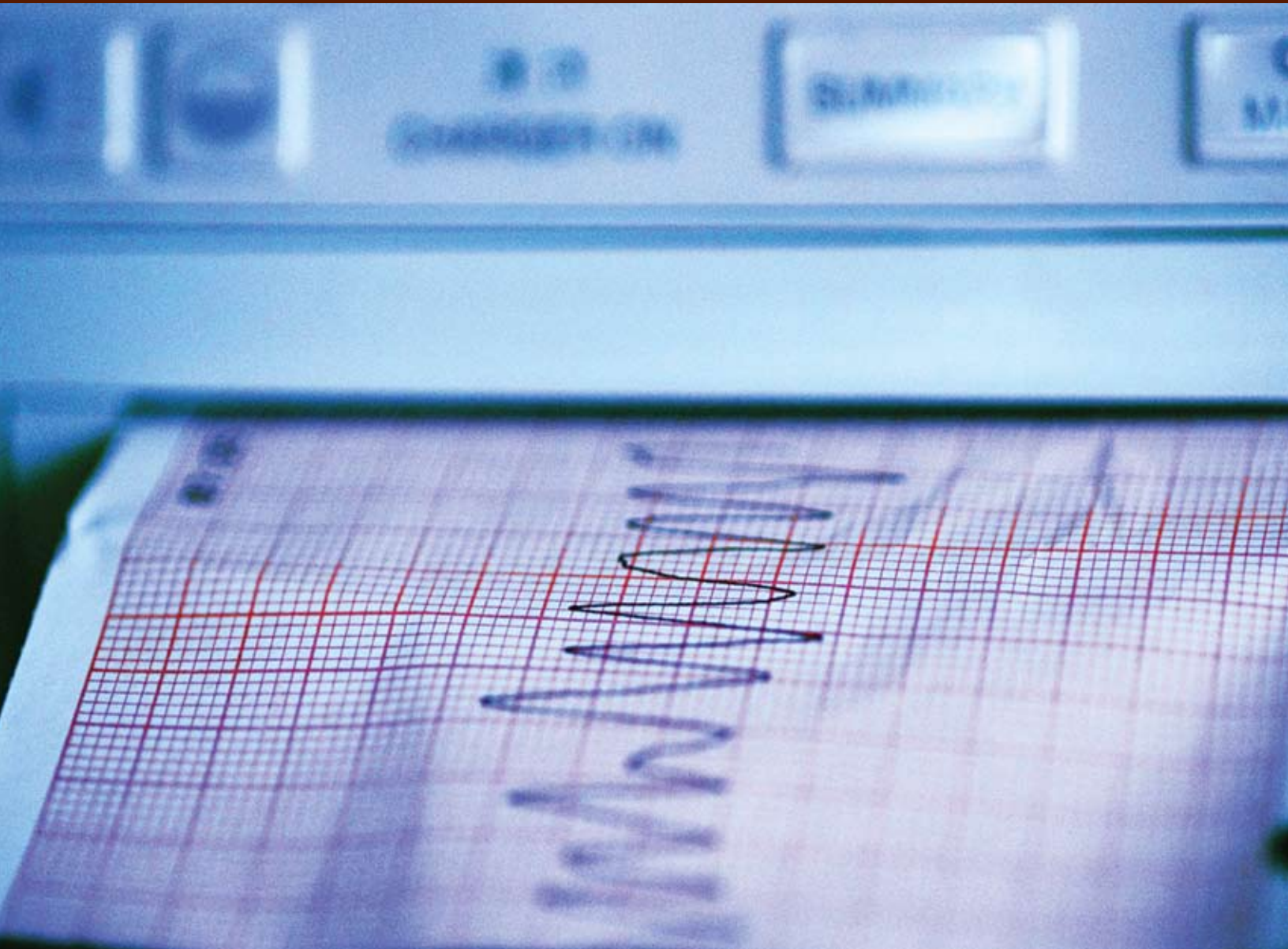MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

Institute for Health Policy

Improving Quality and Achieving Equity:
A Guide for Hospital Leaders

THE DISPARITIES SOLUTIONS CENTER
at MASSACHUSETTS GENERAL HOSPITAL

Dedicated to eliminating racial and ethnic disparities in health care

Improving Quality and Achieving Equity:
A Guide for Hospital Leaders

Acknowledgements

About the Authors

Primary Authors

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Foreword by Peter L. Slavin, MD

The Institute of Medicine Report *Crossing the Quality Chasm* was truly transformative in that it presented our nation with a blueprint for achieving quality. The report urges us to focus on six key areas to deliver on our promise of high-quality care: efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity. Hospitals across the country have heeded the Institute of Medicine's call, and are actively engaged in trying to improve quality – yet, we would be remiss to view any one area of quality as less important than another. This brings me to the issue of equity.

