

Assumed Equity: Early Observations from the First Hospital Disparities Collaborative

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Significant differences exist between the quality of healthcare provided to patients of minority races or ethnicities and that received by nonminority populations. Multiple studies have demonstrated, for instance, that in the United States blacks and Hispanics do not receive the same quality of cardiac care that whites receive (Agency for Healthcare Research and Quality, 2005; Kressin & Petersen, 2001). Yet although the existence of such disparities has been well documented, little is known about how health systems can begin to address equity, which is one of the six recognized domains of healthcare quality (Institute of Medicine [IOM], Committee on Quality of Health Care in America, 2001). Whereas a growing body of research is focused on identifying the underlying causes of disparities, much less work addresses potential solutions.

The first multihospital disparities collaborative may be able to shed light on strategies to eliminate disparities in healthcare in the United States. This article offers insights on how hospitals and healthcare leaders view the nature and causes of disparities as well as their willingness to engage in disparities reduction initiatives. In addition, useful information on the degree to which hospitals are collecting and using patient data to support quality-based disparities reduction activities is provided.

Background

Disparities in healthcare between minority and nonminority populations have received widespread attention in recent years. Considerable research has shown that these disparities persist across many clinical settings and conditions, even after other factors such as access to care, health insurance coverage, and socioeconomic status are taken into account (IOM, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2003). The etiology of these differences in care is complex, but the outcome is not: one group receives care of measurably lower quality than care provided

Abstract: Disparities in healthcare represent a failure in the equity domain of quality. Although disparities have been well documented, little has been written about how hospitals might use improved data collection and quality improvement techniques to eliminate disparities. This article describes early findings from the planning phase of the first hospital-based disparities collaborative. The authors also discuss the changes in policy and practice that may speed hospitals in placing disparities and equity on their quality agendas.

to other groups. For instance, the documented failure of Latinos to receive evidence-based treatment after a myocardial infarction (Agency for Healthcare Research and Quality, 2005) is actually a failure to provide this population with recommended treatment more commonly provided to nonminority populations. Although enormous opportunities to improve the care provided to all Americans remain (McGlynn et al., 2003), the presence of such disparities points to a particular need to address the quality of care provided to people of certain racial and ethnic backgrounds.

Several reports, including the landmark 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, have highlighted the need to identify clinical and operational interventions that health systems can implement to address disparities in the provision of care. One central IOM recommendation is the use of evidence-based guidelines to provide care that is more consistent and equitable for all patients. In theory, if every patient receives the right evidence-based care at the right time, then all patients will receive appropriate care, regardless of race or ethnicity (Lavizzo-Mourey & Jung, 2005). Thus, a focus on quality improvement may improve care for all patients while reducing or eliminating disparities. A 2003 study of the federal End Stage Renal Disease Program found that quality improvement initiatives may indeed reduce disparities (Sehgal,

Key Words

disparities
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2003). Despite a growing body of empirical evidence to support such strategies, the persistence of disparities in many areas of clinical practice indicates that evidenced-based care is more likely to be absent for minority populations.

The importance of addressing disparities is further heightened by the rapidly changing demographic composition of the United States. By 2050, the U.S. population will be about half “minority” populations, and the total number of non-Hispanic whites will begin to decrease, while minority populations continue to grow dramatically (United States Census Bureau, 2004). If the care provided to minorities continues to lag, then the net effect of these changing demographics will be that a larger number of Americans receive poorer quality care.

In 2004, the Robert Wood Johnson Foundation initiated the Expecting Success: Excellence in Cardiac Care program, the first hospital quality improvement collaborative focused on equity and the reduction of disparities. Expecting

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Success was conceived as a “learning laboratory” to develop, implement, and test quality improvement strategies to improve cardiac care for underserved minorities. The collaborative was designed to include 10 acute care hospitals selected through a competitive application process. The first two steps in the collaborative involved a planning phase and the development of a letter of intent (LOI) that was used to solicit applications from interested hospitals. During the initial planning and solicitation phase, two sets of fundamental design questions were explored:

- Did hospitals see disparities as an issue they could or should address? More specifically, did hospitals perceive disparities as arising from treatment decisions made within the hospital, rather than from external factors outside the control of the hospital (e.g., local physician shortages)? Would hospitals be willing to engage in disparities reduction initiatives?
- Have applicant hospitals used patient data for quality improvement activities

to reduce disparities? Would using patient data for these activities be a new endeavor for these hospitals?

Methods

Two primary data collection methods were used to plan the collaborative and screen potential participants. The first method was a series of interviews with “key informants” designed to examine health system leaders’ responses to the first set of questions and obtain input on the design of the actual hospital collaborative. A total of 44 key informants were identified through discussions with national professional associations, major healthcare philanthropies, and health services researchers who investigated healthcare disparities. Of the 44 identified informants, 38 participated in 1-hour interviews. Of this sample, 12 informants were senior health system executives, 9 were engaged in healthcare disparities research, 13 directed major quality improvement initiatives, and 4 represented professional associations.

