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

The headlines are common and the facts are known…

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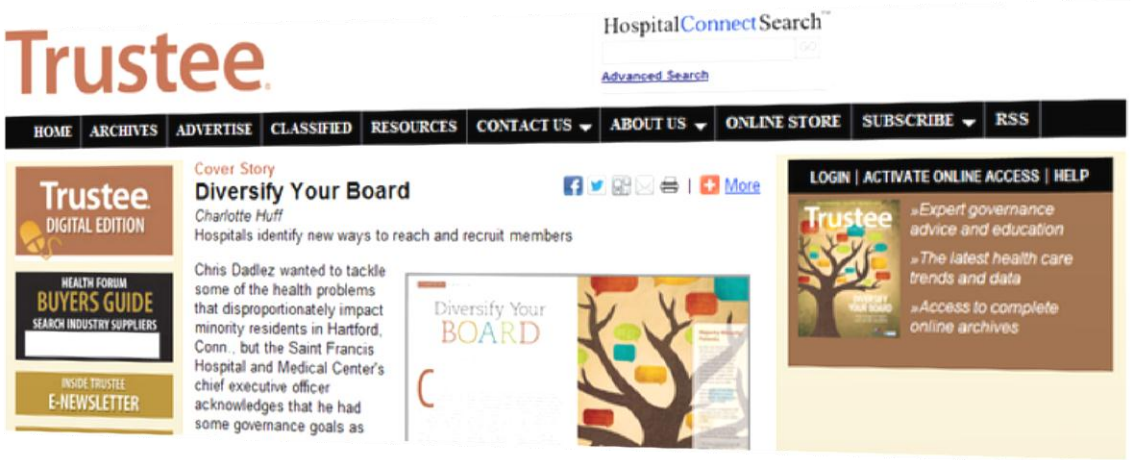
Although they represent only one-third of the total U.S. population, racial and ethnic minorities comprise more than half of the uninsured.
-U.S. Department of Health & Human Services



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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Unequal Treatment

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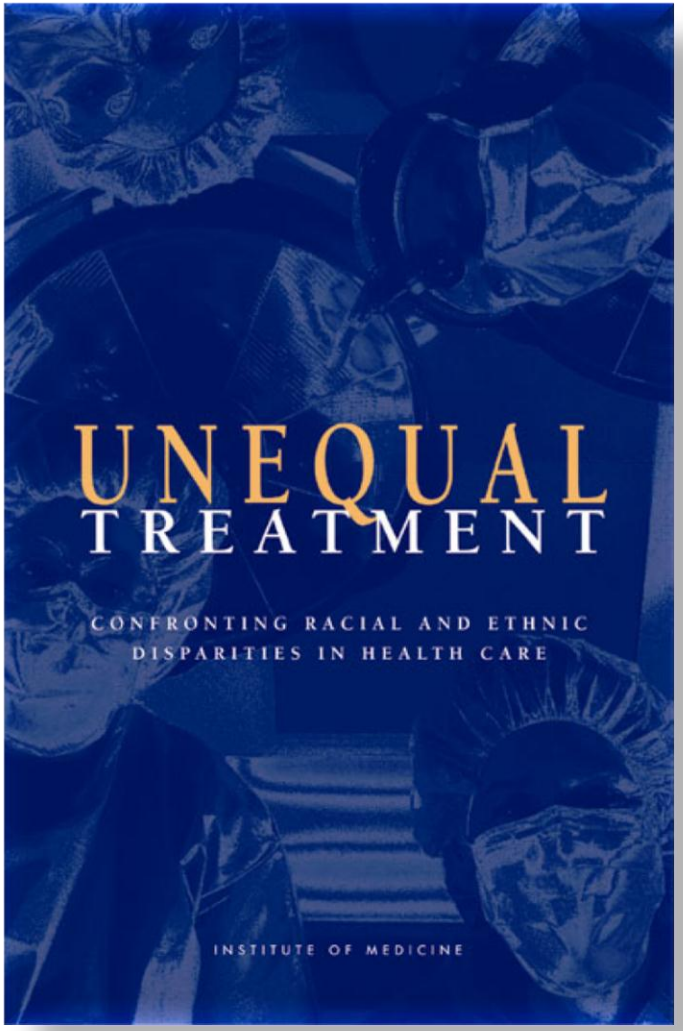

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The Demographic Landscape

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- 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.

