Northwestern University Feinberg School of Medicine

Understanding Drivers of Health Care Disparities and Developing Targeted Interventions

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Topics Covered

- Background-why disparities in health care matter
- Quality/disparities intersection
- Race/ethnicity and language data collection
- Interventions

Definitions

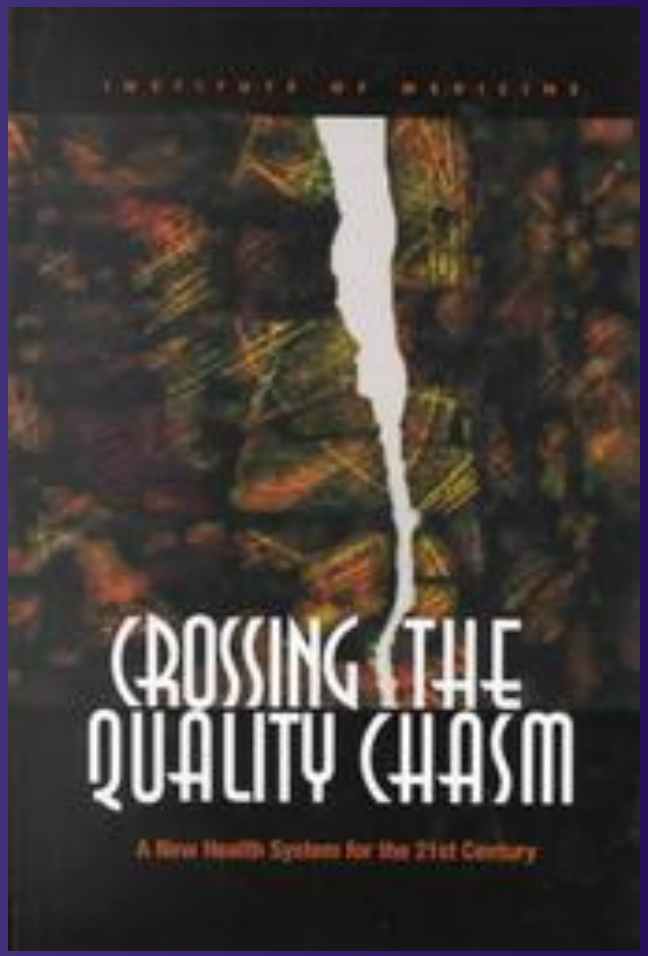
- Health Disparities: Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. (NIH Definition)

- Health Care Disparities: Differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of. Difference in treatment provided to members of different racial (or ethnic) groups that is not justified by the underlying health conditions or treatment preferences of patients. (Institute of Medicine Definition)

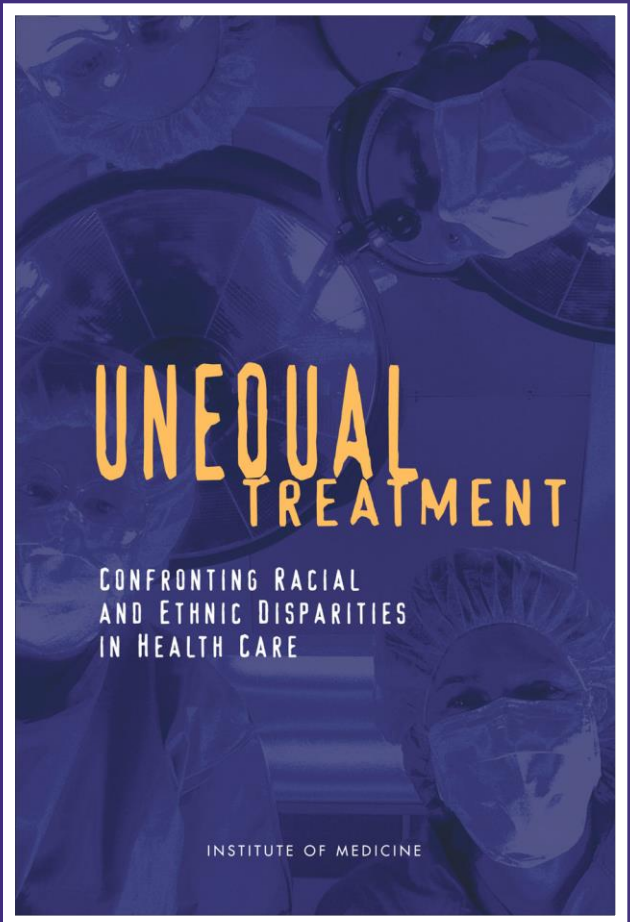
Although disparities in health and health care can be inextricably tied to one another, distinguishing between them increases our understanding of the complexity of the problem.

