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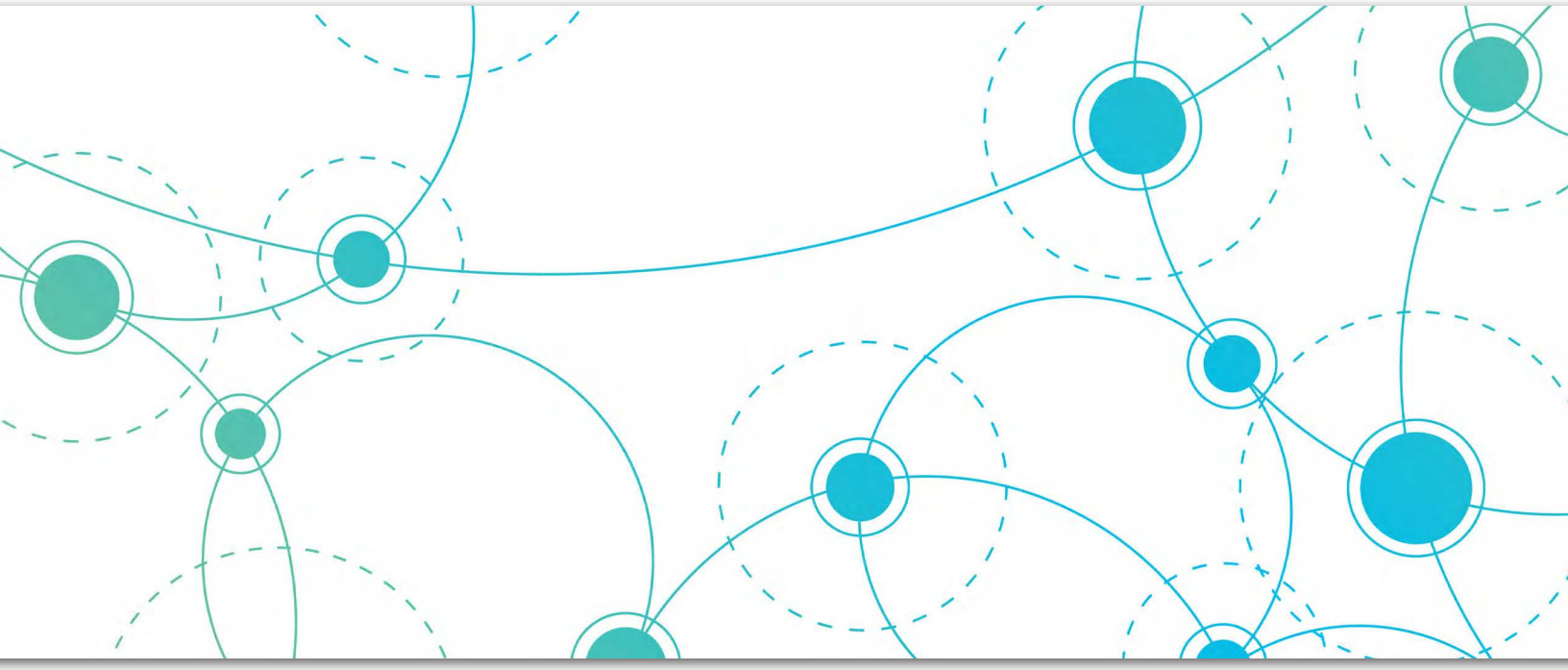
Accelerating Performance Improvement

Equity of Care:
A Toolkit for Eliminating Health Care Disparities



January 2015

INSTITUTE FOR DIVERSITY in Health Management
An affiliate of the American Hospital Association

American Hospital Association®

Equity of Care

Dear Colleague:

To achieve the American Hospital Association's vision of creating a society of healthy communities, where all individuals reach their highest potential for health, we must make faster progress in addressing the health disparities that exist in many of the populations we serve. Each of us has a responsibility and an opportunity to make a tremendous difference in the lives of hundreds of thousands of people by making progress in this area.

To support your efforts to improve quality and health care equity in your communities, we are pleased to release **Equity of Care: A Toolkit for Eliminating Health Care Disparities**. This toolkit is a user-friendly "how-to" guide to help accelerate the elimination of health care disparities and ensure our leadership teams and board members reflect the communities we serve. Whether your organization is beginning this journey or is already deeply engrained in this work, the compendium was created in response to your many requests to gather best practices in one convenient resource.

Equity of Care is a national collaborative effort of the American Hospital Association, American College of Healthcare Executives, America's Essential Hospitals, Association of American Medical Colleges and Catholic Health Association of the United States. Through this platform, the Equity of Care partners issued a **call to action to eliminate health care disparities**. Our goals are to:

- increase the collection and use of race, ethnicity and language preference data;
- increase cultural competency training; and
- increase diversity in governance and leadership.

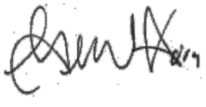
Where to start?

1. Find out where your organization stands in progressing toward the three goals of the call to action.
2. Compare your results to the 2013 Institute for Diversity in Health Management's Diversity and Disparities survey results.
3. Continue quality improvement by:
    - Selecting a quality measure to stratify by race, ethnicity and language preference. If a health care disparity exists, implement a plan to address this gap.
    - Creating a plan to ensure your staff receives cultural competency training.
    - Having a dialogue with your board and leadership team on how you reflect the community you serve and what actions can be taken to address any gaps.
4. Encourage colleagues in the field to join this effort by sharing your journey with them.

Please share this compendium with your team and your trustees and make it part of your quality and strategy discussions. Improving the health of the populations we serve cannot be done without also eliminating the health care disparities that still exist. Equity of Care is not just another item on our long to-do lists; instead, it is foundational to our quality, patient safety and community health initiatives.

We thank you for everything you have done, and everything we know you will do, to achieve our mission as health care leaders to advance the health of all the individuals and communities we serve.

Sincerely,



Eugene A. Woods, FACHE
Chair, Equity of Care Committee
Board of Trustees
American Hospital Association

Rich Umbdenstock
President and CEO
American Hospital Association

Equity of Care: A Toolkit for Eliminating Health Care Disparities

The partners of the National Call to Action to Eliminate Health Care Disparities are working to improve quality of care for all individuals by focusing on three core areas. To help you get started or complement your existing efforts, this toolkit offers a framework for next steps paired with resources to guide your work.

Step One: Increase the collection and use of race, ethnicity and language preference (REAL) data

- Ensure that REAL data collection is systematic and reliable
  - ✓ HRET Disparities Toolkit
  - ✓ Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders
- Use the data to stratify quality metrics
  - ✓ A Framework for Stratifying Race, Ethnicity and Language Data
- Identify disparities or confirm none exist
  - ✓ Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data

Step Two: Increase cultural competency training

- Make cultural competency training a part of the orientation of all employees and ensure all clinical staff receive the training
  - ✓ Building a Culturally Competent Organization: The Quest for Equity in Health Care
- Include training on the following competency areas: language services; family / community interactions; religious beliefs affecting health care; languages spoken by patients; diverse health beliefs held by patient populations
  - ✓ Becoming a Culturally Competent Health Care Organization
- Continually assess training and impact to gauge success and identify opportunities for improvement
  - ✓ Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned

Step Three: Increase diversity at the leadership and governance levels

- Communicate across the organization the business imperative of having a leadership team and board reflective the communities served
  - ✓ Rising Above the Noise: Making the Case for Equity in Care
- Develop chief diversity officer roles to elevate diversity as a strategic priority
  - ✓ The Role of the Chief Diversity Officer in Academic Health Centers
- Think long term to ensure a deep pool of qualified candidates
  - ✓ Best Practices for Building Leadership Diversity Programs

Addendum

- ✓ Diversity and Disparities: A Benchmark Study of U.S. Hospitals in 2013
- ✓ Diversity and Disparities Infographic
- ✓ Equity of Care Resources

HRET Disparities Toolkit

http://www.hretdisparities.org

Endorsed by the National Quality Forum, the Health Research & Educational Trust Disparities Toolkit is a web-based tool that provides hospitals, health care systems, clinics and health plans information and resources for collecting and using race, ethnicity and language (REAL) data from patients.

A cornerstone of any effort to eliminate health care disparities, the collection and use of REAL data is vital to understanding your community and your patient care practices and, ultimately, to target interventions to improve the quality of care for all patients. With this toolkit, health care organizations can assess their organizational capacity to collect REAL data and implement a systematic framework for obtaining this data directly from patients or their caregivers. The toolkit includes information on why the collection of REAL data is important and how to use data once it is collected, as well as training for staff on how to collect these data in a respectful manner.

Toolkit topics include:

- Who should use the toolkit
- Why collect demographic and communication data
- Why collect data using a uniform framework
- The nuts and bolts of data collection
- How to ask the questions
- How to use demographic and communication data to improve quality of care
- How to train staff to collect this information
- How to inform and engage the community
- How to address the communication access needs of populations with sensory disabilities that may impede communication
- Available tools and resources
- Answers to frequently asked questions

This toolkit should be useful for educating staff about the importance of data collection, how to implement a framework to collect REAL data at your organization and how to use these data to improve quality of care for all populations.

To access the toolkit, please visit http://www.hretdisparities.org.

hospitals in pursuit of excellence™
Accelerating Performance Improvement

Signature Leadership Series

Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders

March 2011

American Hospital Association

HRET
HEALTH RESEARCH & EDUCATIONAL TRUST
In Partnership with AHA

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For Additional Information

Maulik S. Joshi, DrPH
Senior Vice President, American Hospital Association
(312) 422-2622
mjoshi@aha.org

Accessible at: http://www.hret.org/health-equity/index.shtml

Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders

Executive Summary

Racial and socioeconomic inequity persists in health care quality. An exploratory interview with four hospitals substantiated by a review of the literature reveals that hospitals are collecting race, ethnicity, and primary language data about their patients. Leading hospitals are now moving beyond data collection to analyzing and using the data to develop targeted interventions for improving access to care for underserved populations. All hospitals are encouraged to follow their lead and, in an era of greater emphasis on community health improvement, devote the necessary resources and infrastructure to use their data in efforts to overcome disparities in care.

The exploratory interviews did identify key strategies that hospitals have adopted to streamline the data collection process:

Key Strategies for Collecting Patient Race, Ethnicity, and Language Data
1. Engage senior leadership
2. Define goals for data collection
3. Combine disparities data collection with existing reporting requirements
4. Track and report progress on an organization-wide basis
5. Build data collection into quality improvement initiatives
6. Utilize national, regional, and state resources available
7. Review, revise, and refine process and categories constantly

A review of literature highlighted several approaches for using the patient data collected by hospitals:

Leading Practices for Using Patient Race, Ethnicity, and Language Data
1. Use an equity scorecard or dashboard to report organizational performance
2. Inform and customize the language translation services you provide
3. Review performance indicators such as length of stay, admissions, and avoidable readmissions
4. Review process of care measures
5. Review outcomes of care
6. Analyze provision of certain preventive care

To meet the needs of their diverse populations, hospitals and health systems will need to bridge the gap between collecting meaningful patient data and reviewing the data to identify inequities in health care provision and utilization, and to implement simple yet effective interventions to improve care for patients.

I. Introduction

Racial and socioeconomic inequity persists in health care quality. The 2001 report from the Institute of Medicine (IOM), *Crossing the Quality Chasm*, stressed the importance of equity in care as one of the six pillars of quality health care, along with efficiency, effectiveness, safety, timeliness, and patient-centeredness.[1] Equity in care can be defined as provision of care that does not differ by geographic location, socioeconomic status, gender, ethnicity, and other patient characteristics. The IOM followed its 2001 report with another report in 2002, *Unequal Treatment,*[2] which found that multiple factors may contribute to disparities in health care. There is therefore no single solution for addressing disparities in health care. The authors of the report offered multiple recommendations for reducing disparities by increasing awareness of the issue, data collection, and research.

According to the 2010 *National Healthcare Disparities Report (NHDR)* released by the Agency for Healthcare Research and Quality (AHRQ), racial and ethnic minorities continue to receive lower quality of care, as measured by performance on core quality measures.[3] Also, in the 2009 *NHDR*, AHRQ and the Department of Health and Human Services noted three major implementation strategies to accelerate the reduction of health care disparities.[4]

1. Train health care personnel to deliver culturally and linguistically competent care for diverse populations
2. Raise awareness of disparities using research and data
3. Form partnerships to identify and test solutions

For years, hospital leaders have realized that reducing disparities in care is the right thing to do. Today, it has become a necessary component of quality and, as such, will have an increasingly greater impact on reimbursement.

Effectively addressing the issue of disparities in health care will require a two-fold approach from health care leaders. The first step—collecting data on patients' race, ethnicity, and primary language—is focused on gaining a complete understanding of the community served by the hospital and the characteristics of patient population. Data collection, if done properly, can facilitate the second step, which involves analyzing quality-of-care and health outcomes data using patient demographics to specifically identify disparities and implement actions to reduce such disparities. Hospitals that currently collect data on patients' race, ethnicity, and primary language encounter barriers in using the data to develop evidence-based strategies for improving health equity.

According to a 2006 study, 78.4 percent of nonfederal acute care hospitals collect information on the race of their patients, and half of these hospitals collect information on patient ethnicity (50.4 percent). State mandates provide a major motivation for hospitals to collect patient data, as mandates currently are in place in 19 states. Additionally, certain culturally and linguistically appropriate services (CLAS) outlined by the Office of Minority Health are required for hospitals to qualify for certain types of federal funding. Most hospitals that currently collect patients' race, ethnicity, and primary language data do so to

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[1] Institute of Medicine, Committee on Quality of Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century (*Washington, DC: National Academy Press, 2001).
[2] Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* B. D. Smedley, A. Y. Stith, A. R. Nelson, eds (Washington, DC: National Academies Press, 2002).
[3] *2010 National Health Quality and National Healthcare Disparities Report (*Washington, DC: The Agency for Healthcare Research and Quality, 2011). http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf
[4] *2009 National Health Quality and National Healthcare Disparities Report (*Washington, DC: The Agency for Healthcare Research and Quality, 2009). http://www.ahrq.gov/qual/nhdr09/Key.htm

fulfill reporting requirements and are unsure of how to mine the data for trends in their patient population and develop interventions to address inequities identified in care.[5]

System-level and patient-level barriers to collecting and using patient race, ethnicity, and primary language data include:[6]

- Lack of standardization of race, ethnicity, and language categories
- Lack of staff understanding of why data is collected
- Information technology limitations
- Staff discomfort about data collection
- Patient privacy concerns

Health care leaders could reap major benefits by making the reduction and elimination of health care disparities an organizational priority. In addition to being the right thing to do, eliminating inequities in health care could have implications for health outcomes, organizational finances, and regulatory compliance.

Quality implications. Disparities in care can have a detrimental effect on the quality of care that is provided to patients. Patients who are racial and ethnic minorities may be more prone to medical errors; they may also have longer hospital stays and more frequent avoidable rehospitalizations, and experience other adverse health outcomes.[7] According to the Joint Commission, language barriers, coupled with low health rates and cultural barriers, contribute to adverse events.[8] Racial and ethnic minorities are also less likely to receive evidence-based care for certain conditions, which explains the disparities in health outcomes and management of patients with conditions such as diabetes, congestive heart failure, and community-acquired pneumonia.[9]

Financial implications. Disparities may increase the cost of care, including through excessive tests to compensate for communication barriers, medical errors, increased length of hospital stay, and avoidable rehospitalizations. The financial implication is further compounded in that payers are linking financial penalties to these outcomes. For example, pay-for-performance contracts now include provisions to address racial and ethnic disparities, a trend that is expected to gain widespread acceptance over time. Additionally, payment reform also features a disincentive for readmissions for certain conditions if they occur within a certain period of time.

Regulatory and accreditation implications. The Joint Commission has released new disparities and cultural competence accreditation standards, and the National Quality Forum has released cultural competence quality measures. Several provisions to reduce disparities were included in the Affordable Care Act. All these national efforts have further enhanced the need for providers to take another look at health care disparities in their organizations and identify solutions to provide more equitable care.

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[5] M. Regenstein, D. Sickler, *Race, Ethnicity, and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care,* National Public Health and Hospital Institute, 2006.

[6] Institute of Medicine, Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement Board on Health Care Services, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*, C. Ulmer, B. McFadden, D. R. Nerenz, eds. (Washington, DC: National Academies Press, 2002).

[7] J. R. Betancourt, A. R. Green, R. R. King, A. Tan-McGrory, M. Cervantes, M. Renfrew, *Improving Quality and Achieving Equity: A Guide for Hospital Leaders,* The Disparities Solutions Center, Massachusetts General Hospital, 2009. http://www.rwjf.org/pr/product.jsp?id=38208

[8] P. M. Schyve, "Language Differences as a Barrier to Quality and Safety in Health Care: The Joint Commission Perspective," *Journal of Internal Medicine,* November 2007; 22 Suppl 2:360-361.

[9] Betancourt et al., *Improving Quality and Achieving Equity.*

A growing collection of resources—in the form of guides, toolkits, research studies and other content—is now available to assist hospital leaders in the development and execution of targeted interventions to improve access to care for underserved populations. *Hospitals in Pursuit of Excellence*, the AHA's strategic platform for accelerating performance improvement and delivery system transformation, has collected these resources and is making them available on a dedicated web page at http://www.hpoe.org/topic-areas/health-care-equity.shtml.

II. Key Strategies for Collecting Patient Race, Ethnicity, and Language Data

In an effort to provide health care leaders with examples of how hospitals with different characteristics and varying patient populations have overcome barriers to collecting and using patient race, ethnicity, and primary language data, we interviewed and profiled the activities of four hospitals. Several of the hospitals profiled stated similar concerns about having limited resources and staff available at their institutions to dedicate to disparities data collection and analysis. However, this barrier did not prevent the organizations from moving forward with efforts to examine and improve the processes for collecting meaningful data about their patients.

The hospitals interviewed identified multiple challenges in using the data they collect to develop and implement targeted interventions for their patients. There were multiple reasons for this. First, several of the hospitals were still in the process of strengthening their data collection systems to collect meaningful patient demographics data. Second, the process of mining the data for trends required more resources than most of the hospitals had. Similarly, these hospitals recognized that developing system-wide interventions is resource-intensive and requires consideration during the regular strategic and operational planning process. All the hospitals did express interest in simple, actionable interventions that they could implement in response to disparities in health outcomes identified in their patient population. Although only one hospital has made significant progress in analyzing patient data for trends in utilization and health care outcomes, all the hospitals provided lessons for hospitals that are currently looking to standardize their data collection process and develop an organization-wide culture around collecting patient race, ethnicity, and primary language data.

Common key strategies emerged from the hospitals profiled as shown in the following table.

Key Strategies for Collecting Patient Race, Ethnicity, and Language Data

Strategy	Rationale
1. Engage senior leadership	- Helps to make efforts a priority for the organization - Maintains sustainability and accountability
2. Define goals for data collection	- Communicates to clinicians and staff that the effort does not end with data collection
3. Combine disparities data collection with existing reporting requirements	- Streamlines activities across multiple departments - Builds on existing hospital/system efforts - Ensures broad-based input
4. Track and report progress on an organization-wide basis	- Periodically disseminating information on patient demographics serves to further engage leadership and staff as they see the diversity in the patient population increase
5. Build data collection into quality improvement initiatives	- Ensures accountability for accuracy and consistency in collecting data
6. Utilize national, regional, and state resources available	- Eliminates the need to start from scratch and presents a learning opportunity, with tools and guidance from various national organizations, such as HRET, NQF, and the Joint Commission, and state governmental agencies, such as state departments of public health
7. Review, revise, and refine process and categories constantly	- Ensures that data collected is relevant - Helps facilitate incremental changes, which could include moving from data collection to data analysis and use

Case Study 1:
Heywood Hospital

Gardner, Massachusetts

Overview

134 beds
Not-for-profit
General, medical, surgical
Annual admissions: 5,768
Annual emergency visits: 18,101
Diversity of patient population: 96% White, 3% Hispanic or Latino, 2% Black or African American, 1% Other
Contact: Barbara Nealon (nea.b@heywood.org)

Background

Heywood Hospital is a medium-sized facility located in an urban area about two hours west of Boston, Massachusetts. Unlike other hospitals in the Boston area, Heywood's geographic area of Gardner, Massachusetts, has very little racial and ethnic diversity. Despite the apparent lack of diversity in its patient population, the hospital has actively collected and used racial, ethnic, language, and religious data and preferences of their patients. Through this collection effort, Heywood has discovered pockets of socioeconomic and minority groups who can benefit from specialized services.

In 1999, the hospital established a multicultural task force with interdisciplinary representation from executive management, information services, telecommunication, nutrition, plumbing services, mental health, social work, and food service. In addition to being multidisciplinary, the task force is also multiracial and multicultural. The executive champion of the task force is the human resource director. The multicultural task force was interested in assessing diversity in the hospital's patient population and determining if the organization's staff reflected the diversity of its patient base.

Heywood Hospital views collection of race, ethnicity, and primary language data as a part of care provision and a critical component of the performance improvement process. As such, the effort has received widespread support from senior management.

Progress

Prior to 1999, when the task force was established, Heywood Hospital only provided interpreter services for American Sign Language. Since then, the diversity of residents in the hospital's geographic area has changed as more people migrated to the area. In 2002, Heywood developed an in-house interpreter program, which offers video relay for deaf and hard-of-hearing patients, a phone interpreter, and in-house interpretation. In the past few years, multicultural services at Heywood Hospital have had a tremendous impact:

Service Provision

- Prior to establishing its in-house interpreter program, Heywood had 56 hospital encounters with the deaf or hard-of-hearing population. A year after establishing the program, the hospital had 252 encounters, followed by 556 and 800 encounters in subsequent years. Last year, the hospital serviced 1,422 encounters with limited English proficiency patients, including deaf patients. The primary language of Heywood patients, after English, is Spanish, followed by American Sign Language.
- Once Heywood started providing Spanish interpretation, it received more demand for the service. Through serving patients, the hospital's staff has become culturally sensitive to the array of dialects within the Spanish language. The hospital provides interpreter services for Vietnamese, the third most frequently used language by its patients, and has just linked up with

the executive director of a Hmong community group to interact and determine the group's needs.

- Heywood has generated attention for increased education in specific patient populations. For example, in 2008, the hospital found that all admissions for one of its smallest minority groups were for chemical exposure. Staff and clinicians were able to link the admissions to workplace conditions and collaborate with community leaders to promote healthy behaviors in the workplace.

Process Change

- To diversify the hospital's staff base, multicultural services worked with human resources staff, volunteer services, and medical staff to self-identify, just as with patients. This information is also used to determine potential staff to be trained as interpreters.
- Heywood Hospital mandates cultural competency training for all new hires and trains its staff on cultural competency issues on an annual basis. The hospital also provides interpreter training annually. For example, April is diversity month at Heywood, and the hospital uses the opportunity to educate staff on specific topics impacting various patient populations.
- The work of the multicultural team is tied to the quality improvement process, so the team reports progress to senior management.

Successes

- The greatest success is establishing a program that is recognized by executive management.
- As staff members have become culturally competent, the hospital has seen an increase in the number of minority patients who seek care at Heywood. The hospital is also able to attract diverse staff and volunteers.
- The local community respects Heywood Hospital and looks to the hospital as a resource for cultural competency issues.

Challenges

- Financial limitations prevent allocating more resources to equity efforts.
- Staff stereotypes about patients still exist; additional staff training is needed to sensitize staff to the importance of providing optimal customer service to all patients regardless of background.
- The "unknown" category in patient race and ethnicity data currently hovers around two percent. The hospital is improving efforts to decrease this number so no patient will be unknown.
- Moving to the next step after identifying trends in patient race, ethnicity, and primary language data is required. It will involve a combination of translating materials into patients' preferred languages, providing specific services for patients, and going out into the community to connect with community leaders and provide education.
- Getting the information technology department on board and convincing them to prioritize the data collection efforts is also a continuing challenge.

Lessons Learned

- Be willing to learn. Heywood Hospital has utilized available resources from the Joint Commission, American Hospital Association/Health Research & Educational Trust, the Massachusetts Department of Public Health, and other state collaborators.
- Combine the disparities data collection and use with existing reporting requirements. This process will ensure streamlining efforts across multiple departments and facilitate broad buy-in. State initiatives, regional programs, and payer policies have also served as facilitators to data collection and use at Heywood Hospital.
- Continually engage executive leadership. The CEO of the hospital is a member of the multicultural task force and reports back to the hospital's board of trustees.

Case Study 2:
San Mateo Medical Center

San Mateo, California

Overview

350–400 beds
County hospital and clinics
General, medical, surgical, primary, and long-term care
Annual admissions: 4,000
Annual emergency visits: 35,500
Annual outpatient visits: 240,000
Diversity of patient population: 59% Hispanic or Latino, 15% White, 9% Asian/Pacific Islander, 5% Black or African American
Contact: Jonathan Mesinger (jmesinger@co.sanmateo.ca.us)

Background

San Mateo Medical Center (SMMC) is a large public health care system that operates outpatient clinics throughout San Mateo County, including an acute care hospital and long-term care facilities. The medical center is also one of 19 member hospitals of the California Association of Public Hospitals and Health Systems (CAPH).

Until a year ago, SMMC collected basic race and ethnicity data required to meet state and federal requirements and used the race and ethnicity classifications required by the Health Resources and Services Administration (HRSA) and the state. In the past year, SMMC has been focused on moving toward collecting patient race, ethnicity, and primary language data (referred to as R.E.A.L. data by the hospital and CAPH) and has worked to modify patient registration to ensure that the medical center is collecting patient demographic information that will yield meaningful data. As part of the new model, SMMC defined a list of 30 granular race and ethnicity classifications. The revised list will help capture the information needed for reporting purposes and, most importantly, capture meaningful patient demographics information that can be used for assessing and improving quality of care and reducing disparities.

Progress

To identify the list of race and ethnicities to be included in the registration process, SMMC sought the input of its cultural competency committee, a multistakeholder group. This committee was able to provide guidance on the appropriate ethnicities to include in the list and solicit feedback and recommendations from various departments and the community.

Process Change

- SMMC will revise the registration process to move away from front-line staff verbally asking patients about their race and ethnicity. The process caused problems because patients are reluctant to divulge information and staff is hesitant to invade patients' privacy. The medical center plans to shift to a self-administered questionnaire, so patients have more privacy and confidence in responding to the questions.
- To allow patients to self-identify, SMMC selected a list of races and ethnicities from among an Office of Management and Budget list of 300, which was representative of the community it serves. The new list is comprehensive but not burdensome for patients or the SMMC data system. The granular list was also informed by the languages included in patients' requests for interpretation.

