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Closing the Disparities Gap in Healthcare Quality With Performance Measurement and Public Reporting

EXECUTIVE SUMMARY

Compared to whites, racial and ethnic minorities in America today face disproportionately higher rates of disease, disability, and mortality, resulting in part from disparities in the quality of healthcare they receive from U.S. healthcare delivery systems. The same is true of low-income populations compared to those who are more affluent. But there are systematic public and private efforts under way to address disparities and deliver measurable improvements in healthcare quality to poorly served groups. The ultimate goal is for all Americans—regardless of their ethnicity, gender, socioeconomic position, or insurance status—to have access to healthcare that meets the Institute of Medicine (IOM) criteria for quality: It must be safe, timely, effective, efficient, patient centered, and equitable.

This National Quality Forum (NQF) Issue Brief highlights the challenges our healthcare system faces as a result of disparities in care. It summarizes important initiatives that are under way at the national, regional, and local levels and also benchmarks notable progress that has been made to improve disparities through data collection, measurement, public reporting, intervention, education, and incentives.

Although progress in reducing the disparities gap has been disappointing during the first half of this decade, the future looks more promising. Multistakeholder groups are tackling serious challenges through the use of data collection and the development of innovative new approaches to close the gap.

Understanding the Healthcare Quality Disparities Gap

IOM has contributed two important reports that have advanced the understanding of disparities. In its 2001 study *Crossing the Quality Chasm: A New Health System for the 21st Century*, IOM identified equity as one of six critical domains of high-quality care.¹ Its 2003 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* provided a policy framework to address the issue of disparities.²

Also in 2003, the Agency for Healthcare Research and Quality (AHRQ) published the *National Healthcare Disparities Report*, the first comprehensive, national report on differences in the accessibility and quality of healthcare presented by priority population. Annual updates have followed.

The most recent AHRQ report, published in 2007, focused on whether disparities in the quality and accessibility of healthcare had narrowed during the five-year period from 2000 to 2005. It concluded that they had not. In fact, it cited an increase in the number of measures that reveal that these disparities exist.³ For example, in almost two-thirds of the core quality measures that are used

➔ *Continued on page 2*

in the analysis, disparities between blacks and whites either stayed the same or worsened. Similarly, as shown by more than two-thirds of the quality measures, disparities between poor people and those with higher incomes also either stayed the same or worsened.

Whites and minorities typically receive care in very different settings. For example, a 2007 report commissioned by the Robert Wood Johnson Foundation (RWJF) found that a small percentage of hospitals care for the vast majority of elderly African American patients in America, and these hospitals often provide a somewhat lower quality of care.⁴ These findings corroborated the results of a 2001 survey conducted by the Center for Studying Health System Change, which found that 80 percent of African American patient visits were clustered among 22 percent of primary care physicians and that those physicians provided only a small percentage of care to white patients. Moreover, the physicians that African American patients visited most often were less likely to be board certified than those visited by white patients, more likely to report that they were unable to provide high-quality care to all of their patients, and often lacked access to superior clinical resources, such as high-quality subspecialists, high-quality diagnostic imaging, and non-emergency hospital admission.⁵

A similar dynamic holds true with Hispanics. A 2008 report commissioned by RWJF found that a small segment of U.S. hospitals cares for more than half of all elderly Hispanic patients nationwide, and the quality of care at those facilities lags behind that provided at hospitals that treat fewer Hispanics.⁶

Although race and ethnicity can exacerbate disparities in the quality of healthcare people receive, socioeconomic status also plays an important role. Studies have found that racial and ethnic minorities are generally poorer than whites and are more likely to have family incomes near the federal poverty level.⁷ Low socioeconomic status usually is associated with substandard access to care, fewer community resources, and higher mortality.^{8,9} Researchers also have found that when

they control for socioeconomic status, health disparities are usually reduced but not eliminated.^{10,11} Although recent developments in biotechnology, medicine, and public health have led to improvements in the health of the nation as a whole, racial, ethnic, and socioeconomic minorities still do not receive equal care (see box 1).