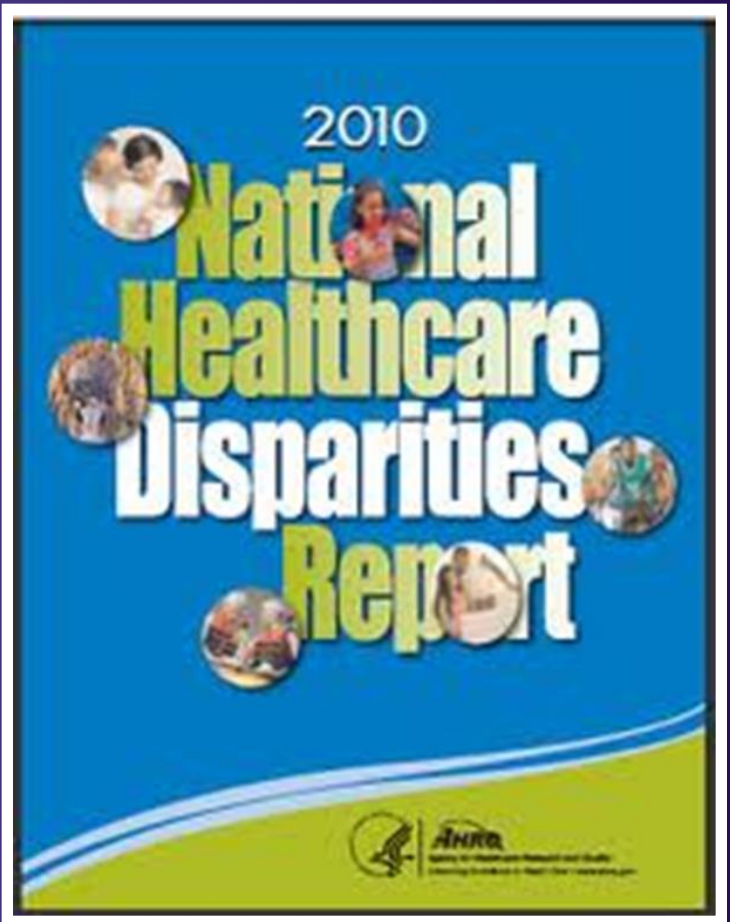
Health Care Should Be

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable



Major Reports on Health Care Disparities





Medical and Policy Literature Provide Extensive Data on Inequities in Care

- The Institute of Medicine (IOM) report, Unequal Treatment identified > 600 studies
- The IOM report identified many areas of concern:
  - Cardiovascular treatments and cerebrovascular disease
  - HIV disease (HAART and PCP prophylaxis)
  - Diabetes
  - ESRD
  - Maternal and child health
  - Cancer care
  - Many surgical procedures

Racial and Ethnic Disparities in Health Care

- In patients *with* insurance, disparities exist for
  - Mammography (Gornick et al.)
  - Amputations (Gornick et al.)
  - Influenza vaccination (Gornick et al.)
  - Lung Ca Surgery (Bach et al.)
  - Renal Transplantation (Ayanian et al.)
  - Cardiac catheterization & angioplasty (Harris et al, Ayanian et al.)
  - Coronary artery bypass graft (Peterson et al.)
  - Treatment of chest pain (Johnson et al.)
  - Referral to cardiology specialist care (Schulman et al.)
  - Pain management (Todd et al.)