Challenges

- Staff training is essential, since the data collected is only as good as those collecting it. Staff training will enable staff to overcome reservations about collecting R.E.A.L data from patients and motivate staff to participate in quality improvement.
- The new system involved changing the online system for registering patients, which required considerable work from the information technology department. Getting IT to prioritize the project has been challenging but also is improving gradually as the initiative gains system-wide focus.

Lessons Learned

- Set a well-defined goal for collecting patient race, ethnicity, and primary language data. SMMC was able to define the goal for the R.E.A.L. data initiative as an approach to collecting patient demographics that will enable the medical center to compare patient health outcomes and reduce disparities. This approach facilitated leadership buy-in.
- Solicit broad multistakeholder and multidepartmental involvement in data collection efforts. SMMC involved multiple departments in identifying the granular list of races and ethnicities to be collected, ensuring the categories are relevant and representative. Multistakeholder involvement also helped ensure that the effort fulfilled the needs of departments involved in data collection and reporting requirements to the state and other funding sources. And involving multiple departments eliminated duplicative efforts.
- Build on momentum established by state and regional initiatives. The California Health Care Safety Net Institute, quality improvement partner of CAPH, has been actively pushing the initiative to collect and use R.E.A.L. data. This effort has elevated the initiative to the attention of the senior leadership of SMMC, who are associated with the CAPH and very aware of the need to collect the data.
- Establish and report metrics for R.E.A.L. data collection and use. The quality leadership team at SMMC is actively involved in pushing data collection and use and has included written data collection as a metric to be reported as part of the Medi-Cal (California's Medicaid program) waiver application. As such, SMMC has to meet specific metrics for data collection and for qualifying for certain kinds of federal funding. This reporting requirement has been effective in garnering system-wide attention to data collection.

Case Study 3:
Lehigh Valley Hospital/Lehigh Valley Health Network

Allentown, Pennsylvania

Overview

500 or more beds
General, medical, surgical
Annual admissions: 65,400
Annual emergency visits: 163,000
Annual outpatient visits: 1.7 million
Diversity of patient population (including newborns): 80.8% White, 8.6% Hispanic or Latino, 4.7% Unavailable or refused, 3.6% Black or African American, 1.2% Multiracial, 0.9% Asian/Pacific Islander, 0.1% Native American
Contact: Judith Sabino (Judith.Sabino@lvhn.org)

Background

Lehigh Valley Health Network (LVHN) includes two full-service hospitals—Lehigh Valley Hospital with two clinical campuses in Allentown, Pennsylvania, and Lehigh Valley Hospital-Muhlenberg in Bethlehem, Pennsylvania—as well as several community health centers, a network of primary and specialty physicians, and other services. The health network is located in east central Pennsylvania, approximately 50 miles north of Philadelphia and 80 miles west of New York City. The largest municipality in the health network's service area is home to a large Hispanic population and currently has a majority minority population distribution.

In 2006, the senior leadership of LVHN organized a patient-centered experience retreat for hospital staff and providers, community organizations, and former patients and family members to speak honestly about their hospital experience in the network. Feedback from the community revealed that despite the high quality of care provided by the network, patients' cultural, religious and ethnic needs were not being met. The retreat served as a tipping point for the cultural competency work of the network and also garnered senior leadership buy-in. Under the guidance of senior leadership, the organization endorsed a strategic plan, which included as objectives understanding the importance of collecting patient demographics to identify disparities and standardizing the collection of patient race, ethnicity, and primary language data.

In October 2008, the organization standardized collection of patient race and ethnicity data. LVHN also provided registrar education and worked with information services to identify the race and ethnicity categories to collect. In January 2011, LVHN revised the data collection process for patient race and ethnicity data to comply with new federal requirements.

Progress

The change made to the registration process enabled LVHN to collect race and ethnicity in separate fields. Prior to that change, the organization had one field for both patient race and ethnicity. The revised categories gave patients the option of refusing to answer the question or indicating that they are unsure of their racial background.

Process Change

- The health network eliminated the use of the "some other race" category in order to collect meaningful data. Prior to 2008, the "some other race" category received the second largest

response for certain quality indicators that were tracked Currently, the "unavailable or refused" category represents 4.7 percent of health network admissions.

Challenges

- Getting staff buy-in was challenging but critical. LVHN engaged Health Research & Educational Trust consultants to provide training to the supervisors of registrars to help supervisors understand the standardized process for patient data collection and the rationale for change, and answer questions about legality. Several in-house training sessions were held to educate the registrars about the new process.
- Refining the race and ethnicity category descriptions to help members of minority populations (specifically Latino, Arabic, and Caribbean populations) self-identify the appropriate category for them.
- Currently, the network has limited resources for reviewing and analyzing the data for trends. A small collaborative was assembled, including members of the health network's health studies and quality departments, to identify methodologies to analyze these data.

Lessons Learned

- Provide staff training, especially registrar education, which is critical for collecting meaningful data. Training registrars to understand the rationale for data collection will better prepare them to field questions from patients and encourage patients to provide accurate and complete responses.
- Work with community partners to gain insight into the cultural differences and diversity that exist between various ethnic groups. LVHN has several partnerships with community residents and organizations that provide insights to the health network regarding cross-cultural care delivery.
- Use various approaches to facilitate leadership buy-in. LVHN's leadership council continues to make cross-cultural care a priority of the organization and has senior leaders who serve as executive champions for the cultural competency work. Also, the senior management council has annual goals tied to equitable health care delivery.
- Learn from other departments and units that have successfully incorporated cultural competency in a cross-cultural environment. For example, the HIV unit at LVHN is much further along in having bilingual and cross-cultural staff deliver care to their patients.
- Recognize that it takes time to attain the kind of organizational culture change that makes providing cross-cultural care a part of everyday operations at an organization.

Case Study 4:
Baylor Health Care System
Dallas, Texas

Overview

North Texas integrated health care system with:
- 26 owned, leased, affiliated, and short-stay hospitals
- 130+ primary care, specialty care, and senior health centers
- 17 ambulatory surgery centers
- 450+ employed physicians in HealthTexas, BCHS-affiliated physician network

Not-for-profit
Annual admissions: 120,000
Contact: James Walton (jameswa@baylorhealth.edu)

Background

Baylor Health Care System (BHCS) is a large, integrated health care system based in Dallas, Texas. It includes 26 owned, leased, affiliated and short-stay hospitals as well as more than 100 ambulatory facilities that serve northern Texas. The system has more than 4,500 affiliated physicians, including more than 450 employed physicians who are part of HealthTexas, its affiliated physician network.

In 2006, BHCS established the Office of Health Equity (OHE) with the purpose of reducing variation in health care access, care delivery, and health outcomes due to:
- Race and ethnicity
- Income and education (i.e., socioeconomic status)
- Age
- Gender
- Other personal characteristics (e.g., primary language skills)

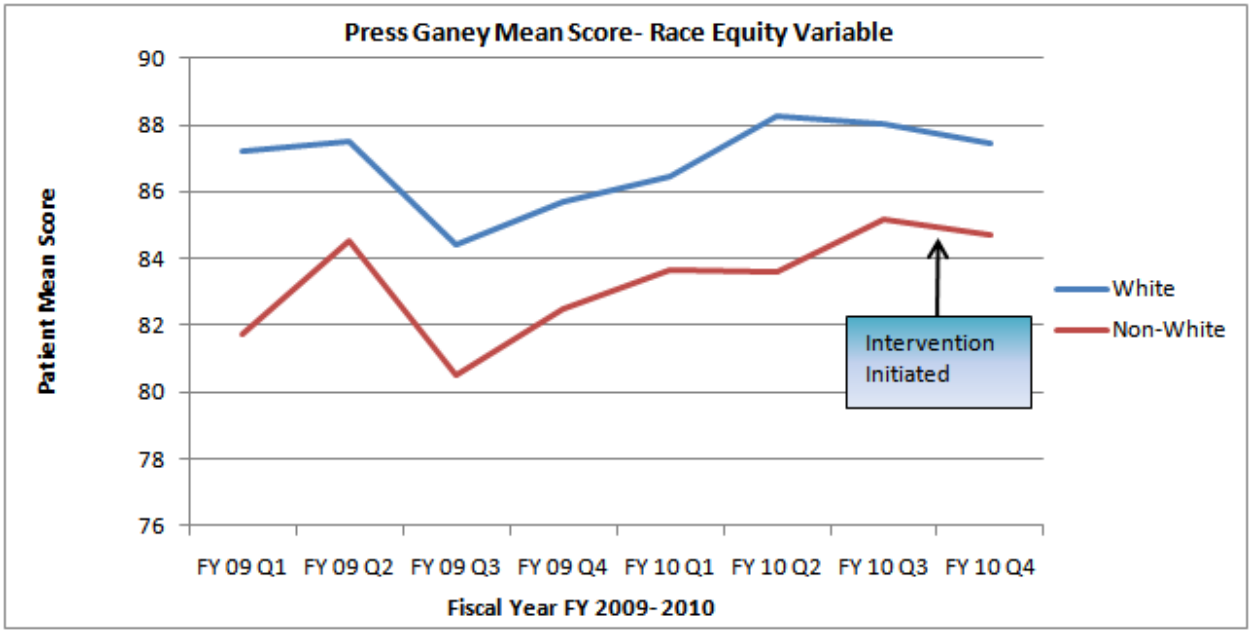
OHE identifies and tracks these variations by producing an annual "BHCS Health Equity Performance Analysis" (HEPA) that reports data on:
Inpatient performance measures:
- Quality of care measures (Joint Commission core measures)
- Experience of care measures (patient experience/satisfaction)
- Outcomes measures (inpatient mortality and 30-day readmission)

Outpatient performance measures:
- Quality of care measures (diabetes, asthma, and chronic heart failure processes of care)

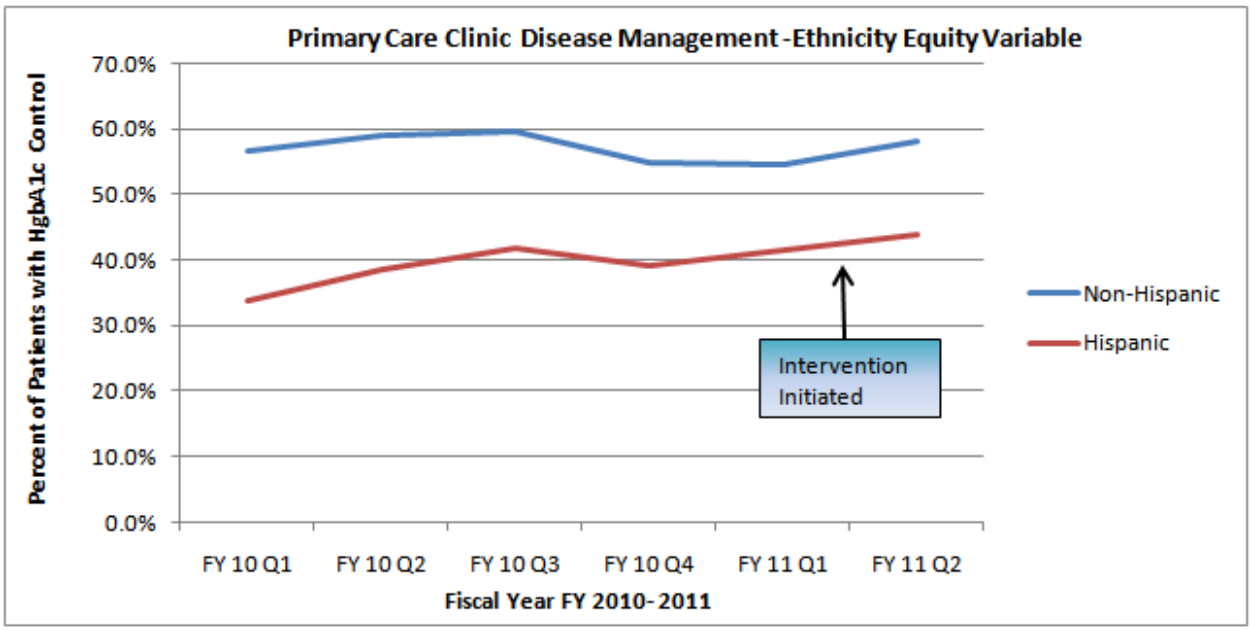
To produce the BHCS HEPA, the first step is to accurately collect race, ethnicity, and primary language data within BHCS hospitals and ambulatory care points of care. Additional variables are routinely collected including insurance status, age, and gender.

Subsequently, the equity measures are aggregated into several dichotomous variables:
- Race: white vs. nonwhite
- Ethnicity: Hispanic vs. non-Hispanic
- SES (socioeconomic status) proxy: commercially-insured vs. self-pay/Medicaid

For each variable, the percentages of eligible patients and the differences between each dichotomous variable are calculated. Differences are tested for statistical significance at a p <= .05. The OHE produces and reports the HEPA in easy-to-read graphics, trending performance over time. For illustration purposes, the following sample graphs are provided from the 2010 BHCS HEPA report showing (1) BHCS ED patient satisfaction by race and (2) BHCS diabetes care management for Baylor's ambulatory clinics by ethnicity (diabetes control: HgbA1c<7%).



Being able to track measures over time allows for documenting performance trends. In the patient satisfaction example, the consistency of the disparity in satisfaction between white and nonwhite patients over two fiscal years points to an opportunity for developing health equity improvement initiatives to reduce the disparity.



In the diabetes care management example, the graphic illustrates a persisting disparity in diabetes care within a cohort of Baylor's primary care practices. When presented to the physicians' quality improvement committee, these data became a powerful tool for creating organizational prioritization and improvement momentum.

The annual HEPA report resides on the BHCS intranet, and the system uses the report to focus resources and efforts to reduce observed disparities and improve the quality of care among the patients and communities it serves.

Progress

In 2010, the OHE launched its first hospital-based health equity improvement strategy. This pilot intervention is a collaboration between OHE and the leadership and staff of two hospitals within the health care system. As part of this work, the staffs are using a continuous quality improvement process with rapid cycle improvement identifying possible causes of observed racial and ethnic differences in patient experience and testing workflow solutions to reduce and eliminate the disparity.

Additionally, in 2011OHE launched its ambulatory care health equity improvement work with Baylor's employed physician organization, HealthTexas Provider Network. Since 2009, patients have self-declared their race, ethnicity, and primary language at the point of service, and the data have been analyzed to identify disparities in care. In 2010, data on diabetes care management pointed to significant differences in the percentage of non-Hispanic and Hispanic patients with superior diabetes control (HgbA1c levels less than 7%), with Hispanics meeting the management goal significantly less often than non-Hispanics. Within the last 24 months, physicians within the network were placed at financial risk for selected quality of care measures. One outcome has been an expressed interest in understanding if a physician's or clinic's overall performance in diabetes care is affected by disparities in a particular subpopulation's achievement of key diabetes care management measures.

As a result of this work, an important and promising project has been launched exporting lessons learned from a successful OHE health equity pilot, the Diabetes Equity Project (DEP). The DEP, funded

by the Merck Foundation for the past two years, is providing diabetes self-management education and patient advocacy for some of the area's underserved populations in partnership with five Dallas County charity clinics. Early results have been encouraging, significantly increasing the number of nonwhite patients attaining superior diabetes control (HgbA1c<7%). Leveraging these results, a recent decision by the HealthTexas Provider Network Quality Committee extended the DEP to four private practice clinics experiencing low diabetes care management performance among Hispanic patients, launching this initiative during the second quarter of 2011.

III. Leading Practices for Using Patient Race, Ethnicity, and Language Data

Even though the majority of hospitals and health care systems collect patient race, ethnicity, and primary language data, many organizations are challenged in using the data to provide equitable patient-centered care. Several valid reasons exist for why organizations have been unable to mine their current data to identify trends in care patterns and provide targeted interventions for specific groups of patients.

The following table highlights leading practices that some organizations have adopted for using the demographics data that they collect about their patients.

Leading Practices for Using Patient Race, Ethnicity, and Language Data	
Practice	**Details**
1. Use an equity scorecard or dashboard to report organizational performance	- Using a dashboard that captures performance on key quality indicators stratified by patient race, ethnicity, and socioeconomic status is an effective tool if updated and reported regularly to senior leadership of the hospital. The dashboard is able to capture progress made in certain areas as well as identify areas of focus. The dashboard also serves to identify patient populations that may be at increased risk for adverse outcomes.
2. Provide interpreter services	- Communication gaps between providers and patients are often a source of medical errors and may lead to costly and excessive testing. They can also result in delay of necessary care. Collection of patient data can help identify areas where trained and professional interpreter services are needed.
3. Review performance indicators such as length of stay, admissions, and avoidable readmissions	- Stratifying average length of stay, admissions, and readmissions by patient demographics can help identify any trends associated with specific patient groups, which then can be addressed to improve key performance indicators and quality of care.
4. Review process of care measures	- Analyzing performance on key process of care measures can identify gaps in care, which could be linked to specific patient groups.
5. Review outcomes of care	- Reviewing outcomes will help identify any trends, especially poor outcomes that are linked to certain patient groups.
6. Analyze provision of certain preventive care	- Analyzing delivery of certain services by race and ethnicity will help identify areas where specific groups are receiving less preventive care, especially screening.

IV. Conclusion

Federal, state, and regional activities over the past few years have highlighted the importance of collecting and using patient race, ethnicity, and primary language data to improve health care equity. Though hospitals have collected this data for years, new requirements have necessitated another look at how the data is collected and the quality of the data collected. The exploratory interviews outlined here reveal several key lessons for organizations looking to improve their data collection and utilization processes:

- Focus on improving registration and information systems to capture more comprehensive demographic information about patients
- Consolidate and standardize efforts across departments to reduce duplicative activities
- Identify internal champions to help advance equity strategy goals and engage effective management
- Develop partnerships with community organizations that can provide insights into the cultural differences in the community served, to better inform strategies to reduce disparities
- Identify and track inpatient and outpatient performance measures and aggregate the measures in dichotomous variables based on race, ethnicity and, if desired, socioeconomic status
- Use a continuous improvement process to identify possible causes of observed racial and ethnic differences in patient care and test workflow solutions to eliminate the disparity

The recurring theme echoed by the hospitals interviewed and others in the field highlights the need for more guidance on how to review data for trends and develop simple interventions that can be implemented immediately to improve care for patients.

Appendix: Resources

- *Assuring Healthcare Quality: A Healthcare Equity Blueprint.* National Public Health and Hospital Institute, September 2008. http://www.naph.org/Main-Menu-Category/Our-Work/Health-Care-Disparities/Equity-Blueprint.aspx?FT=.pdf
  Recommended strategies and practices that can be tailored to individual hospitals as a starting point for designing and implementing interventions

- Betancourt, J.R., Green, A.R., King, R.R., Tan-McGrory, A., Cervantes, M., Renfrew, M. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders.* The Disparities Solutions Center, Massachusetts General Hospital, 2009. http://www.rwjf.org/pr/product.jsp?id=38208
  A guide that presents the rationale for addressing racial and ethnic disparities in health care and highlights model practices from hospitals and leaders who are actively engaged in addressing disparities.

- Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* National Academies Press: Washington, DC, 2001. http://www.nap.edu/openbook.php?isbn=030908265X
  Institute of Medicine report that explores how racial/ethnic minorities experience the health care environment and examines how disparities in treatment may arise in health care systems. Offers recommendations for improvements in medical care financing, allocation of care, availability of language translation, community-based care, and other areas.

- *Cultural Sensitivity: A Pocket Guide for Health Care Professionals.* Oakbrook Terrace, IL: Joint Commission Resources, January 2008. http://www.jcrinc.com/Books-and-E-books/CULTURAL-SENSITIVITY-A-POCKET-GUIDE-FOR-HC-PROFESS-PK-OF-5/1370/
  Quick guide to health care needs, expectations, and perceptions of a variety of racial/ethnic groups.

- Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J. (2007). *Health Research & Educational Trust Disparities Toolkit.* www.hretdisparities.org
  Free 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. Includes scripts, rationale, and a section focused on deaf and hard-of-hearing populations.

- Hasnain-Wynia, R., Yonek, J., Pierce, D., Kang, R., Greising, C. H. *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, 2006. http://www.hret.org/resources/1550998119
  Describes current practices and common barriers as well as the specific resources and tools needed to provide language services to LEP patients.

- Hospitals in Pursuit of Excellence – American Hospital Association. Web page on health care equity. http://www.hpoe.org/topic-areas/health-care-equity.shtml. This web page lists a variety of resources to assist hospital leaders in the development and execution of targeted interventions to improve access to care.

- The Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL: The Joint Commission, 2010. http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf)
  This guide is designed to assist hospitals in integrating concepts and ideas from the fields of communication, cultural competence, and patient- and family-centered care in order to improve their efforts to delivery high quality care.

- Mead, H., Cartwright-Smith, L., Jones, K., Ramos, C., Woods, K., and Siegel, B. *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook.* The Commonwealth Fund, March 2008. http://www.commonwealthfund.org/Content/Publications/Chartbooks/2008/Mar/Racial-and-Ethnic-Disparities-in-U-S--Health-Care--A-Chartbook.aspx
  Provides data on the U.S. population by race/ethnicity, income and language and identifies disparities in health status and mortality, access to health care, and quality. Also documents strategies that may lessen or eliminate disparities in health and health care.

- *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* U.S. Department of Health and Human Services, Office of Minority Health, March 2001. *http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15*
  National standards developed to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

- Weinick, R. M., Flaherty, K., Bristol, S. J. *Creating Equity Reports: A Guide for Hospitals*. The Disparities Solutions Center, Massachusetts General Hospital, 2008. http://www.massgeneral.org/disparitiessolutions/resources.html
  A guide that provides a framework for equity reporting and shares lessons learned from the experiences of several U.S. hospitals.

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A Framework for Stratifying Race, Ethnicity and Language Data

October 2014

Equity of Care

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Contact: hpoe@aha.org or (877) 243-0027

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Joseph R. Betancourt, MD, MPH, Director, The Disparities Solutions Center

Aswita Tan-McGrory, MBA, MSPH, Deputy Director, The Disparities Solutions Center

The Disparities Solutions Center
Massachusetts General Hospital
50 Staniford Street, 9th Floor
Boston, MA 02114
Phone: (617) 724-7658
Email: disparitiessolutions@partners.org

Juana S. Slade, CDM, CCF, Director and Chief Diversity Officer, AnMed Health

AnMed Health
800 North Fant Street
Anderson, SC 29621
Phone: (864) 512-2361
Email: juana.slade@anmedhealth.org

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Executive Summary

Eliminating health care disparities is essential to improve quality of care for all patients. Hospitals and care systems are working to ensure every patient receives high-quality care. In addition, value-based purchasing and pay-for-quality programs necessitate that hospitals and care systems improve patient outcomes. One step in addressing health care disparities and improving patient outcomes is stratifying patient data by race, ethnicity and language data.

By collecting and stratifying patient race, ethnicity and language (REAL) data, hospitals and care systems can identify which, if any, health care disparities exist—and then target interventions to address the disparities. Hospitals and care systems that understand their patient populations and work to make quality improvements across individual patient groups will improve their overall performance.

This guide provides a framework that allows hospitals and care systems to stratify patient data for the purpose of identifying health care disparities. This framework includes five steps.

Five-step Framework for Stratifying REAL Data

1. Assemble a working group that is focused on health care disparities data
2. Validate the REAL data
3. Identify the highest priority metrics for stratification
4. Determine if stratification is possible on the selected metrics
5. Stratify the data

Source: American Hospital Association, 2014.

Each hospital or care system can approach stratifying data differently; however, the general framework for the stratification effort is similar.

Hospitals and care systems can develop dashboards to report stratified REAL data by readmissions, patient satisfaction and hospital core measures. Discussing these dashboards in regularly scheduled quality meetings allows leadership to continuously address gaps in care and work to eliminate disparities. Eliminating health care disparities will improve scores for all patient groups and, in turn, improve overall hospital performance.

Introduction

The purpose of this guide is to provide a framework that allows hospitals and care systems to stratify patient data for the use of identifying health care disparities. Each hospital or care system can approach stratifying data differently; however, the general framework in approaching the stratification effort is similar. Successful stratification involves an organized approach that uses validated data in a collaborative manner.

Racial and ethnic minorities are projected to account for a majority of the U.S. population by 2043, and the future market for health care services inevitably will reflect this change.[1] In addition, the next generation of health care consumers will be increasingly empowered to differentiate providers based on publicly available quality and satisfaction measures. Hospitals and care systems that can accommodate the unique needs of diverse populations will be well positioned for future success. One way to achieve this goal is to collect and use race, ethnicity and language (REAL) data in a meaningful way to understand and address health care disparities among various racial and ethnic groups.

The collection and use of REAL data is part of a larger effort surrounding the use of health care disparities information. The Health Research & Educational Trust and the Institute for Diversity in Health Management found that 95 percent of hospitals collect REAL data; however, only 22 percent use the data in their hospital's decision making.[2] As hospitals strive for continuous quality improvement, the use of REAL data can help hospitals identify where their quality efforts are effective and where opportunities for improvement remain. Use of this existing data can help hospitals to ensure that the care they provide is tailored to the individual needs of their patients.

The use of REAL data involves the practice of stratification. Data stratification is the process of analyzing available data to identify quantitative trends, results and areas in need of quality improvement. To perform stratification, a hospital computes separate performance scores on quality, access or other metrics of interest by the race, ethnicity and language of its patients. For example, a hospital could calculate readmission scores for its English and non-English speaking patients.

By stratifying REAL data, hospitals and care systems can identify which, if any, health care disparities exist. A hospital or care system then can target interventions to those populations with lower quality metrics in order to improve overall quality outcomes and reduce care disparities. Without data stratification, these disparities cannot be properly targeted and addressed. As hospitals seek to understand the needs of the communities they serve, this use of REAL data will provide a more comprehensive look.

Stratification Framework

Stratifying patient data requires an organized, comprehensive planning framework that promotes collaboration across several hospital departments. Before implementing a framework, it is essential to have senior leadership buy-in. With this support, the organization can make changes that address identified health care disparities. Moreover, the trend data resulting from stratification will inform hospital strategic planning and resource allocation. Therefore, an organized framework is necessary to ensure stratification efforts result in reliable and valid conclusions about disparities in a hospital's care.

Stratified data are essential to identifying health care disparities, and these data must be presented in a format that allows hospital leadership to quickly identify and understand gaps in care. For example, many hospitals and care systems develop dashboards that stratify REAL data by clinical and operational metrics. It should be noted that when working with special patient populations, such as pediatric patients and lesbian, gay, bisexual and transgender (LGBT) patients, data collection and analysis are more complex.

