

Time for Nursing Homes to Recognize and Address Disparities in Care

Alexander R. Green, MD, MPH

Racial and ethnic disparities in the quality of care provided to nursing home residents in the United States are well described. If you are black or Hispanic, the quality of care you are likely to receive in a nursing home, across a wide range of quality measures based on nationwide data, is not the same as the quality for white residents.^{1,2} However, more detailed analyses of aggregate data consistently point to the site of care as a major determinant for these disparities.^{3,4} That is, the quality of nursing home care seems to depend more on where the nursing home is located and the proportion of minority residents it serves than on a resident's race per se. Health care disparities can be broken down into their proximate causes with respect to "across facility" variation (certain patients are admitted to facilities with poorer care practices) and "within facility" variation (certain patients are treated differently within a facility).⁵ It follows that a white resident in a nursing home that serves predominantly minority residents is also likely to receive lower-quality care than a minority resident in a nursing home that serves mostly white residents. This same pattern has been shown for a wide range of disparities in different organizations, such as hospitals; health care services; and outcomes.^{6,7}

Recognition of the importance of site of care (across facility) disparities represents an important advance in the past 15 years or so of disparities research. It has led researchers, funders, and policy makers to focus particular attention on minority-serving institutions to broadly improve their quality of care as a strategy to ameliorate health care disparities. The Robert Wood Johnson Foundation, for example, . . .⁸ While this is clearly crucial work, it should not detract from the need to monitor disparities internally within nursing homes, hospitals, and other health care organizations whether or not they serve predominantly minority patients. It is simply impossible to know whether or not disparities exist within one's own organization, and for which groups and which measures, without stratifying existing quality metrics by race/ethnicity at least, but also by language, socioeconomic status, gender, and other factors.⁹

In their article, "Examining Racial and Ethnic Differences in Nursing Home Quality," which appears in this issue of *The Joint Commission Journal on Quality and Patient Safety*, Hefele and colleagues address not on-site-of-care disparities across nursing homes but disparities that occur within

institutions.¹⁰ While the authors cite several articles that have done this on a smaller scale, theirs is the first study to measure within-nursing home disparities across a broad range of quality measures and on a national scale, thereby providing an essential contribution to the growing disparities literature on nursing homes. The authors examined eight nursing home quality measures used by the Centers for Medicare & Medicaid Services, which are also published publicly on Nursing Home Compare report cards.¹¹ They examined data from 15,800 nursing homes and 3 million residents, with a focus on the nursing homes that had a sufficient number of minority residents—at least 30 black and 30 white (1,406 nursing homes) or 30 Hispanic and 30 white residents (284 nursing homes)—to power their analyses. Overall, they found a broad range of disparities in care by race/ethnicity within nursing homes. These disparities were small, on average, with a few cases in which they were considerably larger. Regardless of size, they were often not in the expected direction—that is, the disparities often favored minority groups. That the disparities in nursing home care within institutions are not striking is, of course, good news. However, we must consider several study limitations before reaching the conclusion that the nursing homes in the United States are providing reasonably equitable care.

First, it is important to recognize that most quality measures are not necessarily sensitive to racial and ethnic disparities in care and are not designed to be. They are simply metrics that have been developed (and have come to represent) some degree of good care, and, as such, do not pick up differences in quality that are due to provider factors (for example, biases, miscommunication, mistrust) or systems factors (lack of interpreter services or diversity among staff). Let's take, for example, "Proportion of residents who do *not* lose control of their bowels or bladder during this reporting period"—one of the measures used by Hefele et al.¹⁰ There is no known racial/ethnic disparity reported in the literature for this specific outcome, nor is there any obvious racial/ethnic bias or other explanatory factor that would be likely to lead to a disparity. Inappropriate use of certain medications among minority residents, as compared to whites, could contribute, but no evidence exists regarding this possibility. Many quality measures, perhaps most, fit this description. On the other hand, studies have consistently shown racial disparities in, for example, completion of advance directives on admission to a nursing home—a measure not assessed in the Hefele et al. study—which may be due to lack of effective communication with health care professionals.¹² This measure has both a clear disparity mechanism—for example, difference

in communication by clinicians with minority patients due to bias, discomfort, and language barriers—and literature supporting it.^{12,13} My colleagues and I provide a more detailed explanation of the concept of disparities-sensitive quality measures in a report commissioned and sponsored by the National Quality Forum.¹⁴

Another word of caution about interpreting this study concerns its exclusions. Because most nursing homes in the United States have relatively low numbers of minority residents, for statistical reasons they were not included in the analyses. However, given the emphasis in the study on nursing homes that serve substantial numbers of minority residents, it is possible that many of the primarily white-serving nursing homes would have had more significant intra-institutional disparities. More research is needed to determine whether this is in fact the case. This issue is reflected in the authors' acknowledgement that "we could not make any facility-level black-white comparisons in 11 states, and likewise, could not make any Hispanic-white comparisons in 29 states,"^{10(p. 000)} because of the low numbers of minority residents in many nursing homes (that is, strong residential segregation). Individual minority residents and families are not likely to be concerned about the statistics, though, if the quality of their care is poor.

These limitations in no way detract from the value of this article, which provides a snapshot of intra-institutional racial/ethnic differences and interesting findings. It is reassuring that on average intra-institutional disparities are small, and it is surprising that they often do not favor white residents. Yet the article's importance is that in demonstrating the feasibility of monitoring disparities in quality at the individual nursing home level on a routine basis, it serves as a call to action for nursing homes, regulatory bodies, accreditation agencies, and other organizations to do so. The authors highlight the power of publicly reported data, such as Nursing Home Compare report cards,¹¹ and subsequent consumer responses, to drive quality improvement, particularly efforts that target disparities. As nursing homes' demographics change, reflecting an increasing proportion of minority (black, Hispanic, and Asian-American) residents and a decreasing proportion of white nursing home residents across the United States,¹⁵ it is particularly timely for nursing homes to recognize and address disparities.

In conclusion, by focusing on within-nursing home disparities, Hefele et al. show us how to measure and monitor what we usually think of when we think of disparities—a systematic bias in care that leads to some patients with similar characteristics getting worse care than others by the same providers in the same institution. It is time to heed their advice and begin to craft a national policy to stratify nursing home quality measures by race, ethnicity, and other demographics; to report disparities in care; and to develop culturally tailored interventions to address them.¹⁶ New disparities-sensitive measures should be developed, tested, and put into broad use alongside the standard quality

measures. Although nursing homes may not be ready for prime-time public reporting of disparities in quality metrics now, they may not be able to avoid it for long. People deserve to choose where they will spend their late years of life based on evidence of high-quality care regardless of their race, ethnicity, or other personal characteristics.

Conflicts of Interest. The author reports no conflicts of interest.

Alexander R. Green, MD, MPH, is Associate Professor, Harvard Medical School, and Senior Scientist, Mongan Institute Health Policy Center, Department of Medicine, Massachusetts General Hospital, Boston. Please address correspondence to Alexander R. Green, argreen@mgh.harvard.edu.

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