

## Rising Above the Noise: Making the Case for Equity in Care



# The headlines are common and the facts are known...

Equity of Care



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### Health Care Facing a Disparities Tsunami

By Fred Hobby

July 02, 2012

To achieve both quality and financial goals, hospital leaders must confront the issue of racial and ethnic disparities.

Although they represent only one-third of the total U.S. population, racial and ethnic minorities comprise more than half of the uninsured. -U.S. Department of Health & Human Services

Half of Latinos and more than a quarter of African Americans do not have a regular doctor. -U.S. Department of Health & Human Services

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### Cover Story Diversify Your Board

Charlotte Huff  
Hospitals identify new ways to reach and recruit members

Chris Dadlez wanted to tackle some of the health problems that disproportionately impact minority residents in Hartford, Conn., but the Saint Francis Hospital and Medical Center's chief executive officer acknowledges that he had some governance goals as

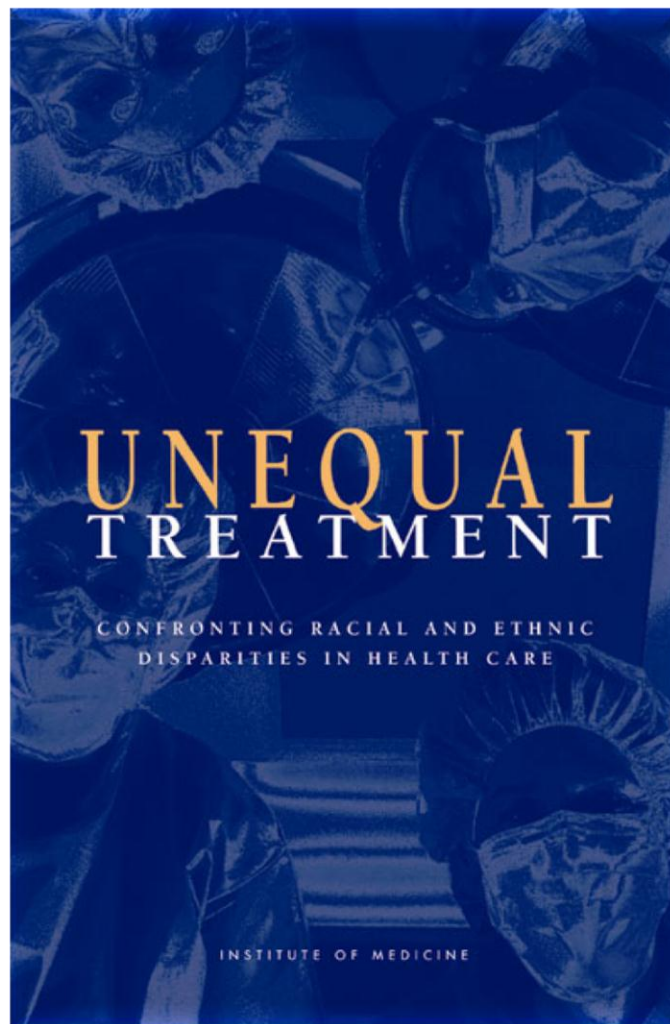
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# Unequal Treatment