Hospital leadership can follow a five-step framework to help facilitate a stratification effort, with several actions needing completion before advancing to the next step.

Five-step Framework for Stratifying REAL Data

1. Assemble a working group that is focused on health care disparities data
2. Validate the REAL data
3. Identify the highest priority metrics for stratification
4. Determine if stratification is possible on the selected metrics
5. Stratify the data

Source: American Hospital Association, 2014.

Step 1: Assemble a working group that is focused on health care disparities data

A health care disparity working group would be charged with assessing the organization's REAL data quality; developing and implementing policies related to registration, data collection and clinical care; and enhancing the collection of REAL data through education and training.

This working group should include leaders from hospital departments that collect REAL data, produce analytics, perform quality improvement and are engaged in community outreach efforts. Involving staff from departments related to diversity, data, analytics, patient safety, information technology, quality/performance improvement, patient experience, corporate auditing and finance in discussions will create a more comprehensive plan.

Here is a sample of key areas from which individuals can be assembled for an effective working group.

- Diversity and inclusion
- Quality and safety
- Information and technology
- Data analytics
- Language services
- Admitting and registration
- Compliance
- Community outreach

Step 2: Validate the REAL data

Stratification based on reliable and valid data can lead to the discovery of trend data and health care disparities. The first task of the working group is to conduct a thorough assessment of the quality of the existing patient data as it relates to race, ethnicity and language metrics. The working group should examine the following:

1. Accuracy – Are the data self-identified and correctly recorded? Data can be self-identified by the patient or by the registration staff. Are there differences in categorization among data sources? Addressing these questions will help ensure that the data are accurate, which is critical as the working group begins to think through use and stratification of these data.
2. Completeness – Are race, ethnicity and language data captured across all service areas? What is the percentage of unknown, other or declined data? A robust data set will present opportunities to do more with the data as the hospital begins to stratify. It also will help address care disparities across the organization as a whole.
3. Uniqueness – Are individual patients represented only once? Are there multiple points where the data might be collected or recorded? How are the data consolidated? Making sure that a complete and thorough process is in place will prevent duplication of collected data or inefficiencies in the collection, which is important for the current and the ongoing processes.
4. Timeliness – Are the data kept up to date? How often are the data updated? Sustainability of this information will best ensure this is not a one-time effort but something that will continually benefit the organization and quality improvement efforts.
5. Consistency – Are the data internally consistent, and do the data reflect the patient population served? A final or continual check of data will further refine and improve any system in place for this work.

The working group should explore the quality of the REAL data, how the data are housed and how the hospital or care system staff is collecting the data. By answering the above questions, gaps in the data collection and consolidation process may be identified and then addressed.

Validating the REAL data is an essential step in ensuring the stratification is accurate. Once the data are validated, the next step is to connect the REAL data to outcomes such as patient satisfaction, patient experience, clinical care processes, hospital core measures and readmissions. This can provide insight into a variety of health care disparities that might have gone unnoticed.

Step 3: Identify the highest priority metrics for stratification

It is important for hospitals and care systems to strike a balance between inpatient and outpatient metrics as well as balance among the services offered by the hospital. A balance will provide a more complete picture of the possible health care disparities in the organization. In the beginning, the stratification effort should address certain basic clinical and patient satisfaction data. For example, when considering patient satisfaction, one might start by analyzing HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores by ethnicity.

The hospital or care system may already have certain priority areas where improvement efforts are underway. But has the organization assessed whether there are disparities existing in these areas based on REAL data? If not, then perhaps these disparities are contributing to the low quality scores. The goal of Steps 2 and 3 is to complete an exhaustive assessment of all available data points and identifying quality metrics. Starting in certain areas will help the organization understand how to stratify the data and ensure the data set is good. From there, the organization can build into other areas.

Table 1 provides examples of metrics that can be considered when identifying specific data elements.

Table 1. Quality metrics and data elements to consider

Quality Metric	Data element to stratify
Clinical • Hospital inpatient quality reporting (IQR) measures (i.e., "core measures") • 30-day readmissions **Patient Satisfaction** • HCAHPS scores **Cost and Efficiency** • Medicare Spending per Beneficiary	**Demographic** • Age • Gender • Race • Ethnicity • Language preference • Language proficiency

Source: American Hospital Association, 2014.

Step 4: Determine if stratification is possible on the selected metrics

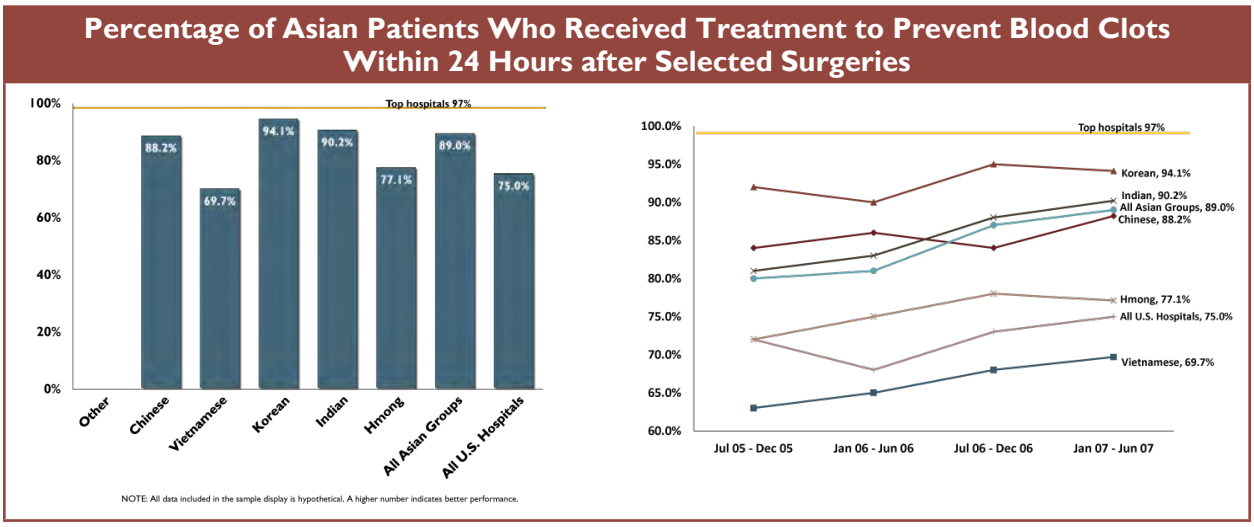
In some cases, it may not be feasible to stratify a metric of interest. For example, the data may be collected in an inconsistent format. If the REAL data quality requires improvement, consider focusing on strategies to collect the data more effectively before stratifying. This can include training front-line staff, conducting quality checks on registration processes, addressing technology barriers and educating patients about why REAL data are collected. If the REAL data quality is good, consider moving forward with stratifying the data.

There also may be instances where there are insufficient data to stratify results on a metric. For example, a hospital attempting to stratify one of its HCAHPS survey questions by the proportion of English, Spanish and Portuguese speakers may find that out of 100 patients, only two are Portuguese speakers. This would likely not provide sufficient data to identify a disparity for Portuguese-speaking patients. The hospital could attempt to overcome this issue by aggregating more data and reanalyzing in the future.

Step 5: Stratify the data

Stratifying valid and reliable data elements allows for the creation of dashboards that display data trends and health care disparities. Incorporating these dashboards into regularly scheduled quality meetings is essential to continually address health care disparities related to REAL data. Figures 1 through 5 display samples of different dashboards that stratify REAL data by readmissions, patient satisfaction and hospital core measures.

Figure 1. Dashboard displaying the association between racial subgroups and post-surgery patient safety measures



Source: Adapted from the Weinick et al., 2008.

Figure 2. Dashboard displaying race and ethnicity associated with 30-day readmissions

30-day Readmissions	White	Hispanic	African-American	American Indian	Asian	Unknown/ Other	Overall
Overall rate	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%
Overall volume	#	#	#	#	#	#	#
Heart failure rate	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%
Heart failure volume	#	#	#	#	#	#	#
AMI rate	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%
AMI volume	#	#	#	#	#	#	#
Pneumonia rate	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%
Pneumonia volume	#	#	#	#	#	#	#
COPD rate	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%	##.#%
COPD volume	#	#	#	#	#	#	#

Source: AnMed Health, 2014.

Figure 3. Dashboard displaying language services by inpatient and outpatient services

Language Services	Outpatient Services	Inpatient Services	Total
Other	##.#%	##.#%	##.#%
Spanish	##.#%	##.#%	##.#%
Vietnamese	##.#%	##.#%	##.#%
Sign Language	##.#%	##.#%	##.#%
Arabic	##.#%	##.#%	##.#%
Chinese/Mandarin	##.#%	##.#%	##.#%
German	##.#%	##.#%	##.#%
Russian	##.#%	##.#%	##.#%
Farsi (Persian)	##.#%	##.#%	##.#%

Source: AnMed Health, 2014.

Figure 4. Template dashboard displaying race and ethnicity by HCAHPS score

HCAHPS (Inpatient)	Non-Hispanic White N=	Hispanic N=	Black/ African-American N=	Asian N=	American Indian N=	Pacific Islander N=	Multiple Races N=
Overall rating	#	#	#	#	#	#	#
Overall hospital recommendation	#	#	#	#	#	#	#
Nurse communication	#	#	#	#	#	#	#
Doctor communication	#	#	#	#	#	#	#
Quiet at night	#	#	#	#	#	#	#
Room cleanliness	#	#	#	#	#	#	#
Pain control	#	#	#	#	#	#	#
Medication information	#	#	#	#	#	#	#
Discharge information	#	#	#	#	#	#	#
Staff responsiveness	#	#	#	#	#	#	#

Source: Massachusetts General Hospital, 2014.

Figure 5. Template dashboard displaying race/ethnicity by the Healthcare Effectiveness Data and Information Set (HEDIS) Quality Indicators

HEDIS Quality Indicators, 2010–2012

	Race/Ethnicity									
	White		African-American		Hispanic		Asian		Other (excludes unknown)	
	N	%	N	%	N	%	N	%	N	%
Preventive Screening										
Breast cancer screening (women 42–74 years old)										
Physician linked										
Practice linked										
Cervical cancer screening (women 21–64 years old, excluding those with total hysterectomy)										
Physician linked										
Practice linked										
Colorectal cancer screening (individuals 52–75 years old)										
Physician linked										
Practice linked										
Prostate cancer screening (men 52–69 years old)										
Physician linked										
Practice linked										
Diabetes Care										
Any LDL cholesterol test within the last year										
Physician linked										
Practice linked										
Any HbA1c test within the last year										
Physician linked										
Practice linked										
Coronary Artery Disease										
Any LDL cholesterol test within the last year										
Physician linked										
Practice linked										

Source: Massachusetts General Hospital, 2014.

Conclusion

As hospitals and care systems work to improve quality of care and prepare for coming changes in the health care field, the ability to fully understand their patient populations and communities is critical. Collecting and using race, ethnicity and language data will help hospitals and care systems understand their patient populations and address health care disparities. While many hospitals are successfully collecting REAL data, fewer are effectively stratifying the data to shed light on health care disparities.

Stratifying REAL data is part of a larger effort surrounding the use of health care disparities information With these data, hospitals and care systems can effectively target interventions. To use REAL data for stratification on an ongoing basis, it is imperative that the hospital culture emphasize utilizing quantitative data to identify disparities in care and to provide insights on the hospital's performance as it relates to serving its diverse patient population.

Stratification using REAL data requires collaboration across different hospital departments to assess the quality and validity of the data and create a more comprehensive plan. Implementing a structured process to begin using these data for strategy also requires strong support from leadership. The framework provided in this guide is a generalized approach to the stratification of REAL data for hospitals and care systems. Stratifying REAL data is part of a greater process of eliminating health care disparities and, in turn, improving patient outcomes and overall hospital performance.

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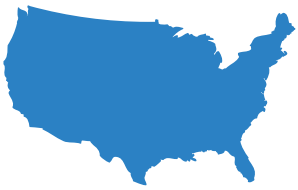
A Framework for Using REAL Data

REAL data is race, ethnicity and language data.



Racial and ethnic minorities are projected to account for a majority of the U.S. population by 2043.

Source: U.S. Census Bureau, 2012.

Hospitals are working to ensure every patient receives high-quality care.

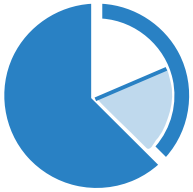
A focus on value and quality necessitate that hospitals improve patient outcomes.

Hospitals that focus on the unique needs of diverse populations will be well positioned for future success.

95%

Most hospitals collect REAL data, but a smaller percentage use the data in decision making.

Source: HRET, 2014.



Using REAL data can help ensure that care provided is tailored to the individual needs of patients.

The use of REAL data can help identify where quality efforts are effective and where there are opportunities for improvement.

5 Step Framework for Using REAL Data

Each hospital or care system can approach stratifying data differently, but the general framework is similar.

1. **Assemble a working group**
2. **Validate the REAL data**
3. **Identify the highest priority metrics**
4. **Determine if you can analyze the selected metrics**
5. **Analyze the data**

Source: HRET, 2014.

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For more information, visit hpoe.org/stratifyingdata

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Resources: For information related to equity of care, visit www.hpoe.org and www.equityofcare.org.

Suggested Citation: Health Research & Educational Trust. (2013, August). *Reducing health care disparities: Collection and use of race, ethnicity and language data.* Chicago: Health Research & Educational Trust. Retrieved from www.hpoe.org.

Accessible at: http://www.hpoe.org/EOC-real-data

Contact: hpoe@aha.org or (877) 243-0027

Background

In 2011, the American College of Healthcare Executives, American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States and America's Essential Hospitals stood together in a call to action to eliminate health care disparities. As national partners, these groups are working together to improve quality of care for every patient by disseminating best practices and resources for equitable care.

The Institute for Diversity in Health Management, an affiliate of the AHA, conducted a national survey in 2011 and found that only 18 percent of hospitals were collecting race, ethnicity and language preference (REAL) data at the first patient encounter and using it to assess gaps in care. As a result, the first goal set forth by the national partners is to increase the collection and use of REAL data to drive the elimination of disparities in care. This guide provides a road map to achieve this goal.

Two additional goals set forth by the national partners are to increase cultural competency training and increase diversity in health care governance and leadership. All three goals and designated milestones are outlined on the Equity of Care website at www.equityofcare.org.

This guide is part of a continuing series that will support hospitals and care systems working to reduce health care disparities and promote equitable care. The partners in the national call to action intend for this series and other resources to markedly increase the percentage of hospitals committed to improving equity of health care in the coming years.

Introduction

Racial and ethnic minorities are projected to account for a majority of the U.S. population by 2043, and the future market for health care services will inevitably reflect this change.[1] In addition, this next generation of health care consumers will be increasingly empowered to differentiate providers based on publicly available quality and satisfaction measures. As such, hospitals and care systems that can accommodate the unique needs of diverse populations will be well positioned for future success. One way to achieve this goal is to collect and use race, ethnicity and language (REAL) data in a meaningful way to understand and address health care disparities among various racial and ethnic groups.

REAL data also can drive success under new payment models that require hospitals and care systems to manage costs while improving the health of their patient populations. For example, both Massachusetts and Maryland have explored distributing incentive payments to hospitals and care systems based on performance metrics stratified by race and ethnicity.[2,3] Recent analysis suggests that 30 percent of direct medical costs for African-Americans, Hispanics and Asian-Americans are excess costs due to health inequities.[4] Using REAL data, hospitals and care systems can identify high-cost drivers, develop interventions to improve care for vulnerable populations and, as a result, appropriately deploy resources.

Given changing demographics, an empowered patient population and new reimbursement models, now is the time to develop thoughtful processes around the collection and use of REAL data. While studies show that most health care providers are collecting some REAL data, significant variation exists in how the data is collected.[5] Furthermore, as few as 14 percent to 25 percent of hospitals and care systems are actually using REAL data to assess variation in quality and health outcomes.[6,7]

This guide includes two sections, which will address both collection and use of REAL data. The first section provides a four-step approach on how to obtain an accurate and usable REAL data set. The second section discusses how hospitals and care systems can use REAL data to achieve clinical, operational, financial and population health benefits.

Section 1: Optimizing REAL Data Collection

Before hospitals and care systems begin using REAL data, they first should obtain a strong data set with which to work. Hospitals and care systems can adopt the four-step approach in Figure 1 to achieve a successful data collection effort.

Figure 1: Four-Step Approach to Ensure Successful REAL Data Collection

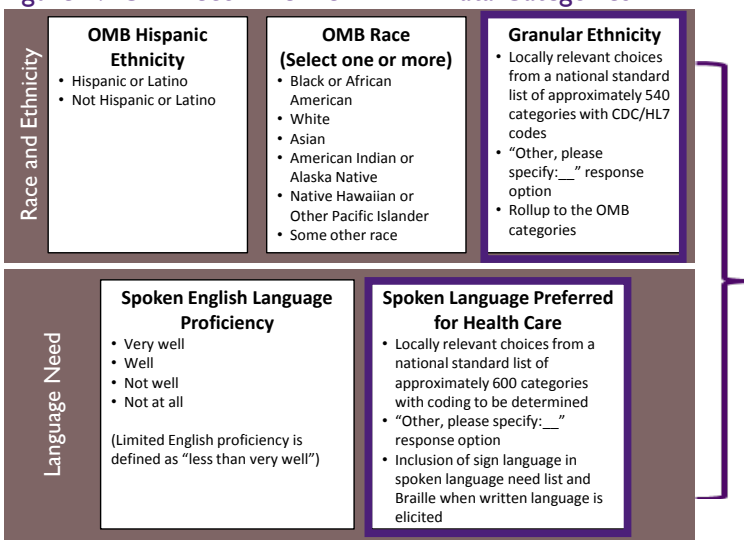
Source: American Hospital Association, 2013.

Step one is to develop a locally relevant and culturally appropriate set of REAL data categories that are standardized across the organization. Steps two through four consist of adopting an organizational process to ensure data integrity, accuracy and comprehensiveness.

Step 1 *Determine the appropriate data categories*

To obtain a good data set, hospitals and care systems should first define the data categories that are appropriate for their patient populations. The U.S. Office of Management and Budget (OMB) originally defined standardized REAL data categories, and the Institute of Medicine (IOM) developed a 2009 report citing the need for more granular ethnicity categories. The IOM's recommendations are outlined in Figure 2.

Figure 2: IOM-Recommended REAL Data Categories



Although the IOM includes more than 500 categories for ethnicity and 600 categories for language, hospitals and care systems should tailor this list to accommodate the populations they serve. To identify the right categories:

1) Use publicly available census data
2) Conduct focus groups and/or surveys with key community organizations
3) Use existing survey data (e.g., from local schools)

For more information on selecting data categories, visit: http://www.mass.gov/eohhs/docs/dph/health-equity/clas-chapter3.pdf

Sources: Institute of Medicine, 2009, "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement"; American Hospital Association, 2013.

Step 2 *Develop a methodology for data collection*

Next, hospitals and care systems will need to develop a methodology for collecting REAL data. Figure 3 outlines some questions to consider when designing this methodology.

Figure 3: Developing a Methodology for REAL Data Collection

Design Question	Options	Considerations / Suggested Method
Who should collect the data?	• Registration staff • Medical assistant • Registered nurse	• Using registration staff has been proven to increase collection rates, although one study found patients preferred being asked in the exam room by nursing staff.[8] Providers should assess staffing levels and determine who is best suited to collect the data. • **Suggested: Registration staff**
When should the data be collected?	• At time of check-in • Over the phone • Pre-exam	• Collecting preferred language data over the phone when a patient is scheduling an appointment can help in planning for interpretation services. • **Suggested: At check-in or over the phone**
What format should be used to collect the data?	• Paper format • Electronic kiosks / tablets • Verbal discussion	• Paper forms, kiosks and tablets allow for patient privacy, although one study has shown that collection rates are highest when patients have the option to also report REAL data verbally.[9] • Paper forms, kiosks and tablets may pose a challenge for patients with limited literacy. • Kiosks or tablets will eliminate the need for staff to transcribe data into the electronic medical record. • **Suggested: Provide options for a more private form of entry (paper form, kiosk or tablet) as well as verbal discussion**

Source: American Hospital Association, 2013.

Patient self-reporting of REAL data is the gold standard of data collection. Staff should never attempt to guess a patient's race, ethnicity or preferred language. While the suggested methods in Figure 3 have proved successful in the past, ultimately hospitals and care systems should choose the best path forward given the populations they serve. As an example, one hospital found that paper forms were often left incomplete in the waiting room, because of the low literacy rate and limited English proficiency of its patient population.[10]

Step 3 *Train staff members on methodology for data collection*

Once a methodology for data collection is defined, hospitals and care systems should provide training to appropriate staff members. Training on standardized processes can increase compliance, ensure data integrity and improve patient buy-in. The Health Research & Educational Trust (HRET) developed a toolkit that provides REAL data collection training materials for hospitals and care systems and can be accessed free at http://www.hretdisparities.org/.

Step 4 *Assign accountability and monitor progress of data collection efforts*

Hospital leadership should assign accountability and monitor data collection efforts to ensure processes are working as planned. For example, registration staff can be held accountable for achieving certain metrics against a baseline, such as a decrease in the number of patients reported as "unknown" for race or ethnicity. Leveraging existing processes can save time and resources. One hospital used an existing post-discharge survey to determine whether or not REAL data was collected at registration.[11] No new costs were associated with this process, and the data helped to increase compliance with collection protocols.

Proper data collection will not be a quick process: it took one hospital several years to reduce the number of patients reported as "unknown" race to less than 1 percent. However, this four-step process gives hospitals and care systems a starting point to obtaining a strong REAL data set.

Section 2: Making Good Use of REAL Data

After obtaining a robust REAL data set, hospitals and care systems will need to make several decisions, including which measures to look at, what to use as a reference point, whether any risk adjustments are needed and what sample size is appropriate. The Disparities Solution Center at Massachusetts General Hospital provides a toolkit with recommendations on how best to conduct REAL data analyses. The toolkit can be found at http://www2.massgeneral.org/disparitiessolutions/z_files/Disparities%20Commissioned%20Paper.pdf. After completing analyses, hospitals and care systems then can use the results in meaningful ways, as outlined in Figure 4.

Figure 4: Using REAL Data Effectively

How to Use REAL Data	Details
Identify the measures where the greatest disparities exist and prioritize which initiatives to pursue.	Given resource constraints, hospitals and care systems can use REAL data to prioritize their agenda for reducing disparities. For example, AnMed Health in Anderson, S.C., created a "Disparities Dashboard" and stratified patient satisfaction and inpatient quality indicators by race and ethnicity to identify disparities. The health system found that while some scores were fairly consistent across race categories, the 30-day readmission rate for acute myocardial infarction was significantly higher among African-Americans compared to other patients. In order to identify the root cause, the hospital dedicated a nurse to interview patients flagged to be at-risk for AMI readmissions.[12]
Understand the demographic makeup of the patient population at a more granular level and develop tailored care plans.	Using REAL data, clinicians can begin addressing disparities during patient visits. For example, studies have shown that breastfeeding rates vary significantly among different Asian ethnicities (91% among Indian women versus 35% among Cambodian women).[13] Using granular ethnicity data, obstetricians can include additional patient education for certain populations. As another example, clinicians at Hennepin County Medical Center in Minnesota will consider ordering vitamin D blood screens for Somali women, who are prone to vitamin D deficiencies.[14, 15]

Develop patient-centered, community-based interventions to reduce disparities.	REAL data can support the development of programs that influence behavior outside the exam room as well. Massachusetts General Hospital in Boston pursued a patient navigator program after finding a significant gap in colorectal cancer (CRC) screening rates between Latino and white populations. The hospital first interviewed a subset of Latino patients to understand common barriers to CRC screening, then trained patient navigators to provide patients with educational materials, emotional support and referral and scheduling services.[16]
Drive board-level decision making on where to invest and deploy resources.	Hospitals and care systems also can use REAL data for operational and strategic decision making. One study found that among providers using REAL data, 40% used it to "inform decisions about resource allocation (e.g., deciding where to build new clinics) and one-third used the data to look at trends in patient demographics for marketing and strategic planning."[17] For example, Vidant Health, based in North Carolina, identified 45 different languages used by its patients. As a result, the health system created a patient-centered communications task force to improve language interpretation services among its 10 hospitals and 40 physician practices.[18]

For designing interventions, it is important to receive feedback from community members to drive program success. Hospitals and care systems can use focus groups, community surveys, advisory boards or other mechanisms to ensure interventions are patient-centered and effective.

Using REAL data can result in a number of benefits to hospitals and care systems, some of which are outlined in Figure 5.

Figure 5: Benefits of Using REAL Data

Benefit	Example
Reduce costs	After discovering high readmission rates among its African-American population, Methodist Le Bonheur Healthcare, based in Memphis, Tenn., implemented a program to help these patients transition from hospital to home. As a result, total health care costs for participants were roughly $8,700 lower, on average, than for nonparticipants, and readmissions for patients with heart failure fell from 35% to 20%.[19]
Reduce disparities in health outcomes	Massachusetts General Hospital in Boston provided culturally tailored individual and group coaching sessions to Latino patients struggling with diabetes self-management. As a result, the gap in the percentage of Latinos compared with whites with uncontrolled diabetes decreased from 13% to 9%.[20]
Reduce hospital readmissions	AnMed Health, based in Anderson, S.C., used an EMR alert and patient navigator program to reduce disparities in readmission rates. The intervention reduced the 30-day AMI readmission rate among African-Americans by 20%, and the gap in readmission rates between African-Americans and other racial subgroups decreased by 16% within one year.[21]
Receive incentive payments	Hospitals and care systems may begin to receive incentive payments for reducing health care disparities. Massachusetts already has a Medicaid pay-for-performance program that provides hospital rate increases "contingent upon quality measures, including the reduction of racial and ethnic disparities in health care." The program asks hospitals and care systems to report on a Clinical Disparities Composite Measure to determine eligibility for payment.[22, 23]
Meet PCMH certification requirements	Hospitals and care systems can meet Standard 6 of NCQA certification for patient-centered medical homes if data collected "is stratified by race and ethnicity," and "the practice identifies areas of disparity among vulnerable populations, sets goals and acts to improve performance in these areas."[24, 25]

Conclusion

While the ultimate goal of collecting REAL data is to reduce health care disparities, the immediate focus for hospitals and care systems should be ensuring data is standardized and collected appropriately. By adopting a four-step approach—defining the right data categories, developing a methodology for collection, training staff, and assigning accountability / monitoring progress—hospitals and care systems will have a strong REAL data set for analysis. With this data, hospitals and care systems can stratify outcomes measures to understand where disparities exist, prioritize where to focus time and resources and develop patient-centered interventions. Effective collection and use of REAL data will position hospitals and care systems for success in an environment where regulators, payers, employers and, most importantly, patients are looking for more differentiated and individualized health care.

