



Healthcare Quality Reporting Program

STEERING COMMITTEE

11/25/13, 3-4:30pm

Department of Health, Room 401

Facilitation: Rosa Baier, MPH and Samara Viner-Brown, MS

Recorder: Ann Messier

Voting Members

- | | | |
|---|--|--|
| <input type="checkbox"/> Ted Almon | <input type="checkbox"/> Michael Fine, MD (<i>Chair</i>) | <input type="checkbox"/> Nicholas Oliver, MPA, CAE |
| <input type="checkbox"/> David Ashley, MD | <input type="checkbox"/> Neal Galinko, MD, MS, FACP | <input type="checkbox"/> Paula Parker, LCSW |
| <input type="checkbox"/> Rep. David Bennett | <input type="checkbox"/> Diane Gallagher | <input type="checkbox"/> Donna Policastro, NP, RCN |
| <input type="checkbox"/> Virginia Burke, Esq. | <input type="checkbox"/> Deidre Gifford, MD, MPH | <input type="checkbox"/> Louis Pugliese |
| <input type="checkbox"/> Tracey Cohen, MD | <input type="checkbox"/> Linda McDonald, RN | <input type="checkbox"/> Gina Rocha, RN, MPH |
| <input type="checkbox"/> Bradley Collins, MD | <input type="checkbox"/> Jim Nyberg | |

Agenda

- 3:00pm **Open Meeting**
Michael Fine, MD, Chair
- Welcome and meeting objectives
 - Review the previous meeting's action items:
 - Invite state senate representative (Dr. Fine/Sam)
 - Provide July Advisory Letter to the committee with the minutes (Rosa/Emily)
 - Share flu reports with the home health and nursing home trade associations (Rosa)
 - Develop DUA for the HIT Survey (Rebekah/Rosa/Emily)
 - Invite Kim Paull to speak about the APCD (Rosa)
- 3:10pm **All Payor Claims Database (APCD)**
Rosa Baier, MPH, Facilitator
Kim Paull, Guest Presenter
- Discuss relationship between program and the APCD (see legislation)
 - Introduce Kim Paull, Director of Analytics at OHIC for guest presentation
 - Discuss the APCD:
 - What are the APCD's goals?
 - How is it being developed and launched?
 - What data will be included?
 - When and how will the data be available?
 - How can the Steering Committee assist with the APCD?
 - What data will be available to the program for reporting?

3:40pm HIT Survey*Rosa Baier, MPH, Facilitator**Emily Cooper, MPH, Facilitator*

- Review data-sharing discussion
- Discuss draft Data Use Agreement (see handout):
 - Does this address all of the survey's privacy concerns?
 - Is there anything we should add or remove?
- Provide update on 2014 survey revisions and next steps

4:00pm Hospital and Nursing Home Summary Reports*Rosa Baier, MPH, Facilitator**Emily Cooper, MPH, Facilitator*

- Review the objectives:
 - Consolidate information for consumers
 - (Nursing home report) Include information for hospital case managers
 - (Nursing home report) Provide data files to hospital case managers (*new*)
- Approve the updated draft report templates (handouts)
- Discuss next steps

4:15pm Other Business/Announcements*Rosa Baier, MPH, Facilitator*

- Program updates:
 - Preliminary research re: treatment equality measures
 - Web analytics (see handouts)
 - Nursing home satisfaction survey process
- Open Forum
- Action items
- **Next meeting: 1/27/14**



Healthcare Quality Reporting Program
STEERING COMMITTEE DATA UPDATES

11/25/13

Data Updates (Reports, Oldest to Newest by Setting)	Update Frequency	Last Updated	Comments
Home Health			
• Clinical quality measures from Medicare	Quarterly	Nov 2009	Now links to Home Health Compare
• Patient satisfaction	2 years	June 2011	Discontinued at agencies' request
• Employee influenza vaccination rates	Annually	Sept 2013	
Hospital			
• Clinical quality measures from Medicare	Quarterly	May 2011	Now links to Hospital Compare
• Hand hygiene processes	Annually	March 2013	
• Surgical Care Infection Program (SCIP) Measures	Quarterly	May 2012	Now links to Hospital Compare
• Central-Line Associated Bloodstream Infections (CLABSI)	Quarterly	Sept 2012	Now links to Hospital Compare
• Pressure ulcer incidence	Quarterly	Sept 2009	Now links to Hospital Compare
• Employee influenza vaccination rates	Annually	Sept 2013	
• MRSA CLABSI incidence	Quarterly	Oct 2013	
• <i>C. Difficile</i> incidence	Once	Nov 2012	Will be reported by Hospital Compare in Jan 2014 (tentatively)
Nursing Home			
• Clinical quality measures from Medicare	Quarterly	Feb 2011	Now links to Nursing Home Compare
• Resident and family satisfaction	Annually	Feb 2013	2014 in progress
• Employee influenza vaccination rates	Annually	Sept 2013	
Licensed Independent Practitioners (Physicians, APRNs, PAs)			
• HIT adoption	Annually	Mar 2013	2014 in progress

TITLE 23

Health and Safety

CHAPTER 23-17.17

Health Care Quality Program

SECTION 23-17.17-9

§ 23-17.17-9 Health care quality and value database. – (a) The director shall establish and maintain a unified health care quality and value database to:

- (1) Determine the capacity and distribution of existing resources;
- (2) Identify health care needs and inform health care policy;
- (3) Evaluate the effectiveness of intervention programs on improving patient outcomes;
- (4) Compare costs between various treatment settings and approaches;
- (5) Provide information to consumers and purchasers of health care;
- (6) Improve the quality and affordability of patient health care and health care coverage;
- (7) Strengthen primary care infrastructure;
- (8) Strengthen chronic disease management;
- (9) Encourage evidence-based practices in health care.

