

Chapter 2 – Why should you care?

“I think the three major arguments for addressing disparities are the quality argument, the caring argument, and the financial argument.”

– William Fulkerson, MD, Chief Executive Officer, Duke University Hospital

Racial and ethnic disparities in health care 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. Addressing disparities is no longer just a moral or ethical imperative – it has now taken on greater importance with significant bottom line implications, and has been acknowledged by Joint Commission and the National Quality Forum as an essential component of quality of care, and as part of community benefit principles. We now present several major “cases” for addressing disparities and achieving equity that are of critical importance to hospital leaders.

The Quality Case: Addressing Disparities, Improving Quality and Achieving Equity

“Health disparities and quality are two sides of the same coin...that’s it in a nutshell. If you’re going to provide quality care and services, then you need to address health disparities.”

– Kimberlydawn Wisdom, MD, Vice President of Community Health, Education and Wellness, Henry Ford Health System

Crossing the Quality Chasm states that to achieve *equity*, systems should provide care that does not vary in quality because of personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status. Equity is the only pillar of quality that was seen as ‘cross-cutting’, meaning that it has implications for safety, effectiveness, patient-centeredness, timeliness, and efficiency. A careful analysis of the pillars of quality provides several important examples of how the inattention to disparities can impede quality of care. The following section provides a summary of these key findings, with efficiency given special attention (see also the five mini-vignettes in Appendix A for practical clinical examples).

Safety

Patients should not be harmed by the care that is intended to help them, and they should remain free from accidental injury, misdiagnosis and inappropriate treatment. Ensuring patient safety also requires that patients be informed and participate as fully as they wish and are able – and that patients and their families should not be excluded from learning about uncertainty, risks, and treatment choices.

“Addressing cultural and linguistic barriers is about saving lives. Any progressive leader can understand that communicating effectively with patients is essential to making healthcare delivery safer. The issue of disparities needs to be embedded in safety policies and procedures.”

– Pete Delgado, CEO, Los Angeles County and University of Southern California Healthcare Network

Disparities and their Impact on Safety

Communication between patients and health care providers, and the barriers many racial/ethnic minorities face in this regard, has an important impact on patient safety. Communication difficulties may lead to misdiagnosis, inappropriate treatment, and limit the process of truly informed consent. We currently have both direct and circumstantial evidence to support the impact of the root causes of disparities on patient safety. For instance:

- 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 by the Joint Commission. Effective communication is compromised by language barriers, cultural differences, and low health literacy, all of which are particularly important issues for racial/ethnic minority patients.⁴

- True informed consent is not possible without effective communication, and according to the Institute of Medicine, “an informed patient is a safe patient.”¹

Exploring patient safety issues through the stratification of medical errors by race and ethnicity should yield improvement opportunities that will not only improve quality, but likely provide cost-savings and yield lessons that will help manage risk.

Effectiveness

Patients should receive care that uses evidence-based guidelines to determine whether an intervention (preventive service, diagnostic test, etc.) produces better outcomes. Included in this principle is the integration of research evidence with clinical expertise (skills to identify each patient’s unique health state and diagnosis, individual risks and benefits of interventions, and personal values and expectations) and patient values (unique preferences brought by each patient to the clinical encounter and must be integrated into clinical decisions).

Disparities and their Impact on Effectiveness

There have been hundreds of carefully controlled studies showing that even when clinically appropriate, minorities tend to receive fewer key diagnostic and therapeutic procedures than their white counterparts. For instance:

- Racial/ethnic minority and limited-English proficient patients are less likely than others to receive some of the most effective, evidence-based treatments for certain conditions.² Racial/ethnic disparities exist in the use of thrombolysis for acute myocardial infarction,³⁸ curative surgery for early non-small cell lung cancer,⁴² renal transplantation for end-stage renal disease,⁴³ and the management of patients with diabetes,⁷¹⁻⁷³ congestive heart failure and community acquired pneumonia,⁴⁴ among many other examples.⁷⁴⁻⁷⁶
- Differences in patient preferences never fully account for the observed racial and ethnic disparities in health care (placement of patients with end-stage renal disease onto the transplantation list is probably the best example in this regard).²

Several of the root causes of disparities (e.g. poor communication, stereotyping, mistrust) contribute to this problem and must be attended to if effectiveness is a priority. Stratifying quality measures by race and ethnicity (i.e. the National Hospital Quality Measures), at a minimum, will allow the opportunity to identify disparities that are amenable to intervention, and improve effectiveness overall.

Patient-Centeredness

The key dimensions of patient-centered care include respect for patient’s values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support; and involvement of family and friends.

