

(5) *QSHC* invites manuscripts from students and trainees that report strategies for quality improvement and patient safety

Students and trainees provide a fresh perspective and a critical lens on quality and safety in patient care. That having been said, the editors of *QSHC* will apply the same rigorous review criteria to these submissions that apply to all manuscripts on these topics. The editorial expectation of excellent scholarship in these reports will provide both an obligation and an opportunity for teachers and investigators to use their students' preparation of such manuscripts as the

context for effective teaching in these fields.

Our readers have provided excellent advice that *QSHC* can readily adopt. We invite your submissions as we endeavor to accelerate the formation of the next generation of health professionals for healthcare quality improvement and patient safety. It is time to turn up the heat.

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REFERENCES

- 1 Stevens DP. Three questions for *QSHC*. *Qual Saf Health Care* 2005;14:2–3.
- 2 Coyle YM, Mercer SQ, Murphy-Cullen CL, et al. Effectiveness of a graduate medical education program for improving medical event reporting attitude and behavior. *Qual Saf Health Care* 2005;14:383–8.
- 3 Arora Y, Johnson J, Lovinger D, et al. Communication failures in patient sign-out and suggestions for improvement: a critical incident analysis. *Qual Saf Health Care* 2005;14:401–7.
- 4 Philibert I, Leach D. Re-framing continuity of care for this century. *Qual Saf Health Care* 2005;14:394–6.
- 5 Aron DC, Headrick LA. Educating physicians prepared to improve care and safety is no accident: it requires a systematic approach. *Qual Saf Health Care* 2002;11:168–73.
- 6 Leach DC. Competence is a habit. *JAMA* 2002;287:243–44.

Racial and ethnic disparities in health care

Reducing racial and ethnic disparities in health care: an integral part of quality improvement scholarship

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It is vital that quality improvement interventions address this unacceptable problem

We advocate three fundamental additions to the draft guidelines for quality improvement (QI) manuscripts proposed by Davidoff and Batalden.¹ The purpose of these additions is to highlight the opportunity that the guidelines offer for reducing racial and ethnic disparities in health care.

Equity is one of the six quality aims defined by the US Institute of Medicine in their 2001 report "*Crossing the Quality Chasm*", along with safety, effectiveness, patient centeredness, timeliness, and efficiency.² So far, effectiveness has been a frequent target of QI programs. Clearly, effectiveness is an important goal, but addressing equity offers great opportunities for profound improvement for both individual patients and society as a whole.

Racial inequity in health care is common to many pluralistic societies and is increasingly regarded as unacceptable. The Institute of Medicine's 2003 report "*Unequal Treatment*" documented substantial racial and ethnic differences in the quality of care in the USA.³ The UK's National Health Service (NHS) and Commission for Racial Equality recently released "*Race Equality Guide 2004*" which provides a

framework for achieving racial equality in the care of patients at NHS facilities.⁴ Racial gaps in care are important because they lead to needless morbidity, medical complications, and mortality.³ We know a considerable amount about the mechanisms causing these disparities.³ There is therefore a crying need for solutions to reduce disparities, and QI interventions must play a key role.

We advocate the addition of three questions to the publication guidelines:

- What is the effect of the QI intervention on racial and ethnic disparities?
- What is the plan for addressing racial and ethnic disparities in health care with the QI intervention?
- Are there important unintended positive or negative consequences from the QI intervention that affect racial and ethnic disparities in health care?

(1) What is the effect of the QI intervention on racial and ethnic disparities?

What is not measured may not be seen. Most of us believe we are unbiased. We are moral and equitable and treat everyone the same. However, time and again health providers, organizations, and

plans are surprised to find that disparities exist when they examine their own data, perhaps because some of the root causes of the differences are subtle or seamlessly embedded within the system of care such as the process by which patients are assigned to physicians or nursing floors. Organizations need to collect accurate racial data as part of routine care, and then reflect upon any differences in care by ethnicity.

(2) What is the plan for addressing racial and ethnic disparities in health care with the QI intervention?