Efforts Under Way to Reduce Disparities

A wide range of stakeholders in the healthcare system, including governmental agencies, public health agencies, healthcare professionals, hospitals and health systems, ambulatory care providers, and researchers, is working to reduce disparities in healthcare quality. They are working collaboratively at the national and regional levels to institute public reporting systems, collect health quality data, develop measures, implement targeted interventions, and provide education and training programs.

Public Reporting Systems

Public reporting of healthcare quality data, often accompanied by pay-for-performance systems, has helped improve quality, and there is much interest in pursuing similar approaches to reduce disparities in the quality of care that is delivered to racial and ethnic minorities.^{12,13,14}

The *National Healthcare Disparities Report* provides national benchmarks for disparities in the quality of and access to

healthcare. To date, it has successfully focused attention on the issue of disparities. However, it is too early to know whether this attention will translate into improved performance. Public reporting and pay-for-performance programs are most useful at a more granular level in holding accountable entities responsible for care—such as hospitals, provider groups, and physicians—and for providing specific feedback about quality and disparities improvement.

Currently, widespread public reporting on disparities at the community or provider level is hampered by data collection challenges, because we have very limited experience with it. A review of the literature on the effects of publicly reporting by Chien et al. found only one empirical study on the effect of public reporting on disparities.¹⁶ This study reported an increase in racial and ethnic disparities in coronary care bypass following the release of the report card. The authors hypothesized that increases in disparities may result from 1) “cherry picking,” which involves avoiding the treatment of minority patients who may have more challenging clinical conditions; 2) the lack of specific programs to target interventions for improvements in healthcare for minorities, as opposed to using a total population approach; and 3) less access to and understanding of healthcare quality information on the part of patients who are disproportionately affected by disparities in care.¹⁷ Conclusions about the effects of public reporting should not be drawn based on

BOX 1

A Lack of Improvement in Healthcare Disparities

A recent National Healthcare Disparities Report has shown that the largest disparities in healthcare quality for each priority group did not improve between the reporting years of 2005 and 2007. Examples of these measures include:¹⁵

- **For blacks:** Children 19-35 months who received all recommended vaccines. New AIDS cases per 100,000 people aged 13 and over.
- **For Asians:** Persons aged 18 or older with serious mental illnesses who have not received mental health treatment or counseling in the past year.
- **For American Indians and Alaskan Natives:** Women not receiving prenatal care in the first trimester.
- **For Hispanics:** Adults who can sometimes or never receive care for illness or injury as soon as wanted.
- **For the poor:** Children whose parents reported poor communication with their health providers.

one study. Rather, it will be important to monitor the results of multiple studies over time to identify and develop strategies to mitigate any unintended consequences of public reporting and pay-for-performance programs.¹⁸

Healthcare Quality Data Collection

To reduce disparities, better data on the race, ethnicity, socioeconomic status, and language challenges of people receiving care are essential. These data document where disparities exist, allow for quality improvement and monitoring progress, and provide the foundation for rewarding good performance. Yet the majority of hospitals, health plans, and physician practices do not routinely capture this information, and few link the data to quality measures or use them for quality improvement. There are many challenges involved in collecting race and ethnicity data, not the least of which is that a few states make it illegal to collect the data. Additionally, there are patient concerns and suspicions about confidentiality; a need for standardized race and ethnicity codes and electronic health records; and a need for consistent data feeds from multiple providers. There also is concern that there may be unintended consequences that may worsen disparities.