Case Study: The Institute for Family Health, New York

The Institute for Family Health operates 17 sites that provide primary health care services to more than 90,000 patients in New York City and the Hudson Valley. In 2006, IFH attempted to assess quality measures stratified by race and ethnicity, only to discover deficiencies in the data sets. As a result, IFH became one of the first institutions to adopt the Institute of Medicine's 2009 recommendations for REAL data collection, with four goals in mind: 1) maximize data collection rates, 2) obtain self-reported data from patients, 3) obtain granular data and 4) create new tools for identifying and addressing health care disparities. IFH embarked on a five-stage process to achieve these goals, which consisted of designing the data collection process, updating the EMR, training staff members, monitoring their progress and using the data meaningfully. During the monitoring stage, IFH saw statistically significant improvements in the proportion of patients with race and granular ethnicity recorded across several sites—an increase of 13 percent in race fields completed and 24 percent in ethnicity fields completed. IFH also was able to use the REAL data sets to identify a need for hepatitis B screening among foreign-born patients from endemic geographies. Using an EMR alert, providers now know when to administer the screening.

Contact:
Diane Hauser, MPA, Senior Associate for Research
212-659-1406, dhauser@institute2000.org
http://www.institute2000.org/

Case Study: Wheaton Franciscan Healthcare, Wisconsin

Wheaton Franciscan Healthcare is a nonprofit, integrated health system serving nearly one quarter of southeast Wisconsin. WFHC recognizes the importance of attaining a strong REAL data set for analysis to reduce health care disparities. The health system not only trains staff on proper data collection techniques but also monitors progress by reviewing collection metrics on a quarterly basis. With support from the health system's executive strategy diversity team and the organization's CEO, WFHC uses REAL data to identify and reduce disparities in health outcomes. Recent analysis revealed a need to improve diabetes management for the hospital's African-American population. To develop a patient-centered intervention, the health system first conducted a series of focus groups to identify common barriers to diabetes self-management among African-Americans. The discussions revealed that traditional, structured diabetes education programs were overwhelming for patients, especially newly diagnosed diabetics. Given the findings, WFHC created an intervention program that uses a community health worker to provide diabetes education and support for participants. The CHW, who is a community member that patients can easily relate to, spends the majority of time engaging patients in both clinical and nonclinical settings. In addition, participants have the opportunity to attend peer support groups at the end of each educational session. The program started in March 2013, and WFHC is currently tracking patient progress on diabetes knowledge, A1C levels, body mass index, weight and blood pressure.

Contact:
Rosha Hamilton, RN, MSW
Director, Community and Patient Health Education Services, Wheaton Direct
414-465-3439, rosha.hamilton@wfhc.org
http://www.mywheaton.org/

Resources

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For Additional Information
Maulik S. Joshi, DrPH
Senior Vice President of Research, American Hospital Association
(312) 422-2622
mjoshi@aha.org

Accessible at: www.hret.org/cultural-competency

Executive Summary

Cultural competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring health of care delivery to meet patients' social, cultural and linguistic needs. A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care.

This guide serves to explore the concept of cultural competency and build the case for the enhancement of cultural competency in health care. It is recommended that hospital leaders undertake the following seven tasks within their organizations and answer the associated self- assessment questions:

1. Collect race, ethnicity and language preference (REAL) data.

- Do you systematically collect race, ethnicity and language preferences of all your patients?

2. Identify and report disparities.

- 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?

3. Provide culturally and linguistically competent care.

- Have your patient representatives, social workers, discharge planners, financial counselors and other key patient and family resources received special training in diversity issues?
- Has your hospital developed a "language resource," identifying 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 your written communications with patients and families available in a variety of languages that reflect the ethnic and cultural makeup of your community?
- Based on the racial and ethnic diversity of the patients you serve, as well as those in your service area, do you educate your staff at orientation and on a continuing basis about cultural issues important to your patients?
- Are core services in your hospital, such as signage, food service, chaplaincy services, patient information and communications, attuned to the diversity of the patients for whom you care?

4. Develop culturally competent disease management programs.

- Does your hospital gather information to determine conditions of high prevalence within your community's minority populations?
- Does your hospital offer disease management programs that effectively address these conditions?
- Do your disease management programs address the barriers to care that are particularly challenging for minority patients?

5. Increase diversity and minority workforce pipelines.

- 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 racial and ethnic minorities in your community?
- Do you acknowledge and honor diversity in your employee communications, awards programs and other internal celebrations?
- Does your human resources department have a system in place to measure diversity progress and report it to you and your board?

6. Involve the community.

- Has your community relations team identified community organizations, schools, churches, businesses and publications that serve racial and ethnic minorities for outreach and educational purposes?
- Do you have a strategy to partner with community leaders to work on health issues important to community members?

7. Make cultural competency an institutional priority.

- Has your board set goals on improving organizational diversity, providing culturally competent care and eliminating disparities in care as part of your strategic plan?
- Is diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers?

This information, coupled with the case studies from high-performing hospitals, will help guide hospital leaders as they seek to improve the quality, efficacy, and equity of care within their own institutions through advances in cultural competency. In addition, this guide provides self-assessment checklists for hospital leaders and a list of relevant cultural competency resources.

Introduction

Minorities currently represent approximately one-third of the United States population. Minorities are anticipated to represent the majority of the population in 2042 and will eventually comprise up to 54 percent of the population in 2050.[1] With a general population that is becoming more diverse, the health of our nation is increasingly dependent on our ability to keep minority populations healthy. Despite this fact, minorities frequently encounter more barriers to care, greater incidence of chronic disease, lower quality of care, and higher mortality rates than white Americans.[2] This fact carries significant ethical and practical implications for care of an increasingly large proportion of our nations' population.

In response, the provision of culturally competent care has the potential to improve health care access, promote the quality of medical outcomes and eliminate disparities in the care delivery process. Cultural competency is becoming the preferred tool among health care providers seeking to manage the complex differences in the ways in which patients express pain, seek and follow medical advice, and participate in their own healing process. At the patient level, the presence of culturally competent employees builds trust, provides patient confidence and reduces costs associated with various types of medical errors. Moreover, at the provider level, advancements in cultural competency can improve quality scores, which are increasingly associated with reimbursement rates.

Minimizing racial and ethnic disparities requires not only culturally competent clinicians but also leaders who create an organizational context in which cultural competence is enabled, cultivated and reinforced. Health care organizations in the United States require leadership that is firmly committed to the concepts of diversity and cultural competency.[3] It is in this interest that this guide provides information to hospital leaders, aligned with the following objectives:

- To provide health care leaders and policymakers with a basic literature review regarding the value of embracing culturally competent care as a tool to improve the quality of medical outcomes;
- To provide case studies from the high-performing hospitals that participated in the Institute for Diversity's "The State of Health Care Disparities and Diversity: A Benchmark Study of U.S. Hospitals" and have employed culturally competent care strategies to create a competitive difference in their markets;
- To share seven key steps necessary to build a culturally competent organization;
- To encourage health care leaders to elevate culturally competent care as a priority in the strategic planning process.

With this information, hospital leaders can improve the quality, efficacy, and equity of care by increasing cultural competency within their own institutions.

Review of Literature on Culturally Competent Care

A significant body of research exists within the field of cultural competency in health care. The following sections provide a brief overview of the literature relating to the needs for and benefits of improving cultural competency within the hospital setting.

Culturally Competent Model for Care Delivery

The delivery of high-quality primary health care requires an in-depth understanding of the sociocultural background of patients, their families and their environments.[4] Such an understanding is commonly referred to as cultural competency.[5] Cultural competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs.[6] Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic health care disparities[7] and improving equity of care.[8]

This knowledge, coupled with major demographic shifts in the U.S. population, underscores the necessity of making all health care organizations culturally competent.[9] A culturally competent health care system is defined as one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes of the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs.[10] Key means of achieving culturally competent care delivery consist of increasing the diversity of the health care workforce and leadership (including trustees and senior management), as well as incorporating strategies to promote diversity within all hiring and recruitment practices.[11] In addition, providing compassionate, patient-centered care will further require health care leaders to assess the existence of bias, stereotypes and prejudice in their own behaviors.[12]

The Importance of Culturally Competent Governance

One critical mechanism for improving cultural competency is the engagement of hospitals' governing bodies.[13] Hospital governance is responsible for identifying and actualizing the institution's core mission and values. In this interest it is essential that hospital governance embrace the concept of cultural competency to ensure that the delivery of culturally and linguistically appropriate care is ingrained within the organization's mandate. Once this is achieved, the delivery of culturally competent care can become an area of priority for hospital executives.[14] This, in turn, provides a strong incentive for executives to enact policies and procedures to improve cultural competency, like diversity management programs, and to ensure that necessary resources, such as interpretation services, are made available. More than any other entity, the governance structure must reflect and promote those practices that earn the public's trust and ensure a delivery process that is safe and equitable.

The Importance of Cultural Diversity in Leadership

As the United States becomes more culturally diverse, it becomes increasingly important to expand minority recruitment efforts in health care to meet the needs of this changing population.[15] Moreover, anecdotal evidence suggests that the lack of diversity in health care leadership can result in policies and procedures that do not adequately meet the needs of diverse populations.[16] Therefore, the goal of managing diversity is to enhance the hospital workforce, promote customer satisfaction, and to further improve organizational performance.[17] Managing diversity is not a social requirement. Rather, diversity management represents a business requirement that will grow in intensity as the general population, and accordingly the patient population, continues to become more racially and ethnically varied.

Regulations, Standards, Laws and Public Trust

There is a strong regulatory and legal framework for promoting culturally competent care. This framework was first established by Title VI of the Civil Rights Act of 1964, which stated that "no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Enforcement of Title VI for health care programs is the responsibility of the Department of Health and Human Services Office for Civil Rights (OCR) and is governed by their regulations and guidelines. In this context, the unequal treatment of racial, ethnic and linguistic minority patients is unacceptable, and efforts to remedy this situation, such as implementing culturally competent care, are duly warranted.

Following the inception of Title VI, several other government actions have reinforced the need for cultural competency in health care. In 2000, the Office of Minority Health (OMH) of the Department of Health and Human Services published national standards for culturally and linguistically appropriate services (CLAS) in health care. The 14 CLAS standards address the appropriate use of language services in the delivery of culturally competent care as well as other forms of organizational support to ensure cultural competency. The CLAS standards were offered by OMH as a guideline for federal and state regulators and private accreditors of health care organizations in an effort to achieve a higher level of cultural competency in health care delivery by upgrading and standardizing expectations. The CLAS standards do not have the force of law in and of themselves, but they are being used increasingly by regulators and accreditors, such as The Joint Commission, in fashioning their standards.

Also in 2000, presidential Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," was issued. This Executive Order offered specific guidance on language services that must be provided under all federal agency service programs to ensure equal access for limited English proficiency (LEP) persons. The Executive Order requires that each federal agency adopt a language services plan consistent with Department of Justice guidelines to ensure that adequate language services are provided by the agency's programs and by organizations receiving federal funds under those programs. Those providing services under Medicare and Medicaid meet Title VI OCR regulations prohibiting discrimination on the basis of national origin and follow OCR guidelines for LEP populations.

Most recently, the 2010 Patient Protection and Affordable Care Act (ACA) further elaborated the need for cultural competency within the health care setting. Section 1557 of the ACA extends existing federal laws prohibiting discrimination by requiring covered entities (i.e., health plans offered through state insurance exchanges) to provide information in a culturally and linguistically appropriate manner. Moreover, Section 4302 of the ACA strengthens federal data collection efforts by requiring that all federally funded programs collect data on race, ethnicity, primary language, disability status and gender.

The Business Case for Equity

The promotion of equity in health care has a direct impact on hospital outcomes. Systemic cultural competence can improve the efficiency of care by helping patients access the appropriate services in a timely fashion.[18] Moreover, the elimination of linguistic and cultural barriers can aid in the assessment of patients and reduce the need for unnecessary and potentially risky diagnostic tests.[19] Additionally, reducing disparities and increasing diversity can increase patient satisfaction scores.[20]

There is a strong economic argument for undertaking appropriate efforts to eliminate unwarranted variations in care when one considers the potential impact that disparities in care can have on readmissions, medical errors, extended length of stay and the potential legal liabilities should the provision of unequal care be challenged in court. It should be noted that improvements in cultural competency confer other potential business advantages as well. These advantages include appealing to minority consumers, increasing competitiveness for private purchaser business, and improving organizations' abilities to respond to the demands of public purchasers.[21] Conversely, failure to improve diversity and cultural competency may harm hospitals' patient and employee bases.

Steps for Building a Culturally Competent Organization

The following steps provide a series of seven actions that hospital leaders can undertake to promote cultural competency within their own institutions. Case studies are also provided in some instances to demonstrate the practical application of such principles.

1. Collect Race, Ethnicity and Language Preference (REAL) Data.
   Gathering data on race, ethnicity and language preferences is a necessary first step in addressing inequalities in care as it enables providers to identify disparities in care or outcomes and then take appropriate steps to eliminate them.[22] It is imperative that hospitals collect accurate data in order to understand the populations that they serve, to tailor the delivery of care to their patients, to obtain feedback regarding their performance on quality measures across patient populations, and to develop appropriate quality improvement interventions when so warranted.[23] There is also a strong need for standardization in data reporting so as to minimize inconsistencies that might bias potential findings. For this reason, using the Health Research & Educational Trust's Disparities Toolkit is recommended for collecting and reporting race and ethnicity data. The Toolkit can be modified to meet most challenges that arise across geographic locations and sensitivity issues encountered in cross-cultural communication. Furthermore, staff must be trained, and in some cases "scripted," to respectfully ask a patient to self-report his or her racial or ethnic identity.

SELF-ASSESSMENT

- **Do you systematically collect race, ethnicity and language preferences of all your patients?**

CASE STUDY: AnMed Health
With diverse communities come language translation issues. Medical interpretation and translation services are costly and therefore pose a challenge to most health care organizations. In response, AnMed Health, a 533-bed hospital based in Anderson, South Carolina, sought to establish customer-focused, cost-efficient communication programs.

Accurate data is essential to the appropriate growth and development of any new business venture. Medical interpretation and translation services are no different. In 2002, AnMed Health assembled a multidisciplinary process-improvement team to develop a system that is currently used to record every patient's race, ethnicity, national origin and language preferences in the medical record during the admissions process.

This information is important, as cultural and linguistic differences may significantly impact the interaction between patient and caregiver and, ultimately, impact the quality of care, treatment outcomes, and satisfaction of the patient. Admissions personnel receive culturally appropriate scripts and in-service training to build their confidence with this sensitive line of questioning. In partnership with its Medical Resource Management department, the Diversity and Language Services department has designed and implemented several technical strategies, or focus studies, that give AnMed Health the ability to quantify services, improve data collection, and monitor the improvement of service quality to LEP patients.

First, all medical interpretations are documented on an Interpretation Services Report and executed by the attending interpreter. A second strategy is the Interpretation Service Satisfaction tool, a survey conducted by telephone. This tool includes a prompted series of questions, generated upon completion of each patient encounter and designed to assess the patient's satisfaction with the interpretation support provided. There are two benefits of this tool: it provides specific information for the interpreter so that he or she may identify areas for improvement, such as accuracy or technique, and it also provides an opportunity to clarify discharge information for the patient. The third and most innovative strategy was created for the organization's obstetrical LEP patients. LEP patients are preregistered at the women's health department, and the information is input into the MIDAS+™ system, providing interpreters with essential information available to caregivers 24 hours per day. In the event of a premature delivery or miscarriage, this information helps ensure accurate and timely communication at a critical time.

AnMed Health has received national recognition for its model language program and is also the first health system in South Carolina to use Deaf-Talk video conferencing technology to improve communication with deaf and hard-of-hearing patients. By utilizing these and other new strategies as they are developed, AnMed Health meets the language interpretation challenges associated with providing service to a diverse community.

2. <u>Identify and Report Disparities.</u>
   Hospitals must plan for and commit resources to the evaluation of medical interventions. Hospital leaders should use quality measures to generate reports stratified by race, ethnicity and language group to examine disparities in clinical processes and patient experiences.[24] Such reporting and performance review has been shown to improve the quality of care provided to patients as it enables the organization to gauge its performance on dimensions of care and services to eliminate disparities.[25] It is further recommended that these evaluations apply qualitative and quantitative methods; include formative and summative assessment; employ action research; use participatory and empowerment approaches; and consider a broad range of outcomes including societal,

environmental, psychological, behavioral/attitudinal change, community capacity, social capital, and quality of life aspects.

SELF-ASSESSMENT

- **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?**

3. Provide Culturally and Linguistically Competent Care.

The provision of culturally and linguistically competent care has the potential to improve health care access, quality and outcomes, and to reduce disparities in care.[26] Adopting activities to enhance patients' access to culturally and linguistically appropriate services is essential for reducing disparities and reaching the ultimate goal of building a health care system that delivers the highest quality of care to every patient, regardless of race, ethnicity, culture or language. Culturally and linguistically competent services should include: cultural competency training for providers, staff and volunteers in patient contact roles; established protocols for serving LEP patients; interpreter services; translators; a bilingual workforce; diverse community health educators; and the use of multilingual signage, etc.[27]

According to the Institute of Medicine report *Unequal Treatment,* increased levels of cultural competency and enhanced patient-provider communications have the potential to improve the accuracy of diagnoses, prevent patients from exposure to unnecessary risk diagnostic procedures, enable providers to better obtain true informed consent, and enable patients to participate in shared decision-making practices.[28] Furthermore, cultural competency training has also been shown to improve the knowledge and attitudes of health care professionals who care for racial, ethnic and linguistic minority patients.[29] Conducting a community or market assessment ensures awareness of the various groups being served by the hospital. Further investigation of the community profile may reveal the epidemiological information necessary to promote prevention and wellness programs that can reduce readmissions and improve the health of the community.

SELF-ASSESSMENT

- **Have your patient representatives, social workers, discharge planners, financial counselors and other key patient and family resources received special training in diversity issues?**
- **Has your hospital developed a "language resource," identifying 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 your written communications with patients and families available in a variety of languages that reflect the ethnic and cultural makeup of your community?**
- **Based on the racial and ethnic diversity of the patients you serve, as well as those in your service area, do you educate your staff at orientation and on a continuing basis about cultural issues important to your patients?**

- **Are core services in your hospital, such as signage, food service, chaplaincy services, patient information and communications, attuned to the diversity of the patients for whom you care?**

4. Develop Culturally Competent Disease Management Programs.
To effectively reduce racial disparities in care, quality improvement interventions need to include disease management programs that effectively address conditions of high prevalence within minority populations.[30] Disease management programs should be tailored to meet the medical needs of minority and other high-risk patients. Accordingly, the development and implementation of such interventions must also address the barriers to care that are particularly challenging for minority patients (i.e., limited English proficiency, diverse health beliefs) while simultaneously addressing more general barriers that will improve the quality of care for all patients.[31]

SELF-ASSESSMENT

- **Does your hospital gather information to determine conditions of high prevalence within your community's minority populations?**
- **Does your hospital offer disease management programs that effectively address these conditions?**
- **Do your disease management programs address the barriers to care that are particularly challenging for minority patients?**

5. Increase Diversity and Minority Workforce Pipelines.
It is important to create a workforce that is as broad and diversified as the patient population that it serves. Health care leaders should recognize the benefits of diversity management, which include better marketing to consumers and the improved management of a multicultural workforce. Further societal benefits are also associated with increased workforce diversity. For instance, it has been demonstrated that racial and ethnic concordance between patient and provider is likely to enhance communication and understanding, provide opportunities for building trust and improve adherence to the medical treatment plan.[32,33] There is also evidence that underrepresented minority providers are more likely to practice in underserved communities,[34] thereby increasing access to care for those living in such areas.

SELF-ASSESSMENT

- **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?**
- **Do you acknowledge and honor diversity in your employee communications, awards programs and other internal celebrations?**
- **Does your human resources department have a system in place to measure diversity progress and report it to you and your board?**

CASE STUDY: Sparrow Hospital
Sparrow Hospital is a 733-bed hospital located in Lansing, Michigan, and part of the Sparrow Health System. Recognizing the need for diversity management, Sparrow Hospital wanted to ensure that all efforts were made to create an environment that better reflected the communities that Sparrow serves. From the board of directors to the executive leadership team, diversity management would become the impetus to achieve these results.

Sparrow's efforts were started by its vice president of human resources, who positioned diversity as a business priority. To provide leadership in this area, Sparrow embarked on a national search to recruit a subject-matter expert with a proven track record for diversity management. This diversity director helped align the institution's diversity goals with its organizational goals. The director also educated hospital leaders on topics pertaining to diversity management and on integrating diversity goals into division, department, functional and individual goals.

As a result, a systemwide diversity and inclusion program is now led by the Diversity and Inclusion Council. The council evaluates and makes recommendations on educational and classroom coaching, and provides activities and events to support a more culturally competent workplace. In addition, Sparrow has revamped internal processes relating to retention and transfer, which include updated exit interview processes, support for employee relations, a new mentoring program, and a Service Excellence Department that works closely with patients and patient advocates. The hospital's materials acquisition staff currently attends career fairs to create sourcing options intended to identify quality candidates of color. Sparrow currently monitors its current workforce against available reports provided by U.S. Census data. The organization currently is at 13.65 percent minority representation, and the regional eight-county availability is 11.4 percent.

By aligning diversity and inclusion goals into an established organizational process from the top down, Sparrow Hospital has successfully internalized a system to maintain a culturally competent internal environment—one that accurately reflects the community it serves.

6. Involve the Community.
   Strategies to effectively reduce disparities in care must engage the broader public through community-based activities and programs. By establishing functional relationships within the community, hospitals can build a bridge to patients in need of care.[35] Exercising cultural competency is essential because barriers to care and solutions to eliminating inequities in care vary widely by religion and culture. Therefore, interventions must be tailored to the community's specific needs and must also reflect the community's demographic and socioeconomic makeup and cultural values, while also remaining functional within the confines of existing infrastructure and support services. One approach is creating a community-based diversity advisory committee. This committee could work with hospital staff to develop programs that would resonate with the community's ethnic groups and also help the hospital to improve the inclusiveness of existing programs.

SELF-ASSESSMENT

- **Has your community relations team identified community organizations, schools, churches, businesses and publications that serve racial and ethnic minorities for outreach and educational purposes?**
- **Do you have a strategy to partner with community leaders to work on health issues important to community members?**

CASE STUDY: Lancaster General
Lancaster General Health is a 640-bed regional health care system located in Lancaster, Pennsylvania. Lancaster General Hospital is tasked with providing care to a very diverse and unique patient population, as Lancaster County is home to approximately 27,000 Amish people.

Practices and customs among Amish people can vary greatly, but in general, guiding principles for Amish daily life also influence health care and safety practices. These principles include doing God's will, separating from the world, giving mutual aid and having self-sufficiency. Therefore, the Amish attempt to maintain and restore good health, but they may not naturally seek extra measures to ensure proper safety because of their religious beliefs. Safety is an issue because there are approximately 5,305 farms in Lancaster County—many of which are worked by the Amish—and farmers typically encounter accidents and other health-related issues. According to the Pennsylvania Department of Agriculture, in 2007 there were 29 farm-related deaths in Pennsylvania, and 16 of these deaths (55 percent), including 3 children, occurred in Lancaster County.

Relationships and trust with leaders in the Amish community are the key elements needed to effectively implement educational strategies. In collaboration with the Amish Safety Committee and the Lancaster County Safe Kids Coalition, Lancaster General Health implements Farm Safety Day Camp twice a year. Since the Amish community became part of the planning process, Lancaster General is able to create meaningful educational opportunities accepted throughout the Amish community. Designed for people who live and work on farms, the Farm Safety Day Camp teaches simple, practical steps to decrease the likelihood of death and injury. Amish and other farmers volunteer to provide experiential modules on how to identify safety hazards and how to implement simple safety measures that families can apply at home and on the farm. Approximately 50 volunteers from the community donate their time and resources to help plan and educate families during these events. Since 2005, over 800 participants have been educated at Farm Family Safety Day events. The success of these events is measured by the number of attendees, survey feedback, and the behavior changes that families intend to implement.

The experience working with the Amish Safety Committee has helped Lancaster General build relationships and develop trust in the Amish community. This trust has opened doors to addressing other health issues that Amish people have previously been unwilling to discuss, such as prevention, early detection and proper use of integrative medicine. Lancaster General is now working to track early entry into care in hopes of decreasing late-stage disease rates within the Amish population.

This year Lancaster General also facilitated health educational sessions for more than 200 Amish women, held in an Amish home. In addition, the hospital established nine points of contact with businesses owned or frequented by Amish families, to use for providing health education fact sheets tailored to the Amish community. A community outreach nurse visits the sites on a quarterly basis to review distribution of the fact sheets, get feedback from the business owners and hear recommendations for future health topics. Lancaster General has also initiated an Amish Health Promoter Program to continue efforts to build trust and cultural competence in serving the Amish community.

7. <u>Make Cultural Competency an Institutional Priority.</u>
   For an institutional cultural competency initiative to be effective, it must involve the entire organization and stem from a companywide commitment.[36] Equity strategies have to be part of the overall strategic plan, and equity initiatives should be incorporated into the overall strategic vision. Efforts to address equity must address issues of evaluation, planning, implementation, communication sustainability and dissemination. In approximately 40 years, racial and ethnic

minority populations will constitute a majority of the total U.S. population.[37] As this occurs, the provision of culturally competent care will move from being merely an appropriate measure to representing a national priority and a business necessity.

SELF-ASSESSMENT

- **Has your board set goals on improving organizational diversity, providing culturally competent care and eliminating disparities in care as part of your strategic plan?**
- **Is diversity awareness and cultural competency training mandatory for all senior leadership, management, staff and volunteers?**

CASE STUDY: Barnes-Jewish Hospital

For diversity efforts to succeed in a large organization, the organization's leaders must be intrinsically involved by providing a vision for diversity and inclusion programs and becoming involved in their development and implementation. Barnes-Jewish Hospital, a 1,200-bed teaching hospital affiliated with the Washington University School of Medicine in St. Louis, Missouri, applied these principles as it worked to provide more culturally competent care throughout the hospital.

