

BoardBrief

Knowledge Resources for Governing Effectiveness

Measuring Equity in Patient Care Access & Treatment: Discussions with the Board

The challenge of delivering high quality, compassionate health care to all patients is a consistent goal for health care leaders and their governing boards. Regardless of the health care diagnostic and treatment services offered, the board must understand whether the services rendered are performed without regard to race, ethnicity, language proficiency or disability. Beyond the ethical considerations, the relationship among health inequities, higher costs and lower quality of care has been established in numerous studies in the past several decades.¹

These key moral precepts are often built-consciously or unconsciously-into the organization's mission and values statements. But how can the board know whether these precepts are actually "lived" when care is accessed or delivered?

The challenge of delivering high quality care equitably is relevant for all healthcare boards not confined to a particular type of setting or treatment modality. The focus of this briefing will be around equity for patients/residents, as opposed to equity internal to the organization, such as diverse leadership and governance representation. Measuring equity of care continues to be an important performance measurement priority, as the current pandemic has highlighted the disproportionate impact COVID-19 has had on people of color and older citizens.

Definition and Foundations

What is "equity of care"? As opposed to equality, where uniformity is the driving principle, equity focuses on impartiality: that the provision of care does not differ due to a

person's race, ethnicity, age, gender, geography, socioeconomic status and other factors.²

The regulatory foundation for equitable care in hospitals can be traced to early efforts to improve patients' rights. Decades ago, The Joint Commission was a pioneer in developing hospital accreditation standards around patients' rights, stating that hospitals must "prohibit discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression"³ as the current requirement states. Additional regulatory federal requirements from Health & Human Services (HHS) occurred with the passage of the Affordable Care Act in June 2010, where patients' rights extended to the patient's ability to designate their visitor(s) as well as the broader insurance provisions.⁴

Where to Begin: Data Collection

Understanding how, when and where patients with varying demographics access

and receive care begins with collecting data. Identifying disparities in care and developing improvement strategies to eliminate any disparities which are occurring must start with collecting standardized data on “REaL”: race, ethnicity and language.⁵ Many health care systems revised their demographic data inputs when implementing new electronic health records over the past several decades.

The data collection elements most relevant to measuring equity include those elements mentioned previously in The Joint Commission Patient Rights standards, along with “Social Determinants of Health (SDoH)” elements, such as housing stability, employment, food insecurity and transportation needs.

Unfortunately, not all healthcare settings consistently collect this data. Most importantly, while some locations collect some of the data elements, the consistency of data stratification and subsequent use in clinical performance improvement is less than 33% of approximately 600 hospitals recently surveyed by the American Hospital Association (AHA).⁶

Once sufficient data is collected electronically, data analysts can then stratify based upon patient demographic market characteristics, patient concerns and identified concerns, as well as clinical studies pointing to disproportionate disease occurrence. The stratified data can help determine where opportunities to improve equitable care exist across the care continuum and clinical services.

Specific measures that address data collection include: 1) the percentage of the workforce trained regarding how to collect the data properly; and 2) the percentage of patient records with complete data, including the ability to verify or edit changes beyond the registration area.⁷

Next Steps After Data Collection and Stratification

Once relevant data has been collected and stratified, the ability to discern differences in access to care (such as length of waiting time to get an appointment in ambulatory care), diagnosis (such as mammography appointment timeliness) and treatment (such as the ability to fill prescriptions as needed or have needed surgeries) can be evaluated by race, ethnicity, gender, etc.

Many boards and senior leaders understand that providing equitable care across patient populations is a complex and value-driven goal. Cultural context and prior experience shape how care providers interact with patients.

Thus, a key initiative undertaken by many organizations is cultural competency training. Innovative health care boards have asked to be included (in addition to management and staff) in these educational efforts, recognizing that goals around health equity require leadership understanding and commitment. Two performance measures the board can use to help evaluate the breadth, depth and success of cultural competency training are: 1) percentage of staff, physicians and leaders who have completed cultural competency education; and 2) patient satisfaction scores.⁸

Next Steps After Data Collection and Stratification

It is important to recognize the sociodemographic and cultural factors which may perhaps unconsciously influence access to care and treatment. Evaluating condition and/or disease-specific clinical care processes and outcomes through stratified data can lead to insights into why a certain patient population’s needs are not being addressed

equitably.