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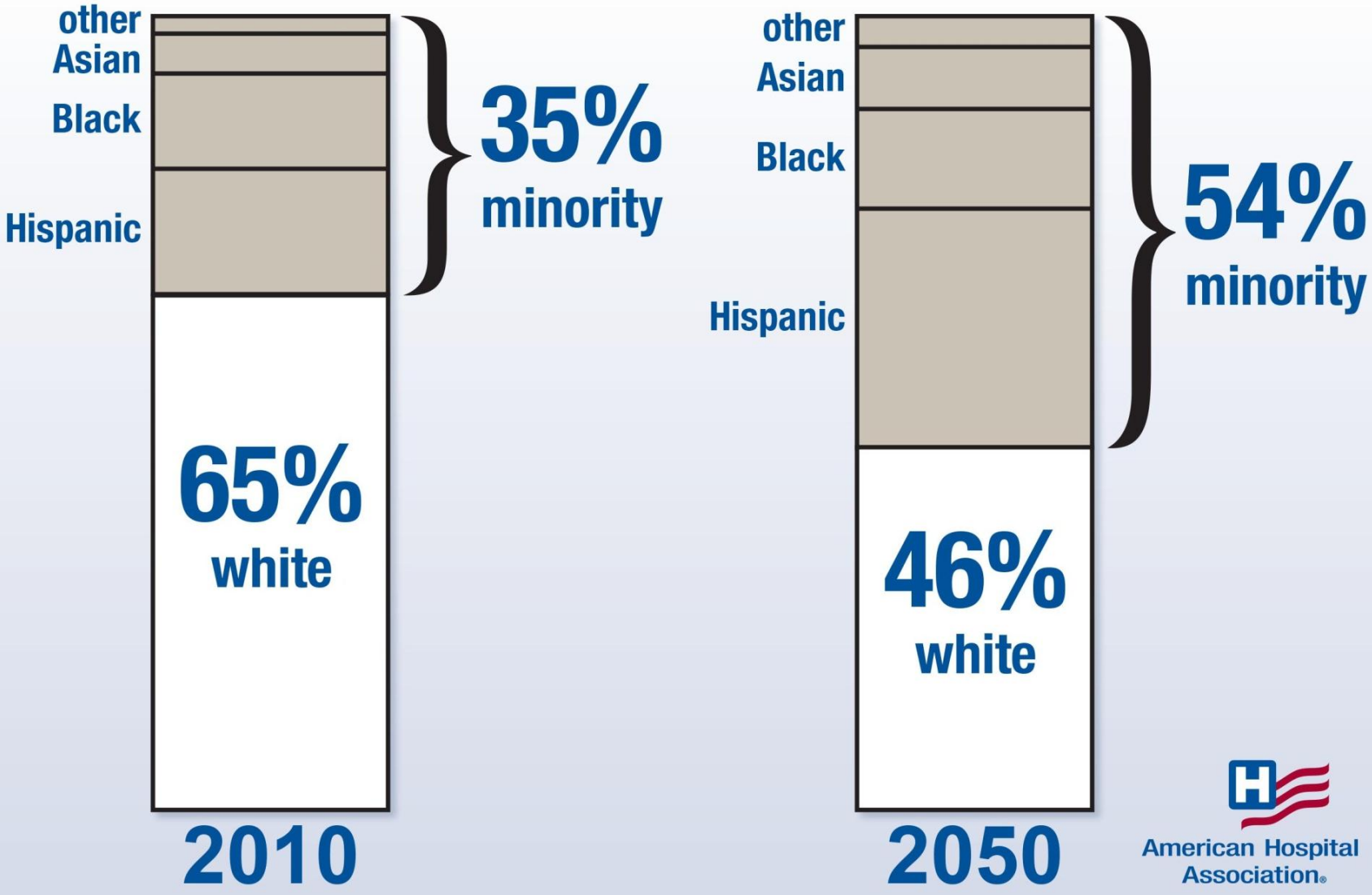

The Equity Imperative

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- 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

