Equity of Care

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Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned

AAMC

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Executive Summary

Achieving health care equity and eliminating health care disparities are a top goal of hospitals and health systems. Health care equity has become an important discussion nationally as policymakers aim to improve quality of care while lowering costs through a variety of changes to existing incentives. Recognizing that there are areas for improvement is a first step, but it must be followed by actionable strategies to make sustainable improvements.

The American Hospital Association, Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems have launched a call to action to eliminate health care disparities. The goals of the group are to (1) increase the collection of race, ethnicity, and language (REAL) preference data to facilitate its increased use, (2) increase cultural competency training for clinicians and support staff, and (3) increase diversity in governance and management.

These three goals represent realistic and fact-based approaches to eliminate disparities in care. Through consistent and reliable data collection, hospitals and systems can understand the characteristics of the communities they serve, identify differences in care, target quality improvement activities, and track progress. Training in cultural competency will increase clinician and staff awareness and help hospitals and systems ensure that patients receive high-quality, individualized care. Greater diversity in hospital leadership positions will ensure that hospitals and health systems reflect diversity in the communities they serve and provide valuable perspective for improvements.

This guide looks at nine hospitals and health systems and summarizes each organization's key successes toward achieving one of the three goals. The case examples offer a snapshot of some best practices and lessons learned for other hospitals and systems working to make improvements.

Introduction

The United States is becoming more diverse demographically, with racial and ethnic minorities projected to become the majority of the U.S. population by 2042[1]. Nearly 47 million people—18 percent of the U.S. population—speak a language other than English at home[2]. There is evidence that the health care system is not meeting the needs of the changing communities it serves, contributing to disparities in care. Research shows that disparities in health care can lead to increased medical errors, prolonged length of stays, avoidable hospitalizations and readmissions, and over- and under-utilization of procedures[3]. While this issue is not new to health care leaders, there is now legislation in place that has the potential to address some of the underlying issues that lead to disparities in care.

The Affordable Care Act not only enacted comprehensive health care reform but also addressed health care disparities in critical ways. Included in the final law are provisions that increase access to and the affordability of care in underserved populations, develop community-based strategies to eliminate local barriers to health care, and improve both the diversity of the health care workforce and its competency in treating patients from different cultural and linguistic backgrounds[4].

The American Hospital Association, the Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems, as part of a national call to action, have defined three goals for hospitals and health systems to eliminate health care disparities. These goals focus on data collection and use, cultural competency training, and leadership diversity. This guide is not intended to be definitive or representative of all types of hospitals and approaches. The purpose is to highlight best practices and lessons learned from several organizations that have implemented strategies to improve their performance in one of these three areas.

While each of these organizations have taken different approaches to improve REAL data collection, increase cultural competency, or increase leadership diversity, the strategies they have implemented share three success factors. First, the organizations have indicated that leadership buy-in, both administrative and clinical, is essential if any of these improvement efforts are to be implemented and sustained. Second, consistent and recurrent training of clinicians and staff involved in the improvement efforts can help to reinforce behaviors and implementation of new processes. Finally, organizations sustained improvements when initiatives to eliminate disparities were incorporated into their overall quality improvement and strategic plans.

As demonstrated by the variety of improvement efforts in the case studies that follow, there is more than one way for an organization to improve equity of care delivery. In addition, specific strategies will be highly dependent upon the local demographics. However, all of these organizations have made a commitment to align more closely with their increasingly diverse communities and to improve the overall quality of care they deliver and the satisfaction of patients they serve.

Increasing Collection and Use of REAL Data

Most hospitals collect demographic information containing components of race, ethnicity, and primary language data, but the quality and entirety of this data is not consistent. The purpose of collecting REAL data is to learn the exact demographic makeup of the communities served, determine what disparities in care exist, decide how the hospital can allocate resources to improve access to health services, and target quality improvement activities. Most hospitals believe they provide care equally to all patients, but only by collecting REAL data can this be quantified.

At some hospitals and systems, data collection is handled by front-line and registration staff who may enter the information based on sight, educated guesses, or secondary sources such as identification documents. The recommended method is for hospitals to ask patients to self-declare their information either by entering the data themselves or through a structured interview during patient registration. Hospitals have used extensive training to motivate and encourage staff to adopt new data collection protocols. In addition, emphasizing the importance of collecting accurate REAL data for overall quality improvement helps organizations overcome any initial resistance from staff. Most hospitals use scripts and role-playing during training sessions to mitigate any concerns that staff may have about asking patients for personal information. Scripts address how staff can ask questions and handle problems that may arise during conversations with patients.