The fact that racial and ethnic minorities in this country may receive poorer quality health care than their white counterparts in hospitals across the country – even when they have health insurance – is indisputable and undeniable. The evidence, so eloquently presented in another Institute of Medicine Report *Unequal Treatment,* clearly points to the fact that the issue of racial and ethnic disparities in health care is an *inequality in quality* that deserves our utmost attention. It is therefore no coincidence that equity is a key pillar of quality.

Although conceiving the notion of unequal treatment can be uncomfortable, and to some unimaginable, given the evidence, it is incumbent upon us to assume that we have disparities in our own institutions unless proven otherwise. The importance of collecting patient race and ethnicity data, developing monitoring and reporting tools, and creating interventions to address disparities when found – as *Unequal Treatment* recommends – cannot be overstated. At Massachusetts General Hospital, we have taken this issue very seriously. Equity receives equal attention to the other pillars of quality from the Board room to the exam room. Our leadership understands that we cannot improve quality without improving equity, and we have engaged in a process of building the systems and interventions necessary to make this a reality. Ultimately, we believe that improving quality, addressing disparities and achieving equity is our responsibility, and that these efforts will improve not just the care of minorities, but of all patients at our institution.

For those who are interested in better understanding the issue of disparities, and why it is a key component of quality, this *Guide for Hospital Leaders* will provide some concrete answers. In addition to presenting the evidence for disparities and the rationale for addressing them, it also gives a view from the field, as well as a guide on how to initiate a portfolio of action in this area. Built on research, real world experiences, and national examples and models, this first-of-a-kind guide is practical, respectful of competing interests and pressures, and strategic – a perfect resource for getting started. Whether you are a CEO and need some background and guidance, or an advocate in need of a tool to convince your leadership to care and act, this guide will meet your needs.

As we move ahead, we can see that there is a quality, safety, cost, and risk management case for addressing disparities. If that is not enough, the changing demographics of the U.S., new pay-for-performance efforts targeting disparities, and the Joint Commission and National Quality Forum's recent attention to these issues, clearly highlight that achieving equity isn't just the right thing to do, it's an important ingredient to business success in health care. This guide can help you map out a successful strategy to improve quality, achieve equity, and address racial and ethnic disparities in health care.

I urge my counterparts to take on this important area of work and join me and other hospital leaders across the country who are striving to meet the challenge of achieving equity and assuring high-quality care for all we serve.

Peter Slavin, MD
President
Massachusetts General Hospital

Executive Summary

Introduction

The Institute of Medicine (IOM) Report *Crossing the Quality Chasm,* released in 2001, highlights that there is a significant gap between the quality of health care people should receive, and the quality of health care people do receive.[1] Just a year later, the IOM released another influential report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* highlighting an even larger quality chasm for racial/ethnic minorities in the United States.[2]

Crossing the Quality Chasm suggests that quality is a system property and that our current system of health care delivery is in need of redesign. To truly achieve quality care, 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 ethnicity, gender, geographic location, and socioeconomic status. Over the last few years, there has been an increased focus by hospital leadership on improving quality by responding to the six key elements proposed in *Crossing the Quality Chasm.* In regards to equity, research has shown that racial and ethnic disparities in health care have an impact on quality, safety, cost, and risk management. Addressing disparities has now been acknowledged by the National Quality Forum and the Joint Commission as an essential component of quality. Despite this, few hospital leaders have the issue of equity, and identifying and addressing disparities, prominently on their radar screen.

The Disparities Solutions Center at Massachusetts General Hospital, with support from the Robert Wood Johnson Foundation, has created *Improving Quality and Achieving Equity: A Guide for Hospital Leaders.* The goals of this guide are to:

- **Present the evidence for racial and ethnic disparities in health care and provide the rationale for addressing them – with a focus on quality, cost, risk management and accreditation.**

- **Highlight model practices – hospitals and leaders who are actively engaged in addressing disparities and achieving equity.**

- **Recommend a set of activities and resources that can help hospital leaders initiate an agenda for action in this area.**