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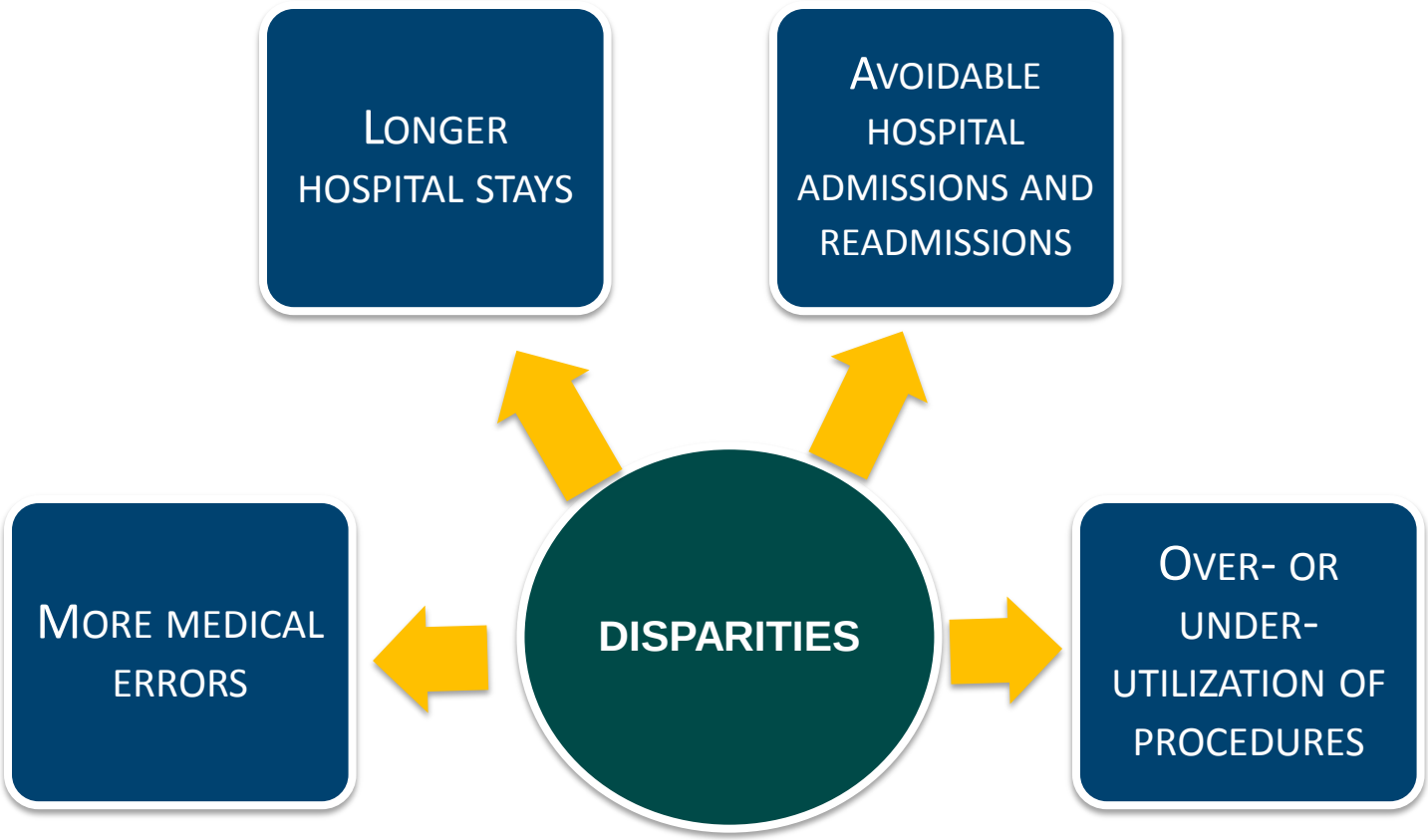

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The Equity Imperative: Quality Implications

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- 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