The “Usual” Explanations

Patient-Level

- Patient “preferences”: Treatment refusal, clinical presentation of symptoms, mistrust
- Communication barriers

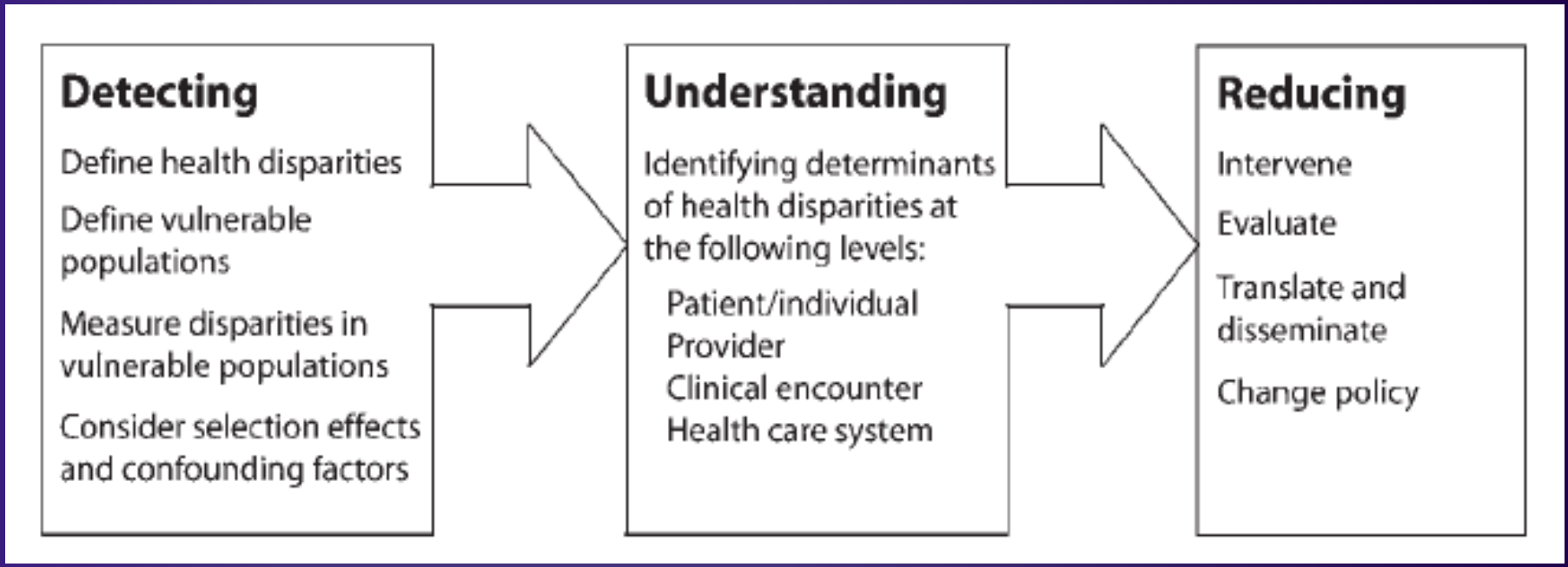
Provider-Level

- Beliefs/stereotypes re: patient health and behaviors
- Inadequate communication
- Bias/prejudice

