

CASE: DISPARITIES IN CARE AT SOUTHERN REGIONAL HEALTH SYSTEM

Tim Hank leaned back in his chair and closed his eyes. While he had been afraid the reports might have bad news, he now had to figure out what to do with this new information. Flipping through the first binder on his desk, reporting results of the recent Robert Wood Johnson Foundation–sponsored assessment of the cardiovascular care provided by his organization, he was increasingly concerned. Southern Regional Health System was based in Jackson, Mississippi, an area known for a highly diverse population and high poverty rates. Black and Hispanic residents in the area were about three times more likely to live in poverty than were whites. Unemployment was also a big problem that affected whites and nonwhites differently—in the Jackson area, black residents were two and a half times more likely to be unemployed and Hispanics over twice as likely to be unemployed as white residents. Beyond poverty and employment differences, though, was the issue of different care given to different patients. This issue of disparities in care was receiving increasing national attention, but Hank had thought the care they provided at Southern Regional was “color blind.” Given the health system’s mission of providing “excellent quality of care for all,” he assumed that the care was equitably delivered across patients and patient populations.

Apparently, this was not the case. This first report showed that there were indeed disparities in the care provided by Southern Regional. Data on heart care had been collected by race and ethnicity for the past year, and these baseline data showed differences. For instance, using the four core measures for heart failure that the Centers for Medicare & Medicaid Services currently collects and reports, only 41 percent of patients were receiving all recommended heart failure care, and the numbers were worse based on race and ethnicity. The analysis showed that while 68 percent of whites received all recommended care, the comparable number among nonwhites was 27 percent. For one measure—the percentage of heart failure patients receiving discharge instructions—only 65 percent of Hispanic patients received the information, compared to 85 percent of non-Hispanic patients. Also troubling Hank was the fact that none of these measures was close to 100 percent—this certainly wasn’t the type of care he’d want offered to his own family. Yet he truly didn’t understand how his hospital could be providing such disparate care.

The second binder on his desk offered little information to ease his concern. This report, the “Assessment of Organizational Readiness to Change” for Southern Regional Health System, showed that few individuals in his hospital were aware of the nationwide problem of disparities in care, and even fewer were aware that such an issue might be problematic within their own hospital. Now he had the data for Southern Regional that showed significant gaps in care provided to African American and Hispanic patients relative to white patients, but the accompanying readiness-to-change evaluation showed a strong tendency among hospital employees and physicians to resist any proposed changes and

instead “go with the flow.” Hank knew that his ability to bring the issue of disparate care to the forefront of hospital concerns and successfully make strides to reduce these disparities would be a legacy he would love to leave. Yet he didn’t know how he could possibly begin to address this issue at Southern Regional Health System.