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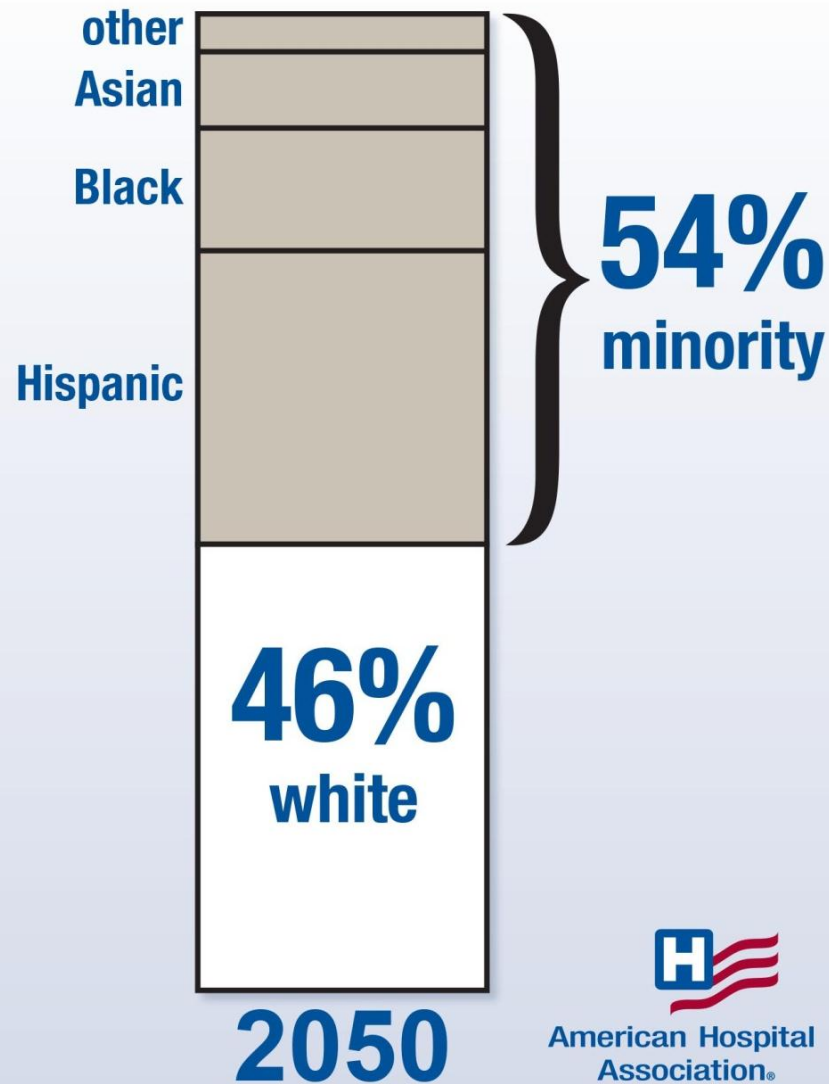
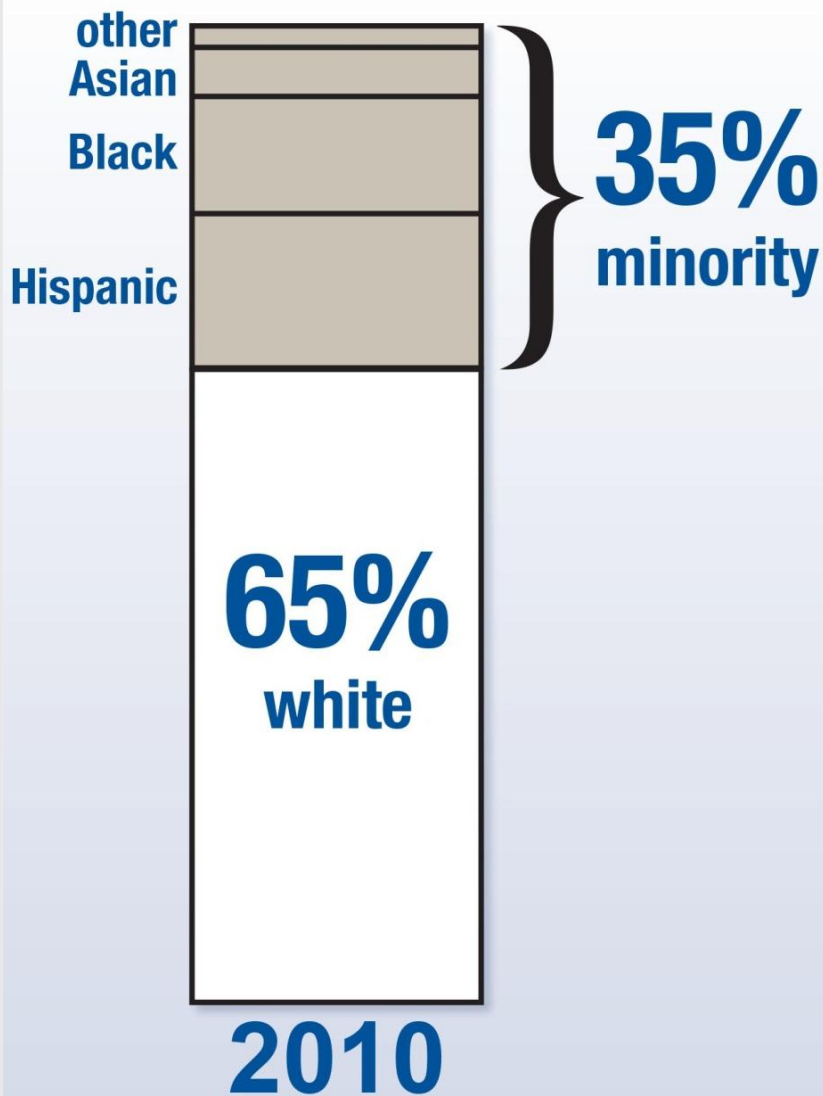


