Section III

The Quality Improvement Imperative

Addressing Healthcare Disparities: The Quality Improvement Imperative

Section Overview

Data collection has long been central to the quality assurance process. If consistent standardized data on race and ethnicity are available, disparities in health care can be addressed through a quality of care framework. This section highlights the central role of quality improvement in reducing disparities and provides resources to integrate targeted disparities measures into quality improvement.

Improved quality of race and ethnicity data will help hospitals and NYS:

- Better identify areas of health care disparity in their communities
- More objectively assess their community needs
- More effectively plan programs an service interventions that would address the identified needs
- Respond to the individual needs of racially and ethnically diverse patients
- Close the existing gaps by providing culturally sensitive and appropriate services to racial and ethnic groups; and
- Improve access and quality of care for all New Yorkers

Tools in this Section

- Quality Improvement to Address Disparities Resources and Toolkits

A. Bringing Equity into Quality Improvement

Despite evidence documenting disparities in virtually all areas of care, health care organizations have been slow to focus on equity. Equity is a fundamental component of quality of care. Disparities in health care (e.g., in access, in the rate at which a treatment is provided when indicated, or in the incidence of adverse events in care) can be the cause of disparities in health (e.g., in the incidence or severity of a disease, in functional level, or in mortality rate) and 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. Efforts to reduce disparities need to be mainstreamed into routine quality improvement efforts. Analyses of disparities in health care can help identify opportunities for quality improvement in care provision that will reduce disparities in health.

B. Quality Data

Identifying problems, targeting resources, and designing interventions all depend on reliable data. To assure the value of analyses, organizations should assess the quality of the data. Completeness of the data can be assessed by reviewing missing data as well as instances where patients declined to respond. Although patients who decline to respond should be respected, examining the rate of such responses can inform whether or not the data collection protocol may need to be adjusted and/or if additional training is required.

It is highly recommended that hospitals standardize:

- Who provides information, patient (self-identification is best)
- When data are collected,
- Use the NYS required race and ethnicity categories

http://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm

- Why race/ethnicity data are being collected,
- How data are stored, and
- How patients' concerns are addressed.

Section IV of this document provides tools and resources for staff training on data collection.

C. Establish Measures for Addressing Disparities

The hospital's focus on measurement in reducing disparities is to ensure that all patients receive the appropriate standard of care. If this standard is not met, it is important for hospitals stratify data by race and ethnicity to determine if gaps in quality care are present.

The National Quality Forum (NQF) has developed a set of criteria to determine whether a quality measure would qualify as "disparities sensitive." Disparities-sensitive measures are those that serve to detect not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groupings (race and ethnicity, etc.).

NQF has established guiding principles for assessing performance measures using "Disparity-Sensitive Principles":

- Prevalence—How prevalent is the condition among minority populations?
- Impact of the Condition—What is the impact of the condition on the health of the disparity population?
- Impact of the Quality Process—How strong is the evidence linking improvement in the measure to improved outcomes in the disparity population?
- Quality Gap—How large is the gap in quality between the disparity population and the group with the highest quality for that measure?
- Ease and Feasibility of Improving the Quality Process (Actionable)—Is the measure actionable among the disparity population?

Some examples include:

- Compare the hospital's service population by race, ethnicity, and language data with those of the catchment community to identify disparities in access or accessibility.
- Analyze clinical quality indicators for all patients to determine if gaps in quality exist by race, ethnicity, or primary language.
- Link patient demographic information to patient satisfaction surveys and analyze grievances and complaints filed to determine if differences in satisfaction fall along racial or ethnic lines.
- Analyze medical errors by patient race, ethnicity, and primary language to identify and address patterns.
- Determine the percent of clinical staff trained in culturally and linguistically competent care.

- Evaluate the percent of race, ethnicity, and language data fields completed.
- Analyze the demand and supply of language services.
- Analyze time to bedside for supplying language services when needed.
- Consider provider-level report cards on clinical quality indicators and appropriate utilization of language services that are stratified by patients' race and ethnicity
- Evaluate clinical quality and service performance data over time to measure the impact of process changes.
- Use data to determine gaps in individual patient care (or experience of care) and study the process leading to gaps in care or service delivery or quality. Apply this knowledge to system redesign or improvement.
- Use data to benchmark the gaps in care based on race and ethnicity
- Benchmark performance and goals on best known results nationally.

The goal of eliminating health disparities can be achieved by using race and ethnicity data to measure quality to identify those disparities that can be addressed by quality improvement initiatives.

Links to QI Toolkit and Guides developed by the Agency for Healthcare Research and Quality and other organizations are available in the Resources Section of this document.

Section III
Tools and Resources

Quality Improvement to Address Disparities Resources and Toolkits

Resources by the Disparities Solutions Center at Massachusetts General Hospital

- Healthcare Disparities Measurement

The report on *Healthcare Disparities Measurement* provides practical recommendations for healthcare organizations to increase their portfolio of race, ethnicity, and language data collection strategies - and consequently, utilize that data to develop disparities-sensitive measures. This report is intended to guide organizations in disparities and quality measurement through the following strategies:

1. Data Collection: Building the Foundation
2. Disparities Measures and Indicators: What to Measure
3. Methodological Approaches to Disparities Measurement: How to Measure and Monitor
4. Priorities and Options for Quality Improvement and Public Reporting of Healthcare Disparities

- Assuring Healthcare Quality: A Healthcare Equity Blueprint

The *Healthcare Equity Blueprint* offers strategies and practices that can be tailored to individual hospitals to address equity in providing quality care. The Blueprint is a starting point for designing and implementing interventions to address racial and ethnic disparities in health care. Aspects of this Blueprint apply to numerous health care settings, but the primary focus is on hospitals.

The proposed improvement strategies are grouped into the following five categories:

1. Create Partnerships with the Community, Patients, and Families
2. Exercise Governance and Executive Leadership for Providing Quality and Equitable Care
3. Provide Evidence-Based Care to All Patients in a Culturally and Linguistically Appropriate Manner
4. Establish Measures for Equitable Care
5. Communicate in the Patient's Language — Understand and be Responsive to Cultural Needs and Expectations

The Blueprint also provides recommended tools, resources, and guidelines on the collection and measurement of data related to addressing health care disparities.

Quality Improvement to Address Disparities Resources and Toolkits

Resource from National Committee for Quality Assurance (NCQA)

- Multicultural Healthcare: A Quality Improvement Guide

A comprehensive quality improvement guide and toolkit to help health care organizations to provide culturally and linguistically appropriate services and reduce health care disparities in the populations they serve.

Resources from the National Quality Forum (NQF)

- Comprehensive Framework and Practices for Measuring and Reporting Cultural Competency

NQF is working to advance measurement of disparities across settings and populations by analyzing the effectiveness of quality measures already in place and identifying gaps. This guide serves as a comprehensive road map for measuring and reporting cultural competency.

- National Voluntary Consensus Standards for Ambulatory Care- Measuring Healthcare Disparities

The report contains 36 disparities-sensitive voluntary consensus standards that address all levels of measurement, including practitioner practices, large and small groups, and health plans. In addition, the report includes performance measures at the community level for the purposes of quality improvement.

Resources from the Agency for Healthcare Research and Quality (AHRQ)

- AHRQ Quality Indicators(QI)™ Toolkit for Hospitals

The **QI Toolkit** is designed to help hospitals understand the QI's from AHRQ and support the use of them to successfully improve quality and patient safety. The tools are practical, easy to use, and designed to meet a variety of needs, including those of senior leaders, quality improvement staff, and multi-stakeholder improvement teams.