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 a more 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.
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.