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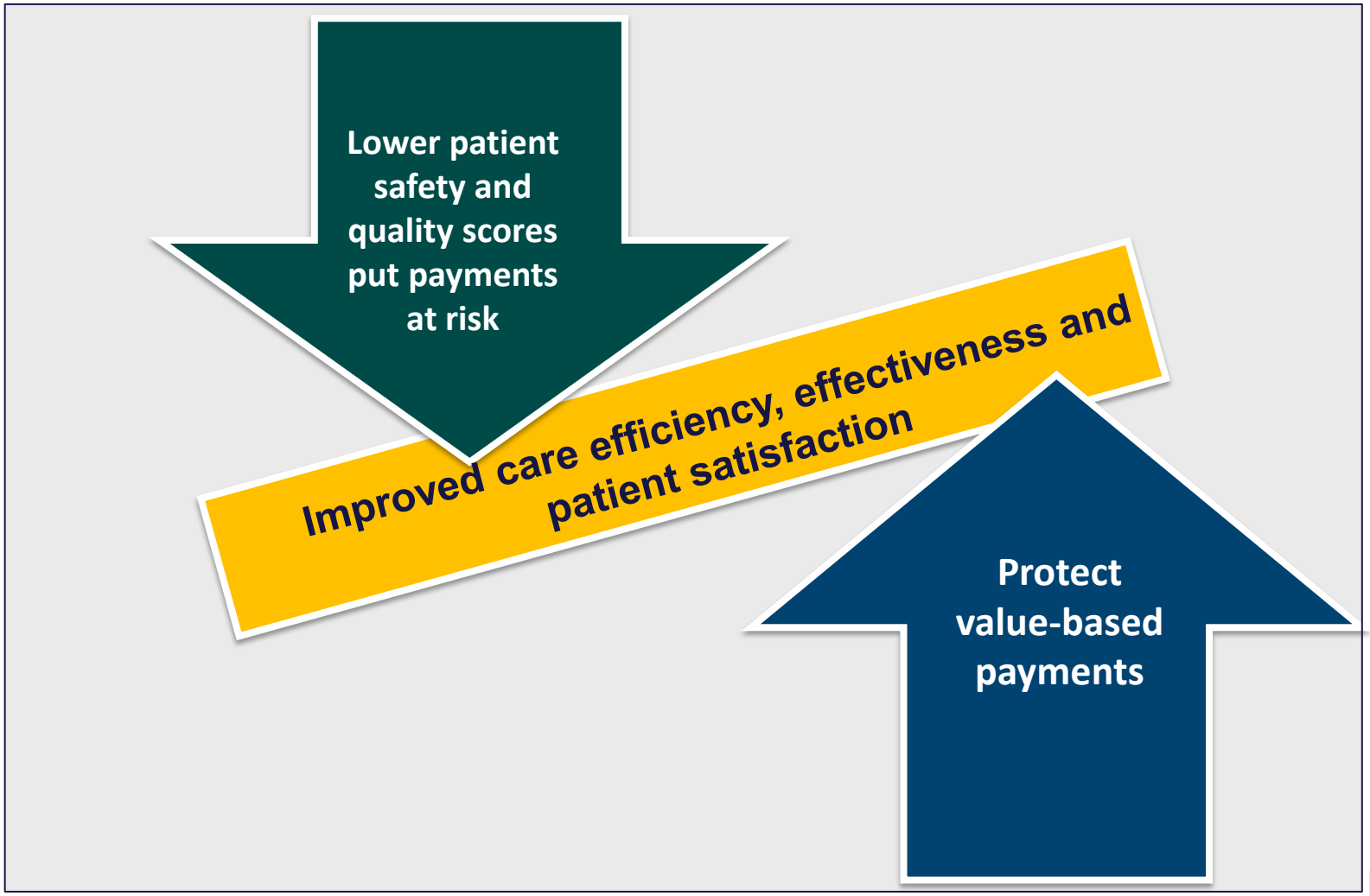
Eliminating disparities reduces costs and financial risk.



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The Equity Imperative: Regulations and Accreditation

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- 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

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- 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

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- 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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AAMC
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American College of Healthcare Executives
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For more information, visit www.equityofcare.org

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Offers free resources for the health care field:

- Best practices
- Monthly newsletter
- Case studies
- Guides
- Webinars and educational opportunities
- Current research

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Priority Areas

- 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)

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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

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- 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

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- 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

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Addressing Diabetes Among the Latino Population