# The Demographic Landscape

- More than 100 million people in the United States are considered minorities.
- Hispanics and Latinos remain the largest minority group with 44.3 million or 14.8% of the population.
- African Americans are the second-largest minority group with 40.2 million or 12% of the population.
- 47 million people in the United States speak a language other than English as their primary language.
- The collective purchasing power of U.S. minorities is more than \$1.3 trillion and growing.

Sources: U.S. Census Bureau, 2012; Selig Center for Economic Growth, 2009.

# Diversity Is a Reality in the U.S.

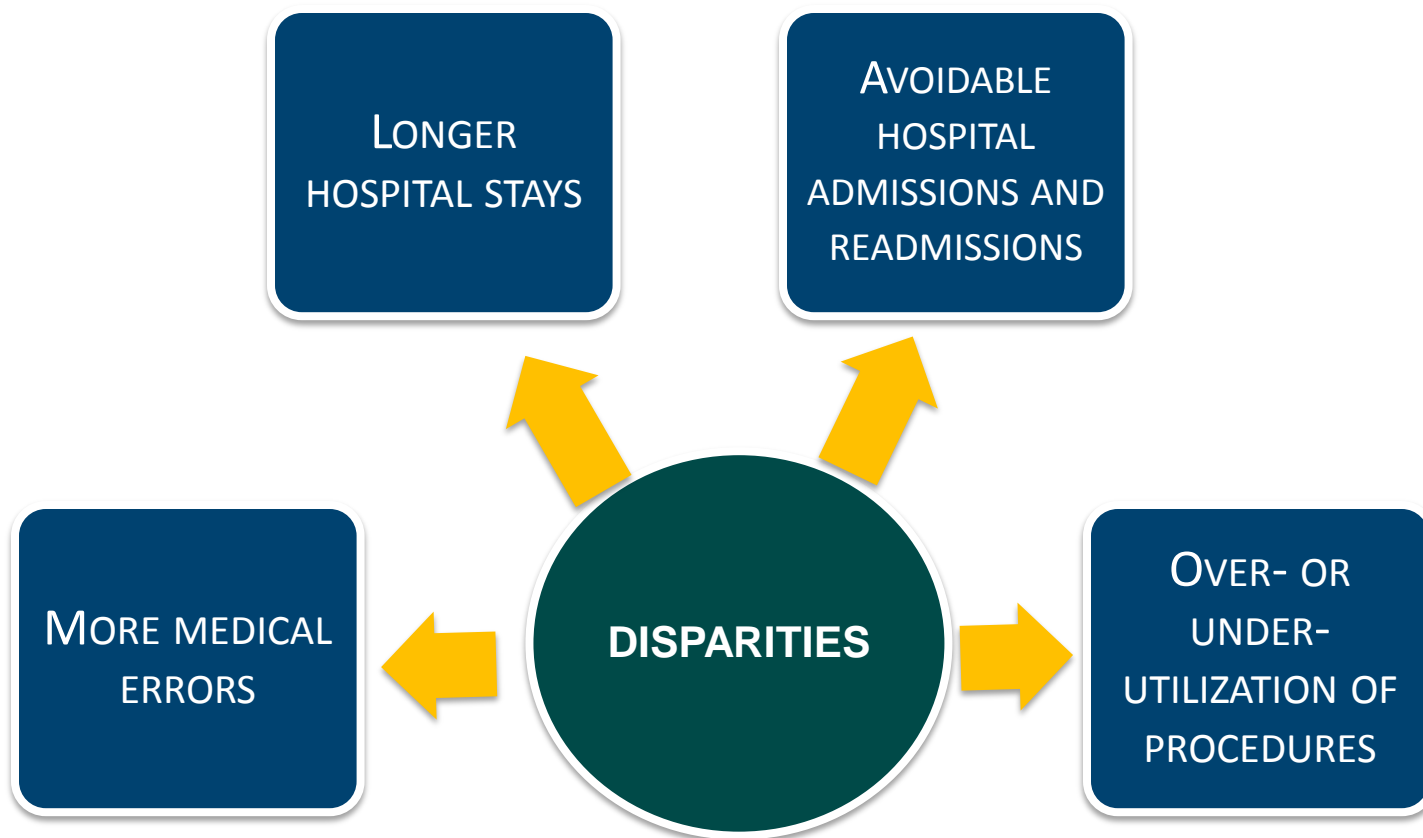


# The Equity Imperative

- Disparities in health care lead to increased costs of care due to excessive testing, medical errors, increased length of stay and avoidable readmissions .
- Pay-for-performance contracts are beginning to include provisions to address racial and ethnic disparities.
- Between 2003 and 2006, 30.6% of direct medical expenditures for African Americans, Asians and Hispanics were excess costs due to health care disparities.
- Eliminating care disparities would reduce direct medical expenditures by \$229.4 billion.
- Eliminating health care inequities associated with illness and premature death would reduce indirect costs by \$1 trillion.

Sources: Disparities Solutions Center, 2008; Joint Center for Political and Economic Studies, 2009.

# The Equity Imperative: Quality Implications



# The Equity Imperative: Quality Implications

- Racial/ethnic minorities are more likely to experience medical errors, adverse outcomes, longer lengths of stay and avoidable readmissions.
- Language barriers can contribute to adverse events.
- Racial/ethnic minorities are less likely to receive evidence-based care for certain conditions.
- Helping patients access appropriate services in a timely fashion improves efficiency.
- Eliminating linguistic and cultural barriers can aid assessment of patients and reduce the need for unnecessary and potentially risky diagnostic tests.
- Eliminating care disparities and increasing diversity can lead to increased patient satisfaction scores.
- Health care disparities are unwarranted variations in care.



# The Equity Imperative: Financial Implications

Eliminating disparities reduces costs and financial risk.



# The Equity Imperative: Regulations and Accreditation

- New disparities and cultural competence accreditation standards from the Joint Commission
- New cultural competence quality measures from the National Quality Forum
- Provisions to reduce disparities in the Affordable Care Act
- State and local laws
- IRS compliance
- MORE...

# The Equity Imperative: Diversity Management

- Improves management of multicultural workforce