REAL data can be used for strategic planning and quality improvement purposes. A hospital can more appropriately allocate resources if it can identify where disparities exist within the communities served and where there is a need to improve access to appropriate services. For example, increasing access points to primary care in underserved communities can provide essential preventive services that may improve overall outcomes, efficiency, and patient satisfaction. Data collected for these purposes needs to be consistent and reliable in order to create a concrete business case for deploying resources and to achieve buy-in from senior and clinical leaders.

Finally, to ensure that data collection is efficient and accurate, organizations should use a multidisciplinary team of individuals to develop the collection process. Involving the registration staff, IT, quality department, and hospital leadership is important to ensure that the data collected aligns with the organization's quality goals, is compatible with existing IT platforms, and alerts stakeholders of the impetus for improvements.

Case Study: Updating EMRs to Include REAL Data

San Mateo Medical Center, San Mateo, California

Overview: San Mateo Medical Center has collected demographic data for many years. But due to a cumbersome framework for collection as required under state and federal guidelines, and inefficient screening practices, the data has been unreliable and not very useful to the hospital's quality and leadership teams. Furthermore, they knew that integrating REAL data into the organization's electronic medical record (EMR) would require a costly upgrade to the existing IT system.

Actions: San Mateo Medical Center is using recommendations from the California Health Care Safety Net Institute to simplify and focus its data collection practices. For example, although the number of race categories is dictated by federal reporting guidelines, the ethnicity categories were expanded to reflect the diversity of its specific patient communities. The medical center also created a multidisciplinary team, including managers from the IT department, health information management, quality department staff, and training supervisors for the clerical staff to oversee and coordinate the changes. With the support of executive management, the REAL data project was included as a goal in the package of Delivery System Reform Incentive Payments (DSRIP) for the medical center's Medicaid waiver, which rewards hospitals for improving quality performance. This advancement will also allow the medical center to eventually load REAL data directly into the EMR.

Results: Although the full changes will not go live until mid-January, patients will soon be able to self-report their ethnicity, language, and race from a preselected, abbreviated list of categories created by the hospital and aligned with community demographics. Patient registration team members will then input the data into the EMR. The medical center is beta testing the new system with its quality team to incorporate this information and ensure the right data is collected. One goal of the changes is the availability of REAL data to identify and address potential disparities for at least 90 percent of patients encountered by late 2012[5].

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Case Study: Analyzing REAL Data to Improve Quality of Care

University of Mississippi Medical Center, Jackson, Mississippi

Overview: University of Mississippi Medical Center wanted to improve the way it collected REAL data and better understand the demographics of the communities that the medical center served. In addition, UMMC wanted to use REAL data to analyze and identify opportunities to improve clinical outcomes for its diverse patient communities.

Actions: UMMC created a Healthcare Disparities Council with 40 members, including interpreters, administrators, nurses, physicians, and members of the registration staff. The council reports to the hospital leadership. Four subgroups support the council's efforts and focus on health literacy, patient access and experience of care, education and awareness, and quality for diverse populations. The council has focused its efforts on several performance improvement initiatives.

One success story has been UMMC's involvement in Expecting Success: Excellence in Cardiac Care, a program of the Robert Wood Johnson Foundation aimed at improving quality of cardiac care for African-American and Hispanic patients by improving care for all patients[6]. During the program, UMMC adopted standardized protocols to collect REAL data, including using standard categories for race, ethnicity, and language data. In addition, staff was trained to interview patients to ask for this information. UMMC used the REAL data to provide monthly reports on care performance measures, stratified by patient race, ethnicity, and primary language. The medical center also tracked core measures of care for patients who had a heart attack or heart failure. Through this effort, UMMC was able to demonstrate how simple, standard collection methods of REAL data can help improve overall patient quality.