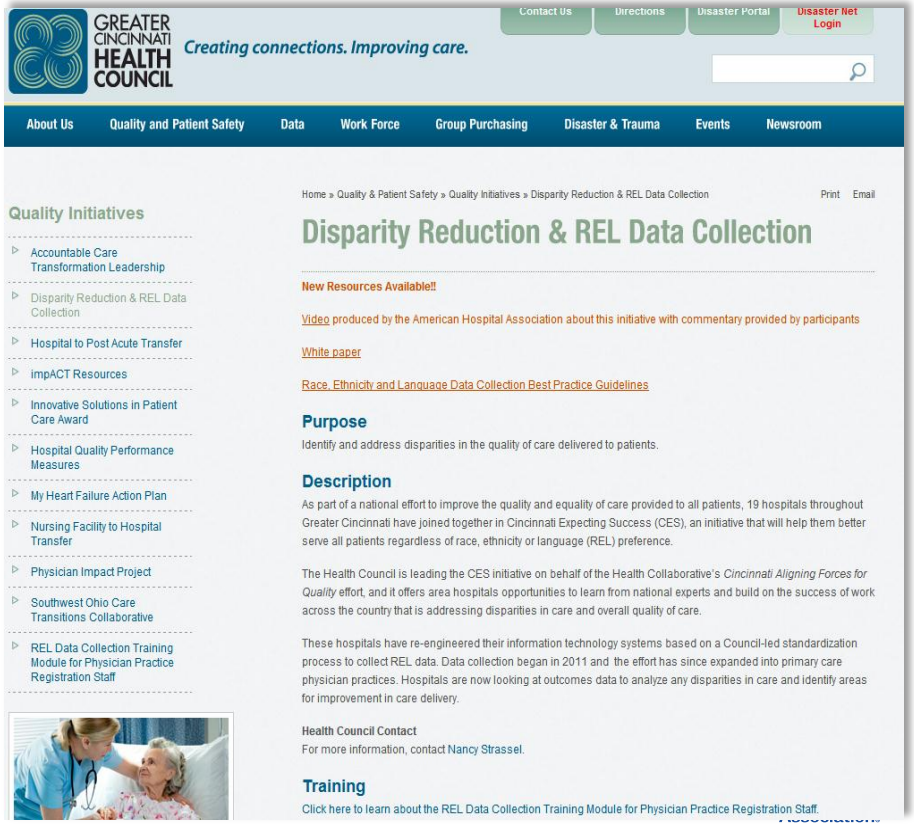
Organization: Kaiser Permanente
Location: Denver, CO

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.



Key Resource: HRET Disparities Toolkit

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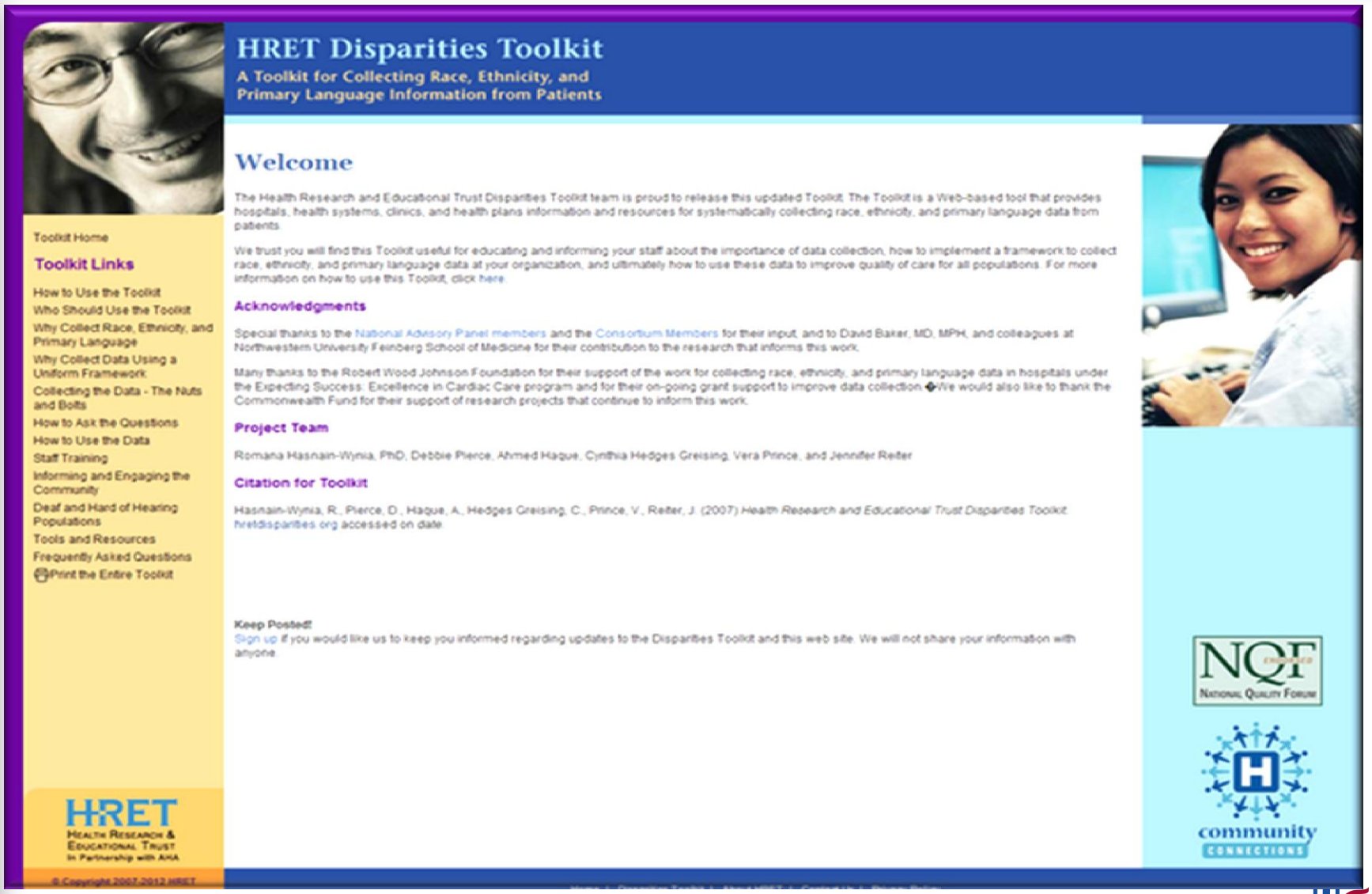