The good news is that many large-scale efforts are under way to improve data collection, including the following:

- Many states report that they require the collection of race and ethnicity data. Wisconsin requires hospitals to collect race and ethnicity data through patient self-identification upon registration.¹⁹
- The AHRQ National Health Plan Collaborative includes 10 health plans with a total of 87 million enrollees.²⁰ It is addressing primary data collection and language access and is building the business case for reducing disparities.
- The Center for Healthcare Strategies' Disparities Health Plan Collaborative, which includes 12 Medicaid health plans covering 3.2 million enrollees, also is collecting race and ethnicity data.²¹

TABLE 1 Sample NQF-Endorsed™ National Performance Measures to Address Healthcare Disparities

Priority	Measure Description
Asthma	<ul style="list-style-type: none"> • Use of appropriate medications
Diabetes	<ul style="list-style-type: none"> • Percentage of patients with most recent A1c level >9.0% (poor control)
Heart disease	<ul style="list-style-type: none"> • Coronary artery disease: beta blocker treatment after a heart attack
Screening	<ul style="list-style-type: none"> • Breast cancer screening • Colorectal cancer screening
Prenatal care	<ul style="list-style-type: none"> • Prenatal screening for HIV • Prenatal anti-D immune globulin
Mental health	<ul style="list-style-type: none"> • Antidepressant medication management
Immunization	<ul style="list-style-type: none"> • Childhood immunization status • Flu shots for adults aged 50 to 64
Prevention	<ul style="list-style-type: none"> • Tobacco use assessment and cessation intervention
Patient experience	<ul style="list-style-type: none"> • Ambulatory Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- The Centers for Medicare & Medicaid Services (CMS) has a large warehouse of administrative and surveillance data, including disparities data fields. However, the coding of administrative data is unreliable for many disparities-related applications, and the survey often does not have large enough sample sizes to target specific populations in specific areas for specific conditions. The agency is studying ways to improve the use of administrative data to adjust for errors and bias and to combine Medicare and private sector all-payer data.
- The Health Research and Education Trust (HRET) created a *Disparities Toolkit*, designed to aid healthcare providers and health systems in assessing their capacity to collect accurate data on race, ethnicity, and primary languages from their patients or caregivers. The *Toolkit* was made available as a free download from HRET's web site in early 2008.²²

There also is a good deal of technical work under way in using secondary data to buttress shortfalls in the direct reporting of race and ethnicity by patients. Such work is addressing the use of geocoding, census

data, and surname analysis to create proxy variables for race, ethnicity, income, and education.

The collection of race and ethnicity data is becoming more widespread. The current challenge is to improve the data's quality and reliability and transform the data into useful information for care improvement without creating an additional data collection burden for providers. What is most needed is work to determine the optimal use of the data that are being collected.

Measure Disparities

In 2004, NQF identified addressing healthcare disparities as a national imperative and developed a set of disparities-sensitive measures that can be used for public reporting, quality, and disparities improvement at the practice level.²³ NQF convened a Technical Advisory Panel to conduct a systematic analysis to identify measures that highlight healthcare disparities. The panel identified a set of 35 performance measures in 8 areas. In addition, it identified a measure of experience of care that is "disparities sensitive," comprehensive, and broadly applicable in ambulatory settings.²⁴ (See table 1 for examples of the disparities sensitive NQF-endorsed measures.)

NQF also endorsed a set of disparities-sensitive measures that addresses community-level performance. The set includes 14 AHRQ Prevention Quality Indicators (PQIs) collected from hospital discharge data that cover hospitalizations that might have been avoidable if appropriate ambulatory care had been provided.²⁵ Examples of the measures include admissions for short- and long-term complications of diabetes, hypertension, and urinary tract infections.

Targeted Interventions

There are many reports of interventions that have included performance measurement efforts that appear to have succeeded in reducing healthcare quality disparities. Examples include targeted disparities reduction in colorectal screening at a health maintenance plan,²⁶ the elimination of disparities for African Americans in mammography use and asthma medication use in a health system and employer partnership,²⁷ improved health outcomes for ethnic minorities who have depression,²⁸ and reductions in HbA1c levels through the use of culturally tailored interventions.²⁹ A review of the literature by Chin et al. concluded that promising intervention strategies include multifactorial interventions that address multiple levels of change, culturally tailored quality improvement, and nurse-led interventions within the context of wider system change.³⁰ More information on interventions used in reducing disparities is available from the Finding Answers Intervention Research database.³¹