- Enhances communication with greater racial and ethnic concordance among patients and providers
  - Leads to greater trust and improved adherence to medical treatment plans
- Decreases employee dissatisfaction
- Ensures compliance with regulations and local, state and federal laws
- Evidence shows that underrepresented minority providers are more likely to practice in underserved communities

# Equity of Care: Challenges to Implement Change

- Limited resources and access to capital
- Reduced reimbursement
- Resistance to change
- Competing regulatory issues and challenges
- Rapidly changing health care landscape
- Unconscious bias

# Equity of Care Partners



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# Priority Areas

## Equity of Care

### Equity of Care



- Increase collection and use of race, ethnicity and language preference data
- Increase cultural competency training
- Increase diversity in governance and leadership

# Goals and Milestones (2013 – 2020)

## Goal 1 – Increasing collection and use of race, ethnicity and language (REAL) preference data:





- 2011 – 18 percent (baseline)
- 2015 – 25 percent
- 2017 – 50 percent
- 2020 – 75 percent



# Best Practice: Race, Ethnicity and Language Preference Data

- Develop consistent processes to collect REAL data
  - Ask patients to self-report their information
  - Train staff (using scripts) to have appropriate discussions regarding patients' cultural and language preferences during the registration process
- Use quality measures to generate data reports stratified by REAL group to examine disparities. Use REAL data to:
  - Develop targeted interventions to improve quality of care (scorecards, equity dashboards)
  - Help create the case for building access to services in underserved communities

# Self-Assessment: Collection and Use of REAL Data

-  Do you systematically collect race, ethnicity and language (REAL) preference data on all patients?
-  Do you use REAL data to look for variations in clinical outcomes, resource utilization, length of stay and frequency of readmissions within your hospital?
-  Do you compare patient satisfaction ratings among diverse groups and act on the information?
-  Do you actively use REAL data for strategic and outreach planning?

# Case Examples

## Addressing Diabetes Among the Latino Population

**Organization:** Kaiser Permanente

**Location:** Denver, CO

Latino patients living with diabetes have a high risk for cardiac events and resulting hospitalization. Working to reduce or lessen the risk, Kaiser Permanente engaged patients in a collaborative management process placing them on an evidence-based therapy intervention that relies on a trio of drugs – Aspirin, Lisinopril and Lovastatin.