“I think the key ‘selling point’ is patient-centered services. I don’t think that there’s a health care executive in the United States that isn’t thinking about the concept of patient and family satisfaction. If you want to deliver patient-centered services, you have to think about issues of equity to make those services more patient-centered.”

– Rohit Bhalla, MD, MPH, Chief Quality Officer, Montefiore Medical Center

Disparities and their Impact on Patient-Centeredness

The key aspects of patient-centered care are indelibly linked to the issues of provider-patient communication, stereotyping, and mistrust, among others that contribute to racial and ethnic disparities in health care. For example:

- Racial and ethnic minorities report more communication difficulties with their doctors, less involvement in clinical decisions, more difficulty understanding instructions on prescription bottles and instructions from their doctor’s offices than their white counterparts.⁷⁷
- Racial and ethnic minorities are more likely to feel like they will receive unequal treatment, than their white counterparts.⁷⁸
- Racial and ethnic minorities feel less satisfied with the quality of care they receive than their white counterparts.⁷⁷

Despite this, not only are routine patient satisfaction survey results (i.e. HCAHPS, Press-Ganey) not stratified at hospitals by race and ethnicity, but often are not administered in multiple languages, and do not include questions specific to issues that are connected to racial and ethnic disparities in health care. Stratification of these survey results by race and ethnicity, administering them in multiple languages, and minor improvements in their content would allow for greater sensitivity in identifying issues related to disparities in patient-centeredness.

Timeliness

Patients should not experience harmful delays in receiving necessary services, and waiting times should constantly be reduced. Health systems must develop multiple ways to meet patient needs.

Disparities and their Impact on Timeliness

Several root causes for disparities have been shown to clearly impact timeliness, and the disparities literature provides several examples where lack of timeliness has led to differences in quality. Overall, minority and limited English proficient patients receive less timely care in a variety of scenarios than their white counterparts.⁷⁹⁻⁸¹ For example:

- Patients with limited-English proficiency have longer waiting times to see a physician in the emergency department⁸¹ and delays in time to appendectomy and time to definitive breast cancer surgery.^{82,83}
- Minorities have longer door-to-needle time for community acquired pneumonia than their white counterparts; they also have longer door-to-balloon time for acute myocardial infarction.⁸⁴
- African-Americans with end-stage renal disease on hemodialysis are less likely to be on the renal transplantation list than their white counterparts.⁴³

Active measurement to assure equity in timeliness is critical to high-quality care for all patients. Systems should be developed to assure that the root causes of disparities do not disproportionately impact the ability of minorities to obtain critical health care services.

The Business Case: Disparities, Efficiency, and the Bottom Line

“Baylor’s focus on Health Equity emerged from its interest in improving quality. We have begun to understand that improving health care quality not only makes the hospital experience safer and more patient-centered, but by also focusing on the improvement of health equity we can simultaneously address avoidable causes of hospitalizations and improve health status for people experiencing disparities in health. As we have begun to address health inequity at Baylor, we have identified opportunities to reduce inefficiencies and waste in the systems of care for a number of minority sub-populations within our health care system. Initially, we have focused upon processes of care changes for low income populations who experience the most health disparities within our community, understanding that these actions were both good medicine and good business.”

– James Walton, DO, VP and Chief Health Equity Officer, Baylor Health Care System

Efficiency is certainly one of the pillars of quality that garners special attention given its link to the financial wellbeing of hospitals, particularly in this time of tight budgets and a contracted health care dollar. New efforts and initiatives often have to either be budget-neutral or show a return-on-investment to justify the expenditure. The ‘efficiency pillar’ states that systems should use resources to get the best value for the money spent. This can be achieved by reducing quality waste and administrative and/or production costs. Some argue that efforts to address racial and ethnic disparities in health care are simply too costly in these challenging financial times—that there is no strong “business case”. A large part of this viewpoint centers on the perception that addressing disparities requires significant cost outlays without clear cost savings. However, a more careful review of the evidence highlights how being inattentive to the root causes of disparities adversely impacts efficiency and the hospital bottom line.

Disparities and their Impact on Efficiency and Cost

- **Medical Errors:**

Patients with limited-English proficiency have more medical errors, with greater clinical consequences, than their white counterparts.^{3,85,86} Line infections, falls, bed sores all may be more common with minority patients who may not be able to communicate effectively with their health care providers—whether it be due to limited-English proficiency, mistrust, or a cultural perception that clinicians are authority figures who shouldn't be questioned. These situations undoubtedly have an impact on efficiency and cost, likely leading to complications that require a prolonged length of stay, and tying up beds that could be used for other services. Even greater financial risk now exists with the Centers for Medicare and Medicaid Services non-reimbursable “never-events,” many of which can be prevented by an empowered patient who can communicate clearly with their health care providers.^{12,87,88} Devising systems to address the root causes of disparities, particularly those related to communication (through the implementation of interpreter services, training in cross-cultural communication for health care providers and staff, etc.), should certainly improve safety and provide both immediate and long-term cost savings.