The Health Resources and Services Administration (HRSA) administers an important national program of health disparities collaboratives (HDCs).³² The HDCs involve a number of national and state government organizations that work collectively to develop evidence-based systems for quality improvement. The HDCs are designed to transform the delivery of healthcare to ensure that all populations have access to the highest level of care. Providers that participate in the HDCs receive technical, programmatic, and implementation support from HRSA in the use of the agency's three transformative models: the Care Model, the Model for Improvement, and the Learning Model.³³

Education and Outreach Programs

A variety of private organizations currently are undertaking national efforts to address healthcare disparities. For example, the National Committee for Quality Assurance (NCQA) has initiated three efforts aimed at improving the "delivery of culturally and linguistically appropriate services."³⁴ First, NCQA's Recognizing Healthcare in Multicultural Healthcare Award Program identifies and publicizes innovative measures and practices that have demonstratively improved cultural competency. Second, NCQA offers a quality improvement toolkit called "Multicultural Healthcare" to healthcare organizations that are interested in implementing quality improvement measures to address healthcare disparities.³⁵ Third, NCQA's Technical Assistance Project provides small primary care practices with direct assistance in implementing quality improvement initiatives targeted to the minority populations they serve.³⁶

Building upon its 2007 report *Hospitals, Language, and Culture*, the Joint Commission's web site provides an extensive list of toolkits, reports, and links to resources that address "culture, language, and diversity."³⁷

Making Progress at the National, Regional, and Local Levels

National Initiatives

Many federal organizations are contributing to national efforts to reduce healthcare disparities. For example, CMS has charged the Center for Medicaid and State Operations (CMSO) with reducing the "racial and ethnic health disparities in Medicaid and SCHIP."³⁸ CMSO is collaborating with national, state, local, and private agencies on the implementation of quality measures associated with reducing health disparities.³⁹

Additionally, the Office of Minority Health (OMH) has developed National Standards on Culturally and Linguistically Appropriate Services (CLAS).⁴⁰ Four of the 14 CLAS standards are federally mandated, while 9 of the standards are recommended by OMH "for adoption by federal, state, and national accrediting agencies."⁴¹

OMH has also created the National Partnership for Action to End Disparities (NPA) to eliminate healthcare disparities generated by cultural differences. NPA's efforts to date have resulted in the creation of a strategic framework for its work;⁴² a growing list of best practices;⁴³ and an ongoing series of regional conversations among state, regional, and federal "experts and practitioners" designed to improve interagency communication and build local action plans for ending disparities.⁴⁴

The Federal Collaboration on Health Disparities Research is a collaboration of federal organizations that is co-led by the Department of Health and Human Services Disparities Council (HDC) and the Department of Education Interagency Committee on Disability Research, which is "working to find new or improved solutions to eliminate health disparities through research that can influence practice and policy."⁴⁵ Participating agencies include OMH, CMS, the Office of Women's Health, the National Institutes of Health, the Centers for Disease Control and Prevention, and the Department of Veterans Affairs.

Regional and Local Initiatives

Regional and local collaboratives are important multistakeholder groups that can foster collaboration among local groups, agencies, and associations that are committed to reducing healthcare disparities and improving healthcare quality. Participating in a regional collaborative can provide an opportunity for governments, nonprofit organizations, and the private sector to identify and achieve mutual goals.

RWJF has been supporting efforts to reduce disparities and improve healthcare at the state and community levels.⁴⁶ RWJF has supported a number of recent initiatives to reduce racial and ethnic disparities in healthcare, including:

- research documenting the extent of racial and ethnic healthcare disparities and evaluating potential solutions;
- efforts to understand the extent to which hospitals, health plans, and others are collecting race and ethnicity data on patients for the purposes of identifying gaps in care;

- the evaluation of clinical interventions to improve the quality of care for minority patients; and
- efforts to foster collaboration between leading experts in healthcare quality and healthcare disparities.