Results: Participating in the RWJF project yielded several positive outcomes for UMMC. First, the number of patients receiving all core measures of care for heart attack and heart failure increased from 74 percent to 82 percent in two years[7]. UMMC also realized that heart attack patients need help to better control and self-manage their disease post-hospitalization. As a result, the medical center established an outpatient heart failure management clinic, led by a nurse practitioner who helps patients manage their disease after leaving the hospital. Approximately one year after the clinic opened its doors, the readmission rate for the clinic's patients was 0 percent.

Today the Healthcare Disparities Quality Subcommittee supporting the Healthcare Disparities Council has created an equity scorecard that specifically monitors performance in cardiac care. The scorecards are updated and reviewed quarterly to identify areas for improvement in caring for diverse populations.

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Case Study: Beyond REAL Data - Community Actions to Improve Diabetes Care and Outcomes

Baylor Health Care System, Dallas, Texas

Overview: The Baylor Health Care System Office of Health Equity (OHE) aims to reduce variation in health care access, health care delivery, and health outcomes among its diverse patient populations. For example, diabetes is a severe epidemic in the state of Texas and also more than twice as likely to occur in minority populations. REAL outpatient diabetes management data analysis indicated the presence of disparities in diabetes management within the primary care practices employed by Baylor Health Care System (BHCS). As a first step in reducing diabetes care disparities, BHCS recognized an opportunity to develop a community-based self-management diabetes education and advocacy intervention, reducing the burden on clinicians while improving diabetes disease control disparities. This low-cost, patient-centered self-management education program was designed to support patient needs with less expensive community health workers, functioning as diabetes health promoters. The OHE developed the Diabetes Equity Project (DEP), with funding from a Merck Company Foundation grant, with the goal of reducing observed disparities in diabetes care and outcomes in the predominately Hispanic, medically underserved communities around BHCS.

Actions: Hispanics with diabetes experience a 50 to 100 percent higher burden of diabetes-related illness and mortality than non-Hispanics[8]. The DEP was designed to improve access to preventive care and diabetes management programs. DEP was deployed in five community charity clinics and makes use of community health workers who receive extensive training in diabetes care and management, enabling them to serve as a bridge between patients and providers. Patients are referred to the DEP from both community and private practice clinics, following emergency room visits and hospitalizations related to uncontrolled diabetes. The DEP seeks to be responsive to patient-reported needs like education, communication and respect, removal of financial constraints, and access to medication and transportation by (1) placing an emphasis on community health worker recruitment and training; (2) building on existing community infrastructure through partnerships with local clinics; (3) integrating the community health workers' role into a health care system's care coordination strategy; and (4) developing an electronic diabetes registry that tracks patient metrics and facilitates disease management communication between community health workers and primary care clinicians.

Results: Enrollment in the Diabetes Equity Project began at the end of September 2009 and, within the first 18 months of the rolling enrollment, had 806 patients in the program. A preliminary analysis of the first year of results revealed a statistically significant drop in HgbA1c value from a baseline of 8.7 percent to 7.4 percent. Patient satisfaction surveys revealed that over 98 percent of participants indicated the highest level of satisfaction with the care they received. The program performance suggests that the long-term value of the program is that sustainable diabetes control can be achieved for participants who have previously experienced poor control by augmenting "usual care" with community health worker-led patient education and advocacy. The next step in the BHCS diabetes management disparity improvement journey will be to apply the community-based success to a group of private practice clinic patients experiencing care management disparities.

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Creating a Culturally Competent Organization

Cultural competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring health care delivery to meet patients' social, cultural, and linguistic needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care. A key component to new care delivery models, such as patient-centered medical homes and accountable care organizations, is the ability to engage and educate patients regarding their health status. While this is challenging to do for all patients, for diverse patient populations it can be even more difficult due to deficits in English-language proficiency and health care literacy, and cultural differences in communication styles.

It is therefore imperative that hospitals not only understand the diverse communities they serve but also prepare their physicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education. The first step in the process is to use REAL data to identify which diverse populations the hospital is serving. Next, organizations need to identify how to develop appropriate training to increase staff members' and clincians' abilities to accurately and consistently communicate with patients.

Translation services are a foundational element used by hospitals to bridge gaps in communication with diverse populations. Some hospitals in communities with large numbers of non-English speaking patients have chosen to employ bilingual and bicultural staff. In addition, many hospitals have developed programs to build upon the bilingual skills that their clinicians and staff may already have. Although staff or clinicians may be bilingual, unless they are adept at translating medical terms and procedures, important messages regarding care delivery can be missed, which will impact outcomes.