Organizational –Level

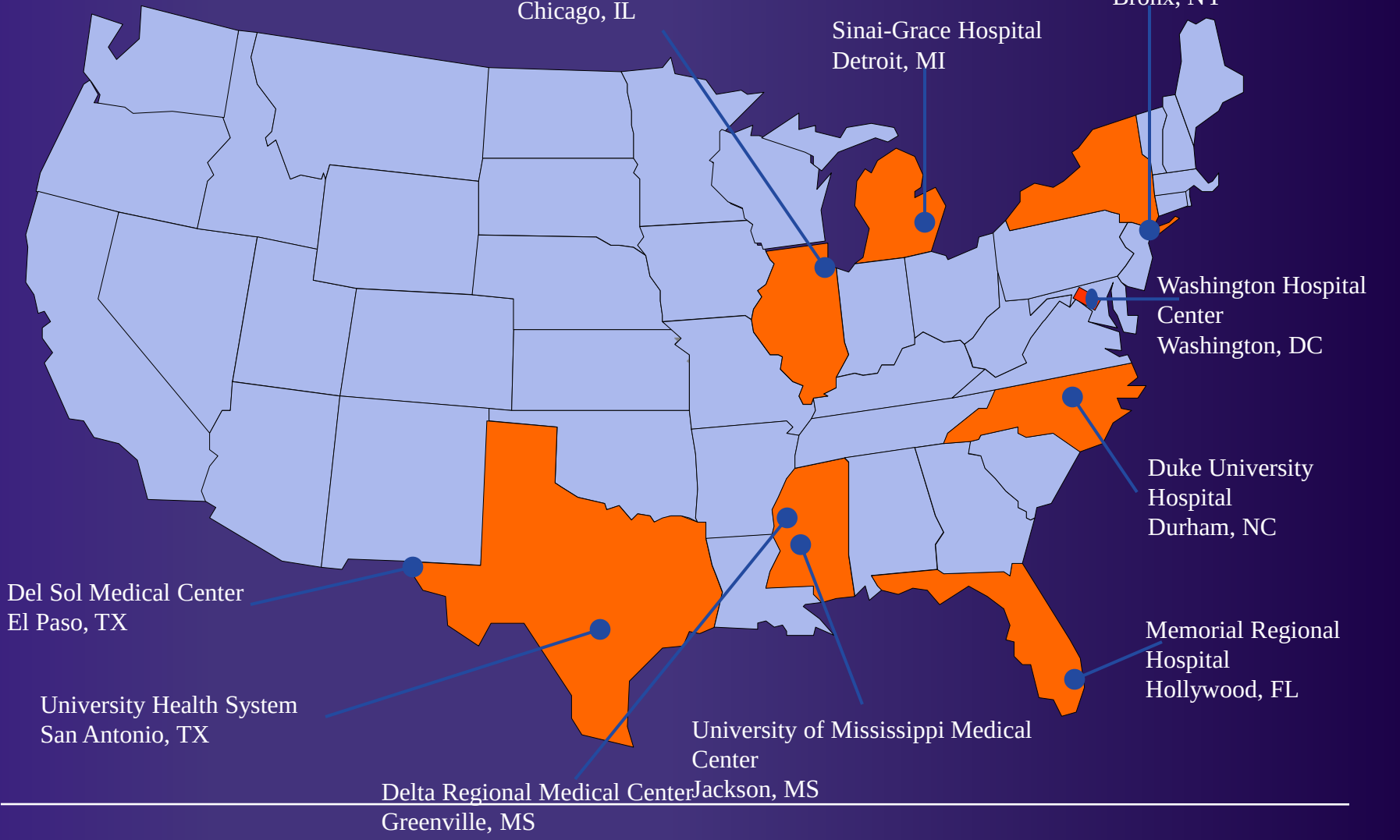
- Structural and resource differences in where different groups receive care

Reducing Disparities Within the Health Care System



Kilbourne AM, et al. *American Journal of Public Health*. 96; 2113-2121: 2006.

Expecting Success: Ten Diverse Hospitals Across the Country



Expecting Success Successes

- Memorial Regional Hospital, Broward County, Florida: Increased heart failure ideal measure from 72% to 97%.
- Del Sol Medical Center, El Paso, Texas: Ideal care measure increased from 15% to 94%.
- Washington Hospital Center, Washington DC: Complete discharge instructions for heart failure patients increased from 29% to 72%.

Detecting and Understanding

- **Quality improvement requires high-quality data.**
  "The first and most critical step for Expecting Success was helping hospitals gather data on patient race, ethnicity and primary language so that they had accurate and complete information about their patients."

- **Hospital leaders need to be willing to discuss the possibility of disparities.**
  "Physicians and hospital leaders are committed to doing the right thing by their patients, but there is a troubling reluctance among some leaders to consider gaps in the quality of care by patient demographics. Hospital staff must be brave enough to gather data and critically examine the evidence to learn if they are providing care that is high quality and equitable."