RWJF also supports coalitions in 14 communities through its Aligning Forces for Quality initiative. The coalitions work with physicians, nurses, and other healthcare professionals to improve quality, with a special emphasis on delivering patient-centered care and reducing racial and ethnic healthcare disparities.⁴⁷

Regional collaboratives face many challenges in their efforts to address disparities. In addition to the challenges of data collection and the need for electronic health records and common coding standards and the like, two overarching strategies are essential for making progress in closing the disparities gap.

First, it is important to establish a strong, ongoing commitment and focus on eliminating disparities in healthcare quality. To that end, NQF has made addressing disparities a core objective of its National Priorities Partnership (NPP) initiative, which is a coalition of 27 major national organizations engaged in a process of identifying a limited set of national priorities for quality measurement and improvement. Each priority area will include explicit goals for addressing disparities, a set of performance measures, and, when available, preferred practices

for closing the disparities gap. The NPP has identified an initial set of priority areas,⁴⁸ and work is now under way to specify goals and measures for monitoring performance.

Second, communities and providers need to routinely incorporate disparities considerations into all quality improvement efforts by starting with the task of stratifying quality measures by gender, race, ethnicity, socioeconomic status, primary language, and income for a given geographic region or provider organization. An example of the steps taken in using stratification as a starting point to understand gaps and opportunities that lead to specific, targeted interventions is provided in table 2.

In addition to the design of the clinical and disparities intervention, coalitions have a variety of levers to complement interventions. They include public reporting, incentive programs, public education, and professional training.

Moving Forward

The most recent *National Healthcare Disparities Report* documents little national improvement in the disparities in healthcare quality and access from 2000 to 2005.⁴⁹ Yet, over the last few years, many programs have been implemented at the national, regional, and provider levels that have shown promise in changing this trend. There also is an increasingly steadfast cadre

of concerned researchers, policymakers, stakeholders, and program activists committed to reducing disparities.

One fundamental challenge that remains is collecting race and ethnicity data and transforming it into useful information for improvements. This parallels an earlier period in the quality measurement enterprise when acceptable measures were not available and concerns about data validity, reliability, burden, and confidentiality were hampering quality improvement. Much has happened in this field during the past 20 years, and the same can be expected in the disparities measurement and improvement field going forward. As data are accumulated and public reporting holds entities accountable for performance, momentum will increase to collect and use more disparities data that are qualitatively better, harmonized, and able to be electronically transmitted.

Local and regional multistakeholder collaboratives are ideal settings for executing cross-payer strategies to collect race and ethnicity data, as they were for implementing all-payer systems for healthcare quality data. They emphasize a community approach to healthcare improvement, and they encourage innovations and demonstrations of interventions to reduce disparities. Great interest has been expressed over the past few years in supporting regional approaches, especially by RWJF, the federal government (through its regional value exchanges), and employers

TABLE 2 Analytic Steps to Target Improvements in Diabetic Care for Hispanics*

- Select the population of Hispanic beneficiaries and a white reference group.
- From those pools, select beneficiaries with diabetes.
- Determine if beneficiaries have received recommended diabetic care.
- Select geographic areas.
- Assign beneficiaries to geographic areas, such as counties.
- Create a disparities index for each area (calculated as the percentage of Hispanic beneficiaries receiving the recommended care divided by the percentage of white beneficiaries receiving the recommended care).
- Identify areas with large numbers of Hispanic diabetic beneficiaries and a large disparities index.
- Design and implement culturally sensitive, evidenced-based intervention programs.

* Derived from a CMS example cited in Reilly T, Using CMS data to address health disparities, cited by Williams T, *Health disparities and pay for performance program administration*, Quality Alliance Steering Committee, Brookings Institute; December 14, 2007

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NQF's mission is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

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(through business and health coalitions across the nation).

Over the last decade, a nationwide movement has emerged to address gaps in healthcare quality. A critical next step will be to concentrate our efforts on the groups that are most in need of healthcare improvements—including the target populations addressed in this Issue Brief—and to sponsor evidence-based, and culturally tailored interventions to eliminate disparities. ●

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