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Goals and Milestones (2013 – 2020)

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Goal 2 - Increasing cultural competency training:

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

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Best Practice: Cultural Competency Training for Improved Patient Care

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- 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

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- 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

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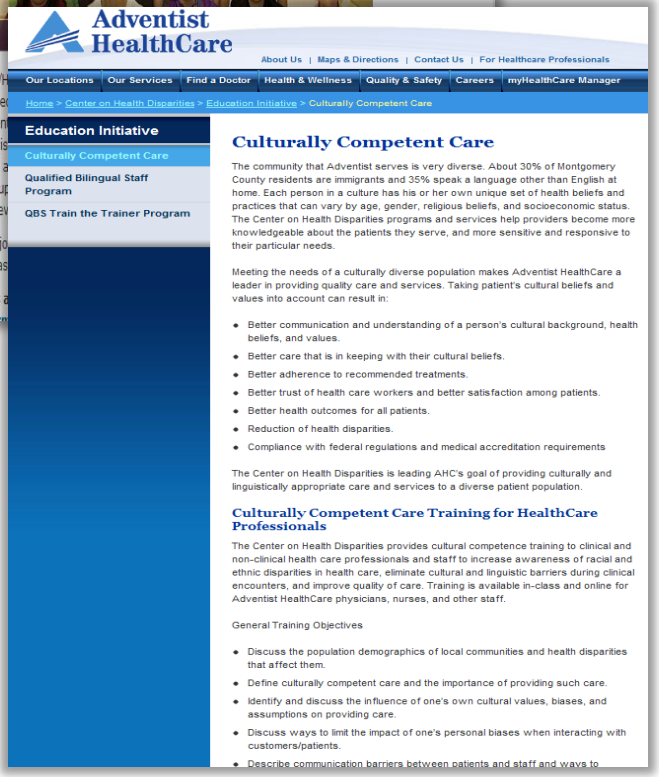