We know that certain diseases occur with greater frequency in particular patient populations. Identifying ‘disparities-sensitive performance measures’ such as controlling Hemoglobin A1c for patients with diabetes; obtaining timely colorectal cancer screening; preventing low-birth-weight and premature births for pregnant women can be an excellent beginning. These clinical performance measures (both process and outcome types) can be stratified by key filters for race, ethnicity, etc., providing clear directions for improving patient outcomes and reducing costs through health equity. A robust list of clinical performance measures can be found in the 2017 National Quality Forum Final Report on “A Roadmap for Promoting Health Equity and Eliminating Disparities...”⁹

Working with the Community

When considering strategies to improve equity of care, the board should encourage organizational leadership to partner with the community. Many community agencies, including religious organizations, charitable foundations, federally qualified health clinics, community nursing centers, senior centers and other non-profit groups, are familiar with serving the needs of marginalized or disadvantaged persons. Working together, the health care organization can better strategize and partner on key opportunities to improve the community’s health outcomes. The Institute for Healthcare Improvement identified

partnering with the community as one of five key avenues to help achieve health equity.¹⁰

Working together with the broader community often reflects the board members’ priorities, as many board members live and sometimes work in the communities the healthcare organization serves. Collaboration to extend limited community resources is a welcome avenue to address some of the SDoH, such as homelessness, food insecurity, transportation and unemployment. Because these factors heavily weigh on health equity, a more comprehensive approach is warranted.

Summary

Achieving equity in healthcare access and treatment will be a long journey. Strategies to address areas where inequities exist requires a multi-year partnership with the board, asking the right questions and supporting efforts to resource key initiatives. Improving health outcomes for all the populations served can only be accomplished with the understanding of the total community’s needs, including those needing more equitable access to care and treatment.

About the Author

Ann Scott Blouin, RN, PhD, FACHE, (ann@psq-advisory.com) is the President & Founder, PSQ Advisory. Ann Scott Blouin founded 'PSQ Advisory' to deliver strategic guidance to America's health systems, hospitals and critical access hospitals. Dr. Blouin works with boards, community groups and senior leaders to help organizations achieve success on financial and clinical metrics through an organizational focus on effective governance, improvement science and harm avoidance.

Dr. Blouin is a governWell™ advisory and regular contributor of thought leadership articles for trustees and senior health care leaders.

Additional governWell™ Resources

The resources and services listed below are available to governWell™ members:

- *BoardBRIEF: The Board's Role in Advancing Healthier, More Equitable Communities*
- *Health Equity Key Concepts & Terms*
- *The Board's Role in Health Equity Initiatives (Virtual board education session)*
- [Consultation with a governWell™ Advisor to discuss health equity initiatives.](#)

References

1. National Quality Forum. (September 14, 2017). Final Report: A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four Is for Health Equity. Washington, D.C. Retrieved from www.nqf.org.
2. American Hospital Association. (December 2020). Health Equity Snapshot: A Toolkit for Action. Washington, D.C. Retrieved from www.aha.org.
3. Joint Commission Resources (2020). The Joint Commission Standards for Hospital Accreditation-Chapter: Rights and Responsibilities of the Individual. (RI.01.01.01, Element of Performance 29). Oakbrook Terrace, IL.
4. Centers for Medicare and Medicaid Services. <https://www.cms.gov/ccio/resources/Regulations-and-Guidance/index#Patient%E2%80%99s%20Bill%20of%20Rights>. Accessed January 8, 2021.
5. Ulmer C, McFadden B, Nerenz DR, eds. Race, ethnicity, and language data: standardization for health care quality improvement. Institute of Medicine (US) Subcommittee on Standardized Collection of Race/ Ethnicity Data for Healthcare Quality Improvement. Washington: National Academies Press, 2009. <https://www.nap.edu/catalog/12696/race-ethnicity-and-language-data-standardization-for-healthcare-quality> <https://doi.org/10.17226/12696>
6. *Ibid.* American Hospital Association, Health Equity Snapshot: A Toolkit for Action, p. 5.
7. American Hospital Association. (2020). Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. Retrieved from www.aha.org.
8. *Ibid.* American Hospital Association, Dashboards, page 5.

9. Ibid. National Quality Forum, pages 46-89.

10. Wyatt R, Laderman M, Botwinick L, et al. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. Accessed January 9, 2021 at [Achieving Health Equity: A Guide for Health Care Organizations | IHI - Institute for Healthcare Improvement](#).

Resources used for research and context purposes have been sourced as accurately as possible at the time of publication. If you believe something has been cited incorrectly, please contact governWell™ at contact@governwell.net.



Illinois Office	Oregon Office
1515 W. 22nd Street, Ste 900	31090 SW Boones Bend Rd
Oak Brook, IL 60523	Wilsonville, OR 97070
630-613-7580	630-613-7580
blorsbach@governwell.net	contact@governwell.net

www.governwell.net