Source: Robert Wood Johnson Foundation, *Expecting Success: Excellence in Cardiac Care Program*

Why Detecting/Understanding is Important

B. Siegel et al. *Journal of Health Care Quality* (2007)

- Hospital and Health Care Leaders---"NIMBY"

N. Lurie, et al. *Circulation (2005)*

344 Cardiologists:

- 34% agree disparities exist overall
- 12% believe disparities exist in own hospital
- 5% believe disparities exist in own practice

S. Taylor, et al. *Annals of Thoracic Surgery* (2005)

208 Cardiovascular Surgeons:

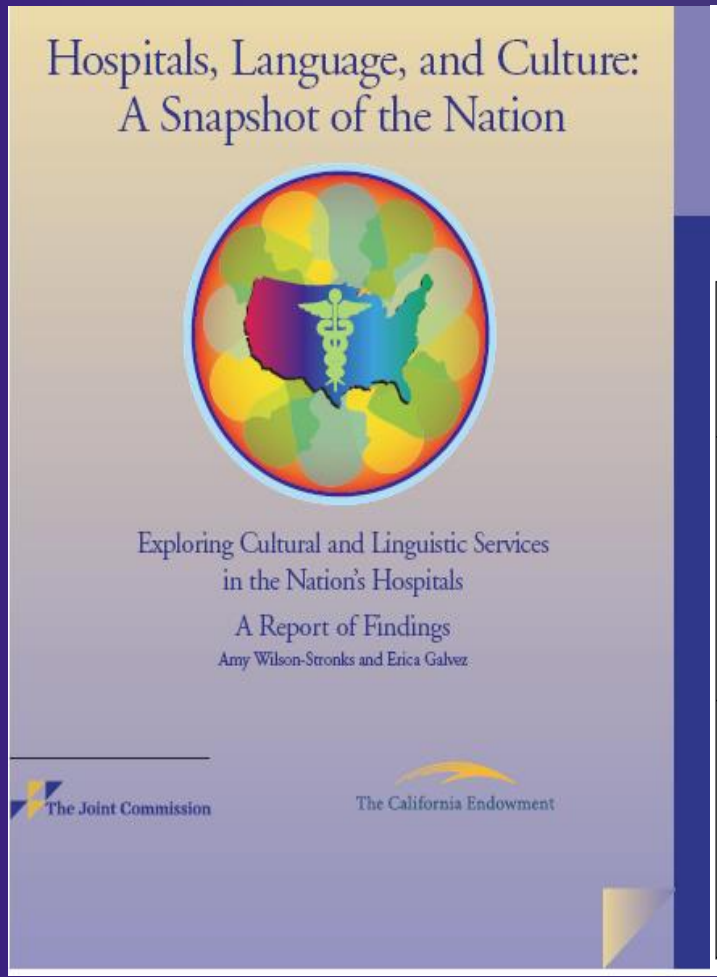
- 13% believe disparities occur often or very often
- 3% believe disparities occur often or very often in own practice

T. Sequist, et al. 2008, *Journal of General Internal Medicine* (2008)

169 Primary Care Clinicians

- 88% acknowledged that disparities in diabetes care existed in U.S.
- 40% acknowledged disparities in own practice

Discrepancy in Perceptions



- Cross-sectional **qualitative study of 60 hospitals**
- In-person **Key Informant interviews**
  - CEO (one-on-one)
  - Leadership and Cultural and Language Services (2 groups of 3 representatives)

	Hospital Survey Results	Key Informant Interviews
Yes, Hospital Collects Patients' Race/Ethnicity	82%	• CEOs-7.5% • Senior Leaders-5.3% • Culture and Language Services Staff-23.3%
Yes, Hospital Collects Patients' Primary language	85%	• CEOs-15% • Senior Leaders-28% • Culture and Language Services Staff-68%

Hasnain-Wynia, Mutha, Rittner, Jacobs, Wilson-Stronks, 2010

Separate And Unequal: Racial Segregation And Disparities In Quality Across U.S. Nursing Homes

Residential segregation in U.S. cities disproportionately places blacks in poorer-performing nursing homes.

by David Barton Smith, Zhanlian Feng, Mary L. Fennel, Jacqueline S. Zinn, and Vincent Mor

Do Hospitals Provide Lower-Quality Care To Minorities Than To Whites?