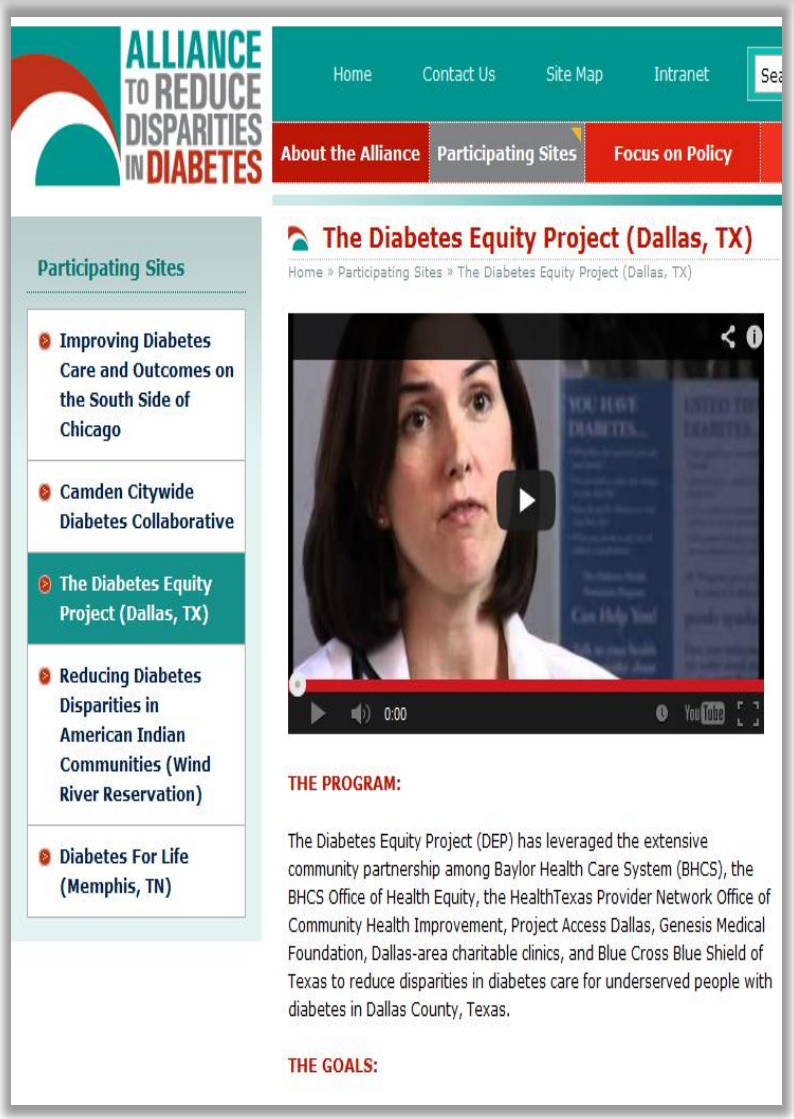

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Key Resource: National CLAS Standards

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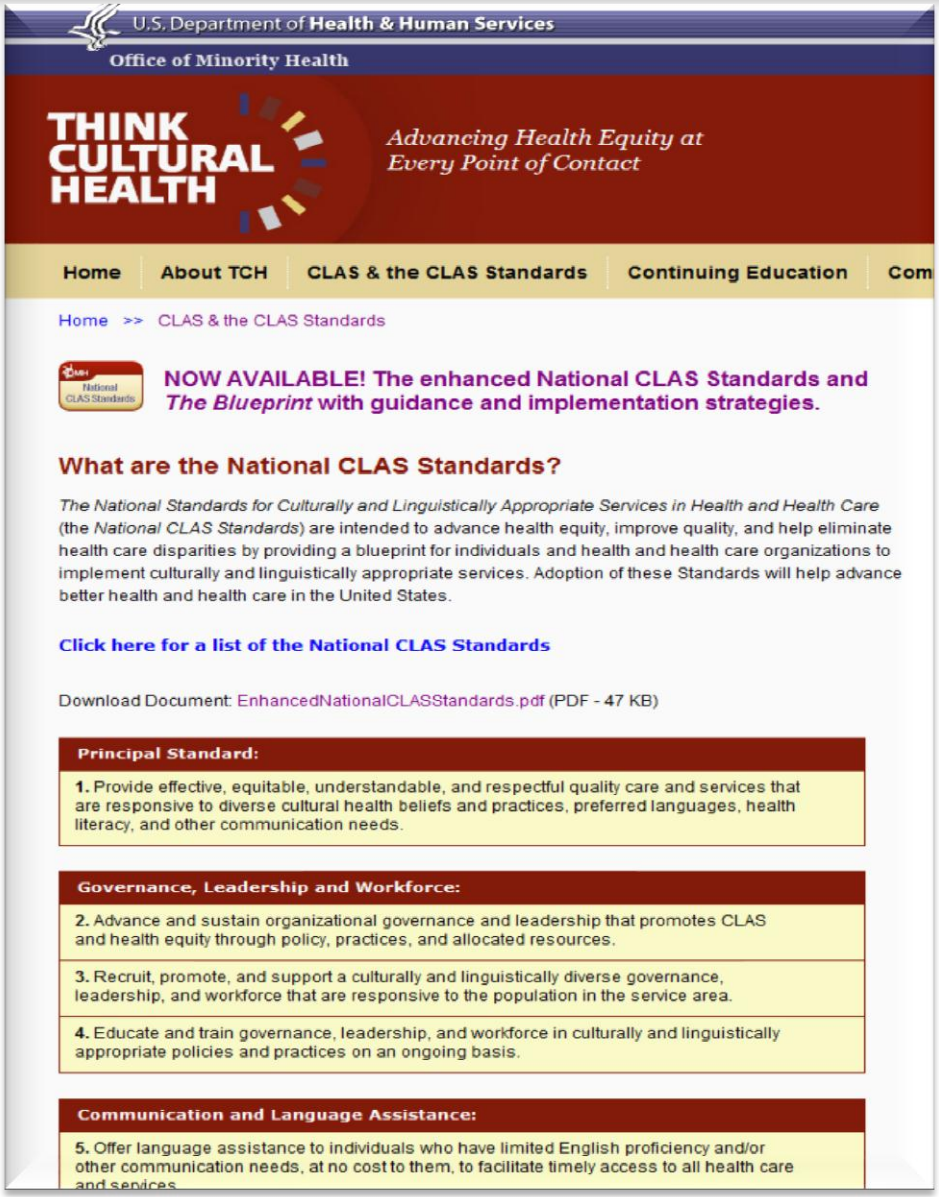