(b) The program authorized by this section shall include a consumer health care quality and value information system designed to make available to consumers transparent health care price information, quality information and such other information as the director determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(c) The health care quality steering committee shall serve as the working group to advise the director on the development and implementation of the consumer health care quality and value information system.

(d) The director, in collaboration with the health insurance commissioner, may require an insurer covering at least five percent (5%) of the lives covered in the insured market in this state to file with the director a consumer health care price and quality information plan in accordance with regulations adopted by the director pursuant to this section.

(e) The director shall adopt such regulations as are necessary to carry out the purposes of this section and this chapter. The regulations may permit the gradual implementation of the consumer health care quality and value information system over time, beginning with health care price and quality information that the director determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The regulations shall permit insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The regulations shall avoid unnecessary duplication of efforts relating to price and quality reporting by insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their reporting obligations under this chapter and other chapters of the general laws.

(f) Requirements for reporting to the health care quality database enumerated in this section and subsequent sections of this chapter shall not apply to insurance coverage providing benefits for:

- (1) Hospital confinement indemnity;
- (2) Disability income;
- (3) Accident only;
- (4) Long-term care;
- (5) Medicare supplement;
- (6) Limited benefit health;
- (7) Specified disease indemnity;
- (8) Sickness or bodily injury or death by accident or both; or
- (9) Other limited benefit policies.

History of Section.

(P.L. 2008, ch. 114, § 1; P.L. 2008, ch. 207, § 1.)

TITLE 23

Health and Safety

CHAPTER 23-17.17

Health Care Quality Program

SECTION 23-17.17-10

§ 23-17.17-10 Reporting requirements for the health care database. – (a) Insurers, health care providers, health care facilities and governmental agencies shall file reports, data, schedules, statistics or other information determined by the director to be necessary to carry out the purposes of this chapter. The reports required by this chapter shall be accepted by the director in any certification commission for health care information technology ("CCHIT") certified form. Such information may include:

- (1) health insurance claims and enrollment information used by health insurers;
- (2) information relating to hospital finance; and
- (3) any other information relating to health care costs, prices, quality, utilization, or resources required to be filed by the director.

(b) The comprehensive health care information system shall not collect any data that contains direct personal identifiers. For the purposes of this section "direct personal identifiers" includes information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number and social security number. All data submitted to the director pursuant to this chapter shall be protected by the removal of all personal identifiers and the assignment by the insurer to each subscriber record of a unique identifier not linked to any personally identifiable information.

History of Section.

(P.L. 2008, ch. 114, § 1; P.L. 2008, ch. 207, § 1.)

TITLE 23

Health and Safety

CHAPTER 23-17.17

Health Care Quality Program

SECTION 23-17.17-11

§ 23-17.17-11 Data collection and information sharing for the health care database. – (a) All insurers shall electronically provide to the director in accordance with standards and procedures adopted by the director in regulation:

- (1) their health insurance claims data;
- (2) cross-matched claims data on requested members, subscribers or policyholders; and
- (3) member, subscriber or policyholder information necessary to determine third-party liability for benefits provided.

(b) For purposes of all data collection and public reporting of data under this chapter the collection, storage and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be governed by the rules adopted in 45 C.F.R. Parts 160 and 164 and other applicable law.

(c) All insurers that collect the health employer data and information set (HEDIS) shall annually submit the HEDIS information and such other relevant industry quality standard measures as the director requires to the director in a form and in a manner prescribed by the director.

(d) The director shall collaborate with the insurance commissioner within the department of business regulation and all health and human service agencies in the development of a comprehensive health care information system and shall make all data collected pursuant to this chapter available to the insurance commissioner and all relevant government agencies in furtherance of the goals of the database set forth herein. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited use data sets, the criteria and procedures to ensure the HIPAA compliant limited use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(e) To the extent allowed by HIPAA and other applicable law, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures and performance in Rhode Island and to enhance the ability of Rhode Island consumers and employers to make informed and cost-effective health care choices. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors and institutional size.

(f) The health care quality steering committee shall advise the director as to the most effective means to make the database accessible to the public for purposes of improving the quality of health care services in Rhode Island.

(g) The director shall adopt regulations to carry out the provisions of this chapter, including standards and procedures and criteria for the required filing of such claims data, eligibility data, provider files and other information as the director determines to be necessary to carry out the purposes of this section and this chapter.

History of Section.

(P.L. 2008, ch. 114, § 1; P.L. 2008, ch. 207, § 1.)



Healthcare Quality Reporting Program

HIT SURVEY DATA USE AGREEMENT

10/24/13

The Recipient acknowledges that access to the Rhode Island Health Information Technology (HIT) Survey dataset(s) is granted solely upon the condition that I agree to abide by the terms set forth in this Agreement.

Part A – ABOUT THE HIT SURVEY

The Rhode Island Department of Health's Healthcare Quality Reporting Program administers the [HIT Survey](#)^{*} annually to licensed independent practitioners (LIPs) in RI.

The survey began with physicians and expanded to include advanced practice registered nurses (APRNs) and physician assistants (PAs). Survey data are collected using an online survey tool and merged with licensure data to create the datasets and public reports.