Finally, hospitals and systems can better understand diverse cultures by seeking advice from individuals and groups in the communities they serve. These constituencies can help hospitals develop educational materials, improve access to services for patients, and increase health care literacy. Community groups such as religious organizations or schools can help hospitals understand how best to interact and communicate with various cultures.

Case Study: Improving Cultural and Linguistic Competency of Health Care Providers and Staff

Adventist HealthCare, Rockville, Maryland

Overview: Adventist HealthCare created the Center on Health Disparities to reduce and eliminate disparities in health status and health care access, treatment, quality, and outcomes throughout the communities served by its system. The center is organized into three focus areas: cultural competence education and training, health disparities research, and health care services partnerships. To ensure the provision of culturally competent, patient-centered health care, the center provides education and training on cultural awareness and cross-cultural communication to health care providers and staff within the Adventist system and at partner organizations. An advisory board composed of representatives from health care, academia, local governments, and community-based organizations provides guidance to the center on its activities.

Actions: The Center on Health Disparities emphasizes organizational and health professional cultural and linguistic competency in several ways. First, the center's staff conducts organizational cultural competence assessments to determine how well hospitals are meeting the needs of their patients and creates strategic plans for leadership to improve health equity. At presentations and in-services and through web-based training to promote patient-centered care, physicians and other health care providers and staff learn about culturally appropriate and effective communication techniques to care for diverse populations. In addition, to ensure that patients receive linguistically appropriate services, the center offers programs such as the Qualified Bilingual Staff Training (QBS) Program. The purpose of this three-day program is to assess language proficiency and train bilingual staff to provide proper foreign language interpretation for patients who speak little or no English. Health care providers and staff learn proper medical interpreting skills to facilitate effective communication during cross-cultural encounters and improve the organization's ability to provide culturally and linguistically appropriate care and services.

Results: With an increased focus on cultural and linguistic competency, the Center on Health Disparities has helped patients better navigate the health care system and improved the care they receive. For example, patients are now more thoroughly screened at registration, and offered language assistance from a hospital-provided language interpreter or a qualified bilingual staff member, when needed.

Since 2007, the center has held 19 QBS training sessions and trained more than 400 providers and staff to provide language access services to non-English speaking patients. The center also has developed and disseminated annual reports at local conferences to bring community stakeholders together and share best practices and community interventions to improve cultural competency and enhance patient experience.

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Case Study: Providing Education and Training to Improve Cultural Competency

Children's Mercy Hospitals & Clinics, Kansas City, Missouri

Overview: The patient population at Children's Mercy Hospitals & Clinics has become more diverse as the Kansas City metropolitan area population has changed demographically. In addition to collecting REAL data, Children's Mercy emphasizes educating and training all staff on diversity and inclusion issues and providing more in-depth cultural competency and language training for front-line admissions staff as well as clinicians. Work on diversity and equity issues at the hospital is guided by an Office of Equity and Diversity and an Equity and Diversity Council composed of staff members at all organizational levels[11].

Actions: The hospital's Office of Equity and Diversity (OED) is working with the Service Excellence Steering Committee to implement an organization-wide strategy on diversity, inclusion, service excellence, and cultural competence. Between 2008 and 2010, more than 6,000 employees at Children's Mercy completed a required course entitled "Honoring Diversity." New employees now complete the training online. In addition, Spanish-speaking admissions staff can enroll in a Spanish proficiency assessment program. Participants who complete and pass a testing process then receive a pay differential. Testing is repeated annually to ensure ongoing competency. The hospital's Equity and Diversity Council is exploring an organization-wide rollout of this competency assessment process. Children's Mercy offers other Spanish language courses to health care workers, all with the aim of providing better care for Spanish-speaking patients and families.

At the hospital's Pediatric Care Center, at least a quarter of the 45,000 visits each year are for Spanish-speaking families. In response, Dr. John Cowden created the CHICOS Clinic (Clinica Hispana de Cuidados de Salud). This program trains select pediatric residents with moderate or better Spanish proficiency to complete a bilingual cross-culture care curriculum as part of their primary care training[12]. Residents speak Spanish with patients with an interpreter in the room as a "safety net," and a bilingual attending doctor provides role modeling and coaching. The program's goal is to develop certifiably bilingual and culturally sensitive clinicians.