- **Inappropriate Test Ordering:**

Communication difficulties (due to language barriers or cultural barriers) can lead health care providers to order expensive tests (such as CT Scans) for conditions that could have been diagnosed through basic history-taking.⁶ This is particularly the case in the emergency setting. Interpreter services can assist health care providers in obtaining an accurate history that in turn prevents the knee-jerk ordering of high-priced tests. This can lead to significant cost-savings and reduction of risk of medical errors (i.e. contrast allergy, IV infection). Finally, limited resources, like CT Scans, will not be inappropriately tied-up and instead used more effectively for those patients who really require them. Investing in systems to assure that a history can be taken effectively in patients of diverse cultural and linguistic populations should decrease inappropriate utilization of potentially high-priced diagnostic procedures, and in turn improve safety and efficiency.

- **Length of Stay:**

Patients with limited-English proficiency have longer hospital stays than English-speakers 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.⁸⁹ There may be many reasons for these findings, but there is no doubt that addressing language and communication barriers can expedite the discharge process and thus decrease length-of-stay and increase efficiency. This issue takes on particular importance for hospitals that run at capacity, as they are often prevented from reliably scheduling high-revenue generating elective surgical procedures, and frequently need to go on emergency room diversion because of bed shortages. Developing strategies for case management (i.e. cross-cultural training, access to interpreter services) that are able to address the cultural and linguistic needs of patients may in turn improve the efficiency of the discharge process and decrease length of stay for these patients.

- **Readmissions:**

Minorities are more likely to be readmitted for certain chronic conditions⁷⁻⁹ – such as congestive heart failure (CHF) – than their white counterparts.¹⁰ This may be due to the fact that when a patient has limited-English proficiency, low literacy, or other communication barriers, they may be more likely to misunderstand discharge instructions. As a result, the risk for readmission may be higher, particularly for chronic conditions (e.g. CHF) in which diet, weight management and adherence to a complex medication regimen is essential. This issue will take on greater financial importance if the Centers for Medicare and Medicaid Services decide to limit or refuse reimbursement for patients with CHF who are readmitted within 30 days of discharge.^{11,12} Given that minorities suffer at greater rates from cardiovascular disease and congestive heart failure, collecting race and ethnicity data to identify patients-at-risk for readmission, and developing targeted discharge planning that addresses cultural and linguistic needs, should be a worthy investment that will improve efficiency and provide cost-savings.

- **Ambulatory Care Sensitive/Avoidable Admissions:**

Minorities may be at greater risk for ambulatory care sensitive/avoidable hospitalizations for chronic conditions (hypertension and asthma) than whites.⁹¹ Contributing to this risk is the fact that minorities, even with health insurance, are less likely to have a medical home where these issues can be better managed in the outpatient setting. The issue of medical homes has garnered significant attention recently as a method of improving quality and it may also play a major role in addressing racial and ethnic disparities in health care. Targeted efforts to support systems that facilitate a medical home for all patients within hospital outpatient settings – including the development of strategies to address cultural and linguistic barriers to care – has the potential to improve quality, efficiency, and equity, as well as save costs.

- **Pay-for-Performance:**

Pay-for-performance is gaining traction as a method for addressing quality of care. For example, health plans are increasingly including pay-for-performance measures for conditions such as diabetes in their contracting with provider organizations, and public payors are also beginning to move in this direction. Some of these contracts have also started including provisions that look to address racial and ethnic disparities in health care – and it is expected this trend will become more widespread over time.⁹² For example, in Massachusetts health care reform linked Medicaid hospital rate increases to various quality measures including the measurement and reduction of racial and ethnic disparities in health care.⁹³ As these initiatives become more evolved, hospitals will undoubtedly have to develop systems to track patients by race and ethnicity, monitor quality, and develop strategies to address disparities. From a financial standpoint this will be particularly important for conditions where pay-for-performance is taking root, such as diabetes.

“With investing in reducing disparities comes fewer errors and this in turn reduces costs.”

– Pat Hagan, MHA Chief Operating Officer and President, Seattle Children’s Hospital

In summary, there are several clear examples of how disparities, when left unattended can impact efficiency and cost. The development of initiatives in a variety of areas—as described above—can not only improve efficiency, but provide both financial gain and cost savings in the short and long-term, all the while improving quality.