Each year, the program publicly reports [five measures of EMR adoption](#)[†] calculated using survey results at the individual practitioner level. Survey non-respondents are included in the datasets and reported as failing the five measures. **The public report is limited to LIPs in active practice and includes name, RI license number, practice state (RI, MA or CT), specialty and HIT adoption measure scores. These data elements are publicly available without a data use agreement.**

Part B – ALLOWABLE AND PROHIBITED USES

This Agreement is required for access to datasets containing any individual-level survey results in addition to those published in the public reports, *unless the requestor's proposed use of the data is disclosed to survey respondents at the time of survey completion*. **Under this Agreement, the only permitted use is aggregate analyses.**

- The dataset cannot be released (in whole or part) to any person other than those individuals or classes of individuals listed in this Agreement. The Recipient will ensure that all approved collaborators understand that they may not share the data set or any part of it.
- The Recipient will not use nor permit the use of these data to conduct analyses other than those described in this Agreement.
- Responses cannot be analyzed or otherwise examined at the individual respondent level.
- Recipients cannot search for specific individuals.
- Respondents may not be contacted using the contact information in the datasets.[‡]
- Respondents may not be contacted based on their responses to specific questions.[‡]
- Data cannot be published, presented or disseminated at the individual respondent level.
- All oral or written presentations of the results of the analyses must be submitted to the Rhode Island Healthcare Quality Reporting Program prior to presentation or submission to a journal.
- All oral or written presentations of the results of the analyses will include an acknowledgment of the Rhode Island Department of Health and the Healthcare Quality Reporting Program.
- When the proposed analyses are completed, all copies of these data will be destroyed (confirmed in writing) or returned to the Rhode Island Healthcare Quality Reporting Program.

^{*} Available: www.health.ri.gov/physicians/about/quality

[†] Available: www.health.ri.gov/publications/qualityreports/physicians/HealthInformationTechnology/SurveyMeasures2012.pdf

[‡] Publicly-available contact information is available for download at: <http://www.health.ri.gov/lists/licensees/>

Part C – AVAILABLE DATASETS

The Recipient is requesting data for the following year(s):[§]

2009

2011

2013

2015

2010

2012

2014

2016

The Recipient is requesting the following dataset (*select the dataset with the minimum information required*):**

Public report, which includes name, RI license number, practice state (RI, MA or CT only), specialty and HIT adoption measure scores [*Stop; a Data Use Agreement is not required*]

Public use, which includes everything in the public report, plus all survey responses used to calculate the measures

Stakeholder, which includes every survey response EXCEPT: Barriers, EMR considered, graduation date and percent Medicaid patients

Research, which includes all survey responses

Part D – PROJECT INFORMATION

This dataset(s) will be used solely for the following (*describe use and list any plans to merge with other datasets*):

The purpose of this project/use is to (*list objectives*):

The Recipient will limit access of the dataset(s) to the following individuals or classes of individuals (*list names or roles*):

If the Recipient becomes interested in pursuing a different topic of interest, a separate request will be made with the Rhode Island Healthcare Quality Reporting Program and a separate Data Use Agreement must be submitted.

If the Recipient would like to share the dataset with individuals or classes of individuals not listed above, a separate request will be made with the Rhode Island Healthcare Quality Reporting Program and a separate Data Use Agreement must be submitted.

[§] Data for 2009-2013 are limited to physicians. APRN and PA data are included beginning in 2014.

** Survey instruments and data dictionaries are available upon request: HITSurvey@health.ri.gov

Part E – STIPULATIONS AND CONDITIONS

The Recipient agrees to the following conditions and stipulations:

1. The information contained in this dataset(s) is necessary for the purposes described above;
2. These data will not be used or further disclosed other than as permitted by this Agreement;
3. Appropriate safeguards will be implemented to prevent use or disclosure other than permitted by this Agreement;
4. Upon learning of any use or disclosure of information not provided for by this Agreement, such unauthorized use or disclosure will be reported to the Healthcare Quality Reporting Program;
5. Should the Recipient fail to comply with the terms and conditions of this Agreement, access to the dataset(s) will be terminated immediately, and all data will be returned to the Healthcare Quality Reporting Program.
6. Any individuals or subcontractors to whom this dataset(s) is provided (named above) must first agree to the same restrictions and conditions set forth in this Agreement; and
7. Any new organizations that wish to access this dataset(s) must complete a separate Data Use Agreement.

Part F - SIGNATURES

The parties signing below agree to the conditions in this Agreement.

The Recipient also accepts responsibility for any misuse of the information provided and agrees to hold the Rhode Island Department of Health harmless for such misuse. Unauthorized use or disclosure of data may be punishable, upon conviction, by a fine and/or imprisonment or both, and/or civil penalties as prescribed by law.

Recipient of the dataset(s):

Signature of Recipient

Date

Name of Recipient (Print)

Organization

Address

City

State

ZIP Code

Phone

Email

Authorized Representative of the Healthcare Quality Reporting Program:

Signature of Authorized Representative

Date

Name of Authorized Representative (Print)

Phone

Email



Healthcare Quality Reporting Program Nursing Home Summary Report

The Rhode Island Department of Health publishes information about nursing homes. If you know that you or a family member will need nursing home care, this information can help you compare nursing homes and choose among them. You may also want to visit nursing homes and to ask friends and family members for their thoughts and experiences.

This report summarizes information from the Department of Health (www.health.ri.gov/nursinghomes/about/quality) and Medicare (www.medicare.gov/nursinghomecompare). Reports with more information are available at those websites.