This guide is constructed to be clear, concise, practical, and easy to read. It is targeted to hospital leaders - including CEO's, VP's, and others that focus on quality, safety, finance, and risk management. The guide was also designed to be used by individuals within hospitals who either would like to help convince their leadership to take action, or who are responsible for making the case for addressing disparities to other leaders in the hospital. It is applicable to all types of hospitals - rural, urban, public, private, and veteran's administration, among others. It was developed over the course of 2008, and includes a thorough review of the peer-reviewed literature, key informant interviews with hospital leaders, and case studies of innovative approaches that hospitals are undertaking to identify and address disparities, as well as to achieve equity. Guidance for the development of *Improving Quality and Achieving Equity: A Guide for Hospital Leaders* was graciously provided by our Sounding Board of health care leaders and experts (Appendix C), and the final draft was reviewed by a panel of leaders in the field of hospital quality and safety (Appendix D).

Equity is a key essential component of quality

- The Institute of Medicine Report *Crossing the Quality Chasm* suggests that quality is a system property, and that our current system of health care delivery is in need of redesign.

- To truly achieve quality of care, 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 ethnicity, gender, geographic location, and socioeconomic status.

Racial and ethnic disparities in quality of care exist

- 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 white counterparts.

- Racial and ethnic disparities have been found in the quality of care delivered to patients with cardiovascular disease (including acute myocardial infarction and congestive heart failure), diabetes, and cancer screening and management, among other conditions.

Achieving equity and addressing disparities has implications for quality, cost, risk management, accreditation, and community benefit

- Research has shown that racial and ethnic disparities in health care, and their root causes described below, have an impact on quality, safety, cost, and risk management. For example:

  - Patients with limited English proficiency (LEP) and racial/ethnic minorities are more likely than their English-speaking white counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.[3-5]

  - Communication problems are the most frequent cause of serious adverse events (as recorded in the Joint Commission database) and arise due to language barriers, cultural differences, and low health literacy, all of which are particularly important issues for racial/ethnic minority patients.[4]

  - In the presence of communication difficulties with patients (i.e. due to language barriers or cultural barriers) health care providers may tend to order expensive tests (such at CT Scans) for conditions that could have been diagnosed through basic history-taking.[6]

  - Patients with limited-English proficiency have longer hospital stays for some common medical and surgical conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement) than their white counterparts.

  - Minorities are more likely to be readmitted for certain chronic conditions,[7-9] such as congestive heart failure.[10] Moving forward, this issue might take on greater financial importance given that the Centers for Medicare and Medicaid Services will likely limit or refuse reimbursement for Medicare patients with congestive heart failure who are readmitted within 30 days of discharge.[11, 12]

  - Minorities, even when controlling for insurance status, may be at greater risk for ambulatory care sensitive/avoidable hospitalizations for chronic conditions (hypertension and asthma) than their white counterparts.

  - Pay-for-performance contracts have started including provisions that look to address racial and ethnic disparities in health care – and it is expected that this trend will become more widespread over time.

  - There are multiple liability exposures that arise when there is a demonstrated failure to address the root causes for disparities. These include patient misunderstanding of their medical condition, treatment plan, discharge instructions, (including how to identify complications and when to follow-up; ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures, and poor or inadequate informed consent).

- Disparities have also captured the attention of the Joint Commission who will soon likely release accreditation standards on this issue, as well as the National Quality Forum, who have recently developed quality measures on disparities and cultural competence.

- As the issues of community benefit and not-for-profit status takes on greater importance for hospitals across the country, addressing racial and ethnic disparities can become a valuable portfolio of work to meet these regulations.

There are many causes for disparities—no one suspect, no one solution

- The existence of racial and ethnic disparities in health care does not imply that a hospital or its providers are intentionally discriminating against certain groups of patients.

- Disparities are ubiquitous and multifactorial.

- 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.

Several hospitals across the country have distinguished themselves as leaders

- Several hospitals 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, the development of quality measurement tools to monitor for disparities, community-based efforts to improve primary care services and create medical homes, development and expansion of interpreter services, and interventions to address disparities when found.

- These efforts have been motivated by the quality case and the business case for achieving equity.

Hospital leaders can develop systems to improve quality, address disparities and achieve equity

A recommendation checklist is included here in the executive summary, and more details on the recommendations can be found in Chapter 5.

- *Getting Started*
  Create a multidisciplinary ***disparities committee*** of individuals representing quality, operations, patient registration, social services, human resources, nursing and physician-leaders from several clinical services to assess what is being done in the area of disparities at the hospital (such as whether patient race/ethnicity and language is collected), and to develop an initial strategic plan. Educate leadership team on the issue and the approach.