At the beginning of the program, clinical data was analyzed using surname and geocoding analysis to identify which Latino patients were not achieving optimal diabetes outcomes.

Using that information, the program launched in a clinic setting that served, almost exclusively, a Spanish speaking Latino population. Using a bicultural, bilingual staff model and the evidence-based therapy method, Kaiser Permanente demonstrated improved adherence to a diabetic medical protocol.

**Lessons learned:** Emphasize data. Data helps make the case that improvement opportunities exist. Without data, there's no way to provide a basis for establishing interventions and involving staff.

The screenshot shows the Greater Cincinnati Health Council website. The header includes the logo and tagline "Creating connections. Improving care." with navigation links for Contact Us, Directions, Disaster Portal, and Disaster Net Login. A search bar is also present. The main navigation menu includes About Us, Quality and Patient Safety, Data, Work Force, Group Purchasing, Disaster & Trauma, Events, and Newsroom. The page content is titled "Disparity Reduction & REL Data Collection" and includes a breadcrumb trail: Home > Quality & Patient Safety > Quality Initiatives > Disparity Reduction & REL Data Collection. A "Quality Initiatives" sidebar lists various programs, with "Disparity Reduction & REL Data Collection" highlighted. The main content area features a "New Resources Available!" section with links to a video, a white paper, and best practice guidelines. Below this is a "Purpose" section stating the goal is to identify and address disparities in care, and a "Description" section detailing the national effort to improve care quality and equality for all patients. A "Health Council Contact" section provides information to contact Nancy Strassel for more details. A "Training" section offers a link to learn about the training module for registration staff. A small image of a healthcare professional interacting with a patient is visible at the bottom left of the page.

# Key Resource: HRET Disparities Toolkit



## HRET Disparities Toolkit

A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients

### Welcome

The Health Research and Educational Trust Disparities Toolkit team is proud to release this updated Toolkit. The Toolkit is a Web-based tool that provides hospitals, health systems, clinics, and health plans information and resources for systematically collecting race, ethnicity, and primary language data from patients.

We trust you will find this Toolkit useful for educating and informing your staff about the importance of data collection, how to implement a framework to collect race, ethnicity, and primary language data at your organization, and ultimately how to use these data to improve quality of care for all populations. For more information on how to use this Toolkit, click [here](#).

### Acknowledgments

Special thanks to the [National Advisory Panel members](#) and the [Consortium Members](#) for their input, and to David Baker, MD, MPH, and colleagues at Northwestern University Feinberg School of Medicine for their contribution to the research that informs this work.

Many thanks to the Robert Wood Johnson Foundation for their support of the work for collecting race, ethnicity, and primary language data in hospitals under the Expanding Success: Excellence in Cardiac Care program and for their on-going grant support to improve data collection. We would also like to thank the Commonwealth Fund for their support of research projects that continue to inform this work.

### Project Team

Romana Hasnain-Wynia, PhD, Debbie Pierce, Ahmed Haque, Cynthia Hedges Greising, Vera Prince, and Jennifer Reiter

### Citation for Toolkit

Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J. (2007) Health Research and Educational Trust Disparities Toolkit. [hretdisparities.org](http://hretdisparities.org) accessed on date

### Keep Posted!

Sign up if you would like us to keep you informed regarding updates to the Disparities Toolkit and this web site. We will not share your information with anyone.



[Toolkit Home](#)

#### Toolkit Links

- [How to Use the Toolkit](#)
- [Who Should Use the Toolkit](#)
- [Why Collect Race, Ethnicity, and Primary Language](#)
- [Why Collect Data Using a Uniform Framework](#)
- [Collecting the Data - The Nuts and Bolts](#)
- [How to Ask the Questions](#)
- [How to Use the Data](#)
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- [Tools and Resources](#)
- [Frequently Asked Questions](#)
- [Print the Entire Toolkit](#)



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# Goals and Milestones (2013 – 2020)

## Goal 2 - Increasing cultural competency training:

- 2011 – 81 percent (baseline)
- 2015 – 90 percent
- 2017 – 95 percent
- 2020 – 100 percent

# Best Practice: Cultural Competency Training for Improved Patient Care

- Educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities
- Require all employees to attend diversity training
- Provide culturally and linguistically appropriate services such as:
  - Interpreter services and translators
  - Bilingual staff
  - Community health educators
  - Multilingual signage

# Self-Assessment: Cultural Competency Training for Improved Patient Care

- ✓ Have your clinicians, patient representatives, social workers, discharge planners, financial counselors and other key patient and family caregivers received special training in diversity issues?
- ✓ Has your hospital developed a “language resource” to identify qualified people, inside and outside your organization, who could help your staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds?
- ✓ Are written communications with patients and families available in a variety of languages that reflect the diversity of your community?
- ✓ Are core services in your hospital, such as signage, food service, chaplaincy services, patient information and other communications, attuned to the diversity of the patients you care for?

