Moving Toward Equity in Intracerebral Hemorrhage Care

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See related article, p XXX.

In 2003, the Institute of Medicine published Unequal Treatment, a groundbreaking indictment of bias and discrimination in medical care in the United States.1 In addition to the copious data documenting race/ethnic health disparities and the deleterious effects of overt and perceived discrimination, the Institute of Medicine set forth several suggestions to remedy this unconscionable state of affairs. Among these were the use of quality measures and organized means to deliver high quality medical care to all patients regardless of race, ethnicity, or socioeconomic status. In the United States, The Joint Commission’s certification of primary and comprehensive stroke centers seeks to promote this evidence-based approach to providing consistent, high quality medical care to all patients.

In the present issue of STROKE, Xian et al2 use the remarkably comprehensive Get with the Guidelines (GWTG) database to answer questions about the association of race/ethnicity, quality measures, and intracerebral hemorrhage (ICH) outcome in the United States. The article suggests that minority populations (African Americans, Hispanics, and Asian Americans) are cared for with at least the same, if not better, quality and have decreased in-hospital mortality, despite worse initial stroke severity compared with non-Hispanic whites. This is all welcome news in a country where stroke disparities are well documented.3 But should we celebrate this as a victory?

GWTG incorporates data from 72% of US hospitals who voluntarily provide stroke data. Although this number is formidable, it is unknown if minority subjects are more likely to be cared for at the remaining 28% of hospitals, and more importantly, if their care at those 28% of hospitals is the same, better, or worse than it is at the GWTG participating hospitals. Further, GWTG stops at hospital discharge, long-term outcome is not provided in this article, and previous work has suggested that minority subjects may decline more after hospital discharge compared with non-Hispanic whites.4 Indeed, the article addresses in-hospital mortality rather than long-term functional outcome. The study demonstrated increased survival among minority patients, despite the fact that minority ICH patients were initially more severe. Minority patients were less likely to have withdrawal of care. This raises the possibility that minority subjects are surviving ICH with greater disability, and that warrants further study.

An intriguing part of this article is that, although the authors promise in the introduction to examine the relationships between patient’s race/ethnicity, adherence to evidence-based care processes, and outcomes for ICH, they do not formally test the association, but rather provide separate data on care processes and outcome and let the reader infer an association. So, should we conclude that since African Americans score better on 4 of 6 processes measures and have less in-hospital mortality that there is a causal relationship? The answer is probably no. As the authors point out, it is difficult to make a case that increased stroke education, rehabilitation assessment, dysphagia screening, and deep venous thrombosis prophylaxis would explain the significant in-hospital mortality differences among African American and non-Hispanic whites, although it is possible that reduced pulmonary emboli and pneumonia could have a mortality effect. Indeed most performance measures are related to secondary prevention and cannot be addressed by data sets that end at the time of hospital discharge. In a time when many of us and our hospitals are spending lots of time and money to comply with The Joint Commission’s certification processes, it would be good to have more compelling data that process is linked with a variety of good outcomes.

Certainly, efforts such as GWTG and The Joint Commission’s primary and comprehensive certification programs have raised awareness and standardized evidence-based approaches to deliver high-quality stroke care. Further understanding and reductions in health disparities will need to examine functional and long-term outcomes poststroke. And yes, the Xian et al’s article is cause for celebration of moving toward equity in ICH care. While celebrating, we must continue the fight against stroke disparities, not only in the United States but throughout the world.5,6

Disclosures

None.

References


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Stroke. published online September 11, 2014;
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the
World Wide Web at:
http://stroke.ahajournals.org/content/early/2014/09/11/STROKEAHA.114.006970.citation

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