- *Creating the Foundation*
  Develop a plan to ***collect patient race/ethnicity data*** (if not already done) and create medical policies to support this work. Assign an organizational leader as the key report for this work and engage in efforts to raise awareness of the issue among faculty and staff. Solidify community partnership and relationships in anticipation of future interventions.

- *Moving to Action*
  Create a "disparities dashboard" composed of key quality measures stratified by race and ethnicity (i.e. National Hospital Quality Measures, HEDIS outpatient measures, patient satisfaction, etc.) that can be routinely presented to leadership and monitored. If disparities are found, create pilot programs to address them (examples include disease management programs with health coaches, navigators, or community health workers).

- *Evaluate, Disseminate, Reengineer*
  Evaluate pilot studies and develop a dissemination strategy to post results; chart a new course and **reengineer** strategies from lessons learned. **Embed** successful practices into standard programs of care.

Frequently Asked Questions

The following is a set of frequently asked questions regarding the issues of quality, equity, and racial and ethnic disparities in health care.

1. Why is equity an important component of quality?

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.

2. Given all the competing interests and priorities our hospital is facing, why should we focus on equity?

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 white counterparts; they have longer lengths of stay for the same clinical condition; they may undergo more high-priced diagnostic tests due to challenges related to communication; they 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 which are now under close federal scrutiny.

3. Is there evidence that hospitals may be providing care that is not equitable?

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 white 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, among others. **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.

4. How do disparities apply to our hospital? We treat all our patients the same regardless of their race/ethnicity.

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 haven't looked at your quality data stratified by race and ethnicity, you can't assume that you don't 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.

5. Aren't racial and ethnic disparities in health mainly due to socioeconomic factors like poverty, poor education, and lack of insurance?

There is no doubt that socioeconomic status, education, 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.

6. New studies suggest that racial and ethnic disparities in health care are primarily due to where patients are seen, and by whom. Shouldn't disparities efforts focus on improving quality at predominately minority serving institutions?

Research has shown that racial/ethnic disparities are due not only to differences in care provided within hospitals, but also as a result of from whom or where minorities receive their care (i.e. specific providers, geographic regions, or hospitals that have limited financial resources, access to specialists, and as a result are lower performing in the area of quality).[13-15] In sum, research, including those studies presented in *Unequal Treatment,* show that racial and ethnic disparities in health care can happen anywhere,[16] and among patients cared for by any provider.[17] 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.

7. Are there hospitals actively engaged in disparities work across the country?

Several hospitals 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, the development of quality measurement tools to monitor for disparities, community-based efforts to improve primary care services and medical homes, development and expansion of interpreter services, and interventions to address disparities when found.

8. What are some basic things we should be doing to address the issue of disparities?

First, develop a system to routinely collect patient race and ethnicity data. Second, begin to stratify quality measures by race and ethnicity to assess equity; this should be formalized into a disparities dashboard or equity report that can be monitored routinely by the leadership. Third, if a disparity is identified, develop an intervention to address it. All of this work should be done in collaboration with, and supported by, the Board, hospital leadership, faculty and staff. Please reference our Resource Section which highlights several toolkits, web-based seminars and models for how to do this effectively.

9. Are there strategies that work to address disparities once they are found?

For the past decade, research has focused on documenting disparities, but new research is emerging that documents promising practices to address them as well. These include the use of culturally-competent disease management models,[18-21] bilingual health coaches,[22-25] as well as navigators,[26-30] and the implementation of community outreach programs.[22, 31-36] This Guide will provide an overview of what action leaders can take at their own organizations to move towards the elimination of healthcare disparities, including resources for identifying, monitoring, and developing interventions to address disparities.

Recommendation Checklist

Getting Started

☐ Create a Disparities Committee or Task Force.

    • A multidisciplinary team, charged with assessing what is being done to identify and address disparities, including whether patient's race and ethnicity data is being collected. Develop initial strategic plan.

☐ Educate leadership team on disparities, quality, equity via champion, local national expert.

Creating the Foundation

☐ Begin to build foundation to address disparities (including race/ethnicity data collection, stratification of quality measures, etc.).

☐ Develop medical policies to support all new work.

☐ Finalize a strategic plan of action with 1, 3 and 5 year goals.

☐ Assign an organizational leader who can liaison with Disparities Committee; align with other hospital champions.

☐ Engage in efforts to raise awareness of the issue among faculty and staff, and provide broad education on the issue.

☐ Develop any community-based relationships that are necessary.

