

# Health Equity and Quality of Care Assessment: A Continuing Challenge

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Reducing racial and/or ethnic disparities in a variety of health outcomes from neonatal, infant, and adult mortality to premature birth rates has been a hospital, state, and national goal. One area of focus has been differences in the types of care (or quality of care) that patients from minority racial/ethnic groups receive compared with non-Hispanic white patients. Profit et al<sup>1</sup> provide new evidence of this potential issue as applied to perinatal medicine. By using data from >100 perinatal hospitals in California, the authors document substantial differences in the care quality received by non-Hispanic African American and Hispanic patients compared with non-Hispanic white patients. The magnitude of these differences as assessed by the Baby-MONITOR care tool varied between hospitals, with some hospitals showing higher quality of care in minority racial and/or ethnic patients and other hospitals showing much lower quality. Beyond these important findings, though, this research also highlights the substantial challenge when combining health equity goals with the measurement of health care quality.

Researchers and policy makers can take 1 of 3 approaches to assess the care quality differences that may underlie health disparities. Profit et al<sup>1</sup> use the most common mechanism: apply a set of previously validated quality measures to patients of different racial/ethnic groups and quantify the difference in performance between these racial/ethnic groups. This descriptive technique in which disparity-sensitive quality measures are used can highlight those providers

and health care settings with small or large differences between racial/ethnic groups. Then, individual providers can identify potential areas for change surrounding the quality of care, develop quality improvement projects, and monitor racial/ethnic differences in these specific metrics over time. Such work is illustrated by the reduction in racial/ethnic differences in breastfeeding previously.<sup>2</sup>

Although on the face this is a reasonable strategy to identifying and reducing disparities, there are some substantial challenges. First, few if any of these measures were specifically validated for use in a specific racial/ethnic group, leading to questions about whether the same risk adjustment models should be used in the development of racial-specific and/or ethnic-specific measures. Second, there is substantial evidence that some of the racial/ethnic disparities in health outcomes and quality measures are related to factors outside of the traditional purview of a clinician or hospital, such as racial segregation,<sup>3</sup> access to health care, and socioeconomic status.<sup>4</sup> In the life course theory of health outcomes, differences in childhood experiences, particularly around adverse childhood experiences, may contribute to disparities in measures of mortality and morbidity that are frequently part of a quality of care measure.<sup>5</sup> Additionally, perinatal regional centers and children's hospitals, which care for a large percentage of very low birth weight infants in the United States, have larger geographic catchment areas than the typical hospital, including rural patients who

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may have even worse access to care than many urban-residing patients from minority racial/ethnic groups.<sup>6</sup> The inability to account for this risk may confound our measures of disparities in care. In a sense, when it pertains to health equity, using disparity-sensitive quality measures may reflect more on the health care system and the community in which patients reside than their direct experience within a specific hospital or with a specific health care provider.

In light of these issues, another approach uses conditions that only or predominantly affect minority groups, such as sickle cell disease. In these cases, measuring the quality of care received by patients with these conditions provides a more homogenous population to study the care of racial/ethnic minorities. However, it is not clear whether the assessed quality of care for 1 condition (such as the hematology clinic managing sickle cell disease) can be applied to other providers (such as obstetricians and neonatologists managing high-risk pregnancies).<sup>7</sup> It is more likely that these assessments apply specifically to the conditions measured, unless there are explicit studies to suggest otherwise.

Finally, quality measures could assess the underlying drivers for observed disparities in health and health outcomes.<sup>8</sup> Such assessment could include broad areas spanning topics such as discrimination, racism, and implicit bias, to provision of linguistic services and other culturally sensitive care models. These measures address the underlying latent factors that

result in observed differences in either health outcomes or receipt of care. Unfortunately, there are currently few to no validated, endorsed measures of health equity, particularly in perinatal care. Few institutions routinely capture whatever information is available, and even fewer regional or state agencies have access to these data. Implementing valid measures of such care, such as the Consumer Assessment of Healthcare Providers and Systems Cultural Competence Item Set,<sup>9</sup> may offer alternative sets of data to support the quality improvement work in this field.

As we see from this work and the broader literature, using the existing health care quality measurement framework for the assessment of health equity is challenging. Much of our work describes some part of the health care experience of patients: some measure of health, some aspect of accessing health care, or some specific process of care that is deemed important to optimize the outcome of a child, mother, or infant. Because many of the drivers of disparities in health care outcomes may lie outside the purview of 1 provider or health care system, we should be careful to understand what a specific set of quality measures really says about the care delivered to different racial/ethnic groups. Perhaps measuring the underlying drivers of these differences and addressing these drivers through a quality measurement framework will provide the most direct method of identifying actionable items for specific health care providers to minimize these continued differences in health and care.

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