When minority patients receive hospital care, they receive the same standard of care that white patients receive.

by Darrell J. Gaskin, Christine S. Spencer, Patrick Richard, Gerard F. Anderson, Neil R. Powe, and Thomas A. LaVeist

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Primary Care Physicians Who Treat Blacks and Whites

Peter B. Bach, M.D., M.A.P.P., Hoangmai H. Pham, M.D., M.P.H., Deborah Schrag, M.D., M.P.H., Ramsey C. Tate, B.S., and J. Lee Hargraves, Ph.D.

Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?

Practice resources appear to be a determining factor in whether or not physicians treating predominantly minority patients deliver care of adequate quality.

by James D. Reschovsky and Ann S. O'Malley

ORIGINAL INVESTIGATION

Disparities in Health Care Are Driven by Where Minority Patients Seek Care

Examination of the Hospital Quality Alliance Measures

Romana Hasnain-Wynia, PhD; David W. Baker, MD, MPH; David Nerenz, PhD; Joe Feinglass, PhD; Anne C. Beal, MD, MPH; Mary Beth Landrum, PhD; Raj Behal, MD, MPH; Joel S. Weissman, PhD

Quality of Care Framework

Health care disparities should be brought into the mainstream quality assurance and continuous quality improvement discussions

Fiscella, et al. “Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care.” *JAMA.* 2000

Data are Key

HOW to collect relevant data to:

- Target specific groups to design appropriate programs and materials
- Evaluate which interventions are effective for different groups
- Meet reporting requirements

Data Collection is….

- Inconsistent
- Inaccurate
- Incomplete
- Fragmented
- In silos

HOSPITALS

82% collect race/ethnicity data but….

- Categories vary within and across hospitals
- Staff mostly collect through observation
- Staff at some hospitals had been trained to “not ask.”
- The vast majority do not use data for quality improvement

Barriers to Collecting Data

- Legal concerns
- Privacy concerns
- Patients' perceptions/culture
- System-level barriers
- Staff discomfort in explicitly asking patients to provide this information
- Validity, reliability, and utility of data
- Appropriate categories

Systematic Implementation

- Conduct education and feedback sessions with leadership and staff

- Define issues and concerns and identify how you will respond to them

Training and education components should include

- Policy context
- Revised policies
- New fields
- Screens
- Leadership-staff materials
- Staff scripts
- FAQs and potential answers
- Specific scenarios
- Staff questions
- Monitoring

Institute of Medicine Recommendations

Health Care organizations must have data on the race, ethnicity, and language of those they serve in order to identify disparities and to provide high quality care.

Detailed “granular ethnicity” and “language need” data, **in addition to the OMB categories**, can inform point of care services and resources and assist in improving overall quality and reducing disparities.

The Case for Standardization

- Standardized race, ethnicity and language data:
- Support comparisons across organizations and regions and over time
- Support combination of data across organizations or regions to create pooled data sets (especially important for getting beyond small sample concerns)
- Support reporting of, and replication of, successful disparity-reduction initiatives

Institute of Medicine, 2009

Existing Guidance

- OMB Directive – 1997
  - Hispanic/Latino Ethnicity
  - 5 Race Categories

- Progress has been made in incorporating the OMB categories into many data collection activities – not all are aligned

- The OMB categories are insufficient to illuminate many disparities and to target QI efforts efficiently

The Affordable Care Act: Section 4302

Understanding Health Disparities: Data Collection and Analysis

Focuses on federal national data collection efforts and the analysis and reporting of these data

Race and Ethnicity

- Guided by OMB standards for race and ethnicity
- Consultations with OMB, Dept of Labor, Bureau of Census and other federal partners
- Informed by recent IOM reports on data granularity

- **Section 4302 has great potential to improve data collection by**
  - ❖Requiring the DHHS Secretary to establish data collection standards
  - ❖Calling for the use of the standards in federal data collection
  - ❖Instructing that the data be used for analyses and that the results be reported
  - ❖Articulating some important language about funding

Data Standards

Must be for self-reported measures

- Or for parents to report for children and guardians to report for legally incapacitated adults

Must comply with OMB standards

- The law states current OMB standards for race and ethnicity must be used at a minimum