Barnes-Jewish leadership is engaged in several efforts to promote diversity and inclusion. For example, diversity and inclusion practices are included as a component of the hospital's strategic plan under the people and service categories. Hospital leaders have participated in planning and implementing several aspects of the plan's development, including recommending that the board of directors develop the Center for Diversity and Cultural Competence. Barnes-Jewish leadership agreed to an initial allocation $1.56 million to establish the center and also participated in several hours of diversity and inclusion training. Since opening the center, Barnes-Jewish leadership has committed more than $3.2 million dollars to its diversity efforts.

In addition, Barnes-Jewish leadership committed to an organizational assessment to evaluate its efforts to become a more diverse and inclusive organization. This evaluation provided a roadmap for Barnes-Jewish in further developing and implementing strategies for diversity and inclusion. In 2008, the entire executive leadership team, along with more than 22 members of the hospital's Diversity and Inclusion Council, participated in a three day off-campus training session with the National Conference for Community and Justice to identify and understand barriers to and facilitators of diversity and inclusion. In April 2010, Barnes-Jewish executive and senior leadership teams spent an additional eight hours learning how to integrate cultural competence and inclusion in everyday work.

Barnes-Jewish is experiencing a culture change in regard to diversity. The program's impact is reflected in the diversity scores from an employee engagement survey, which indicates an increase in workforce diversity in recent years. Diversity outcomes have also improved between 2007 and 2010. In addition, diversity scores at the management level have increased from 11 percent to 14 percent from 2007 to 2010.

Conclusion

Hospital leaders are encouraged to embrace cultural competency interventions as an important step toward reducing disparities in health care. Promoting culturally and linguistically appropriate care, expanding diversity within hospital leadership, institutionalizing cultural competency into hospitals' central missions, collecting race, ethnicity and primary language data, and increasing the diversity of the leadership, governance and workforce at hospitals—all represent methods that health care leaders should use to improve the equity of care. Through these initiatives, hospital leaders can help improve the quality, efficacy, and equity of care within their own institutions.

Additional Resources

Resource	Description	Address
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 (IFD)	The Institute for Diversity provides several resources for managing diversity in the health care field	www.diversityconnection.org
IFD Summer Enrichment Program	IFD's Summer Enrichment Program places promising graduate students in internships in a hospital setting	www.tinyurl.com/InstituteSEP
Does Your Hospital Reflect the Community It Serves? A Diversity and Cultural Proficiency Assessment Tool for Leaders	This AHA document provides a resource to help hospital leaders assess diversity and cultural competency activities within their institutions.	www.aha.org/aha/content/2004/pdf/diversitytool.pdf
Minority Trustee Candidate Registry	The AHA, 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.	www.americangovernance.com/americangovernance_app/candidatesProgram/index.jsp?fll=S1
Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile	This document presents an analytic framework for assessing cultural competence in health care delivery organizations and identifies specific indicators that can be used for measurement.	www.hrsa.gov/CulturalCompetence/healthdlvr.pdf
Improving Quality and Achieving Equity: A Guide for Hospital Leaders	The Disparities Solution Center offers a guide for hospital leaders interested in promoting equity and reducing health care disparities.	www2.massgeneral.org/disparitiessolutions/guide.html

Resource	Description	Address
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care A Roadmap for Hospitals	In this document, The Joint Commission offers a series of resources to enhance cultural competency and communication.	www.jointcommission.org/Advancing_Effective_Communication/
Institute of Medicine (IOM)	The IOM book *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* builds the case for enhancing the diversity of America's health care workers.	http://books.nap.edu/openbook.php?record_id=10885&page=1

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Becoming a Culturally Competent Health Care Organization

June 2013

Equity of Care

INSTITUTE FOR DIVERSITY in Health Management
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Resources: For information related to equity of care, visit www.hpoe.org and www.equityofcare.org.

Suggested Citation: Health Research & Educational Trust. (2013, June). *Becoming a culturally competent health care organization.* Chicago, IL: Illinois. Health Research & Educational Trust Accessed at www.hpoe.org.

Accessible at: http://www.hpoe.org/becoming-culturally-competent

Contact: hpoe@aha.org or (877) 243-0027

Becoming a Culturally Competent Health Care Organization

Background

This guide is part of a continuing series that will support hospitals and care systems as they work to reduce health care disparities and promote diversity in health care governance and leadership. Becoming a culturally competent health care organization is a critical component in reducing health care disparities. A recent survey by the Institute for Diversity in Health Management, an affiliate of the American Hospital Association, found that 81 percent of hospitals educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities, and 61 percent of hospitals require all employees to attend diversity training. This is a positive start, but more work needs to be done in this area.

In 2011, the American College of Healthcare Executives, American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems stood together in a call to action to eliminate health care disparities. Our focus is on increasing the collection of race, ethnicity and language preference data; increasing cultural competency training; and increasing diversity in governance and leadership.

As national partners, we are committed to these focus areas and will support quality improvement in health care through shared best practices and resources. Ensuring that all hospitals prepare their clinicians and staff to meet the care needs of all patients is an important component of an overall effort to improve equitable care and a goal of the call to action.

Introduction

Cultural competence in health care describes the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring health care delivery to meet patients' social, cultural and linguistic needs[1]. 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 about their health status. While doing this is challenging with all patients, for diverse patient populations it can be even more difficult due to language barriers, health literacy gap, and cultural differences in communication styles.

It is imperative that hospitals and health care systems understand not only the diverse patients and communities they serve but also the benefits of becoming a culturally competent organization. Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. To improve understanding of diverse cultures, hospitals and care systems should seek advice from individuals and groups in the communities they serve. These constituencies can help hospitals and care systems develop educational materials, increase patient access to services and improve health care literacy.

In 2013, the Office of Minority Health, U.S. Department of Health and Human Services, issued enhanced National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care, and a blueprint with guidance and strategies to help implement them. This first update to the standards since their initial release in 2000 expands upon the concepts of culture to reflect new developments and trends, and focuses on leadership and governance as drivers of culturally competent health care and health care equity[2]. More information on CLAS Standards is available at the end of this guide.

Benefits of Cultural Competence

Cultural competence in a hospital or care system produces numerous benefits for the organization, patients and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients, and increased participation from the local community[3]. Additionally, organizations that are culturally competent may have lower costs and fewer care disparities[4].

Figure 1. Benefits of Becoming a Culturally Competent Health Care Organization

Social Benefits

- Increases mutual respect and understanding between patient and organization
- Increases trust
- Promotes inclusion of all community members
- Increases community participation and involvement in health issues
- Assists patients and families in their care
- Promotes patient and family responsibilities for health

Health Benefits

- Improves patient data collection
- Increases preventive care by patients
- Reduces care disparities in the patient population
- Increases cost savings from a reduction in medical errors, number of treatments and legal costs
- Reduces the number of missed medical visits

Business Benefits

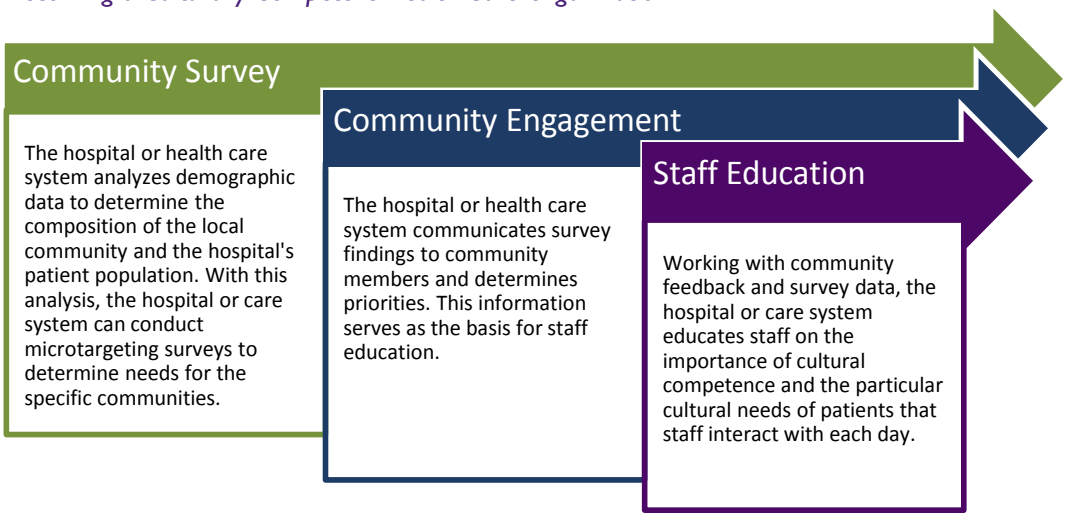
- Incorporates different perspectives, ideas and strategies into the decision-making process
- Decreases barriers that slow progress
- Moves toward meeting legal and regulatory guidelines
- Improves efficiency of care services
- Increases the market share of the organization

Source: American Hospital Association, 2013.

Steps to Becoming a Culturally Competent Organization

Before a health care organization becomes culturally competent, leaders must understand the local community and the role the organization plays within the community. Steps to becoming culturally competent include (1) analyzing data and microtargeting surveys to improve service for the local community, (2) communicating survey findings to determine priorities and (3) educating staff and aligning programming and resources to meet community needs. Figure 2 highlights the process involved for a health care organization to become culturally competent.

Figure 2. Becoming a Culturally Competent Health Care Organization

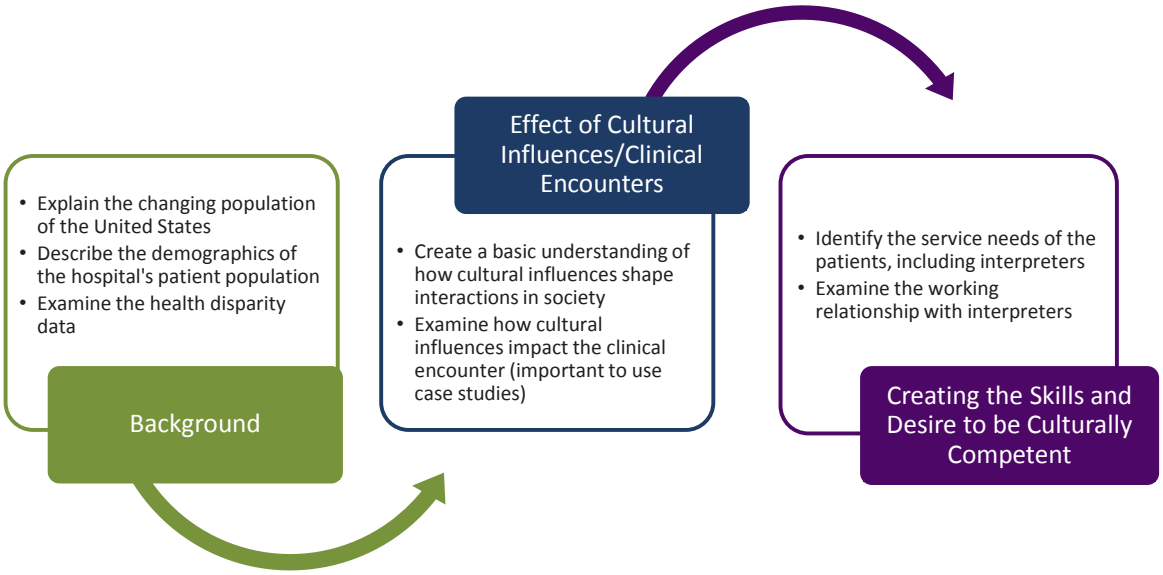


Source: American Hospital Association, 2013.

Educational Principles for Cultural Competence

Becoming a culturally competent organization requires a thorough understanding of the principles that characterize cultural competence (see Figure 3). First, staff needs to understand the factors that are pushing hospitals and care systems to become culturally competent. Hospital staff also needs to recognize and understand the cultural and clinical dynamics in interactions with patients. Becoming culturally competent involves developing and acquiring the skills needed to identify and assist patients from diverse cultures. With the necessary skills and mindset, staff can quickly identify the services required by a patient, thereby increasing positive health outcomes.

Figure 3. Educational Principles for Cultural Competence

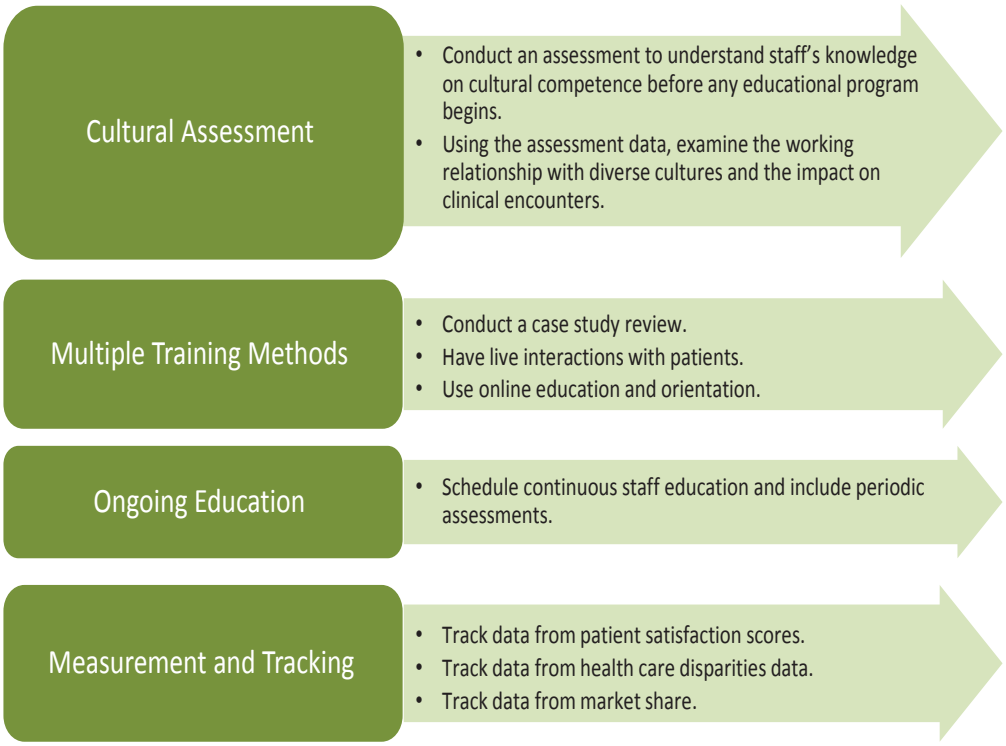


Source: American Hospital Association, 2013.

Staff Education for Cultural Competence

An effective educational or training program for cultural competence correlates with a lasting awareness and understanding by hospital staff. Although there are several approaches to educate staff, a successful educational program includes (1) cultural assessment, (2) multiple training methods, (3) ongoing education and (4) measurement and tracking (see Figure 4).

Figure 4. Staff Education for Cultural Competence



Source: American Hospital Association, 2013.

Conclusion

Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. Cultural competence is needed to provide care to patients with diverse values, beliefs and behaviors. Hospitals and care systems, as part of their mission, are eager to reduce variations in care and are using a variety of efforts to train staff to become culturally competent.

Hospitals and care systems first must understand the benefits of cultural competence and the diverse patients and communities they serve. The steps to becoming culturally competent begin with understanding the background of the community and patient population, the effect that cultural influences have on care delivery, and the skills needed by clinicians and staff. Effective educational programs and training for hospital staff include a cultural assessment, multiple training methods, ongoing teaching, and measurement and tracking. Culturally competent health care organizations have improved patient outcomes, increased respect and mutual understanding from patients, and increased participation from the local community.

Case Example: Advocate Lutheran General Hospital, Chicago, Illinois

Background: One of the largest hospitals in the Chicago area, Advocate Lutheran General is a 645-bed teaching and research hospital. To become a culturally competent organization, Advocate Lutheran focused on improving its staff's cultural awareness and enhancing the organization's connection to local ethnic communities the hospital served. Challenges that the organization encountered included the staff's lack of knowledge about different cultures, language barriers, and socioeconomic and ethnic barriers.

Interventions: To develop a robust educational program to train hospital staff, Advocate Lutheran analyzed local demographic data and patient data to determine the ethnic composition of the individuals being served. Based on this analysis, education on the importance and implications of cultural competence was added to new employee orientation. Additionally, the hospital CEO meets with new employees to discuss the organization's cultural competence initiatives.

The hospital also formed a diversity group made up of staff members who organize cultural awareness days. These cultural awareness events allow hospital staff to interact with individuals from different cultures that are represented in the greater community served by the hospital. To engage local ethnic communities, Advocate Lutheran surveyed the community to determine potential barriers and opportunities for providing care to the South Asian population. In response, the hospital established a South Asian Cardiovascular Center, the first cardiovascular center in the Midwest that aims to educate, screen, prevent, and treat South Asians for their high risk of cardiac disease.

Results: Although its cultural competence initiatives are still being expanded, Advocate Lutheran has seen progress in providing culturally competent care to its ethnically diverse patient population. Patients needing special care to accommodate their ethnic beliefs or practices are being identified more quickly as a result of the increased cultural competence of hospital staff.

Contact:
Advocate Lutheran General Hospital
Anthony A. Armada, FACHE
President
Phone: (847) 723-8446
http://www.advocatehealth.com/luth/

Case Example: Lutheran Medical Center, Brooklyn, New York

Background: Lutheran Medical Center, part of Lutheran HealthCare, is a 468-bed acute care hospital and trauma center. Serving an extremely diverse community in Brooklyn, Lutheran Medical Center estimates its patients and staff members speak about 73 languages and celebrate 30 different ethnic holidays.

Interventions: Embracing the wide variety of cultures in the community, Lutheran Medical Center developed the resources necessary to become culturally competent. A cultural competence department was created with a cultural initiatives coordinator and vice president of cultural competence. Patient relations staff includes multilingual and multicultural individuals. The medical center also uses community liaisons and cultural advisory committees to reach out to the community. Care delivery forms and hospital signage are translated into the five primary languages spoken in the community. Hospital staff and medical residents are required to receive cultural competence training. Lutheran Medical Center created a Chinese unit within its health system to address specific cultural issues for Chinese patients.

Results: Lutheran Medical Center tracks the impact of its cultural competence programs through bed occupancy and the number of patients from the local community. Many patients seen at the hospital are from the local community, and with growth in the ethnic and religious groups in the area, the hospital is consistently occupied to capacity. Patient satisfaction scores indicate high satisfaction with health care delivery.

Contact:
Lutheran HealthCare
Virginia S. Tong
Vice President, Cultural Competence
Phone: (718) 630-7236
http://www.lutheranmedicalcenter.com/

Resources

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End Notes

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4 Ibid.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

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:

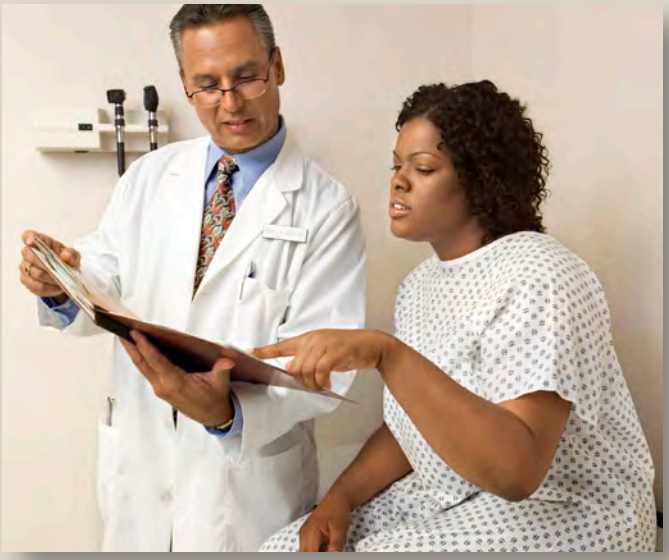
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Equity of Care

February 2012



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

AAMC

American College of Healthcare Executives

American Hospital Association

CHA Catholic Health Association of the United States

National Association of Public Hospitals and Health Systems

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

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For Additional Information
Matthew Fenwick
American Hospital Association
(312) 422-2820
mfenwick@aha.org

Accessible at:

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].

Contact: Jonathan Mesinger (jmesinger@co.sanmateo.ca.us)

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.

Contact: Mary Mixon (mmixon@umc.edu)

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.

Contact: James W. Walton (jameswa@BaylorHealth.edu)

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.

Contact: Marcos Pesquera (mpesquer@adventisthealthcare.com)

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.

Contact: Gabriela Flores (giflores@cmh.edu)

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.

Contact: J. Emilio Carrillo (ecarrill@nyp.org)

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.

Contact: Brenda Battle (bab3098@bjc.org)

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].

Contact: Kinneil Coltman (kcoltman@ghs.org)

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].

Contact: Donnie Perkins (Donnie.Perkins@UHhospitals.org)

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

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Equity of Care

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

The headlines are common and the facts are known…

Equity of Care

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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American Hospital Association.

Unequal Treatment

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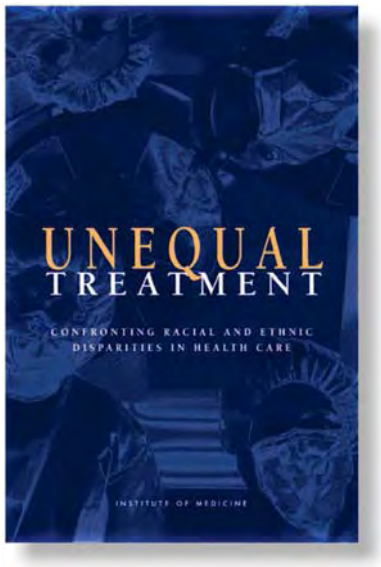

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American Hospital Association.

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.

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Diversity Is a Reality in the U.S.

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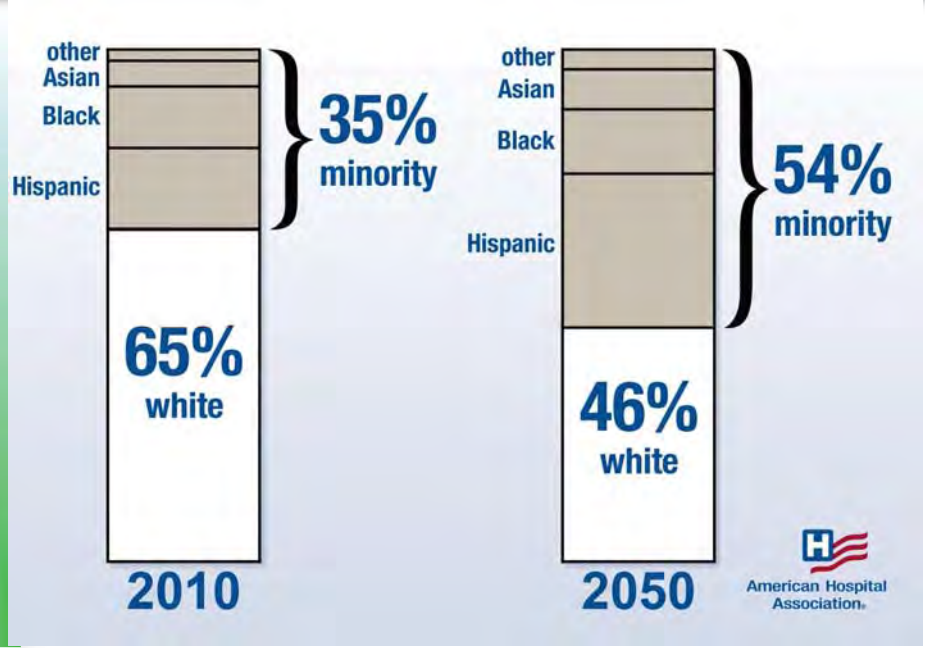

The Equity Imperative

Equity of Care

- 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.

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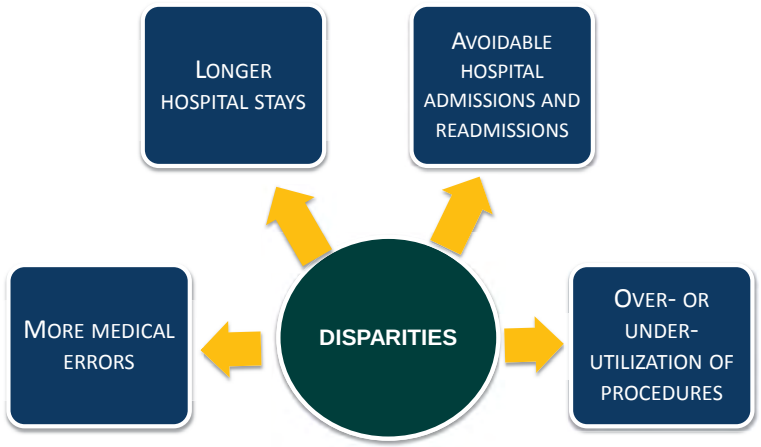
American Hospital Association

The Equity Imperative: Quality Implications

Equity of Care



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The Equity Imperative: Quality Implications

Equity of Care

- 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.

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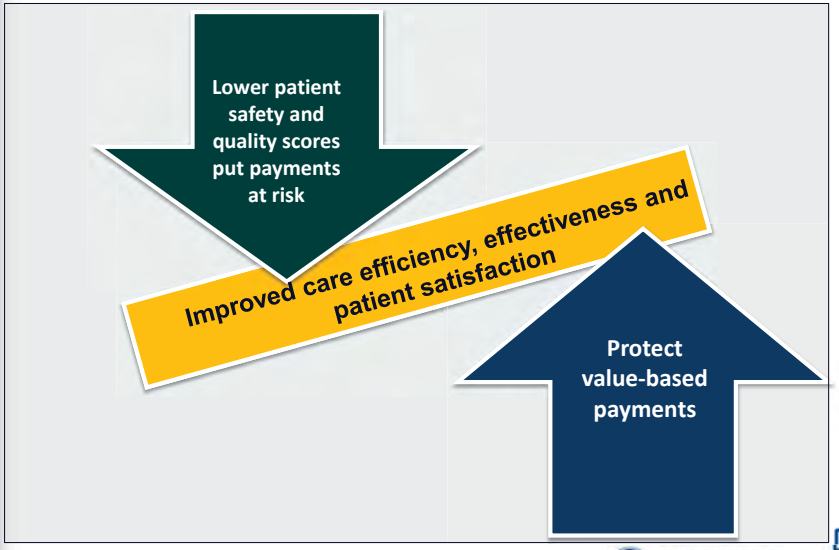
The Equity Imperative: Financial Implications

Equity of Care

Eliminating disparities reduces costs and financial risk.



