan to address disparities, standardized collection of patient's race and ethnicity, stratification of quality measures by race and ethnicity, development of quality measurement tools to monitor for disparities, implementation of community-based efforts to improve primary care services and medical homes, development and expansion of interpreter services, and interventions to address disparities when found.

Hospital Leader Recommendation Checklist

Getting Started

- ☐ Create a Disparities Committee or Task Force.
  - A multidisciplinary team, charged with assessing what is being done to identify and address disparities, including whether patient's race and ethnicity data is being collected. Develop initial strategic plan.
- ☐ Educate leadership team on disparities, quality, equity via champion, local national expert.

Creating the Foundation

- ☐ Begin to build foundation to address disparities (including race/ethnicity data collection, stratification of quality measures, etc.).
- ☐ Develop medical policies to support all new work.
- ☐ Finalize a strategic plan of action with 1, 3 and 5 year goals.
- ☐ Assign an organizational leader who can liaison with Disparities Committee; align with other hospital champions.
- ☐ Engage in efforts to raise awareness of the issue among faculty and staff, and provide broad education on the issue.
- ☐ Develop any community-based relationships that are necessary.

Moving to Action

- ☐ Monitor for disparities by stratifying quality measures by race/ethnicity and presenting findings routinely to leadership via a disparities dashboard.
  - Examples include National Hospital Core Measures of congestive heart failure, acute myocardial infarction, community acquired pneumonia, surgical infection prophylaxis as well as other high-impact measures of interest, such as diabetes and breast, cervical, and colon cancer screening.
  - Standardize processes related to stratification of quality measures.
- ☐ Develop pilot interventions to address them
- ☐ Expand measurement capabilities to other areas.

Evaluate, Disseminate, Reengineer

- ☐ Evaluate pilot interventions.
- ☐ Disseminate points of actions and success.
- ☐ Reengineer efforts as necessary.

Source: : Betancourt JR, Green AR, King RR, Tan-McGrory A, Cervantes M, and Renfrew M. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders. Boston, Mass:* The Disparities Solution Center at Massachusetts General Hospital, Institute for Health Policy;2008.

Resources

The Disparities Solutions Center at Massachusetts General Hospital

- **Improving Quality and Achieving Equity: A Guide for Hospital Leaders**
- ***Healthcare Disparities Measurement***
- **Assuring Healthcare Quality: Healthcare Equity Blueprint**

American Hospital Association: Hospitals in Pursuit Excellence

- **Improving Health Equity Through Data Collection and Use: A Guide for Hospital Leaders**

Leading Improvement Across the Continuum: Skills, Tools and Teams for Success