Results: Equity and diversity have become part of the culture of safety and service excellence at Children's Mercy. The organizational structure created in the OED and its partner council has provided stability and strategy for wide-ranging improvement activities. New hospital standards for assuring language competency and excellent communication have resulted in critical conversations about how patients have been treated in the past and a vision for more equitable care moving forward.

Participation in the CHICOS Clinic has increased to 11 residents, from 3 the first year. Overall at Children's Mercy Hospital, feedback from patients and the community has been impressive, and patient satisfaction has increased. Physicians and other health care workers enjoy the improved ability to interact with and treat patients. Many patients previously lacked an access point for care, partly due to language barriers, but they now can receive individualized care and improved access to follow-up treatments due to improved communication. In addition, the OED is planning an organization-wide cultural competency assessment to evaluate its current strengths and weaknesses and assist in developing future programming.

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Case Study: Integrating Cultural Competency into Population Health Initiatives

New York-Presbyterian Hospital, New York, New York

Overview: New York-Presbyterian Hospital's Columbia University Medical Center campus serves a predominately Hispanic community with high rates of asthma, diabetes, heart disease, and depression[13]. Recognizing that health disparities and gaps in care coordination existed in this community, NYP developed a strategy to improve clinical care coordination, increase cultural competency among providers, and introduce integrated information systems across sites of care.

Actions: NYP established the Regional Health Collaborative to improve care coordination and cultural competency through four main strategies: (1) implementation of seven National Committee for Quality Assurance designated patient-centered medical homes focused on diabetes, CHF, asthma, and depression, (2) centralization of call center functions such as scheduling, test results, and follow-up information for all seven sites, (3) employment of bilingual and bicultural community health workers and navigators in the medical homes and emergency departments, and (4) implementation of a four-hour training program to build a workforce that can better address linguistic, cultural, and health literacy needs of the community. Physicians also receive training with patient-based cross-cultural care, which assists with cultural competency and communication with patients and families. This training helps physicians become more aware of their patients' perspectives in addition to their own[14].

Results: As of May 2011, approximately 600 employees have received cultural competency training[15]. The collaborative has helped decrease the number of emergency department visits for ambulatory care - sensitive conditions by 9.2 percent.

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Increasing Diversity in Governance and Management

Many hospitals and health systems recognize that they need to increase the diversity of their senior leadership and board to reflect the diversity of the communities they serve. But many hospitals have encountered difficulties recruiting and retaining qualified candidates to their facilities. The pool of qualified candidates can be small. Some hospitals have successfully implemented complementary strategies related to recruitment, retention, and "candidate pipeline development."

As a first step, hospitals need to develop a formal recruiting strategy that targets qualified candidates and establishes metrics that can be used to monitor the number of minority or underrepresented candidates who apply and advance through the hiring process. A long-term solution is to expand the number of leadership candidates within a community. To encourage more minorities to pursue a career in health care, hospitals have formed partnerships with local schools and universities and offered internships, held educational fairs, and awarded scholarships—all to highlight the benefits and value of working at a hospital.

Retention and succession planning are also important components for increasing diversity in governance and senior management. Improving cultural competency within the organization and providing mentorship programs to support new employees and potential candidates can enhance efforts to recruit and retain culturally diverse candidates. The changes required to establish a successful recruiting and retention program will require changes across several internal departments. Support and acknowledgment by the board and senior leadership team are required, and incorporating diversity efforts as part of an organization's strategic mission is critical.

Case Study: Setting Goals to Increase Diversity in Leadership

Barnes-Jewish Hospital, St. Louis, Missouri

Overview: Barnes-Jewish Hospital created the Center for Diversity and Cultural Competence in 2006, One of the center's goals is to ensure that the professional, management, and senior leadership team reflects the diverse community it serves.