The Equity Imperative: Regulations and Accreditation

Equity of Care

- 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

Equity of Care

- 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

Equity of Care

- 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

Equity of Care

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

American College of Healthcare Executives
for leaders who care®

American Hospital Association

CHA
Catholic Health Association of the United States

AMERICA'S ESSENTIAL HOSPITALS

For more information, visit www.equityofcare.org

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Equity of Care Platform

Equity of Care

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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

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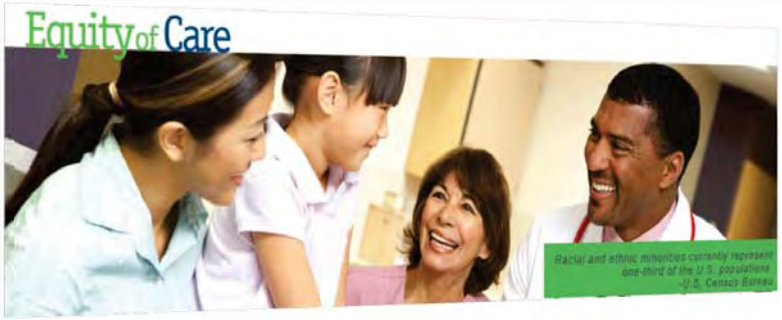

- Increase collection and use of race, ethnicity and language preference data
- Increase cultural competency training
- Increase diversity in governance and leadership

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American Hospital Association

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

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American Hospital Association

Best Practice: Race, Ethnicity and Language Preference Data

Equity of Care

- 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

Equity of Care

- ☑ 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

Equity of Care

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

Equity of Care

Goals and Milestones (2013 – 2020)

Equity of Care

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

Equity of 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

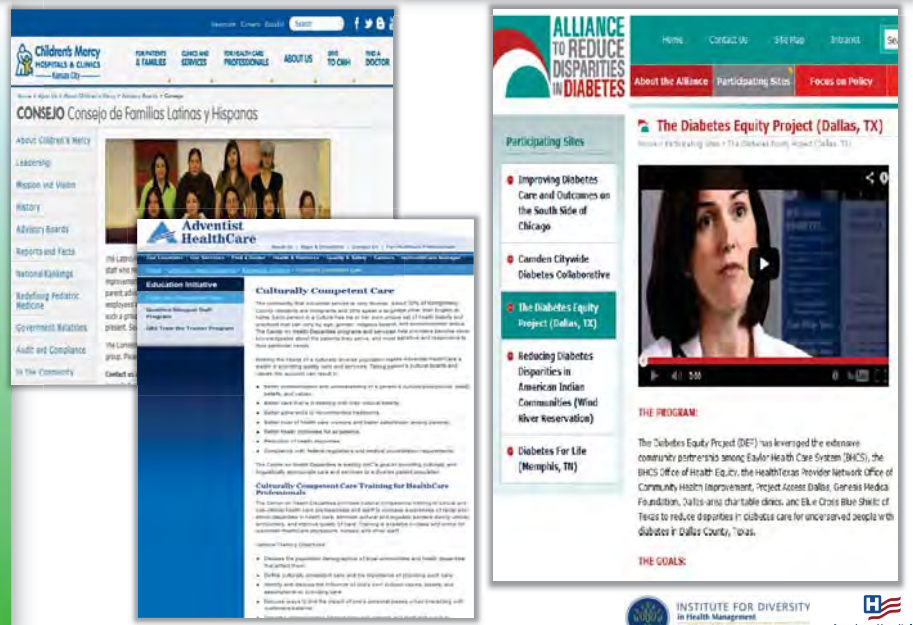
Self-Assessment: Cultural Competency Training for Improved Patient Care

Equity of 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?

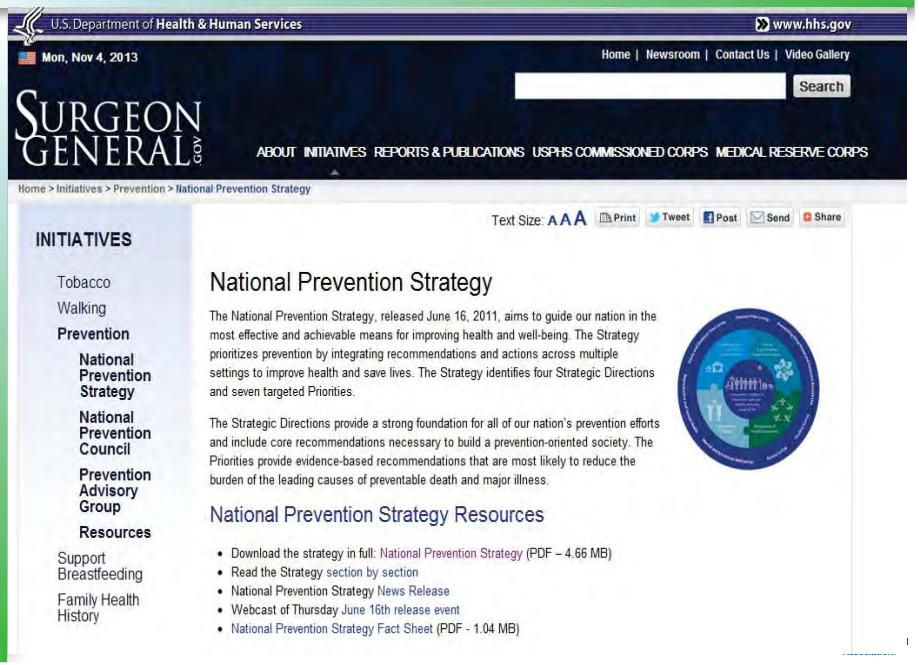
Case Studies

Equity of Care



Key Resource: National CLAS Standards

Key Resource: National Prevention Strategy



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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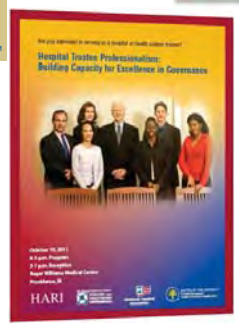

Key Resource: American College of Healthcare Executives

National Call to Action to Eliminate Health Care Disparities

Equity of Care

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 Logo

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.

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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The Role of the Chief Diversity Officer in Academic Health Centers

November 2012

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AAMC's Diversity Policy and Programs team that led this project include:
Marc Nivet, Ed.D., Chief Diversity Officer
Laura Castillo-Page, Ph.D., Senior Director, Diversity Policy and Programs
Tiffani St.Cloud, Lead Program Management Specialist
Jessica Vaughan, Administrative Specialist
Kate Gampfer, Administrative Associate
Emily Yunker, Administrative Specialist

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Foreword

In recent years we have witnessed growing appreciation for diversity and inclusion as strategic assets in academic medicine. Earnest efforts to build a diverse and inclusive organizational culture pay dividends of increased institutional effectiveness.

In response, many medical schools and teaching hospitals are strengthening their approach to diversity and inclusion by lifting these efforts into the C-suite, creating chief diversity officer (CDO) positions. This expansion of the roles and responsibilities of strategic diversity leaders is essential to fully activate the value of diversity and inclusion for institutional excellence.

Within this environment of change, there is a need for clarity on the CDO's scope of work, reporting relationships, and ideal qualifications. Recognizing that need, the AAMC (Association of American Medical Colleges) and the American Hospital Association's Institute for Diversity in Health Management (AHA-IFD) partnered to commission this report, convening the first-ever forum on CDOs in academic medicine and acute care hospitals.

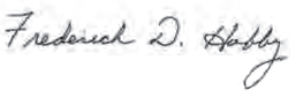
This resource builds on the research of executive search firm Witt/Kieffer on the compensation and responsibilities of diversity leaders in health care. The value of this report stems from the panel of experts assembled to outline the purview of CDOs in medical schools, community-based hospitals, teaching hospitals, and the requisite competencies needed by all.

What we heard confirmed anecdotal evidence that diversity leaders in academic medicine are charged with broad responsibilities across multiple dimensions, which differ based on the needs and structure of the institution. Some institutions view health care quality and equity as the CDO's domain, while others design the position as a primarily academic or business function. Assigned functions range from leadership and faculty development to student affairs and from community engagement to human resources.

While the scope of work is flexible, certain aspects are universal: The CDO portfolio must be clearly defined, matched to experience, and aligned effectively with relevant offices and initiatives. To be effective, a diversity leader requires appropriate positioning, resources, staff, and influence to impact the trajectory of the organization. In turn, the skills, background, and demonstrated competencies of a potential CDO must be commensurate with an executive-level charge.

We have come to learn that diversity and inclusion are strategic aims which require dynamic, ongoing leadership. In that sense, the CDO joins a line of other new C-level executives helping organizations adapt to rapidly changing competitive realities. Diversity and inclusion are not something to achieve and forget, but goals to attain and maintain. This primer represents the latest intelligence on how to craft this important role.

Marc A. Nivet, Ed.D.
Chief Diversity Officer
Association of
American Medical Colleges



Frederick D. Hobby, MA, CDM
President & CEO
Institute for Diversity in Health Management
American Hospital Association

Introduction

Now more than ever leaders in academic medicine are searching for ways to "reframe the narrative" of diversity and embrace a "strategic diversity leadership" approach to selecting students, educating and training culturally competent and diverse physicians, engaging in culturally relevant research, and providing quality health care to *all* their patients.[1] In response to this changing reality, an increasing number of leaders are developing chief diversity officer (CDO) roles to elevate diversity as a strategic priority for their organizations.[2] All too often, leaders are faced with the challenge of creating these roles with little or no guidance. In response to this challenge, the AAMC (Association of American Medical Colleges) and the American Hospital Association Institute for Diversity in Health Management (AHA-IFD) commissioned this monograph for leaders in academic medicine looking to design and implement effective CDO roles in their organizations.

The CDO Forum: Meeting Overview

This monograph grew out of a daylong meeting in January 2012 hosted by the AAMC in partnership with the AHA-IFD. Dr. Christopher Metzler, Senior Associate Dean at Georgetown University School of Continuing Studies, moderated the meeting of CDOs, higher education leaders, and national experts dedicated to exploring the cultural, organizational, and leadership dynamics associated with advancing issues of diversity, equity, and inclusion in academic medicine. Dr. Damon A. Williams, Vice Provost, Chief Diversity Officer, and member of the faculty at the University of Wisconsin-Madison, provided remarks designed to frame the discussion of the CDO role.

A total of 16 meeting attendees, six from medical schools and 10 from teaching hospitals, participated in a series of round-table discussions centered on the role of CDOs in academic medicine (Appendix 1). Topics included defining the CDO role across the many different organizations that constitute the complex and multidimensional nature of academic medicine, defining key competencies associated with the CDO leadership role in health care organizations generally, and exploring various themes of organizational design, including administrative roles, salary concerns, and how diversity and inclusion efforts differ between a medical school and a hospital/health care system. These discussions were recorded.

Complementary Interviews & Discussions

The CDO Forum was complemented by a series of 10 interviews with participants from the meeting and others with expertise about the CDO role in academic medicine. Several questions guided these discussions including: "What are the key competencies of leading as an effective CDO in academic medicine?"; "If you were going to design an optimal

1 See Nivet, M. (2011). *Commentary: Diversity 3.0: A Necessary Systems Upgrade.* Academic Medicine, Vol. 86, No. 12. December 2011.

2 See Dexter, B. (2010). *The chief diversity officer today: Diversity gets down to business.* Chicago, IL: Heidrick & Struggles. Metzler, C. (2008). *Defining key emerging competencies of the chief diversity officer (CDO): Historical, analytical, and situational perspectives of a promising leadership role and its organizational significance.* Ithaca, New York: Cornell University. Williams, D. & Wade-Golden, K. (2008). *The Chief diversity officer: A primer for college and university presidents.* Washington, DC: American Council of Education (ACE). Williams, D. & Wade-Golden, K. (Press). The Chief diversity officer: Strategy, structure, and change management. Fairfax, VA: Stylus Publishing Press. Witt/Kieffer (2011). Chief diversity officers assume larger leadership role. Philadelphia, PA: Witt/Keiffer.

CDO role, what would that role entail?"; "What are some of the key challenges associated with leading as a CDO in academic medicine and health care in general?"

These additional interviews allowed for a more robust understanding of key themes noted in the CDO Forum, as well as a connection to the overall literature about the role of CDOs in higher education and the corporate sector generally. Additional reading on the CDO role is included in Appendix A to provide a platform for greater exploration among leaders interested in designing and optimizing the CDO role in their organization.

Monograph Overview

This monograph is organized into four major sections:

- The first section outlines key themes that emerged in discussions and interviews regarding the CDO role in academic medicine.
- The second section provides an overview of key competency areas associated with the CDO role in academic medicine.
- The third section provides a checklist for assisting with designing the CDO role.
- The fourth section addresses CDO compensation data.

The monograph concludes with several recommendations for deans and health center CEOs designed to support leaders in their efforts to create substantive CDO roles in academic medicine.

Section 1: Summary of Major Themes from the CDO Forum and Interviews

CDO Forum participants were organized into facilitated discussion groups regarding the CDO role in academic medicine. The following is a summary of key themes cited by the participants in the forum and interviews conducted in consultation with this monograph. These themes highlight complexities and challenges associated with the CDO role in academic medicine as well as their broad-spanning responsibilities in academic medicine. Themes associated with CDO competencies are highlighted in the next section to provide a clear treatment of the multidimensional aspects of leadership required to serve as a CDO in academic medicine.

Complexity & Challenges Associated with the CDO Role in Academic Medicine

Forum and interview participants highlighted the complexities and challenges that often surround the CDO role in academic medicine. There was universal acknowledgment that each CDO role may look radically different depending upon the organization's overall diversity goals, the commitment level of senior leadership to developing a meaningful CDO position, and acceptance of the business case for diversity as part of the discussion of health care and health care reform nationally.

In a poll of officers participating in the CDO Forum, each of the participants had different titles, responsibilities, backgrounds, reporting relationships, budgets, and staff/units that they supervised. These realities highlight the emerging nature of the CDO role in academic medicine, and a need for clarifying guidance that can assist deans, presidents, and health system CEOs in the development of high caliber CDO roles to support the mission and overall delivery of their organization's diversity, inclusion, and health care equity priorities.

Some of the major points that emerged in the discussion regarding the complexities and challenges associated with the CDO role included, but were not limited to:

1. The CDO role is not a one-size fits all position. The role has to be calibrated to match the organization's goals, history, culture, and priorities. It may look different depending upon the context of whether it's located in a medical school, hospital, or an integrated academic health center. This idea was often summarized as whether the role would have a health care, academic, or recruitment/procurement/business administrative focus.

2. Some CDOs have no staff, while others lead a department, and still others lead a division that may include numerous units and numerous staff members. (**See Exhibit 1.**) The lack of a clear portfolio of staff and direct reporting units can create challenges for the CDO unless these dynamics are addressed in the form of committees, taskforces, working groups, dual reporting relationships, and clarity regarding the way that the CDO is expected to collaborate, supervise, or partner with other leaders.

3. Regardless of the size of their staff or divisional portfolios, CDOs emphasized the importance of working collaboratively across the organization to build alliances,

develop strategic partnerships, and engage internal and external partners to accomplish diversity, equity, and inclusion goals.

4. Some of the most well positioned CDOs are able to influence hundreds within their organizations through a combination of diversity committees and counsels, employee resource groups (stratified in terms of race, gender, LGBT, and other identity profiles), dual reporting relationships, and accountability systems.

5. Some CDOs have hybrid responsibilities that may include a focus on diversity management and other areas of administrative priority such as human resources, training and leadership development, community engagement, student affairs, and others.

6. CDOs have varying titles and levels of rank that run the gamut from vice president, to dean, associate dean, executive director, and/or special assistant. Indeed, the use of the CDO nomenclature is far from universal as some officers may not even have CDO as part of their formal administrative title.

The lack of a standard definition and infrastructure for the CDO role was identified as a major impediment to advancing the role universally, and is something that must be addressed if the role is to be fully activated as a strategic asset for more organizations hoping to accomplish their diversity, equity, and inclusion goals. Moreover, it was noted that many positions are symbolic with little positioning, resources, staff, or ability to influence the reality of their organizations. Contributors to this perspective especially highlighted the importance of serving in the president's, dean's, or CEO's senior leadership team as critical to their visibility and ability to influence other officers and the leadership trajectory of the organization.

Exhibit 1. CDO Leadership & Duties Overview

Supervising Leadership	Integrative Leadership
What areas might the CDO supervise?	*What types of committees and groups might the CDO chair or participate in?*
• Affirmative Action, Equity, and Compliance Offices • Community Relations Offices • Diversity Pipeline Development Programs (pre-college, undergraduate, graduate, fellowships) • Health Equity Research Centers • Language Service Units • Learning, Training, & Intergroup Relations Programs • Minority/Multicultural Student Affairs • Workforce Development Offices & Initiatives • Human Resources • Population Health Initiatives	• Admissions Review Committees • Community Advisory Counsels • Consultants (external/internal) • Curriculum Reform Committees • Diversity Councils • Diversity Liaisons/Leaders • Diversity Trainers • Employee Resource/Affinity Groups • Executive Recruitment Companies • Quality Care Committees • Workforce Planning Committees

A major challenge associated with the CDO role was a lack of understanding of how to qualify and quantify the impact of the position on their organization's bottom line. While forum participants were clear in their need to address this challenge, it was tempered by the realization that CDOs cannot be singularly responsible for affecting the diversity process and outcomes, and that many must be assessed to determine the impact of an organization's diversity and inclusion efforts, not just the CDO.

Officers emphasized the entrepreneurial and creative nature of their job and the need to have the support, freedom, and resources necessary to develop new initiatives to help their organization innovate around issues of diversity and inclusion. Successful CDOs require resources that they can use to build new alliances, create partnerships, and sway

Exhibit 2. Examples of CDO Duties

- Coaching senior leadership around diversity and inclusion issues
- Cultural competency training for organizational members
- Developing diversity metrics and processes to assess diversity, equity, and inclusion efforts
- Diversity and inclusion strategy development
- Diversity communication to internal and external constituents
- Enforcing EEO & compliance efforts
- Infusing diversity into the academic and clinical experience of students
- Integration of diversity and inclusion efforts with patient care, quality, and safety
- Language service initiatives
- Making the case for diversity for internal and external constituents
- Recruitment and outreach to diverse communities of potential students, faculty, and staff
- Strategic partnerships with community organizations, higher education, government, and others
- Supplier diversity and development efforts

behavior. In the words of one officer, "You need more than sweat equity to get the job done, and having resources is a key part of that equation along with the support of senior leadership."

Officers emphasized that while their roles might be designed to play a role in human resources issues, they were not, in most instances, human resources officers. Moreover, officers were clear that they should not report to human resources, but rather serve in a senior leadership role that has boundary-spanning responsibilities that may touch human resources, academic affairs, curriculum and instruction, and other areas.

Broad-Spanning Leadership Role of Chief Diversity Officers

Forum and interview participants agreed that the CDO role in academic medicine is broad and multi-dimensional. Just as each position looks different structurally, the CDO role also varies in terms of operational priorities. This was apparent throughout the discussion as officers discussed a number of different priorities that included a focus on both classic and contemporary issues associated with the ever-evolving nature of diversity and inclusion work in the 21st century, and how it varies depending upon the academic medical context within which an officer operates.

As **Exhibit 2** indicates, officers discussed the complexity of their work in building community relationships, infusing cultural diversity into the clinical experience, recruiting diverse students, diversity training, and building diverse linguistic and cultural capabilities into their hospitals and organizational systems. Analyses of these revealed six overall areas of priority that frame the work of the CDOs. They are:

- Academic diversity engagement
- Supplier diversity and business development
- Community engagement and partnerships
- Creating a climate of inclusion and support
- Affirmative action and compliance
- Addressing disparities in care and outcomes within the patient experience

Academic Diversity Engagement

Officers located in medical schools and colleges often focused their work on issues of academic diversity, particularly as it relates to increasing the diversity of the faculty and student bodies of their organizations, diversifying the learning experience of students, and promoting health equity research. This area also includes a focus on embedding cultural issues into the classroom and clinical experience of students, and promoting health equity research. Indeed, some officers' areas of supervision were already focused

into one of these domains within their organization, leading health equity research centers, minority student affairs offices, and institutional and grant programs dedicated to expanding the pipeline of diverse students going to medical school and the health professions broadly.

Supplier Diversity and Business Development

Officers working in hospitals and broad-spanning health care systems often prioritize the importance of sourcing diverse vendors for their organizations operating diversity procurement programs. These programs focus on expanding the number of certified minority, women, and other diverse business relationships that may have contracts with their organization. While not a priority of many officers located in medical schools and colleges, supplier diversity and business development were critical issues for officers operating in the more corporate sector of the academic medicine arena.

Community Engagement

Officers were involved with a number of community engagement efforts that allowed them to expand the reach of their organizations into diverse communities. Some major initiatives included community health fairs, health equity campaigns, K-12 partnership programs, faith-based community partnerships, and other efforts designed to create a deeper relationship between their organization and diverse communities in their area. Some initiatives focused on bringing health care providers, graduate students, and researchers into diverse communities, while other efforts focused on inviting community members to visit the medical school, hospital, or health center. The focus of these efforts is governed by educational outreach and health care goals of the sponsoring organization.

Creating a Climate of Inclusion and Support

A number of officers talked of the important work that they lead in creating inclusive and supportive work and learning environments. Common efforts included the development of one-time workshops, ongoing leadership development credentialing programs, and other efforts designed to enhance the diversity and inclusion abilities of clinicians, faculty, graduate students, and employees within their respective organizations. It is important to note that officers mentioned that it is particularly difficult to create learning platforms for clinicians and faculty members who may struggle to understand the value added benefit to their primary role as physicians, researchers, and educators. Officers also touted the importance of supporting affinity groups of minorities, women, and members of the LGBT community as a way to engage in the needs, priorities, and challenges of these groups.

Affirmative Action and Compliance

While affirmative action and compliance is a less dominant narrative of diversity and inclusion efforts in most organizational sectors, a number of officers talked of the need to keep their organizations compliant with the *Office of Federal Contract Compliance Programs (OFCCP), the Office of Civil Rights (OCR), and relevant employment, admissions, and financial aid case law regarding issues of diversity and inclusion. While not a major component of our discussion, a number of CDO roles are rooted in legacy diversity positions with Equal Employment Opportunity (EEO) roots. Officers focused in this area emphasize diversifying the workforce of their organizations, and working towards the elimination of sexual harassment, discrimination, and prejudicial behavior.*

Addressing Disparities in the Patient Experience

At the core of the leadership tasks provided by CDOs is improving the patient experience, which includes concepts of quality, safety, and effective communication. It also concerns reducing inequities in all aspects of organizational functions including such practices as promoting patient access, staff recruitment, employment, and satisfaction.

Section 2: CDO Competencies in Academic Medicine

Leadership competencies serve as the foundation for performing a particular job or role within any organization. Understanding the type of competencies required by a CDO is key to choosing someone who has the potential to be successful in this very complex and demanding leadership role. Officers that participated in the daylong forum and in follow-up interviews were clear that the CDO role in academic medicine is complex, requiring a number of competencies not typically associated with serving as an affirmative action, equal employment opportunity officer, or even a multicultural student development specialist.

Seven Essential Competency Areas

Exhibit 3 presents seven essential competency areas for leading as CDO. These competencies emerged from discussions at the CDO Forum, interviews with officers in academic medicine, and a review of the relevant literature in these areas. The specific traits column of **Exhibit 3** is based on data from the CDO Forum.

Chief diversity officers must have: Chief diversity officers must have: strategic vision and executive acumen, change management expertise and will, political savvy, persuasive communication abilities, the ability to navigate the culture of academic medicine, the ability to innovate and generate new ideas and approaches to leading change, and cultural intelligence and technical mastery of diversity and inclusion strategy in academic medicine. While an individual may be stronger in selected domains, each of these qualities is critical to long-term success in the role.

Strategic Vision and Executive Acumen

CDOs must understand the core mission of their organization and possess a firm grasp of academic medicine, exhibiting the same kind of leadership and administrative skills as deans, health center CEOs, and other executive leaders. This means having strategic insights into the big-picture challenges facing academic medical centers, the overall direction of the health care industry, and how issues of diversity, equity, and inclusion fit into this picture. In addition to having a firm grasp of academic medicine, CDOs must accept the premise that all health care is local. CDOs must have a thorough understanding of hospital operations and the prevailing business culture and hierarchical arrangements of silos and informal leaders. It is not enough to simply understand niche marketing strategies, race and ethnic relations, cross-cultural communication, and motivational terminology. Health care delivery and hospitals specifically are the most complex institutions in our society characterized by diverse stakeholders who are often not aligned. A lack experience and exposure to the complete health care environment decreases the potential for effectiveness and success.

Change Management Expertise & Will

CDOs are best defined as "change management specialists" because of the importance they must place on strategies designed to intentionally move the culture of their organizations. As a result, CDOs collaboratively develop new strategies, plans, initiatives, accountability systems, and partnerships that make diversity a high-level priority, however an organization's diversity goals may be defined. Beyond their technical acumen for leading change, the best CDOs have great will, allowing them to overcome setbacks and organizational resistance while continuing to encourage their organization to move forward.