A variety of conceptual models explain the mechanisms leading to differences in care.^{3–6} These models describe multiple levers for influencing change including healthcare organization, financing, provider, and patient. What levers relevant for disparities does the QI intervention affect? Does the intervention meld general QI techniques and ethnically tailored solutions to ensure that patients of all races benefit maximally?

(3) Are there important unintended positive or negative consequences from the QI intervention that affect racial and ethnic disparities in health care?

For example, if the QI intervention includes provider profiling, does it penalize physicians who care for ethnic minority patients who are more sick, more poor, or non-English speaking, and thus unintentionally give incentives to dump such challenging patients? Is any case mix adjustment tool used? Are the direct costs or opportunity costs of the QI initiative disproportionately borne by racial groups? For example, are the resources used for QI taken from programs serving racial minority groups?

DISCUSSION

These three questions reflect the philosophy that QI should be an integral part of the plan to reduce disparities in care. The challenge is making sure that QI is not divorced from efforts to reduce racial disparities. For example, on a local level, a health system might have a community health fair or hire a community outreach liaison. These might be useful efforts but the danger is that they create the impression that reducing racial disparities is a marginalized activity distinct from the mainstream QI efforts of an organization.

QI can play a major role in strategies to reduce inequalities in care. Quality of care can be improved in virtually every setting and disparities are common. QI efforts therefore need to occur both in institutions that treat predominantly minority patients as well as in organizations that care for patients from a variety of ethnic groups. National initiatives adopting this philosophy are currently rare. For example, the Quality Improvement Organizations (QIOs) that oversee the quality of care in each of the 50 American states have been required by the Centers for Medicare and Medicaid Services to implement projects to reduce disparities. This initiative provides a wonderful national opportunity to modify and integrate the QIOs' traditional tools of QI with culturally sensitive interventions to reduce disparities.

Creative approaches are needed in this area, and one example of strategic thinking by a private philanthropy is the Robert Wood Johnson Foundation (RWJF) effort to reduce racial and ethnic disparities with QI methodologies. RWJF recently launched three major related programs:

- “Finding Answers: Disparities Research for Change”: the discovery and evaluation of interventions to reduce disparities;
- “Expecting Success”: a QI collaborative of 10 hospitals to narrow cardiovascular disparities in African Americans and Latinos; and
- “Leading Change: Disparities Solutions Initiative”: disseminating evidence on what decreases disparities and training healthcare leaders in this work.

Overall, these initiatives intend to attack multiple leverage points for eliminating differences. Diverse interventions might include pay for performance to change organizational behavior, cultural competency programs for providers, patient empowerment, and partnerships between healthcare organizations and community based organizations.

It is clear that QI activities, exemplified by “Expecting Success”, are a vital part of the answer to reducing disparities. Virtually every QI intervention presents a critical opportunity for addressing this unacceptable problem. The RWJF's disparities effort provides an innovative example of how to stimulate new discoveries, disseminate findings, and translate results into real world practice through an integrative mechanism.

We commend Drs Davidoff and Batalden for beginning an important dialogue on improving QI scholarship and the dissemination of important results.¹ Attention to equity will make the guidelines even more useful and beneficial in improving care for some of the most vulnerable disempowered patients. Failure to incorporate disparity

reduction goals into QI work would be a potentially tragic missed opportunity.

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REFERENCES

- 1 **Davidoff F**, Batalden P. Toward stronger evidence on quality improvement. Draft publication guidelines: the beginning of a consensus project. *Qual Saf Health Care* 2005;14:319–25.
- 2 **Institute of Medicine**. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press, 2001.
- 3 **Smedley BD**, Stith AY, Nelson AR, eds. *Unequal treatment: confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academy Press, 2003.
- 4 **National Health Service and Commission for Racial Equality**. *Race equality guide 2004: a performance framework*. London: North Central London Strategic Health Authority, 2004.
- 5 **Cooper LA**, Hill MN, Powe NR. Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *J Gen Intern Med* 2002;17:477–86.
- 6 **Williams DR**. Racism and health: a research agenda. *Ethn Dis* 1996;6:1–8.