Actions: A diversity council, which reports to the hospital's executive council and board, was established in 2007. The diversity council's recommendation to meet the goal of recruiting and retaining 25 percent or more individuals from diverse backgrounds in professional and management positions was approved and incorporated into the strategic goals of Barnes-Jewish Hospital. As a result, specific metrics were established to track the number of underrepresented minorities who currently hold professional and management level positions through recruiting efforts and promotions, or who are emerging into leadership roles. To ensure a diverse pool of qualified candidates, new hiring processes were implemented, such as engaging a consultant with expertise in diversity recruiting, using certified diversity internet recruiters, utilizing minority search firms, recruiting though community organizations, and social networking. Outcomes are reported on a dashboard, enabling the executive leadership, board, management, and staff at large to monitor progress in reaching this goal. Understanding how many minorities apply and interview for an open position allows the council to develop strategies for recruitment, retention, and succession planning.

Results: Barnes-Jewish Hospital conducts an annual employee engagement survey. Diversity scores on this survey increased by a statistically significant percentage, raising the overall employee engagement score to 82 points from 2008 to 2010. The diversity component of the employee engagement survey reflected an overall improvement in areas such as respect and support of a diverse workplace, and efforts by the organization to become more diverse. Recruitment, promotion, and retention of staff from diverse backgrounds in professional and management positions increased from 10 percent in 2006 to 18 percent in 2011. Although it acknowledges there is more work to be done, Barnes-Jewish Hospital has implemented a framework for measuring progress and the tools to implement changes.

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Case Study: Establishing a Process to Increase Diversity in Recruitment Initiatives

Greenville Hospital System University Medical Center, Greenville, South Carolina

Overview: The diversity of the leadership team—director level and above—at Greenville Hospital System University Medical Center (GHS) lagged in comparison to the diversity of the workforce and the communities it served. In addition, there was no consistent method for hiring members of the leadership team, and no metrics were in place to measure progress on recruitment and retention.

Actions: The leadership search and selection process was overhauled, and a new method of hiring employees at the director level and above was put in place. For each leadership team vacancy, a diverse search and selection committee was established to develop a diverse pool of highly qualified candidates. The committee also is responsible for recommending the top two candidates to the hiring manager. Michael Riordan, GHS's CEO, established as one of his five personal goal to focus on having at least one racial or ethnic minority in the final round of onsite interviews for leadership team positions. To ensure that GHS's leadership understood the rationale for this focus on diversity, GHS worked with Furman University, also in Greenville, to send key leaders at GHS through a five-month educational program designed to train existing local leaders in diversity and its importance to an organization.

Results: The first year after implementation of the new process, 70 percent of leadership team appointments were from underrepresented groups, and 50 percent were racial and ethnic minorities[16].

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Case Study: Building a Pipeline to Increase Diversity Recruitment

University Hospitals, Cleveland, Ohio

Overview: To address the changing demographics of its patient community and provide equitable care, University Hospitals' senior leadership created a Diversity Council that includes physicians, nurses, administrators, and nonclinical staff. The Diversity Council's mission is to ensure that diversity and inclusion are an integral part of University Hospitals' culture. The council focuses on three main goals: (1) ensuring a multicultural group of administrative leaders, (2) recruiting and retaining a talented pool of minority faculty and other health care professionals, and (3) building partnerships with minority- and family-owned businesses in the Cleveland area.

Actions: Specific initiatives have been established to recruit and retain a diverse group of leaders and physicians at UH. The David Satcher Clerkship, established in 1991, annually hosts 10 to 15 fourth-year minority medical students who will be seeking residencies. This clerkship offers hands-on exposure to career opportunities in an urban academic medical center. Using a grant from the Joan C. Edwards Charitable Foundation, UH and Case Western Reserve University School of Medicine have established a multifaceted outreach program to encourage promising students at John Hay High School to pursue careers as physician-scientists. For this initiative each year, eight paid summer internships are offered to underserved and underrepresented students, and laboratory-based work-study positions are available at UH Case Medical Center during the academic year for CWRU undergraduate medical students.

UH also provides job shadowing opportunities for 40 students and a half-day class, Introduction to Business and Finance Careers in Health Care, for 100 students at John Hay High School. Ten students from Central Catholic High School and Shaw High School receive 16 hours of career exposure to health careers during the summer. UH also supports Future Connections, a mentoring program that links 10 Central Catholic students with mentors in health care and other professions. For the most promising students at John Hay High School, another program provides scholarships that cover all tuition and fees for undergraduate and medical school. The Minority House Staff Organization was created to support residents and fellows throughout their education, by involving them in community service projects, mentoring minority medical students, and assisting recruitment to UH.