Exhibit 3. Seven CDO Competency Areas

Competency	Description	Characteristics	Specific Traits
Strategic Vision & Executive Acumen	The CDO must have intimate understanding of his or her organization's core mission and the ability to understand the big-picture issues facing health care and academic medicine specifically.	• Perspective regarding the shifting identity of today's patient, the realities of ethnic and racial health disparities, and their implications for health care • Perspective regarding shifting hospital standards of care, national health care reform, and the evolution of medical school accreditation standards and their implication for health care • Ability to cultivate a vision, strategic plan, and engage others based on the strategic landscape of academic medicine that informs every other aspect of the competency model	Analytical ability Ethical decision making Financial understanding Fundraising skills Intellectual acumen Manage teams Multi-tasking Problem solving Resilience Strategist Succession planning Visionary perspective
Change Management Expertise & Will	The ability to engage stakeholders in change efforts that are incremental or transformational, leveraging evidenced-based practice, data, and a focus on achieving results even in the face of obstacles.	• Ability to build a collaborative vision for change • Skills to develop and implement diversity plans and strategies • Ability to manage the change journey as a process of building systems, capacity, and new behavior • Focus on change goals even in the face of resistance • Focus on change that is both incremental and transformative	Ability to execute Monitor, facilitate, develop accountable techniques Operates with a sense of urgency Outcomes-driven Systems thinking orientation Total Quality Management expertise
Political Savvy	The ability to leverage a political style of leadership that aligns the interests of multiple stakeholders using a team-centered approach that is always mindful of competing interests and the need to create alignment.	• Ability to understand the political challenges of diversity • Ability to align the competing interests of multiple parties • Ability to use conflict, negotiation, and coalition-building techniques to accomplish change	Building strategic alliances Conflict resolution Decisiveness Establish credibility Lobbying skills Negotiation skills Tact Political expertise Resolution development

Competency	Description	Characteristics	Specific Traits
Persuasive Communicator & Framer of Information	The ability to speak and write in a clear and concise manner that frames diversity as fundamental to organizational excellence, inspiring others, aligning the organizations and the community's interests, and at times leveraging diverse language skills.	• Ability to communicate persuasively in written and verbal forms • Ability to leverage the diversity 3.0 narrative of why diversity is relevant and critical in the 21st century • Ability to leverage the language of academic medicine and the health care industry in general • Ability to inspire others and inspire them to action • Diverse language skills and abilities	Ability to communicate effectively Coaching senior leaders Communicate across differences Communicate the value of diversity Communicate with majority culture Influence without authority Multi-lingual Translate messages
Ability to Navigate the Culture of Academic Medicine	The ability to successfully navigate the hierarchy, tradition, competitiveness, and at times, the exclusionary culture of academic medicine.	• Diversity and health equity expertise • Ability to navigate the culture of higher education generally • Ability to navigate the culture of the health care industry • Ability to navigate the medical school and hospital culture specifically	Knowledge of medical school culture Knowledge of hospital culture Connecting diversity and inclusion with the clinical experience
Innovators DNA	Because the field of strategic diversity leadership is still evolving and change always takes place in a particular organizational context, the CDO must possess the DNA of an innovator.	• Ability to associate across contexts • Ability to question their organization around issues of diversity • Ability to observe and define new ways of doing things • Ability to network and learn from others • Focus on experimenting and trying new ideas to spark change	Entrepreneurial spirit Risk-taker Experimentation New initiatives
Cultural Intelligence & Technical Mastery of Diversity & Inclusion Strategy	The CDO's must have a high degree of cultural intelligence and technical mastery of diversity and inclusion strategy in academic medicine.	• Knowledge of the cultures of diverse groups • Savvy ability to lead cross-cultural groups • Technical mastery of recruitment and retention of diverse students, faculty, and staff • Technical mastery of diversity and intergroup relations • Technical mastery of how to infuse diversity into curriculum and clinical experiences • Technical mastery of diversity procurement	Adult learning theory Inclusive mindset Openness to difference Self-awareness Social conscience Strategic sourcing of diverse talent Curriculum change Sourcing diverse vendors Building diversity talent pipelines

Source: Adapted from Williams & Wade-Golden (In Press).

Political Savvy

CDOs are politically savvy as their effectiveness is often determined by their ability to navigate competing priorities, subversive political agendas, and provide incentives that encourage partnerships and alignment. They must possess an ability and willingness to find win-win solutions when contentious circumstances arise, know how to build consensus, accrue buy-in, and work through competing interests. One of the CDO's greatest skills is measuring each situation to determine when it is appropriate to engage in conflict, negotiation, or coalition building to move the diversity and inclusion agenda forward.

Persuasive Communication Abilities

Given that much of their work will be accomplished through lateral coordination, CDOs must have the ability to cross boundaries, fluidly adapting language and styles to different audiences. The best officers have a dynamic personality, highly evolved relational abilities, and a consensus-oriented leadership style even if they supervise many staff. It is essential that these officers have the ability to "frame" and "reframe" organizational reality from a number of different diversity and organizational perspectives. CDOs in academic medicine will spend a considerable amount of time framing diversity as a strategic priority of their organizations. The officers must be clear and persuasive in their presentation, reports, statements to the media, and interpersonal interactions.

Ability to Navigate the Culture of Academic Medicine

CDOs must be able to navigate the complex and multidimensional culture of academic medicine. Academic medicine exists at the intersection of the health care reality of hospitals, the academic culture of medical schools, and the corporate culture of both. This means understanding not only the culture of tenure and promotion, but faulty dynamics that characterize the minority pipeline into medical school. It also means understanding the increasing pressure hospitals face to illustrate how cultural linguistic training adds value, lessens risk, and increases the quality of care provided within the hospital. CDOs must possess a healthy understanding of this complexity and an ability to operate in both worlds, seamlessly moving from classroom to board room, and from clinical setting to community event.

An Innovators DNA[3]

Because their role is highly change-management focused, CDOs must be innovators. They can never be satisfied with the status quo, although there may be times when they are not able to move their organizations in new directions. They must be masters of "searching and reapplying" successful ideas in the service of diversity and inclusion. Piloting new or reframed initiatives is key to accelerating the process of change. This is a very valuable skill for CDOs because many will face resistance. Piloting or experimenting with new approaches allows CDOs to develop a rationale, or business case, for a new initiative. It allows leaders that must be involved in a particular project to test the waters on a promising effort without the fear of being locked into the effort forever. Experimentation is key to gaining buy-in and overcoming resistance to change because it allows the CDO to prove a concept that they believe will ultimately enhance their organization's ability to accomplish diversity-themed change.

3 See Dyer, J., Gregerson, H., and Christensen, C. (2011). *The Innovators DNA: Mastering the Five Skills of Disruptive Innovation*. Boston, MA: Harvard Business School Publishing.

Cultural Intelligence and Technical Mastery of Diversity and Inclusion Strategy

The final competency is that CDOs must have a high degree of cultural intelligence and technical mastery of diversity and inclusion strategy in academic medicine. Officers must have a strong grasp of the diversity dynamics of different groups as a part of their core knowledge base. As an extension of this competency, officers must understand best practice techniques for engaging issues of diversity and inclusion in academic medicine. Generally, this means understanding the challenges of diversifying the health professions, creating inclusion initiatives in medical schools and hospital cultures (where leaders "don't have time to participate"), diversity-themed procurement initiatives, building multicultural affinity organizations and diversity counsels to support diverse communities, infusing diversity into the clinical training experience of residents and others, fostering a context for research and community engagement that centers on eliminating health disparities between diverse groups, along with other diversity-themed activities designed to enhance the culture of inclusion in their organization.

Section 3: A Checklist for Developing the CDO Role

A clear theme of many participants' comments during the CDO meeting and in conversations with other officers was that many well-intentioned leaders in medical schools, hospitals, and health care centers often do not know what questions to ask when developing the CDO role, despite their wish to strengthen the diversity, equity, and inclusion efforts of their organizations. According to one chief diversity officer:

> *"I would rather them not fund a position than to create one that is doomed for failure or is simply a figurehead position. It's got to be a real position with stature and authority to move things forward. The CDO should not exist in isolation and needs to have the resources necessary to partner and be a player with the other department heads and vice presidents."*

When developing CDO roles in academic medicine and community-based hospitals, leaders should be guided by a series of questions that allow a strategically effective role to emerge. These questions include, but are not limited to:

1. What is the reporting structure to and from the CDO?
2. What are the CDO priorities? What areas will the CDO lead -- students, faculty, staff, curriculum, committees, or community issues?
3. What resources will the CDO have access to and manage?
4. Will the CDO have responsibility for community outreach and engagement as it relates to health equity issues?
5. How will the CDO influence institutional/hospital and recruitment policies?
6. Will the CDO supervise cultural and linguistic services, diversity procurement initiatives, health equity research centers, multicultural/minority affairs offices, or work with these areas through committees, task forces, etc.?
7. How should the CDO partner with human resources?
8. Should the person have a terminal degree? Tenure? What degrees are most relevant to the domains for which the CDO will have responsibility?
9. What are the most relevant preparatory experiences for a new CDO?
10. Should the CDO have a clinical, teaching, or administrative background? Or a combination of the three?

These and other questions are central to developing a meaningful CDO position and informed a number of the discussions held by officers that participated in the CDO Forum and interviews.

Section 4: CDO Compensation

A common question that is often raised when hiring a new CDO is "How much compensation is required?" There is no easy answer to this question as CDO salaries should be determined by several factors that must be considered dynamically and within a particular organizational context. This context must involve an understanding of the specific organizational salary structure, market dynamics, personal salary, and leadership credentials, as well as national trend data in the field of strategic diversity leadership.

Indeed, in these austere times, the question of CDO salary is more important now than ever, as executive compensation has become such a hot-button topic in higher education.[4] While not necessarily on the national radar in the same way as presidential compensation, CDO compensation, particularly at public institutions, is always the subject of intense scrutiny. Nonetheless, compensation should be set at competitive levels as these leaders bring a unique set of leadership competencies to their work and operate at executive levels of their organizations. Attracting and retaining that type of talent requires competitive levels of compensation as dictated by the marketplace to hire someone capable of leading in the new paradigm of diversity's importance across sectors and industries.

Currently, there is a dearth of research around CDO compensation, particularly CDOs in the health professions. What can be stated definitively is that CDOs are members of an organization's executive staff and should be compensated accordingly. When creating the position of CDO, the president or CEO should look at the salaries being earned by the executive level team and set the CDO salary at a competitive level. Given that executives' salaries vary between institutions, a salary that is targeted at being competitive with the rest of the executive team is most likely to interest a candidate capable of filling this role. While little research is available in this domain, we have included an analysis of the existing data sources in Appendix B. Unfortunately, these data provide limited information to accurately guide CDO salaries in the health professions as they were primarily gathered from CDOs serving in other higher education settings or the private sector.

Data limitations did not allow for more in-depth analyses of key variables that inevitably drive compensation among CDOs. As we have alluded to here, organizational size, rank, administrative duties, relevant experience, education, scholarly credentials, clinical background, and other factors all play a role in determining the compensation of CDOs and other executives. Indeed, it is often the cumulative effect of multiple factors that ultimately defines the reality of an individual job and the resulting compensation. While these data is far from perfect, they hopefully will prove helpful to leaders as they work to create compensation packages for top talent they wish to recruit and retain within their organizations.

4 See Stripling, J. and Fuller, A. (2012). Presidential pay is still a potent political target: One public system struggles to recruit the best amid scrutiny. The Chronicle of Higher Education. Downloaded from: http://chronicle.com/article/Presidents-Pay-Remains-Target/131914/, May 21, 2012.

Conclusion & Recommendations For Leaders

This monograph was developed to help leaders at all levels in designing effective CDO roles, as it presents definitions, frameworks, and critical principles. In the end, it offers helpful insights to organizational decision-makers confronted with decisions about how to create, structure, evolve, and staff the CDO role. It takes up the challenge of further professionalizing the role, clearly articulating the competencies required, and reviewing some of the complexities associated with successful design and performance of the CDO role.

The most forward-thinking leaders will not only create a new diversity leadership role, but also make a number of structural changes that embolden how this officer is empowered to provide collaborative leadership organization-wide. (**See Exhibit 6** for an example of several recommendations that emerged during this project.) They will recognize that simply appointing a new officer is not enough; as the goal is to develop new capacity that significantly raises the bar regarding what is possible organizationally around issues of diversity, equity, and inclusion. If chief executives and deans in academic medicine want CDOs to play a key role advancing their organization's strategic plan for diversity and inclusion, they have to create the type of environment that will allow that to happen. The role cannot be a symbolic figurehead with no resources, portfolio, or material ability to collaboratively lead change within their medical school, hospital, or health center.

Exhibit 6. Final Recommendations for Effective Chief Diversity Officers

- When developing or reframing your chief diversity officer (CDO) role, conduct an internal audit of current diversity capabilities and priorities to establish a plan for how various offices, units, and initiatives might fit together in the same leadership portfolio as part of a collaborative partnership between the CDO and other leaders, or as members of a committee or taskforce.
- Consider developing the CDO role in such a way that the position can influence the most critical diversity issues like curriculum reform, recruiting, retaining and hiring diverse faculty, establishing community partnerships, establishing a diverse vendor program, enhancing the quality of care within the hospital, and further diversifying the senior leadership team and governance structures.
- Position the CDO in the dean's, president's, or CEO's leadership cabinet, allowing the officer to have visibility and opportunities for engagement with the school, college, health center, and/or the hospital's most senior leadership team.
- Provide the CDO with sufficient financial resources to build partnerships, spark new initiatives, and work creatively with internal and external stakeholders to advance issues of diversity, equity, and inclusion.
- Hire leaders who possess the competencies and skills required to serve as a CDO, balancing the presence of a particular set of leadership skills and competencies against the desire to hire someone who may bring great clinical experience to the role of CDO, but may be a neophyte to the process of leading broad-scale organizational change.
- When hiring a new CDO, ensure that everyone on the senior leadership team has a clear understanding of the new officer's role and priorities, particularly if it is a newly designed or reframed position.
- Empower the CDO to lead with the reflective voice of the dean, president, or CEO as a way of strengthening their effectiveness within the organization.
- Develop a transition plan to help the new officer get off to a fast start, building strong collaborative ties and learning about critical operational issues involving the new CDO.

Strategic diversity leadership cannot exist as a silo that is only relevant to the CDO; rather, it must be central to strategic planning and the big-picture vision for the organization as a whole. As a result, partnerships, accountability, senior leadership commitment, financial incentives, and coordinating structures must be established that centralize the CDO as a coordinating, boundary-spanning role that enables a stronger diversity commitment and infrastructure to emerge over time. However, as the elevation of the CDO role occurs, it requires a commitment from the top. It is essential for a CEO or dean to set the tone for the role's importance. Many institutions talk about having a commitment to diversity, but many may not have an explicit commitment from senior leadership to make diversity a true strategic priority. That commitment must also include the financial backing to support the CDO and other leaders in their efforts to develop a range of diversity initiatives. These initiatives may include creating a culture of diversity and inclusion, advancing health equity research, encouraging community engagement, and facilitating student and faculty recruitment and retention efforts. The full range of opportunities are too numerous to include here.

Appendix A: Additional Reading on the Role of the CDO

Arnold, J., & Kowalski-Braun, M. (2012). The Journey to an Inaugural Chief Diversity Officer: Preparation, Implementation and Beyond. ***Innovative Higher Education*****, 37(1), 27-36.**

In this article, we discuss the necessary components for successfully creating and implementing a chief diversity officer (CDO) position within a four-year public institution. We explore information about critical stages of the process such as the creation of the position, the recruitment process, and compatibility with the institution's mission. Our research emphasizes the need for modeling intercultural competence at all stages of the process. We underscore the significance of infusing institutional values into a position that is meaningful to all constituencies. We suggest ways of keeping the politics, structures, and culture of readers' own institutions at the forefront of the planning and implementation process.

Dreachslin, J. L., PhD., & Hobby, F. (2008). Racial and ethnic disparities: Why diversity leadership matters. ***Journal of Healthcare Management, 53*****(1), 8-13.**

Minimizing racial and ethnic disparities requires not only culturally competent clinicians, but also leaders who create an organizational context in which cultural competence is enabled, cultivated, and reinforced. Without effective diversity leadership, even the most culturally competent clinicians will not be able to perform to their full potential. This article focuses on the role of diversity leadership in decreasing disparities in the process and outcome of care at the health care provider or institutional level. Given the right infrastructure, clinicians who are motivated to deliver culturally and linguistically competent care are empowered and enabled to do so. Disparities can be reduced through the focused and dedicated action of leaders and organizations that excel in the context of diversity. By engaging in specific actions to enable, cultivate, and reinforce cultural and linguistic competence, diversity leaders can do their part to reduce racial and ethnic disparities in the process and outcome of care.

Metzler, C. (2008). ***Defining key emerging competencies of the chief diversity officer (CDO): Historical, analytical, and situational perspectives of a promising leadership role and its organizational significance.*** **Ithaca, New York: Cornell University.**

This report is grounded in a series of meetings, focus groups, and a national survey of diversity professionals in the corporate sector. The report discusses key insights gleaned from a 2006 meeting of CDOs at Cornell University that led to the launch of a national survey by the Survey Research Institute at Cornell. Generally, the report discusses the historic evolution of diversity professional roles in organizational life, key challenges in the field of strategic diversity leadership, competencies associated with the role of the CDO in the corporate sector, and the future of the CDO role as a profession.

Some key findings include the need to broadly communicate the historical context of Affirmative Action (AA), Equal Employment Opportunity (EEO), diversity, and inclusion as related, but distinctive areas of diversity practice that the modern CDO must understand and deploy in their practice. The author also notes that the CDOs must be located in the "C-Suite" of their organization, reporting to the same officer as other members of the "C-Suite" if they are going to be effective as leaders. The CDO must have a depth-of-industry competence regarding the core-business of their company, regardless of whether they work in package goods, retail, fast food, technology, energy,

or any other industry. Other competency areas include: entrepreneurial orientation to leveraging diversity to build the business, results-driven focus on accomplishing diversity goals, commitment to focusing on aligning diversity with the mission, vision, and goals of the company, savvy ability to build partnerships, expertise leading change, and an understanding of how to lead others in the pursuit of the organization's diversity and business goals. Finally, the CDO must have the know-how to engage diversity issues from a domestic and global context, in terms of the many broad dimensions of diversity at the individual, interpersonal, and organizational levels.

Williams, D. and Wade-Golden, K. (2008). *The Chief Diversity Officer: A Primer for College and University Presidents.* Washington, DC: American Council of Education (ACE).

The authors used data from the *National Study of Chief Diversity Officers in Higher Education* to outline the role of CDOs and the three key archetypes of vertical structure associated with more than 110 CDOs at colleges and universities. The researchers identified three primary models of vertical structure including the collaborative officer, unit, and portfolio divisional models. While each of these models is characterized by a high degree of institution-wide collaboration, they are distinguished by varying degrees of human and financial resources.

The collaborative officer model features a half-time or full-time CDO role with little or no staff beyond shared administrative support personnel, students, and other part-time staff. The unit model is characterized by the presence of a full-time CDO role, full-time administrative support personnel, diversity specialist's roles (e.g. diversity trainers, researchers, etc), other diversity officers (e.g. assistant vice provost for diversity), and technical staff that help to deliver the office's mission (e.g. graphic designer, Web designer, etc). The portfolio divisional model is also characterized by a full-time CDO role that may be complemented by the various aspects of the unit model, but also includes a number of direct reporting units that comprise a divisional portfolio. Some units that were found in the divisional model include retention and pipeline units, research centers and institutes, ethnic, gender, and women's studies areas, community outreach units, training and intergroup relations offices, international affairs areas, multicultural and minority affairs offices, cultural centers, affirmative action and equity units, and campus-wide student service units. The monograph concludes with several recommendations for creating presidents to support CDOs on college and university campuses.

Williams, D. and Wade-Golden, K. (press). *The Chief Diversity Officer: Strategy, Structure, and Change Management*. Fairfax, VA: Stylist Publishing Press.

In this expansive treatment of the CDO role, the authors leverage data from a national study of more than 3,000 colleges and universities that yielded nearly 800 usable surveys, more than 200 hours of audio recorded interviews with CDOs, and site-visits to institutions across the country. Across nine chapters, the book defines the CDO role and key competencies, presents a comprehensive design system for developing high caliber roles, the Chief Diversity Officer Development Framework (CDODF), and compares the institutional diversity capabilities of CDO and non-CDO organizations in terms of diversity planning, accountability, faculty diversification, and other areas of priority associated with building strategic diversity leadership capacity. Largely, CDO institutions have much more advanced strategic diversity leadership competence, as they were more

likely to have diversity plans, institution-wide accountability systems, individual merit-based accountability systems, diversity-infused missions, and other areas of capacity.

The authors also takes a deep dive into the key issues most discussed as impediments to successfully leading as a CDO by focusing on the challenges of rank, supervision, direct reporting lines, insufficient budgets, organizational realignment, and the need to supervise other diversity offices, units, and initiatives that exist organization-wide. The authors end with a chapter focusing on developing a CDO transition framework and recommendations for getting off to a fast start as a new CDO. The book concludes with the first meta-comparison of the CDO role in higher education and the corporate sector, leveraging primary and secondary analyses of data from multiple studies conducted on the CDO role in recent years. Points of comparison include a demographic comparison of officers in terms of race, gender, and educational background, compensation packages, organizational rank, historical background of the roles, and key areas of strategic priorities and importance.

Witt/Kieffer. 2011. Chief Diversity Officers Assume Larger Leadership Role.

The increase in CDO searches, as well as the changing nature of the role, especially among private colleges and universities, led us to seek feedback from professionals in the field on the nature and structure of the position, tenure, skills and experience required for success. In March 2011 Witt/Kieffer conducted a national survey of over 1,800 CDOs. Ninety-four individuals responded, representing a five percent response rate. Respondents represented both public and private institutions. The responses provide a baseline of data regarding these positions, including what institutions can expect to see as they seek talented, skilled, experienced professionals to fill these important senior leadership roles.

Witt/Kieffer. 2011. Building the Business Case. Healthcare Diversity Leadership: A National Survey Report.

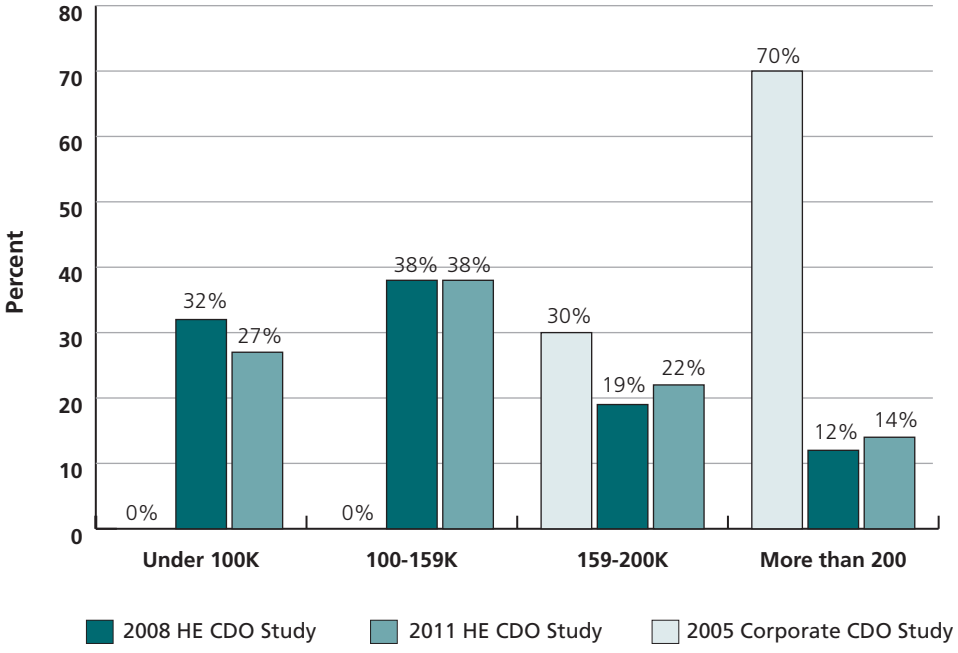
In 1998 Witt/Kieffer conducted a national survey on Diversity in Health Care Leadership to determine advances in and barriers to recruiting and retaining women and minority leaders. The survey included racial and ethnic minorities. Both majority and minority survey respondents agreed that having a diverse senior management team is important to their organization's goals and objectives. Yet there was considerable divergence of opinion about why few people of color had reached the executive suite. To determine how far the health care industry has come — or has yet to go — Witt/Kieffer conducted a follow-up survey on Advancing Diversity Leadership in Health Care in the summer of 2006. This report is the result of a follow-up survey conducted in 2011 to determine how perceptions of diversity have changed.

Appendix B: A National Picture of CDO Compensation

To paint a picture of the compensation landscape among (CDOs) in higher education and the corporate sector, we examined data from multiple studies conducted over the last five years. **Exhibit 4** presents data from three surveys[5] that provide a picture of the CDO salary landscape in 2005, 2008, and 2011. The Diversity Best Practices (2005) survey captured data from 177 CDOs working in the private sector. The national survey of CDOs by Williams and Wade-Golden (2008) (n=110), and Witt/Kieffer (2011) (n=88), captured data on the CDO role in higher education. Secondary analyses of these data allowed for an interesting comparison across sectors and years that contribute uniquely to this discussion of the CDO role in academic medicine. While a detailed salary study of strategic diversity professionals in academic medicine is necessary, these data provide some preliminary context for understanding the basic patterns of CDO compensation for calibrating salaries both internally and nationally.

The range of compensation varies considerably between corporate and higher education CDOs. Every corporate officer received base compensations in excess of $150,000 per year with more than 70 percent reporting annual income levels above $200,000; many also received a bonus not included in these data. By comparison, higher education CDOs were compensated at lower salaries. Only 31 percent (2007) and 33 percent (2008) reported receiving more than $150,000 in annual compensation, and 14 percent received salaries above $200,000 (**Exhibit 4**).

Exhibit 4. Higher education corporate CDO salary comparison data 2005, 2007, and 2011



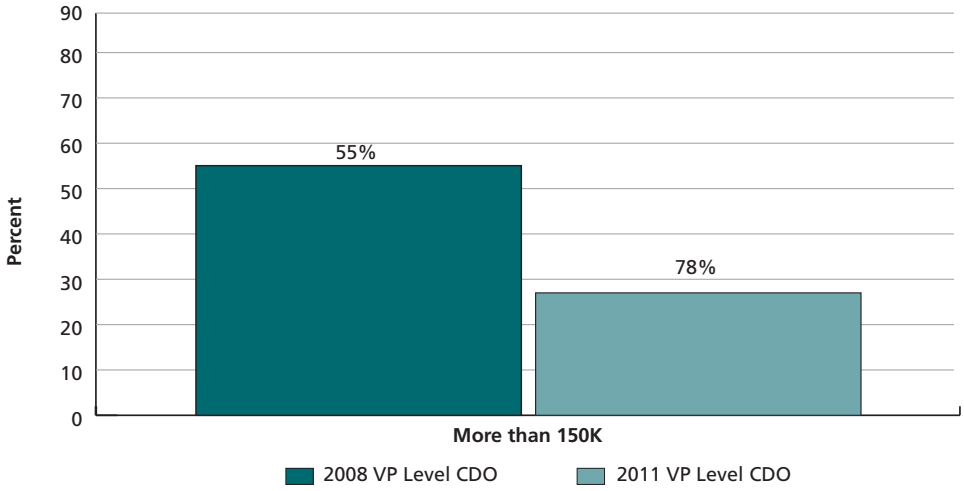
Source: Diversity Best Practices (2005); Williams & Wade-Golden (2008); Witt/Kieffer (2011)

These salary trends are consistent with the general pattern of higher salaries in the private sector and come as no surprise as a comparison of presidents, chief operating officers, and chief information officers would inevitably yield similar results (Bloomberg Business Week, 2012). At the same time, we offer these data as a way for leaders to calibrate salaries for CDOs operating in the more corporate academic medical context, where the salaries may trend higher. This inclusion is important, as many health center presidents and deans are often the best compensated at their institutions (CUPA-HR, 2011).