The informants were queried using a semi-structured interview guide devised to elicit their perceptions of whether and to what degree disparities reduction was an organizational priority within their own health systems or within other health systems with which they were familiar. Informants were also asked about the ideal characteristics of a healthcare disparities collaborative, the types of hospitals that should participate, and the resources that hospitals would need in order to implement quality improvement techniques for reducing disparities in care.

Information from these interviews was used to construct a 22-item Web-based LOI to be used by hospitals interested in joining the collaborative. The LOI included questions about hospital characteristics, patient population, performance on specific quality measures, and data collection efforts. The LOI solicited detailed information concerning applicants’ past, current, and planned formal quality improvement and disparities initiatives. Because of an interest in including hospitals with substantial black and Hispanic cardiac patients, a list of target hospitals was generated, and a written solicitation to complete the LOI was sent to those hospitals. The target list consisted of 380 hospitals; 283 hospitals were selected using Medicare inpatient claims data to identify hospitals with the largest number of black and Hispanic cardiac admissions for Major Diagnostic Category 05. For the remaining hospitals, the mailing

list of a national association was used to solicit safety net providers, which tend to have large numbers of non-Medicare minority cardiac admissions. A total of 122 hospitals responded to the solicitation with completed LOIs.

Results

Interviews with Key Informants

All the 38 key informants indicated that disparities in healthcare are not an organizational priority for U.S. hospitals. Most informants noted that these institutions did not tend to believe that there were disparities in the quality of care they provided among the different populations they served. Instead, according to these experts, hospitals continue to perceive any disparities in care as a function of social and economic conditions beyond their control (e.g., lack of health insurance for employed people). Indeed, 11 of the 12 senior health system executives interviewed believed this perception to be true for their own organizations. Moreover, 9 executives believed that hospitals would be reluctant to participate in a collaborative designed to address “disparities,” because this might be viewed as an admission of inequitable care.

Letters of Intent

Analysis of the 122 completed LOIs revealed that 96.7% (118) of applicant hospitals reported that they collect data on patients’ race and ethnicity, and 68.9% stated that they had the ability to stratify quality-related data by race and ethnicity. However, only 4.9% (6) of applicant hospitals indicated that they had planned or implemented formal quality improvement initiatives specifically designed to reduce ethnic or racial disparities in the care they provide.

Discussion

These findings offer a complex picture of how America’s hospitals handle disparities in the context of quality improvement. The leaders of health systems that were interviewed clearly viewed disparities as essentially a problem of the social fabric, as opposed to one that, even in part, reflected inconsistencies or inequities in the way that health systems deliver care. This viewpoint seems incongruous in light of the many articles and reports documenting the existence of disparities independent of social factors (Lillie-Blanton, Rushing, & Ruiz, 2003). This unwillingness of providers to view disparities as indicators of health system performance has been documented elsewhere (Lurie et al., 2005)

and can be explained in a number of ways.

First, as some of the interviewees noted, efforts to reduce disparities may be read as signs of past failings in this regard. More specifically, hospital administrators, clinicians, and others may fear that any acknowledgment of disparities is tantamount to an admission of discriminatory practices on their parts. The not-too-distant history of segregated hospitals in America prior to 1965 probably reinforces these apprehensions (Smith, 2005).

A second explanation is not so much that hospitals are unwilling to acknowledge their roles in creating disparities, but rather that they simply assume that they provide equitable care to all because that is their mission. One might see this as a case of *assumed equity*; providers assume that they provide equal care to the various groups whom they serve, yet they never test this assumption. Stratifying their publicly reported quality measures by patient race and ethnicity to investigate whether this assumption withstands scrutiny would either provide support for their assumption or identify areas for quality improvement work.

Other work also supports the assumed equity explanation. In a study of five public hospitals with large minority populations and their performance on established quality measures stratified by race and ethnicity, none had previously stratified their publicly reported quality measures by race, ethnicity, or language (Siegel, Regenstein, & Jones, 2007). In the case of these five hospitals, analysis demonstrated that their assumptions about equitable care were generally supported by the data. The analysis, however, also uncovered some disparities on measures that required communication with patients—an important finding for hospitals that wish to target resources to improve their performance on publicly reported data.

Finally, hospitals may already be overburdened by the great many activities they must undertake to comply with mandated quality reporting, licensure, and accreditation demands, among many others. In light of these burdens, it is not hard to understand why performing additional discretionary analysis has not received much focused attention.

Unfortunately, a second set of findings gives evidence of a very real, lost opportunity. Although the majority (97%) of LOIs indicated that hospitals currently collect patient race and ethnicity data, almost none reported using the data for quality improvement purposes. This finding is striking, particularly because these

hospitals applied to be a part of a disparities collaborative and are therefore among those most likely to have begun using quality data to identify and reduce inequities in care.