In addition, to ensure a multicultural group of administrative leaders, UH created the Edgar B. Jackson Jr., MD, Endowed Chair for Clinical Excellence and Diversity. The physician appointed to this permanent position has the opportunity to mentor and serve as a role model for minority medical students and post-graduate trainees, recruit diverse physicians, and lead a systemwide effort to reduce health disparities in Northeast Ohio. UH also grows the number of diverse physicians by conducting the Minority Faculty Development Award Program, the KeyBank Faculty and Administrative Fellowship Program, and Timothy Stephens Fellows Program.

Results: More than 200 medical students from more than 40 different medical schools have participated in the David Satcher Clerkship. All of UH's diversity initiatives have helped to double the percentage of African-American physicians on UH's faculty. Today about 6 percent to 9 percent of doctors in residence are underrepresented minorities, up from 1.8 percent in 1991[17].

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Leader Expectations

Increase Collection and Use of REAL Data:

- Develop consistent processes to collect REAL data. Ask patients to self-report their information, or train staff using scripts to have appropriate discussions regarding patients' cultural and language preferences during the registration process.
- Go beyond collection of REAL data—use the data to improve performance. REAL data can be used to develop targeted interventions to improve quality of care for diverse patients with specific conditions (e.g., improving cardiac care for African-American males) and can help create the case for building access to services in underserved communities.

Create Culturally Competent Organizations:

- Leverage the diversity of the existing workforce. Provide additional training opportunities for bilingual staff to improve their abilities to communicate medical information and education to patients.
- In addition to training all staff on cultural competency, look for opportunities to employ bicultural clinical and administrative staff to improve education, care delivery, and ultimately, outcomes.

Increase Leadership Diversity:

- Set measurable goals for increasing the percentage of diverse candidates who interview for and fill positions in leadership and governance.
- Look for opportunities to support minority students pursuing careers in medicine, science, and health care administration in local communities.
- Provide mentorship programs to help support the careers of up-and-coming minority clinical and administrative leaders.

Conclusion

Disparities in health care impact all hospitals and health systems. Finding and implementing solutions should be an ongoing effort and part of a national dialogue. Although hospitals have long promoted equity in care, eliminating health care disparities has increasingly focused on quality improvement. Hospitals and health systems, as part of their mission, are eager to correct inappropriate variations in care.

Additional Resources

Resource	Description	Address
American Hospital Association	To help the hospital field improve the care provided to minorities and eliminate disparities in care, the AHA has convened the Equity of Care Committee. The group examines and provides guidance on how hospitals can help eliminate disparities in care.	http://www.aha.org/advocacy-issues/disparities/index.shtml
Association of American Medical Colleges	The AAMC's commitment to diversity includes embracing a broader definition of "diversity" and supporting our members' diversity and inclusion efforts.	https://www.aamc.org/initiatives/diversity/
American College of Healthcare Executives	The American College of Healthcare Executives has undertaken a number of initiatives to further diversity within ACHE and the health care management field.	http://www.ache.org/policy/diversity_resources.cfm
Catholic Health Association of the United States	The Catholic Health Association and the Catholic health care ministry are committed to the importance of diversity—both in the workforce and in meeting the needs of diverse patients—and to ending health disparities.	http://www.chausa.org/Diversity_and_Health_Disparities.aspx
Catholic Health Care's Response to Disparities	CHA has collected stories on member programs that showcase creative and collaborative approaches to decrease disparities.	http://www.chausa.org/Pages/Our_Work/Diversity_and_Disparities/Disparities_Resources/Response_to_Disparities/
Equity of Care	This site was created to help hospitals, health systems, clinicians, and staff improve the quality of care for every patient. Through free resources, shared best practices, and national collaborative efforts, Equity of Care is leading the health field on a clear path to eliminate disparities.	www.equityofcare.org
Hospitals in Pursuit of Excellence	This website provides evidence-based guides for hospital quality improvement efforts aimed at reducing disparities.	http://www.hpoe.org/topic-areas/health-care-equity.shtml
HRET Disparities Toolkit	The HRET Disparities Toolkit is a web-based tool that provides hospitals, health systems, clinics, and health plans with information and resources for systematically collecting race, ethnicity, and primary language data from patients.	www.hretdisparities.org
Institute for Diversity in Health Management	The Institute for Diversity is committed to expanding health care leadership opportunities for ethnically, culturally, and racially diverse individuals.	www.diversityconnection.org
Minority Trustee Candidate Registry	An online registry of candidates from diverse backgrounds who are interested in serving on the board of their local hospital or health system.	http://www.americangovernance.com/americangovernance/candidatesProgram/index.jsp?fll=S1%3f
National Association of Public Hospitals and Health Systems	More than half of public hospital patients are racial and ethnic minorities, and a majority of patients are uninsured or qualify for Medicaid. The NAPH works to investigate and disseminate promising practices to achieve health equity.	http://www.naph.org/Main-Menu-Category/Our-Work/Health-Care-Disparities.aspx