This report is updated every time there is new information for one of the columns below. You can learn more about what is in this report, including definitions and time periods for each column of information, by reading the Methods Report. Please contact nursing homes directly with questions, to inquire about private insurance, to check on bed availability or to schedule a tour.

Contact Information:				Capacity			Certification		Quality And Satisfaction:				
Facility,				Number of Beds	Number of Skilled Beds	Secure Dementia Unit	Medicare	Medicaid	Quality Of Care	Resident Satisfaction	Family Satisfaction	Healthcare Workers Who Received	Influenza Vaccination
Alphabetical By County	City	Phone	Fax										
Bristol County													
Crestwood Nursing Home	Warren			76									
Grace Barker Nursing Home	Warren			86									
Saint Elizabeth Manor, East Bay	Bristol			133									
Silver Creek Manor	Bristol			128									
Warren Skilled Nursing & Rehabilitation	Warren			63									
Kent County													
Alpine Nursing Home	Coventry			60									
Avalon Nursing Home	Warwick			31									
Brentwood Nursing Home	Warwick			96									

Reports with more information about quality and satisfaction are available at www.health.ri.gov/nursinghomes/about/quality.



Healthcare Quality Reporting Program

Hospital Summary Report

The Rhode Island Department of Health publishes information about hospitals. If you know that you or a family member will need hospital care, this information can help you compare hospitals and choose among them. You may also want to ask your doctor, friends and family members for their thoughts and experiences.

This report summarizes information from the Department of Health (www.health.ri.gov/hospitals/about/quality) and Medicare (www.medicare.gov/hospitalcompare). Reports with more information are available at those websites.

This report is updated every time there is new information for one of the columns below. Some of the information is for all patients in the hospital and some is for patients receiving intensive care. You can learn more about what is in this report, including the patients included, definitions and time periods for each column of information, by reading the Methods Report. Please contact hospitals directly with questions.

Contact Information:	Quality:	Emergency Department (ED):	Infections:	Satisfaction:
Facility, Alphabetical Bradley Hospital Butler Hospital Eleanor Slater Hospital Kent Hospital Landmark Medical Center Memorial Hospital Newport Hospital Our Lady of Fatima Hospital Rhode Island Hospital Roger Williams Medical Center South County Hospital The Miriam Hospital The Westerly Hospital Women & Infants' Hospital	Falls and Injuries Severe Pressure Sores (Bed Sores) Rate of Readmission after Discharge Serious Surgical Complications	Average time spent in the ED before being seen by a healthcare professional Average time spent in ED after the doctor decided to admit them before being taken to their inpatient room	Catheter-Associated Urinary Tract Infections Central Line-Associated Bloodstream Infections C. Difficile Infections Hand Hygiene is Measured Healthcare Workers Who Received Flu Vaccination MRSA Bloodstream Infections	Patients who Reported The Hospital Was Clean Patients who Gave Their Hospital a 9 or 10 Patients who Would Recommend the Hospital

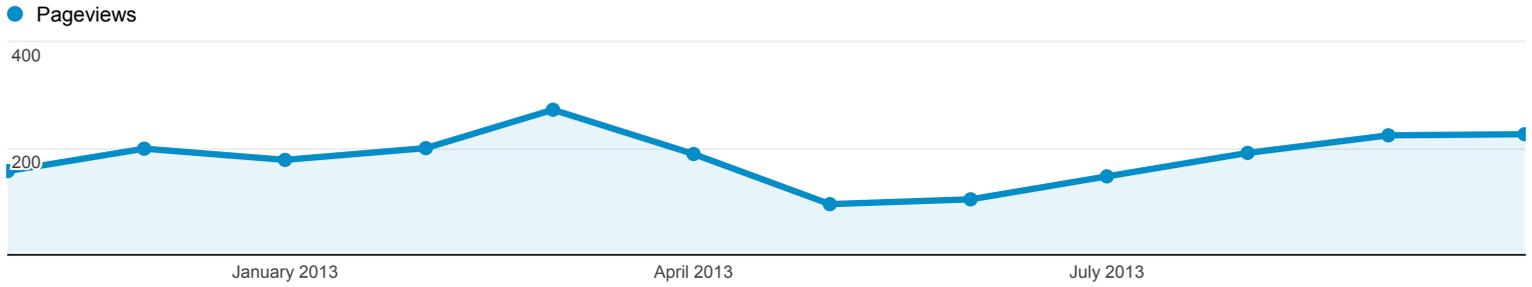
◆ *Worse than expected*, ◆◆ *about the same as expected*, ◆◆◆ *better than expected*
 Reports with more information are available at www.health.ri.gov/hospitals/about/quality.

Main Page

Nov 1, 2012 - Oct 31, 2013

All Visits
0.06%

Report Tab



Month of Year	Pageviews	Unique Pageviews	Avg. Time on Page	% Exit	Bounce Rate
	2,182 % of Total: 0.06% (3,525,901)	1,428 % of Total: 0.06% (2,351,759)	00:00:43 Site Avg: 00:01:43 (-58.68%)	19.02% Site Avg: 35.85% (-46.94%)	43.29% Site Avg: 48.58% (-10.90%)
1. 201211	157	102	00:00:26	10.83%	14.29%
2. 201212	199	128	00:00:42	14.07%	38.89%
3. 201301	178	130	00:00:38	16.29%	29.03%
4. 201302	200	142	00:00:28	15.00%	42.86%
5. 201303	272	165	00:00:57	19.85%	40.58%
6. 201304	189	125	00:00:21	20.11%	51.43%
7. 201305	95	75	00:00:29	27.37%	54.55%
8. 201306	104	70	00:00:49	19.23%	33.33%
9. 201307	147	99	00:00:54	24.49%	66.67%
10. 201308	191	121	00:00:53	26.18%	56.25%
11. 201309	224	122	00:00:49	18.30%	38.64%
12. 201310	226	149	00:00:54	20.35%	36.17%