U.S. Department of Health & Human Services

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.

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Key Resource: National Prevention Strategy

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U.S. Department of Health & Human Services www.hhs.gov

Mon, Nov 4, 2013

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Home > Initiatives > Prevention > National Prevention Strategy

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INITIATIVES

- Tobacco
- Walking
- **Prevention**
  - **National Prevention Strategy**
  - **National Prevention Council**
  - **Prevention Advisory Group**
  - **Resources**
- Support Breastfeeding
- Family Health History

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)

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Goals and Milestones (2013–2020)

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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

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- 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

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- 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

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- 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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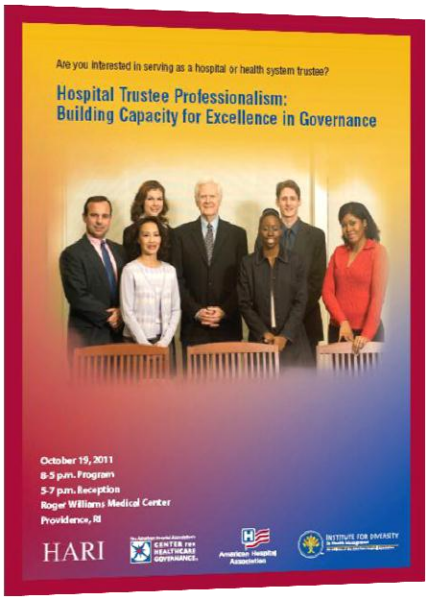
in Health Management
An affiliate of the American Hospital Association

The American Hospital Association's
CENTER FOR HEALTHCARE GOVERNANCE™



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Key Resource: American College of Healthcare Executives

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About ACHE

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Information Links:

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- Governance
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- Diversity Resources
- Ethics Resources/Policy
- Policy Statements
- Public Policy Initiatives
- Social Responsibility
- Fund for Innovation
- Connect
- Contact ACHE

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[1] (non Hispanic or Latino) while 65 percent of the population is white[2] (non Hispanic or Latino), according to the most recent U.S. Census Bureau data.

National Call to Action to Eliminate Health Care Disparities

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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)

Goal1) 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.

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Equity of Care:
Where are we…

Your Organization

Your
Logo

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)

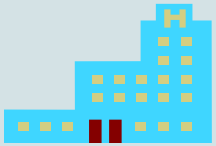
- ***Describe – lessons learned, challenges, successes…***

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.

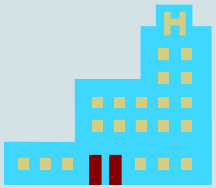


Your Logo

Your Organization

Equity of Care: Telling our story…

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



Your Logo

Your Organization

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