The Risk Management Case: Addressing Disparities and Limiting Risk

Identifying areas that expose the hospital or its health care providers to liability is critical in managing risk. When such situations are identified, there is an opportunity to engage in a set of activities that can prevent tort and untoward settlements – which can be both costly as well as detrimental from a public relations standpoint. There are multiple liability exposures that arise when providing care to diverse patient populations. They include situations that relate to:⁹⁴

- Patient comprehension of their medical condition, treatment plan, discharge instructions, complications and follow-up.
- Inaccurate and incomplete medical history.
- Ineffective or improper use of medications or serious medication errors.
- Improper preparation for tests and procedures.
- Poor or inadequate informed consent.
- Use of interpreters who are not properly trained, cannot accurately translate medical terms and conditions or are not adequately conversant in the patient’s and physician’s languages.

Many of these areas also constitute patient safety issues, and therefore take on added importance. For example, a patient’s ability to read, understand and act on health information has a direct impact on the physician-patient interaction and patient safety. As it relates to prescriptions, a patient’s ability to know if they have received the correct medication, or their ability to follow instructions regarding their medication (including dose, frequency and time), both constitute safety and risk management scenarios. Written communications, in the form of appointment slips (appropriate time, date, location), referral slips (reason for referral, name and location of provider, instructions regarding preparation), intake and discharge instructions, and most commonly, informed consent, are all fair game for liability.

Risk management experts have recently reviewed case law and settlements with an eye towards issues related to patients’ race, ethnicity, culture, and language proficiency.⁹⁴ Communication issues represent a key component of claims filed

by patients whose culture, ethnicity, religion and/or English language ability differ from that of the physician or other healthcare provider. Hallmarks of poor communication leading to tort have included:

- insufficient explanations
- discounting pain and suffering
- failure to recognize or take into account the patient's cultural, religious, or ethnic beliefs
- the use of language suggesting abandonment

Settlements related to communication problems between the patient/family and provider have centered on lack of, or inadequate informed consent for surgical or invasive procedures as well as inadequate identification of provider and/or provider's professional designation; inadequate understanding of explanation, educational material, follow-up instructions and/or discharge instructions; inadequate information provided regarding adverse events and proposed corrective action; poor or negative rapport; and poor telephone communication.

In sum, identifying root causes for disparities that are centered on race, ethnicity, culture, or language proficiency may provide an opportunity to manage risk. As our patient population becomes increasingly diverse, settlements in the area of disparities will no doubt continue to emerge. Developing mechanisms to identify and address disparities will improve patient safety and minimize risk.

The Accreditation and Regulation Case: New Standards and Measures for Quality and Equity

“Hospitals pay very close attention to Joint Commission and their upcoming requirements, goals, etc. and they really do set the stage and foundation for what hospitals try to become.”

– California Hospital Quality Leaders: Views on Culturally and Linguistically Appropriate Services (CLAS) & the Potential Role of the Joint Commission: Summary of Key Findings

The previous sections provide a solid and compelling rationale for hospitals and other health care organizations to identify and address disparities in care. Improving quality, addressing efficiency and cost, and managing risk are powerful drivers. However, one of the true signs that the issue of addressing disparities and achieving equity is becoming mainstream is the attention the issue has received from the Joint Commission. The Joint Commission has published two reports based on its project *Hospitals, Language and Culture: A Snapshot of the Nation*, a national, qualitative study exploring how 60 hospitals across the country provide health care to culturally and linguistically diverse patient populations.^{95,96} This project is the first of its kind in the nation, and the fact that it has been taken on by the Joint Commission foreshadows the development of new accreditation standards in this arena. The most recent Joint Commission report, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations* provides a set of recommendations for hospitals on how to effectively provide culturally and linguistically appropriate services to their patients, and includes items on measuring and addressing racial and ethnic disparities in health care.⁹⁶ The Joint Commission is now beginning a project to develop standards based on the findings above, which will be much more rigorous than their current standards for culturally and linguistically appropriate services. These will likely go into effect in 2010, yet hospitals will need to begin planning for these new measures well in advance.

Similarly, the National Quality Forum is working on a series of quality measures with particular attention to the provision of culturally and linguistically appropriate services.⁶⁹ These measures are being developed to guide hospitals on systems development in the area of disparities and equity, and will also serve for national benchmarking purposes. The planned release date for these measures is 2009.

Finally, as the issue 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.⁹⁷ Based on findings from the Senate Finance Committee, hospitals with not-for-profit status are under greater scrutiny by the Internal Revenue Service, Congress and state officials, and will need to demonstrate what they do in return for their tax exemptions.⁹⁸ Community based efforts to address the root causes of disparities – such as the use of community health workers, navigators, and coaches – have successfully been reported as community benefit activities.⁹⁹