Rows 1 - 12 of 12

Nursing Home Reports

Nov 1, 2012 - Oct 31, 2013

All Visits
0.21%

Month



Month of Year	Pageviews	Unique Pageviews	Avg. Time on Page	% Exit	Bounce Rate
	7,304 % of Total: 0.21% (3,525,901)	4,151 % of Total: 0.18% (2,351,759)	00:01:56 Site Avg: 00:01:43 (12.83%)	38.73% Site Avg: 35.85% (8.05%)	52.38% Site Avg: 48.58% (7.82%)
1. 201211	694	376	00:01:38	36.17%	52.60%
2. 201212	627	303	00:01:51	30.14%	45.65%
3. 201301	899	473	00:01:57	34.93%	45.59%
4. 201302	707	373	00:02:07	34.94%	54.23%
5. 201303	643	377	00:01:38	41.21%	56.11%
6. 201304	727	400	00:01:31	37.55%	55.28%
7. 201305	376	222	00:01:51	42.02%	55.46%
8. 201306	436	272	00:02:01	40.60%	48.18%
9. 201307	580	366	00:02:16	44.14%	55.14%
10. 201308	554	358	00:02:25	45.31%	57.14%
11. 201309	520	312	00:02:00	40.58%	48.34%
12. 201310	541	319	00:02:16	43.81%	53.29%

Rows 1 - 12 of 12

Hospital Reports

Nov 1, 2012 - Oct 31, 2013

All Visits
0.05%

Report Tab



Month of Year	Pageviews	Unique Pageviews	Avg. Time on Page	% Exit	Bounce Rate
	1,742 % of Total: 0.05% (3,525,901)	1,198 % of Total: 0.05% (2,351,759)	00:00:54 Site Avg: 00:01:43 (-47.58%)	35.48% Site Avg: 35.85% (-1.03%)	62.17% Site Avg: 48.58% (27.97%)
1. 201211	164	108	00:01:10	29.88%	56.52%
2. 201212	155	80	00:00:34	21.29%	53.33%
3. 201301	109	82	00:00:55	32.11%	65.52%
4. 201302	198	146	00:01:11	42.42%	68.60%
5. 201303	192	133	00:00:56	34.38%	53.62%
6. 201304	172	120	00:00:46	36.63%	53.62%
7. 201305	88	67	00:01:06	48.86%	69.77%
8. 201306	91	65	00:00:45	35.16%	65.79%
9. 201307	129	97	00:00:59	42.64%	68.00%
10. 201308	128	93	00:00:31	46.88%	66.67%
11. 201309	155	101	00:00:52	29.03%	72.97%
12. 201310	161	106	00:01:01	32.92%	54.17%

Rows 1 - 12 of 12

Home Health Reports

Nov 1, 2012 - Oct 31, 2013

All Visits
0.03%

Report Tab



Month of Year	Pageviews	Unique Pageviews	Avg. Time on Page	% Exit	Bounce Rate
	991 % of Total: 0.03% (3,525,901)	609 % of Total: 0.03% (2,351,759)	00:01:13 Site Avg: 00:01:43 (-29.28%)	28.15% Site Avg: 35.85% (-21.46%)	56.44% Site Avg: 48.58% (16.18%)
1. 201211	79	48	00:01:09	32.91%	71.43%
2. 201212	79	43	00:01:18	25.32%	77.78%
3. 201301	99	49	00:00:43	18.18%	57.14%
4. 201302	77	41	00:01:18	27.27%	77.78%
5. 201303	102	59	00:01:08	22.55%	35.29%
6. 201304	76	46	00:01:21	26.32%	75.00%
7. 201305	58	41	00:01:10	24.14%	42.86%
8. 201306	71	52	00:00:35	36.62%	35.71%
9. 201307	70	54	00:01:29	34.29%	66.67%
10. 201308	85	55	00:01:12	28.24%	45.00%
11. 201309	123	73	00:01:28	30.08%	50.00%
12. 201310	72	48	00:01:50	36.11%	61.54%

Rows 1 - 12 of 12

INSTITUTE OF MEDICINE

Shaping the Future for Health

UNEQUAL TREATMENT: WHAT HEALTHCARE PROVIDERS NEED TO KNOW ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTH- CARE

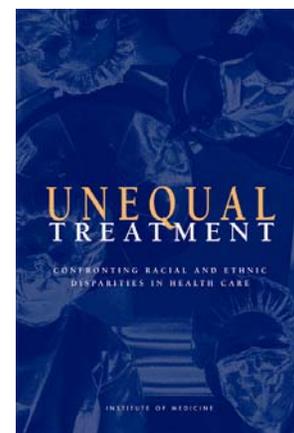
News accounts of the state of healthcare delivery seem to be full of bad news, including concerns about rising healthcare costs, patient safety and medical errors, and the growing numbers of uninsured Americans. To add to these problems, many recent news reports indicate that racial and ethnic minorities receive lower quality healthcare than whites, even when they are insured to the same degree and when other healthcare access-related factors, such as the ability to pay for care, are the same.

The Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, added to the media fray when the IOM concluded that “(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.”