Some observers might suggest that it is premature for hospitals to use this patient demographic data to address disparities in care. Previous research into hospital data collection practices has identified problems with the reliability and comparability of the data being collected, including inconsistencies in collection and reporting. Hospital practices for data collection vary widely, as do the racial and ethnic

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classifications used (Hasnain-Wynia & Baker, 2006). Nonetheless, even if the data collected cannot be compared between institutions, the data might at least allow each hospital to identify existing disparities in care and track trends for different patient populations. From this limited sample it appears that few hospitals that collect the necessary data and have demonstrated an interest in reducing disparities have taken any real steps toward doing so. Understanding this paradox may be another key step in getting hospitals to make equity in care a fundamental, measurable priority.

Change may require that the specific data collection and analysis activities needed to support efforts to reduce disparities are “hard-wired” into quality improvement initiatives. There are a number of ways to make this happen. Hospitals have already become accustomed to analyzing and reporting data in response to accreditation and reimbursement needs driven by the Joint Commission and the Centers for Medicare & Medicaid Services. The explicit measurement of quality by patient race, ethnicity, and language could be the logical next step on the quality agenda. Although few overt incentives or mandates for hospitals or other providers to collect patients’ race, ethnicity, and language data currently exist, this landscape is starting to change. In January 2006, the Joint Commission implemented a new accreditation standard requiring hospitals to collect patients’

language in the medical record. In addition, 19 states now have mandated the collection of patient race and ethnicity data in hospitals (Health Research and Educational Trust, 2005).

Increasing providers’ investments in electronic health records offers another promising avenue for addressing disparities. Conceivably, the routine and standardized collection of reliable, consistent race and ethnicity data could be dramatically helped by the use of uniform patient classifications in health information technology (HIT). These systems could also make any quality analyses (including those on disparities) easier and quicker. Faster adoption of HIT could thus ease the way for health systems to address disparities; however, the attitudinal barriers noted above will remain.

Finally, although countless hospitals are actively engaged in activities to improve the quality of care they provide, relatively few address the issue of equity across their own patient populations. Despite the copious literature documenting disparities in healthcare, information remains scarce on ways to eliminate them. Without clear evidence of what works, the issues of disparities and quality improvement may remain segregated in the minds of healthcare providers, and the creation of a high-quality healthcare system for all Americans, regardless of race or ethnicity, will remain an elusive goal.

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References

- Agency for Healthcare Research and Quality. (2005). *2005 national healthcare disparities report* [Electronic version]. Retrieved December 27, 2006, from www.ahrq.gov/qual/nhdr05/nhdr05.pdf.
- Hasnain-Wynia, R., & Baker, D. (2006). Obtaining data on patient race, ethnicity, and primary language in health care organizations: Current challenges and proposed solutions. *Health Services Research, 41*(4), Part 1, 1501–1518.
- Health Research and Educational Trust. (2005). *Collecting race, ethnicity, and primary language data: Tools to improve quality of care and reduce health care disparities* [Electronic version]. Retrieved October 15, 2006, from www.hret.org/hret/publications/content/isbr1105.pdf.
- Institute of Medicine, Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century* (J. M. Corrigan, M. S. Donaldson, L. T. Kohn, S. K. Maguire, & K. C. Pike, Eds.). Washington, DC: National Academies Press.
- Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care* (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Eds.). Washington, DC: National Academies Press.

- Kressin, N. R., & Petersen, L. A. (2001). Racial differences in the use of invasive cardiovascular procedures: Review of the literature and prescription for future research. *Annals of Internal Medicine*, 135, 352–366.
- Lavizzo-Mourey, R., & Jung, M. (2005). Fighting unequal treatment: The Robert Wood Johnson Foundation and a quality-improvement approach to disparities. *Circulation*, 111, 1208–1209.
- Lillie-Blanton, M., Rushing, O., & Ruiz, S. (2003). *Key facts: Race, ethnicity and medical care* [Electronic version]. Retrieved December 5, 2006, from www.kff.org/minorityhealth/upload/Key-Facts-Race-Ethnicity-Medical-Care-Chartbook.pdf.
- Lurie, N., Fremont, A., Jain, A., Taylor, S. L., McLaughlin, R., Peterson, E., et al. (2005). Racial and ethnic disparities in care: The perspectives of cardiologists. *Circulation*, 111, 1264–1269.
- McGlynn, E., Asch, S. M., Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., et al. (2003). The quality of health care delivered to adults in the United States. *New England Journal of Medicine*, 348, 2635–2645.
- Sehgal, A. (2003). Impact of quality improvement efforts on race and sex disparities in hemodialysis. *Journal of the American Medical Association*, 289(8), 996–1000.
- Siegel, B., Regenstein, M., & Jones, K. (2007). *Enhancing public hospitals' reporting of data on racial and ethnic disparities in care*. New York: Commonwealth Fund.
- Smith, D. (2005). The politics of racial disparities: Desegregating the hospitals in Jackson, Mississippi. *Milbank Quarterly*, 83(2), 247–269.
- United States Census Bureau. (2004). *U.S. interim projections by age, sex, race, and hispanic origin* [Electronic version]. Retrieved December 1, 2006, from www.census.gov/ipc/www/usinterimproj/.

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