Moving to Action

☐ Monitor for disparities by stratifying quality measures by race/ethnicity and presenting findings routinely to leadership via a disparities dashboard.

    • Examples include National Hospital Core Measures of congestive heart failure, acute myocardial infarction, community acquired pneumonia, surgical infection prophylaxis as well as other high-impact measures of interest, such as diabetes and breast, cervical, and colon cancer screening.

    • Standardize processes related to stratification of quality measures.

☐ Develop pilots to address them.

    • Coaching, navigators, community outreach workers.

☐ Expand measurement capabilities to other areas.

Evaluate, Disseminate, Reengineer

☐ Evaluate pilot interventions.

☐ Disseminate points of action and success.

☐ Reengineer efforts as necessary.

Resources

A. The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* *http://www.iom.edu/?id=16740*

B. *HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity and Primary Language from Patients.* *http://www.hretdisparities.org/*

C. *Creating Equity Reports: A Guide for Hospitals.* *http://www.massgeneral.org/disparitiessolutions/resources.html*

D. The Joint Commission's *Hospital, Language and Culture: A Snapshot of the Nation study.* *http://www.jointcommission.org/PatientSafety/HLC/*

   a. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*

   b. *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*

E. The Office of Minority Health. *www.omhrc.gov*

F. The Office of Minority Health's Final Report on *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* *http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf*

G. *Assuring Healthcare Equity: A Healthcare Equity Blueprint.* h*ttp://www.naph.org/Template. cfm?Section=Home&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9428*

H. National Quality Forum. *http://www.qualityforum.org/*

I. The MGH Disparities Committee at Massachusetts General Hospital. *www.mghdisparities.org*

J. The MGH Disparities Dashboard at Massachusetts General Hospital. *http://qualityandsafety.massgeneral.org/measures/equitable.aspx?id=4*

K. Hablamos Juntos, which has the latest information on interpreter services. *www.hablamosjuntos.org*

L. Robert Wood Johnson Foundation's *Speaking Together: National Language Service Network Toolkit* *http://www.rwjf.org/qualityequality/product.jsp?id=29653.* This toolkit provides advice to hospitals on improving quality and accessibility of language services.

M. Robert Wood Johnson Foundation's *Expecting Success: Excellence in Cardiac Care* *http://www.expectingsuccess.org/* aimed at improving quality of cardiac care while reducing racial, ethnic and language disparities and their toolkit available at *http://www.rwjf.org/pr/product.jsp?id=28433*

N. Robert Wood Johnson Foundation's *Finding Answers: Disparities Research for Change* awards and manages research grants totaling $6 million to healthcare organizations implementing interventions aimed at reducing disparities. *http://www.solvingdisparities.org/*

O. Hospitals interviewed for this guide

   a. Baylor Health Care System – *www.baylorhealth.com*

   b. Contra Costa Health Services – *www.cchealth.org*

   c. Cooper Green Mercy Hospital – *www.coopergreenmercyhospital.org*

   d. Duke University Health System – *www.dukehealth.org*

   e. Henry Ford Health System – *www.henryfordhealth.org*

   f. Los Angeles County and University of Southern California Healthcare Network – *www.lacusc.org*

   g. Massachusetts General Hospital – *www.massgeneral.org*

   h. Montefiore Medical Center – *www.montefiore.org*

   i. Seattle Children's Hospital – *www.seattlechildrens.org*

   j. University of Mississippi Medical Center – *www.umc.edu*

P. The Disparities Solutions Center's Archived Web Seminars *http://www.massgeneral.org/disparitiessolutions/web.html*

    a. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders*

    b. *Getting Started: Building a Foundation to Address Disparities through Data Collection*

    c. *Getting it Right: Navigating the Complexities of Collecting Race/Ethnicity Data*

    d. *Collecting Race and Ethnicity Data is Not Enough: Measuring and Reporting Disparities*

    e. *Creating Equity Reports: A Guide for Hospitals*

    f. *Using Multi-Disciplinary Teams to Address Disparities: Navigators, Health Coaches and Community Health Workers*

    g. *QI and the EMR: Identifying and Addressing Disparities in Chronic Disease Management*

    h. *Improving Quality and Addressing Disparities: Accreditation Standards, Market-Strategies and Levers for Action*

Q. PowerPoint presentations (See Appendices B, E and F)

    a. Improving Quality and Achieving Equity: A Guide for Hospital Leaders

    b. Disparities and Quality: Why Now and What Are We Doing About It?

    c. Leading Change

R. Peer-reviewed Articles (See Appendix G)