This finding was alarming to many healthcare professionals, the vast majority of whom work hard under very challenging conditions to ensure that patients receive the best possible healthcare to meet their needs. How could bias, prejudice, and stereotyping contribute to unequal treatment, particularly given that healthcare providers are sworn to beneficence and cannot, by law, discriminate against any patient on the basis of race, ethnicity, color, or national origin? This brief summary of the IOM *Unequal Treatment* report addresses this question, and summarizes other relevant findings to help healthcare professionals meet the objective of providing high-quality care for all patients.

DO RACIAL AND ETHNIC MINORITIES RECEIVE A LOWER QUALITY OF HEALTHCARE?

In 1999, Congress requested that the IOM assess the extent of racial and ethnic disparities in healthcare, assuming that access-related factors – such as insurance status and the ability to pay for care are the same; identify potential sources of these



...the IOM concluded that “(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.”

disparities, including the possibility that overt or subtle biases or prejudice on the part of healthcare providers might affect the quality of care for minorities; and suggest intervention strategies.

To fulfill this request, an IOM study committee reviewed well over 100 studies that assessed the quality of healthcare for various racial and ethnic minority groups, while holding constant variations in insurance status, patient income, and other access-related factors. Many of these studies also controlled for other potential confounding factors, such as racial differences in the severity or stage of disease progression, the presence of co-morbid illnesses, where care is received (e.g., public or private hospitals and health systems) and other patient demographic variables, such as age and gender. Some studies that employed more rigorous research designs followed patients prospectively, using clinical data abstracted from patients' charts, rather than administrative data used for insurance claims. The study committee was struck by the consistency of research findings: even among the better-controlled studies, the vast majority indicated that minorities are less likely than whites to receive needed services, including clinically necessary procedures. These disparities exist in a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures, including routine treatments for common health problems.

WHAT ARE THE SOURCES OF HEALTH CARE DISPARITIES?

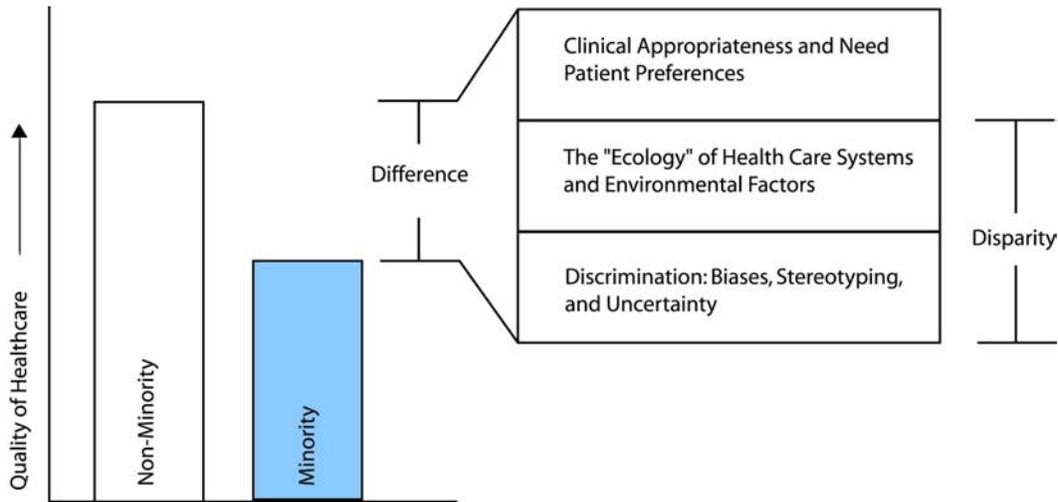
Many factors may contribute to the health care disparities observed in these studies. Some researchers suggest that there may be subtle differences in the way that members of different racial and ethnic groups respond to treatment, particularly with regard to some pharmaceutical interventions, suggesting that variations in some forms of treatment may be justified on the basis of patient race or ethnicity. In addition, patients vary in help-seeking behavior, and some racial and ethnic minorities may be more likely than whites to avoid or delay seeking care. However, the majority of studies find disparities in clinical services that are equally effective for all racial and ethnic groups. Further, the studies that the IOM reviewed suggest that racial differences in patients' attitudes, such as their preferences for treatment, do not vary greatly and cannot fully explain racial and ethnic disparities in healthcare. A small number of studies, for example, find that African Americans are slightly more likely to reject medical recommendations for some treatments, but these differences in refusal rates are generally small (African Americans are only 3-6% more likely to reject recommended treatments, according to these studies). It remains unclear why African-American patients are more likely to reject treatment recommendations. Are they refusing treatment because of a general mistrust of health care providers? Or do some decline treatment because of negative experiences in the clinical encounter or a perception that their doctor is not invested in their care? More research is needed to fully understand treatment refusal because the reasons for refusal may lead to different strategies to help patients make informed treatment decisions.

If minority patients' attitudes toward healthcare and preferences for treatment are not likely to be a major source of health care disparities, what other factors may contribute to these disparities? As shown in the figure below, the IOM study committee considered two other sets of factors that may be associated with disparities in healthcare, assuming that all populations have equal access to care. The first set of factors are those related to the operation of healthcare systems and the legal and regulatory climate in which they operate. These include factors such as cultural or linguistic barriers (e.g., the lack of interpretation services for patients with limited English proficiency), fragmentation of

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healthcare systems (as noted earlier, these include the possibility that minorities are disproportionately enrolled in lower-cost health plans that place greater per-patient limits on healthcare expenditures and available services), the types of incentives in place to contain costs (e.g., incentives to physicians to limit services), and where minorities tend to receive care (e.g., minorities are less likely to access care in a private physician's office, even when insured at the same level as whites).



Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare.
SOURCE: Gomes and McGuire, 2001

The second set of factors emerges from the clinical encounter. Three mechanisms might be operative in healthcare disparities from the provider's side of the exchange: bias (or prejudice) against minorities; greater clinical uncertainty when interacting with minority patients; and beliefs (or stereotypes) held by the provider about the behavior or health of minorities. Patients might also react to providers' behavior associated with these practices in a way that also contributes to disparities. Research on how patient race or ethnicity may influence physician decision-making and the quality of care for minorities is still developing, and as yet there is no direct evidence to illustrate how prejudice, stereotypes, or bias may influence care. In the absence of such research, the study committee drew upon a mix of theory and relevant research to understand how these processes might operate in the clinical encounter.

Clinical Uncertainty

Any degree of uncertainty a physician may have relative to the condition of a patient can contribute to disparities in treatment. Doctors must depend on inferences about severity based on what they can see about the illness and on what else they observe about the patient (e.g., race). The doctor can therefore be viewed as operating with prior beliefs about the likelihood of patients' conditions, "priors" that will be different according to age, gender, socioeconomic status, and race or ethnicity. When these priors are considered alongside information gathered in a clinical encounter, both influence medical decisions.

Doctors must balance new information gained from the patient (sometimes with varying levels of accuracy) and their prior expectations about the patient to make a diagnosis and determine a course of treatment. If the physician has difficulty accurately understanding the symptoms or is less sure of the "signal" – the set of clues and indications that

Any degree of uncertainty a physician may have relative to the condition of a patient can contribute to disparities in treatment.

physicians rely upon to make diagnostic decisions – then he or she is likely to place greater weight on “priors.” The consequence is that treatment decisions and patients’ needs are potentially less well matched.

The Implicit Nature of Stereotypes

A large body of research in psychology has explored how stereotypes evolve, persist, shape expectations, and affect interpersonal interactions. Stereotyping can be defined as the process by which people use social categories (e.g., race, sex) in acquiring, processing, and recalling information about others. The beliefs (stereotypes) and general orientations (attitudes) that people bring to their interactions help organize and simplify complex or uncertain situations and give perceivers greater confidence in their ability to understand a situation and respond in efficient and effective ways.

Although functional, social stereotypes and attitudes also tend to be systematically biased. These biases may exist in overt, explicit forms, as represented by traditional bigotry. However, because their origins arise from virtually universal social categorization processes, they may also exist, often unconsciously, among people who strongly endorse egalitarian principles and truly believe that they are not prejudiced. In the United States, because of shared socialization influences, there is considerable empirical evidence that even well-intentioned whites who are not overtly biased and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes. Both implicit and explicit stereotypes significantly shape interpersonal interactions, influencing how information is recalled and guiding expectations and inferences in systematic ways. They can also produce self-fulfilling prophecies in social interaction, in that the stereotypes of the perceiver influence the interaction with others in ways that conform to stereotypical expectations.

Healthcare Provider Prejudice or Bias

Prejudice is defined in psychology as an unjustified negative attitude based on a person’s group membership. Survey research suggests that among white Americans, prejudicial attitudes toward minorities remain more common than not, as over half to three-quarters believe that relative to whites, minorities – particularly African Americans – are less intelligent, more prone to violence, and prefer to live off of welfare. It is reasonable to assume, however, that the vast majority of healthcare providers find prejudice morally abhorrent and at odds with their professional values. But healthcare providers, like other members of society, may not recognize manifestations of prejudice in their own behavior.

While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that healthcare providers’ diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients’ race or ethnicity. Schulman et al. (1999), for example, found that physicians referred white male, black male, and white female hypothetical “patients” (actually videotaped actors who displayed the same symptoms of cardiac disease) for cardiac catheterization at the same rates (approximately 90% for each group), but were significantly less likely to recommend catheterization procedures for black female patients exhibiting the same symptoms. In another experimental design, Abreu (1999) found that mental health professionals subliminally “primed” with African American stereotype-laden words were more likely to evaluate the same hypothetical patient (whose race was not identified) more negatively than when primed with neutral words. Further, in a study based on actual clinical encounters, van Ryn and Burke (2000) found that doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with

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medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than white patients, even after patients' income, education, and personality characteristics were taken into account. These findings suggest that while the relationship between race or ethnicity and treatment decisions is complex and may also be influenced by gender, providers' perceptions and attitudes toward patients are influenced by patient race or ethnicity, often in subtle ways.

Medical Decisions Under Time Pressure with Limited Information

Indeed, studies suggest that several characteristics of the clinical encounter increase the likelihood that stereotypes, prejudice, or uncertainty may influence the quality of care for minorities. In the process of care, health professionals must come to judgments about patients' conditions and make decisions about treatment, often without complete and accurate information. In most cases, they must do so under severe time pressure and resource constraints. The assembly and use of these data are affected by many influences, including various "gestalts" or cognitive shortcuts. In fact, physicians are commonly trained to rely on clusters of information that functionally resemble the application of "prototypic" or stereotypic constellations. These conditions of time pressure, resource constraints, and the need to rely on gestalts map closely onto those factors identified by social psychologists as likely to produce negative outcomes due to lack of information, to stereotypes, and to biases (van Ryn, 2002).