# Case Studies

Equity of Care

**Culturally Competent Care**

The community that Adventist serves is very diverse. About 30% of Montgomery County residents are immigrants and 35% speak a language other than English at home. Each person in a culture has his or her own unique set of health beliefs and practices that can vary by age, gender, religious beliefs, and socioeconomic status. The Center on Health Disparities programs and services help providers become more knowledgeable about the patients they serve, and more sensitive and responsive to their particular needs.

Meeting the needs of a culturally diverse population makes Adventist HealthCare a leader in providing quality care and services. Taking patient's cultural beliefs and values into account can result in:

- Better communication and understanding of a person's cultural background, health beliefs, and values.
- Better care that is in keeping with their cultural beliefs.
- Better adherence to recommended treatments.
- Better trust of health care workers and better satisfaction among patients.
- Better health outcomes for all patients.
- Reduction of health disparities.
- Compliance with federal regulations and medical accreditation requirements

The Center on Health Disparities is leading AHC's goal of providing culturally and linguistically appropriate care and services to a diverse patient population.

**Culturally Competent Care Training for HealthCare Professionals**

The Center on Health Disparities provides cultural competence training to clinical and non-clinical health care professionals and staff to increase awareness of racial and ethnic disparities in health care, eliminate cultural and linguistic barriers during clinical encounters, and improve quality of care. Training is available in-class and online for Adventist HealthCare physicians, nurses, and other staff.

**General Training Objectives**

- Discuss the population demographics of local communities and health disparities that affect them.
- Define culturally competent care and the importance of providing such care.
- Identify and discuss the influence of one's own cultural values, biases, and assumptions on providing care.
- Discuss ways to limit the impact of one's personal biases when interacting with customers/patients.
- Describe communication barriers between patients and staff and ways to



## Participating Sites

Improving Diabetes Care and Outcomes on the South Side of Chicago

Camden Citywide Diabetes Collaborative

The Diabetes Equity Project (Dallas, TX)

Reducing Diabetes Disparities in American Indian Communities (Wind River Reservation)

Diabetes For Life (Memphis, TN)

## The Diabetes Equity Project (Dallas, TX)

Home » Participating Sites » The Diabetes Equity Project (Dallas, TX)



### THE PROGRAM:

The Diabetes Equity Project (DEP) has leveraged the extensive community partnership among Baylor Health Care System (BHCS), the BHCS Office of Health Equity, the HealthTexas Provider Network Office of Community Health Improvement, Project Access Dallas, Genesis Medical Foundation, Dallas-area charitable clinics, and Blue Cross Blue Shield of Texas to reduce disparities in diabetes care for underserved people with diabetes in Dallas County, Texas.

### THE GOALS:




# Key Resource: National CLAS Standards

U.S. Department of Health & Human Services  
Office of Minority Health

**THINK CULTURAL HEALTH** *Advancing Health Equity at Every Point of Contact*

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Home >> CLAS & the CLAS Standards

 **NOW AVAILABLE! The enhanced National CLAS Standards and The Blueprint with guidance and implementation strategies.**

### What are the National CLAS Standards?

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

[Click here for a list of the National CLAS Standards](#)

Download Document: [EnhancedNationalCLASStandards.pdf](#) (PDF - 47 KB)

**Principal Standard:**

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

**Governance, Leadership and Workforce:**

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Communication and Language Assistance:**

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

# Key Resource: National Prevention Strategy

U.S. Department of Health & Human Services [www.hhs.gov](http://www.hhs.gov)

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Home > Initiatives > Prevention > National Prevention Strategy

## INITIATIVES

Tobacco

Walking

Prevention

National Prevention Strategy

National Prevention Council

Prevention Advisory Group

Resources

Support Breastfeeding

Family Health History

Text Size: **AAA**

## National Prevention Strategy

The National Prevention Strategy, released June 16, 2011, aims to guide our nation in the most effective and achievable means for improving health and well-being. The Strategy prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives. The Strategy identifies four Strategic Directions and seven targeted Priorities.