Endnotes

1. U.S. Census Bureau. (2008). *An older and more diverse nation by midcentury*. http://www.census.gov/newsroom/releases/archives/population/cb08-123.html

2. U.S. Census Bureau. (2000). *Profile of Selected Social Characteristics: 2000* (Table DP-2). Available at http://factfinder.census.gov

3.Institute of Medicine. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press.

4. Koh, H.K., Graham, G. & Glied, S.A. (2011). Reducing racial and ethnic disparities: The action plan from the department of Health and Human Services. *Health Affairs*, *30*, 1822-1829.

5. San Mateo Medical Center. (n.d.). *SMMC Waiver Milestones Proposal*. Retrieved from http://www.dhcs.ca.gov/Documents/10_SMMC%20Milestones%20Proposal%20FINAL.pdf

6. Robert Wood Johnson Foundation. (2008). *Expecting Success: Excellence in Cardiac Care*. Retrieved from http://www.rwjf.org/files/research/expectingsuccessfinalreport.pdf

7. Robert Wood Johnson Foundation. (2008). *Expecting Success: Excellence in Cardiac Care*. Retrieved from http://www.rwjf.org/files/research/expectingsuccessfinalreport.pdf

8. Spencer, M.S., Kieffer E.C., Sinco B.R., et al. (2006). Diabetes-specific emotional distress among African Americans and Hispanics with type 2 diabetes. *Journal of Health Care for the Poor and Underserved*, *17* (2 Suppl), 88-105.

9. Hospitals in Pursuit of Excellence. (n.d.). *The Center on Health Disparities*. Retrieved from http://www.hpoe.org/case-studies/2040004760

10. Adventist HealthCare. (n.d). *Center on Health Disparities.* Retrieved from http://www.adventisthealthcare.com/health-disparities/

11. Children's Mercy Hospitals & Clinics. (2010). *Children's Mercy Hospitals & Clinics Equity & Diversity 2010 Annual Report* (p. 36). Kansas City, MO: Author.

12. Children's Mercy Hospitals & Clinics. (2010). *Children's Mercy Hospitals & Clinics Equity & Diversity 2010 Annual Report* (p. 33). Kansas City, MO: Author.

13. Carrillo, J.E., Shekhani, N., Deland, E.L., Fleck, E.M., Mucaria, J., Guimento, R., et.al. (2011). A regional health collaborative formed by NewYork-Presbyterian aims to improve the health of a largely Hispanic community. *Health Affairs, 30*, 1955-1964.

14. Carrillo , J.E. (2007, March 29). *Organizational Changes to Promote Heallth Literacy and Cultural Competency: The NewYork-Presbyterian Hospital Experience*. PowerPoint. http://www.iom.edu/~/media/Files/Activity%20Files/PublicHealth/HealthLiteracy/RoundtableonHealthLiteracyMeeting4EmilioCarrillowebpost.pdf

15. Carrillo, J.E., Shekhani, N., Deland, E.L., Fleck, E.M., Mucaria, J., Guimento, R., et.al. (2011). A regional health collaborative formed by NewYork-Presbyterian aims to improve the health of a largely Hispanic community. *Health Affairs, 30*, 1955-1964.

16. Institute for Diversity in Health Management. (n.d.). *Ensuring Diversity at the Top: A Case Study of Greenville Hospital System University Medical Center in Greenville, South Carolina*. Retrieved from http://www.diversityconnection.org/diversityconnection/workforce-strategies/case-study/Second%20Quarter%20Greenville%20Hospital%20System.pdf

17. University Hospitals. (2011). *University Hospitals Report on Diversity 2010-2011*. Cleveland, OH: Author.