In the process of care, health professionals must come to judgments about patients' conditions and make decisions about treatment, often without complete and accurate information.

Patient Response: Mistrust and Refusal

As noted above, the responses of racial and ethnic minority patients to healthcare providers are also a potential source of disparities. Little research has been conducted as to how patients may influence the clinical encounter. It is reasonable to speculate, however, that if patients convey mistrust, refuse treatment, or comply poorly with treatment, providers may become less engaged in the treatment process, and patients are less likely to be provided with more vigorous treatments and services. But these kinds of reactions from minority patients may be understandable as a response to negative racial experiences in other contexts, or to real or perceived mistreatment by providers. Survey research, for example, indicates that minority patients perceive higher levels of racial discrimination in healthcare than non-minorities. Patients' and providers' behavior and attitudes may therefore influence each other reciprocally, but reflect the attitudes, expectations, and perceptions that each has developed in a context where race and ethnicity are often more salient than these participants are even aware of.

Little research has been conducted as to how patients may influence the clinical encounter.

WHAT CAN HEALTHCARE PROVIDERS DO TO HELP ELIMINATE DISPARITIES IN CARE?

Given that stereotypes, bias, and clinical uncertainty may influence clinicians' diagnostic and treatment decisions, education may be one of the most important tools as part of an overall strategy to eliminate healthcare disparities. Healthcare providers should be made aware of racial and ethnic disparities in healthcare, and the fact that these disparities exist, often despite providers' best intentions. In addition, all current and future healthcare providers can benefit from cross-cultural education. Cross-cultural education programs have been developed to enhance health professionals' awareness of how cultural and social factors influence healthcare, while providing methods to obtain, negotiate and manage this information clinically once it is obtained. Cross-cultural education can be divided into three conceptual approaches focusing on *attitudes* (cultural sensitivity/awareness approach), *knowledge* (multicultural/categorical approach), and *skills* (cross-cultural approach), and has been taught using a variety of interactive and experien-

tial methodologies. Research to date demonstrates that training is effective in improving provider knowledge of cultural and behavioral aspects of healthcare and building effective communication strategies.

Healthcare providers should be made aware of racial and ethnic disparities in health-care, and the fact that these disparities exist, often despite providers' best intentions.

Standardized data collection is also critically important in efforts to understand and eliminate racial and ethnic disparities in healthcare. Data on patient and provider race and ethnicity would allow researchers to better disentangle factors that are associated with healthcare disparities, help health plans to monitor performance, ensure accountability to enrolled members and payors, improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices. Unfortunately, standardized data on racial and ethnic differences in care are generally unavailable, and a number of ethical, logistical, and fiscal concerns present challenges to data collection and monitoring, including the need to protect patient privacy, the costs of data collection, and resistance from healthcare providers, institutions, plans and patients. In addition, health plans have raised significant concerns about how such data will be analyzed and reported. The challenges to data collection should be addressed, as the costs of failing to assess racial and ethnic disparities in care may outweigh new burdens imposed by data collection and analysis efforts.

Many other strategies must be undertaken, in conjunction with the training and educational strategies described here, to eliminate racial and ethnic disparities in healthcare. As noted in the report, these include, for example, policy and regulatory strategies that address fragmentation of health plans along socioeconomic lines, and health systems interventions to promote the use of clinical practice guidelines and promote the use of interpretation services where community need exists. In short, a comprehensive, multi-level strategy is needed to eliminate these disparities. Broad sectors – including healthcare providers, their patients, payors, health plan purchasers, and society at large – must work together to ensure all patients receive a high quality of healthcare.

Many other strategies must be undertaken, in conjunction with the training and educational strategies described here, to eliminate racial and ethnic disparities in health-care.

GUIDE TO INFORMATION SOURCES

An increasing number of resources are available to healthcare providers and their patients to increase awareness of racial and ethnic healthcare disparities and means to improve the quality of care for racial and ethnic minorities. The following is only a partial list of some of these resources, and is not intended as an endorsement of the products or individuals and groups that produced them:

American Board of Internal Medicine. (1998). *Cultural Competence: Addressing a Multicultural Society: The ABIM Report 1997-1998*. Philadelphia: American Board of Internal Medicine.

American Medical Association. (1999). *Cultural Competence Compendium*. Chicago, IL: American Medical Association. Product Number OP209199/ Phone # 1-800-621-8335.

Betancourt JR, Like RC, and Gottlieb BR, eds. (2000). Caring for diverse populations: Breaking down barriers. *Patient Care*, Special Issue, May 15, 2000.

Lavizzo-Mourey R, and Mackenzie ER. (1996). Cultural Competence: Essential Measurements of Quality for Managed Care Organizations. *Annals of Internal Medicine* 124, pp. 919-21.

National Alliance for Hispanic Health. *Quality Services for Hispanics: the Cultural Competency Component*, Rockville, MD: U.S. Department of Health and Human Services, 2000.

In addition to these sources, the Henry J. Kaiser Family Foundation and the Robert Wood Johnson Foundation have recently joined forces to sponsor an initiative to increase dialogue among physicians regarding healthcare disparities. To learn more about this initiative, please visit the “Why the Difference?” website at www.kff.org/whythedifference.

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van Ryn M, Burke J. 2000. The effect of patient race and socio-economic status on physician's perceptions of patients. *Social Science and Medicine* 50:813-828.



For More Information...

Copies of *Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care* are available for sale from the National Academy Press; call (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area), or visit the NAP home page at www.nap.edu. The full text of this report is available at <http://www.nap.edu/catalog/10260.html>

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