The Strategic Directions provide a strong foundation for all of our nation's prevention efforts and include core recommendations necessary to build a prevention-oriented society. The Priorities provide evidence-based recommendations that are most likely to reduce the burden of the leading causes of preventable death and major illness.



## National Prevention Strategy Resources

- Download the strategy in full: [National Prevention Strategy](#) (PDF – 4.66 MB)
- Read the Strategy [section by section](#)
- National Prevention Strategy [News Release](#)
- Webcast of Thursday June 16th [release event](#)
- [National Prevention Strategy Fact Sheet](#) (PDF - 1.04 MB)

# Goals and Milestones (2013–2020)

## Goal 3 - Increasing diversity in governance and leadership:

- 2011 - Governance 14 percent / Leadership 11 percent (*baseline*)
- 2015 - Governance 16 percent / Leadership 13 percent (*or reflective of community*)
- 2017 - Governance 18 percent / Leadership 15 percent (*or reflective of community*)
- 2020 - Governance 20 percent / Leadership 17 percent (*or reflective of community*)

## Best Practice: Increased Diversity in Governance

- Actively work to diversify your board to include voices and perspectives that reflect your community
- Incorporate specific goals into the board workplan with accountability for goals
- Engage the broader public through community-based activities and programs
- Consider creating a community-based diversity advisory committee

# Best Practice: Increased Diversity in Leadership

- Regularly report on the ethnic and racial makeup of senior leaders
- Support and assist the development of mentoring programs within health care organizations
- At every opportunity, advocate the goal of achieving full representation of diverse individuals at entry, middle and senior levels
- Advocate diversity in appointing job search committee members and promote a diverse slate of candidates for senior management positions.

## Self-Assessment: Increasing Diversity in Governance and Leadership

- ✓ Does your organization have a mentoring program in place to help develop your best talent, regardless of gender, race or ethnicity?
- ✓ Are search firms required to present a mix of candidates reflecting your community's diversity?
- ✓ Do your recruitment efforts include strategies to reach out to the racial and ethnic minorities in your community?
- ✓ Does your human resources department have a system in place to measure diversity progress and report it to you and your board?
- ✓ Has your community relations team identified community organizations, schools, churches, businesses and publications that serve racial and ethnic minorities for outreach and educational purposes?

# Key Resource: Minority Trustee Training Program

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## INSTITUTE FOR DIVERSITY in Health Management

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#### Welcome

Are you looking for qualified individuals from diverse racial, ethnic and cultural backgrounds to serve on your hospital's board of directors?

The American Hospital Association, along with its Institute for Diversity in Health Management and Center for Healthcare Governance, has created an online registry of candidates from diverse backgrounds who are interested in serving on the board of their local hospital or health system. If you are looking to increase the diversity of your board, we encourage you to use this registry to identify candidates whose skills and interests may be a good match for your organization.


[SEARCH FOR CANDIDATES NOW](#)









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## Diversity Digest

e-newsletter  
Spring 2012

### Shining through: How to get on a hospital board

By Don Follen  
Do you want to be on a hospital board. When do you begin? How do you stand out from others? What attributes make a good board member?

According to John K. Campbell, CEO, American Hospital Association senior vice president, president and COO, Center for Healthcare Governance, the most important thing someone can do before trying to get on a board is to understand what governance is, how it functions, and how it differs from the role of operations of an organization.

"Governance is really about setting the direction for the organization. For planning for the future of the organization," Dr. Campbell said. "It gets its work done from the managers. It tries to ensure it makes sense the operations of the organization. If you think about it on the basis of an organization that you'll be able to direct every other course, that is the foundation."

Education in governance should begin with reading. Dr. Campbell suggests people become familiar with Trustee Magazine, which is published by Westwood, and an American Hospital Association information company. He also recommends two books, "Governance in Leadership" by Kenneth C. Davis, William P. Hahn, and Richard B. Taylor and "Board Action" by Dennis D. Kofner and James E. O'Keefe.

After doing research on governance, the next step is getting to know the hospital board. According to Dr. Campbell, some of the best ways to do this is by volunteering at the hospital, attending hospital community outreach events, or getting involved in making relationships through membership in a network or professional organization, such as the state or local hospital association. Dr. Campbell said it is essential to make yourself known to community and hospital leaders.

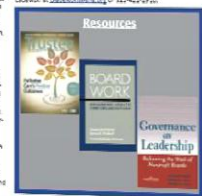
"You need to be seen as somebody who is a supporter of health care in your locality, that you are concerned about having high-quality health care in your community," said Dr. Campbell. "You don't do this either volunteering directly at the hospital or participating in the hospital association through a variety of activities and trying to get involved in your community."

Dr. Campbell lists there are certain characteristics that define a good board member. These include:

- Being a team player
- Having a strong ethics sense
- Collaborative in approach to issues
- Understanding of different personalities
- Good listener
- Participates in discussions
- Ready to take charge situations

"You also have to be committed to the mission of the organization and be willing to do the hard work of a board member," Dr. Campbell said. "You need to participate in the discussions. Listen to what is being said, and really understand the needs of the organization. These are great skills to have going forward."

For more information on available resources, contact Bill Johnson at [billjohnson@aha.org](mailto:billjohnson@aha.org) or 781-742-1210.



# Key Resource: American College of Healthcare Executives

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## Policy Statements

### Increasing and Sustaining Racial/Ethnic Diversity in Healthcare Management

- July 1990
- May 1995 (revised)
- December 1998 (revised)
- March 2002 (revised)
- November 2005 (revised)
- November 2010 (revised)

#### Statement of the Issue

One of the hallmarks of a democratic society is providing equal opportunity for all citizens regardless of race or ethnicity. In the healthcare sector, racially/ethnically diverse employees represent a growing percentage of all healthcare employees, but they hold only a modest percentage of top healthcare management positions. For example, according to the American Hospital Association, in 2010, 94 percent of all hospital CEOs were white<sup>1</sup> (non Hispanic or Latino) while 65 percent of the population is white<sup>2</sup> (non Hispanic or Latino), according to the most recent U.S. Census Bureau data.



# National Call to Action to Eliminate Health Care Disparities

Launched in 2011, the National Call to Action is a national initiative to end health care disparities and promote diversity. The group is committed to three core areas that have the potential to most effectively impact the field.

## Goals and Milestone (2013 – 2020)

### Goal 1) Increasing the collection and use of race, ethnicity and language preference (REAL),

2011 – 18 percent \*(baseline)

2015 – 25 percent

2017 – 50 percent

2020 – 75 percent

### Goal 2) Increasing cultural competency training,

2011 – 81 percent (\*baseline)

2015 – 90 percent

2017 – 95 percent

2020 – 100 percent

### Goal 3) Increasing diversity in governance and leadership.

2011 - Governance 14 percent / Leadership 11 percent (\*baseline)

2015 - Governance 16 percent / Leadership 13 percent (*or reflective of community served*)

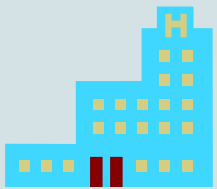
2017 - Governance 18 percent / Leadership 15 percent (*or reflective of community served*)

2020 - Governance 20 percent / Leadership 17 percent (*or reflective of community served*)

## \*Survey Questions:

- 1) Race, ethnicity and primary language data is collected at the first patient encounter and used to benchmark gaps in care.
- 2) Hospital educates all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities.
- 3) Racial/ethnic breakdown for each of the hospital's executive leadership positions and members of the hospital's board of trustees.

# Equity of Care: Where are we...



**Your  
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## Your Organization

# Equity of Care: Where are we...



**We collect race, ethnicity and language preference data. (Yes or No)**

**We use this data to benchmark gaps in care. (Yes or No)**

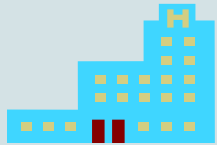
- *Describe – lessons learned, challenges, successes...*

**We provide cultural competency training to all clinicians and staff. (Yes or No)**

**Minorities represent XX% of our patient population.**

**Minorities comprise XX% of our board.**

**Minorities comprise XX% of our leadership team.**



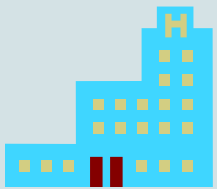
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## Your Organization

# Equity of Care: Telling our story...



*Describe your current efforts as they relate to equity of care.*



**Your  
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## Your Organization

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