These data illustrate that CDO salaries in higher education have been incredibly stable over the last five years, reflecting the importance of diversity in higher

5 Diversity Best Practices (2005). *The Chief diversity officer report.* Washington, DC: Diversity Best practices Inc. Williams, D. & Wade-Golden, K. (2008). *The Chief diversity officer: A primer for college and university presidents.* Washington, DC: American Council of Education (ACE). Witt Kieffer (2011). Chief diversity officers assume larger leadership role. Philadelphia, PA: Witt Keiffer.

Exhibit 5. VP rank CDO salaries in 2008 and 2011



Source: Williams & Wade-Golden (2008); Witt/Kieffer (2011).

education. Overall, 68 percent of higher education CDOs had salaries above $100,000 in 2007, with 74 percent reporting salaries at this level in 2011 (**Exhibit 5**).

Senior Executive CDO Compensation

If we restrict our analyses to those higher education officers operating at the vice president, vice chancellor, and vice provost levels (VP), we find that these officers were compensated at an even higher level than their peers at lower levels of rank, with this trend deepening in recent years. Among the 33 percent of officers at the VP level in 2008, 55 percent made more than $150,000. In the 2011 survey, 78 percent made more than $150,000.

Appendix C: List of Participants

AAMC-AHA Chief Diversity Officer Forum
January 16 – 17, 2012
Washington, DC

Antoine Andrews
Director, Diversity & Inclusion
Gap, Inc.
2 Folsom St.
San Francisco, CA 94105

Kevin Antoine, J.D.
Chief Diversity Officer
Assistant Vice President of Diversity and Inclusion
State Univ. of NY Downstate Medical Center
College of Medicine
440 Lennox Road
Brooklyn, New York 11203

Brenda Battle
Director, Center for Diversity and Cultural Competence
Barnes-Jewish Hospital
1 Barnes-Jewish Hospital Plaza
Mailstop 90-72-427
St. Louis, MO 63110-1003

Cheryl Bevel
Vice President, Diversity
Saint Luke's Health System
10920 Elm Avenue
Kansas City, MO 64134

Wayne Boatwright, CDM
Vice President, Cultural Diversity
Meridian Health
1430 Route 34
Neptune, NJ 07753-6807

VeLois Bowers
VP, Diversity and Inclusion
CHRISTUS Health
2707 North Loop West
Houston, TX 77008

Lisa M. Coleman, Ph.D.
Chief Diversity Officer & Special Assistant to the President
Harvard University
Holyoke Center 935
1350 Massachusetts Avenue
Cambridge, MA 02138

Rosa M. Colon-Kolacko, Ph.D., MBA
Senior Vice President System Learning
Chief Diversity Officer
Executive Director, Learning Institute
Christiana Care Health System
4755 Ogletown-Stanton Road
Newark, DE 19718

Antoinette Green, MA, PHR
Vice President, Office of Diversity & Inclusion
Trinity Health
34605 Twelve Mile Road
Farmington Hills, MI 48331-3221

William Harvey, Ph.D.
Dean, North Carolina A&T School of Education
Proctor Hall - 105 Hodgin Hall
1601 East Market Street
Greensboro, NC 27411

Gertrude F. Jones
VP, Community Relations
Lifespan Corporate Services
Coro Building
167 Point St., Suite 1c
Providence, RI 02903

J. Renee Navarro, Pharm.D., M.D.
Vice Chancellor, Diversity and Outreach
University of California, San Francisco
3333 California St.
Suite S-16
San Francisco, CA 64143

Donnie J. Perkins
Vice President for Diversity & Inclusion
University Hospitals Case Medical Center
11100 Euclid Avenue
Lakeside Suite 1020, Mail Stop: BSH 7057
Cleveland, OH 44106

Deborah L. Plummer, Ph.D.
Associate Vice Chancellor
Diversity and Equal Opportunity Office
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655

Joan Reede, M.D., MPH, MBA
Dean, Diversity and Community Partnership
Harvard Medical School
164 Longwood Ave, Rm 210
Boston, MA 02115

Juana Slade, CDM, CCF
Director, Diversity and Language Services
AnMed Health
800 North Fant Street
Anderson, SC 29621

Cynthia Stewart
Director of Diversity Resources & Language Services
Columbia St Mary's Health System
2320 North Lake Drive
Milwaukee WI 53211

Oliver Tomlin
Vice President, Education, Not-for-profit and Healthcare Practices
Witt/Kieffer
1600 Arch Street, Suite 918
Philadelphia, PA 19103

FACILITATOR

Christopher Metzler, Ph.D.
Senior Associate Dean
Georgetown University
School of Continuing Studies
3307 M St NW, Suite 202
Washington, DC 20057

STAFF PARTICIPANTS

Juan Amador
Group Program Leader
Group on Diversity and Inclusion
Association of American Medical Colleges

Craig Blassingame
Consultant
Institute for Diversity in Health Management

Larry Callahan
Senior Director of New Initiatives
Academic Affairs
Association of American Medical Colleges

Laura Castillo-Page, Ph.D.
Senior Director
Diversity Policy and Programs and Organizational Capacity Building Portfolio
Association of American Medical Colleges

Gwen Garrison, Ph.D.
Director of Policy, Research and Knowledge Development
Association of American Medical Colleges

Fred Hobby, MA, CDM
President and CEO
Institute for Diversity in Health Management

Lily May Johnson, M.S.
Manager, Constituent Diversity Services
Association of American Medical Colleges

Marc Nivet, Ed.D.
Chief Diversity Officer
Association of American Medical Colleges

Norma Poll-Hunter, Ph.D.
Director of Human Capital
Association of American Medical Colleges

Tiffani St. Cloud
Lead Program Management Specialist
Association of American Medical Colleges

Equity of Care

Best Practices for Building Leadership Diversity Programs

Building a diverse leadership team requires commitment, time and a variety of best practices. Diversity practices that best fit a health care organization will be highly customized to the organization's governance, culture and community needs. Through self-examination, hospital and health care system leaders can identify blind spots and match best practices to address those areas. Each best practice can be molded to fit different career levels within the organization, though some best practices may be more appropriate for one or more levels. Best practices being used by hospitals and health care systems include mentoring programs, partnerships with educational groups, and internal diversity committees, described with examples in the table "Best Practices for Building Leadership Diversity Programs." In addition to commitment and time, allocating funds such as tuition reimbursement or seed money is important to support formal mentoring programs and fellowships.

Best Practices for Building Leadership Diversity Programs

Best Practices	Entry Level	Mid-career Level	C-suite Level	Board Level
External Resources Local and national diversity-related organizations offer resources that range from exposure to new ideas through shared best practices, conferences and case studies, to fellowships and formal mentoring programs. **Case Study** The Institute for Diversity in Health Management's Summer Enrichment Program matches and places minority health administration graduate students with health care organizations for a 10-week paid internship. More than 700 students have successfully completed the program.[1] The Institute for Diversity and the Center for Healthcare Governance also host the Hospital Trustee Professionalism program, a series of American Hospital Association-sponsored educational programs designed to prepare participants for service as hospital board members. The institute's Minority Trustee Candidate Registry compiles profiles and resumes from everyone who has attended one of the Hospital Trustee Professionalism events. Attendees may maintain their profile on the registry, using connections with the AHA, to be available and eligible for placement on a hospital trustee board.[2] In addition, the institute's Career Center offers an online searchable database, which links health care employers and diverse job candidates.[3]	X	X	X	X

Best Practices	Entry Level	Mid-career Level	C-suite Level	Board Level
Mentoring Programs Hospital and health care system leaders identify staff and pair them with an experienced professional to develop specific skills and knowledge that are aligned with the organization. These working relationships allow the health care organization to provide one-on-one training and identify future leaders. **Case Study** Baystate Health, based in Springfield, Massachusetts, has two formal mentorship programs available to its workforce. Both programs have an external educational component with an aligned internal mentorship and leadership development program. External opportunities for professional development and education are provided on soft skills such as negotiating, branding and conflict resolution. Baystate Health's programs engage participants and help them build networks and grasp opportunities to develop their careers. Participants then either identify a mentor within the organization or are matched with a mentor. The entire mentorship program, including the external education, spans one year. The mentorship program is linked back to the organization's talent improvement initiatives, and the program's effectiveness and impact are measured on an ongoing basis.	X	X		
Partnerships with Educational Institutions Collaboration with high schools, community colleges, universities and graduate schools allows hospitals and health care systems to expose students to the work in their organization and in the health care field. For example, a hospital or health care system can partner with a hospital administration graduate program to identify candidates and interns for jobs at their organization. **Case Study** For nearly 20 years, Robert Wood Johnson University Hospital in New Jersey has partnered with the New Brunswick Health Sciences Technology High School, supporting a program that engages local Latino and African-American high school students in health care careers. Today, more than 40 students who have completed the program are working in a variety of jobs at RWJUH — ranging from doctors of pharmacy, nurses, professional staff and other paraprofessional jobs.[4]	X	X	X	X

Best Practices	Entry Level	Mid-career Level	C-suite Level	Board Level
Fellowships Hospital and health care systems can create fellowship programs that select candidates for hands-on education and training. Though roles vary within the hospital, fellowships for C-suite positions can be used to provide experience and to expose the fellow to many different functions of the health care organization. **Case Study** The Minority Faculty Development Awards program at University Hospitals Case Medical Center in Cleveland provides mentoring, education and hands-on leadership experience to several high-potential junior faculty physicians each year. Participants, chosen by individual departments, plan a three-year project that focuses on career growth while targeting work to eliminate health care disparities. Working with a mentor, participants execute their plans with the help of a $75,000 cash award for research, equipment, academic enrichment and professional development. In its first six years, the program has included six African-American women, six African-American men, five Hispanic women and two Hispanic men.[5]		X	X	
Diversity Committees Internal committees that are focused on diversity initiatives and programs allow hospitals and health care systems to identify potential leaders with an interest in diversity. Individuals who participate on and lead these committees gain valuable experience that is transferable to new positions. Additionally, these committees help guide and recommend changes related to diversity within the organization. **Case Study** The University of Mississippi Medical Center created a Healthcare Disparities Council with 40 members, including interpreters, administrators, nurses, physicians and members of the registration staff. Four subgroups support the council's efforts and focus on health literacy, patient access and experience of care, education and awareness, and quality of care for diverse populations.[6]	X	X	X	

Best Practices	Entry Level	Mid-career Level	C-suite Level	Board Level
Enhanced Hiring Practices By developing and implementing enhanced hiring practices, hospitals and health care systems can identify a diverse group of candidates for an open job position. Ensuring a diverse candidate pool involves additional effort by the hospital or health care system. Hiring managers can advertise job openings via community bulletin boards, cultural community groups and local community centers. It is important that hiring practices align with the health care organization's internal benchmarks for diversity. **Case Study** Greenville Health System in South Carolina overhauled its leadership search and selection process to better match the diversity of its workforce and the communities it serves. For each leadership team vacancy, a search and selection committee with a diverse membership is established to develop a diverse pool of highly qualified candidates. 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.[7]	X	X	X	
New Job Titles and Responsibilities Hospitals and health care systems can create new job positions — such as a chief diversity officer — that are dedicated to promoting diversity within the organization. In addition, health care organizations can set up internal diversity committees and designate staff to serve as leaders for increasing diversity. **Case Study** Recognizing the need for diversity management, Sparrow Heatlh System in Lansing, Michigan, hired a diversity director to help align the oganization's diversity goals with its overall strategic goals. The director has helped with the creation of a Diversity and Inclusion Council and also educates hospital leaders on topics pertaining to diversity management and on integrating diversity goals into division, department, functional and individual goals.[8]			X	X

Source: American Hospital Association, 2014.

Endnotes

1. Institute for Diversity in Health Management. (2014). Summer Enrichment Program Overview. Retrieved from http://www.diversityconnection.org/diversityconnection/education/education-SEP-Program-Overview.jsp?fll=S4&sll=S40

2. Institute for Diversity in Health Management. (2014). Trustee Education Program & Minority Trustee Candidate Registry. Retrieved from http://www.diversityconnection.org/diversityconnection/education/About%20Trustee%20Prof%20Prog.jsp?fll=S5

3. Institute for Diversity in Health Management. (2014). Career Center. Retrieved from http://www.diversityconnection.org/diversityconnection/career-center/Career-Resource-Center.jsp?fll=S3

4. Robert Wood Johnson University Hospital, New Jersey. (2014). Equity of Care Award Application. Unpublished award submission.

5. University Hospitals, Cleveland. (2014). Equity of Care Award Application. Unpublished award submission.

6. 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 [now America's Essential Hospitals]. (February 2012). Eliminating health care disparities: Implementing the National Call to Action using lessons learned. Chicago, IL: American Hospital Association.

7. 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 [now America's Essential Hospitals]. (February 2012). Eliminating health care disparities: Implementing the National Call to Action using lessons learned. Chicago, IL: American Hospital Association.

8. Health Research & Educational Trust, Institute for Diversity in Health Management. (July 2011). Building a culturally competent organization: The quest for equity in health care. Chicago, IL: Health Research & Educational Trust.

Diversity and Disparities

A Benchmark Study of U.S. Hospitals in 2013




INSTITUTE FOR DIVERSITY in Health Management
An affiliate of the American Hospital Association

HRET HEALTH RESEARCH & EDUCATIONAL TRUST

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- About the Survey 1
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- Collection and Use of Data 6
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About the Survey

- **In 2013, the Institute for Diversity in Health Management,** an affiliate of the American Hospital Association (AHA), commissioned the Health Research & Educational Trust (HRET) of the AHA to conduct a national survey of hospitals to determine the actions that hospitals are taking to reduce health care disparities and promote diversity in leadership and governance.
- **Data for this project were collected through a national survey** of hospitals mailed to the CEOs of all 5,922 U.S. registered hospitals at the time of the survey.
- **The response rate was 19%** (1,109 hospitals), with the sample generally representative of all hospitals.
- **All data are self-reported.**

For more information on the survey, contact Matt Fenwick, AHA senior executive director of personal membership groups, at *mfenwick@aha.org* or (312) 422-2820.

Additional information on the survey and resources on this issue can be found at:
www.hret.org
www.diversityconnection.org
www.equityofcare.org

Summary Findings

- **Hospitals and health systems possess a great opportunity** to affect health care disparities using three core areas:
  - **Increasing the collection and use** of race, ethnicity and language preference (REAL) data
  - **Increasing cultural competency training**
  - **Increasing diversity in leadership and governance**
- **The survey results highlight** that, while more work needs to be done, some progress is being made in key areas that can promote equitable care, such as collecting demographic data, providing cultural competency training, and increasing diversity in leadership and governance.
- **The survey results offer a snapshot** of some common strategies used to improve the quality of care that hospitals provide to all patients, regardless of race or ethnicity.
- **This overview provides data** to help the health care field focus attention on areas that will have the most impact and establish a benchmark to gauge hospitals' progress in the coming years.

Summary Findings on Collection and Use of Data

The collection and use of patient demographic data is an important building block to identify areas of strength and opportunities for improvement in providing the highest quality of care for all patients.

- **Overall, hospitals are actively collecting patient demographic data,** including race **(97%)**; ethnicity **(94%)**; and primary language **(95%).**
- **22% of hospitals have utilized data** to identify disparities in treatment and/or outcomes between racial or ethnic groups to analyze (one or more of the following): clinical quality indicators, readmissions or CMS core measures. **This is an increase from 20% in 2011.**

Summary Findings on Cultural Competency Training

Cultural competency training ensures that caregivers have a deeper understanding of patients they care for, ensuring individualized care based upon their needs.

- **86% of hospitals educate all clinical staff** during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities. **This is an increase from 81% in 2011.**
- **64.5% of hospitals require all employees to attend diversity training. This is an increase from 60.5% in 2011.**

Summary Findings on Leadership

A leadership and governance team that reflects the community served encourages decision making that is conducive to best care practices.

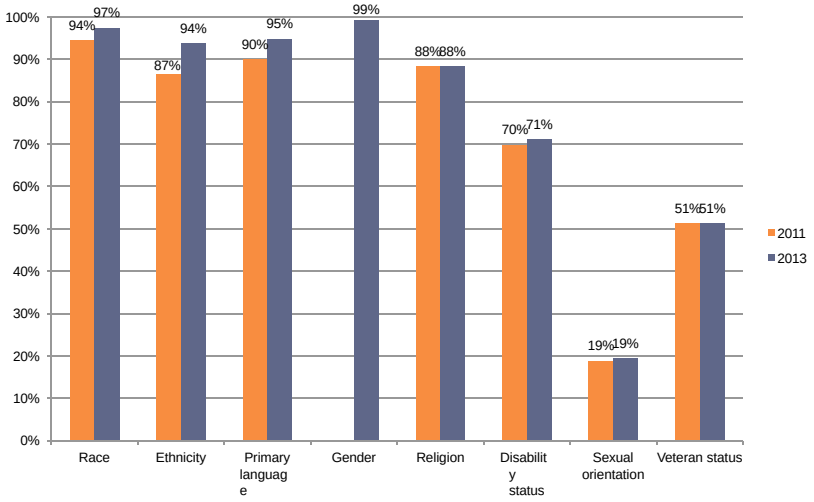
- **The survey found that minorities represent 31% of patients nationally, up from 29% in 2011.**
- **Minorities comprise:**
  - **14%** of hospital board members, unchanged from 2011;
  - **12%** of executive leadership positions, unchanged from 12% in 2011;
  - **17%** of first- and mid-level management positions, up from 15% in 2011.

Collection and Use of Data

- **Overall, hospitals appear to be actively collecting patient demographic data, including:**
  - Race (97%)
  - Ethnicity (94%)
  - Gender (99%)
  - Primary language (95%)
  - Religion (88%)
  - Disability status (71%)
  - Sexual orientation (19.5%)
  - Veteran status (51%)
- **Data used to benchmark gaps in care for:**
  - Race (29.5%)
  - Ethnicity (29%)
  - Gender (32%)
  - Primary language (28%)
  - Religion (15%)
  - Disability status (19%)
  - Sexual orientation (7%)
  - Veteran status (13%)

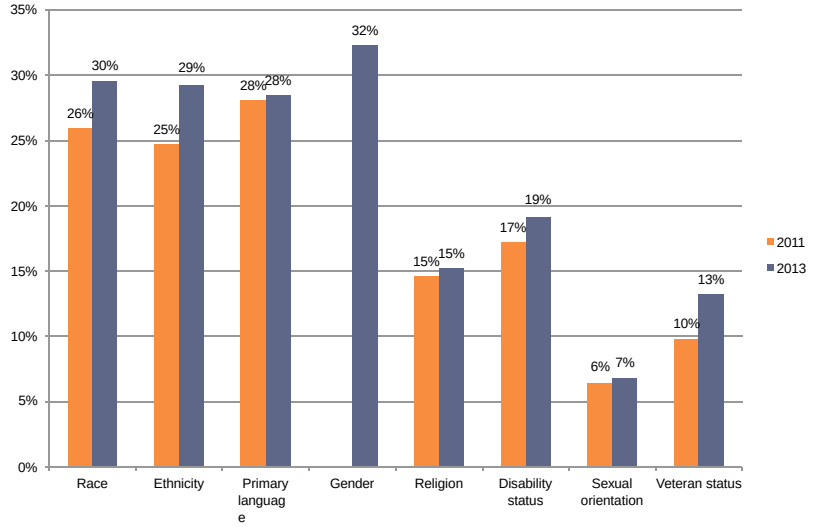
Collection and Use of Data

Patient Data Collected at First Encounter



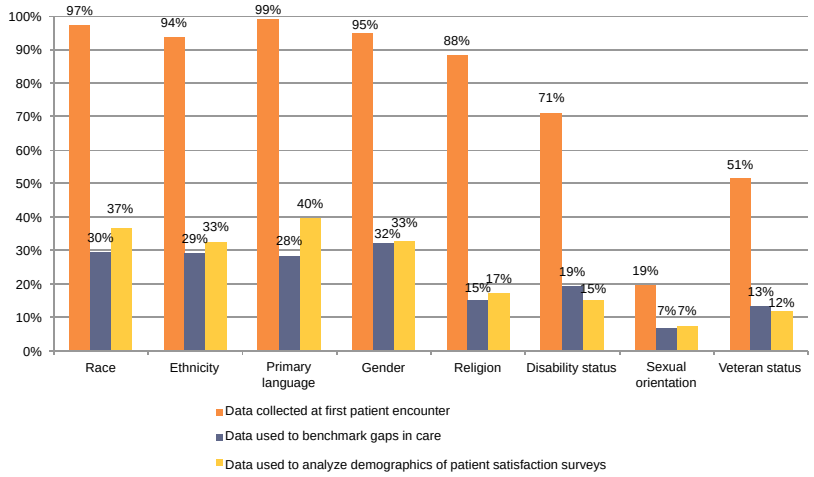
Collection and Use of Data

More hospitals are using patient demographic data to benchmark gaps in care in 2013 than in 2011, but more work needs to be done.



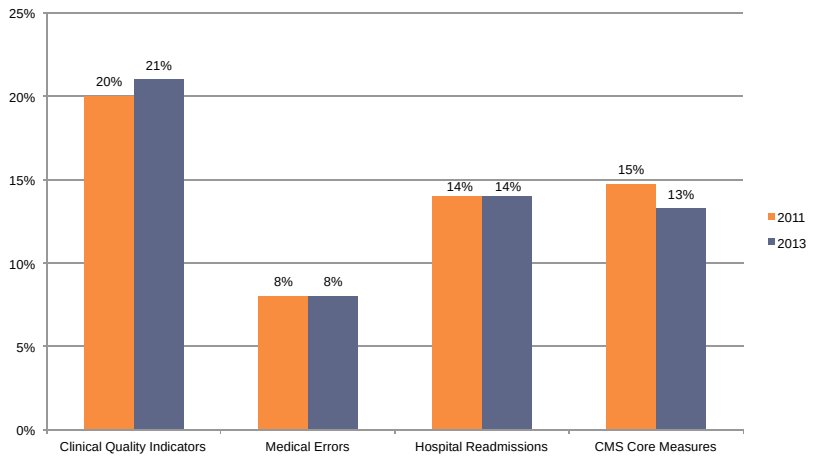
Collection and Use of Data

Collection and Use of Patient Demographic Data – 2013

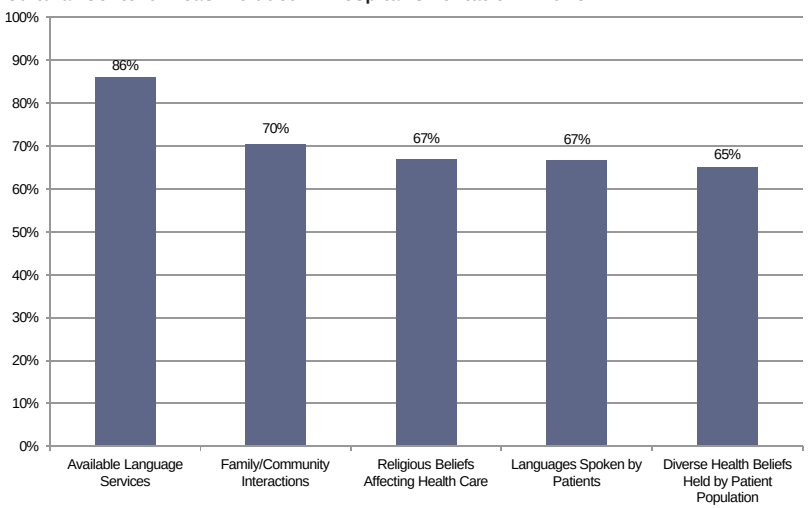


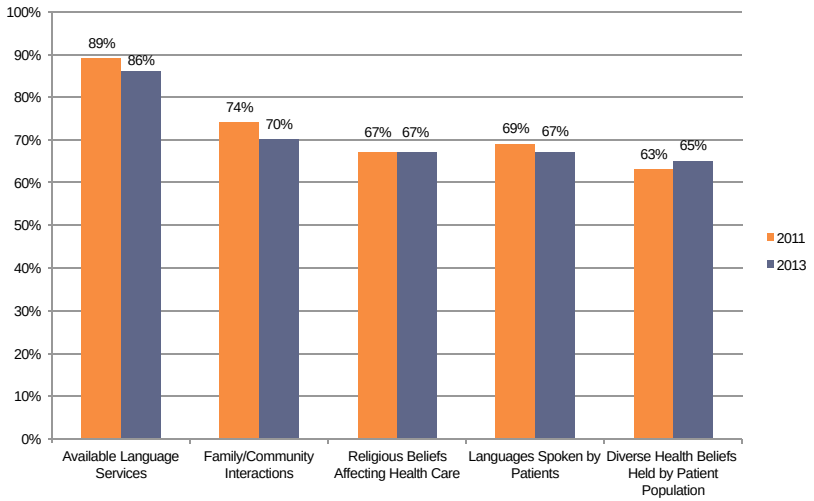
Collection and Use of Data

Utilizing data to identify disparities in treatment and/or outcomes between racial or ethnic groups

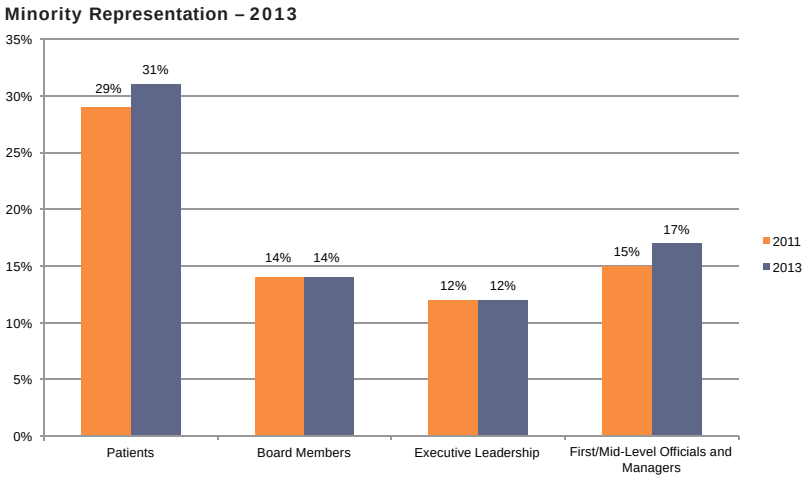


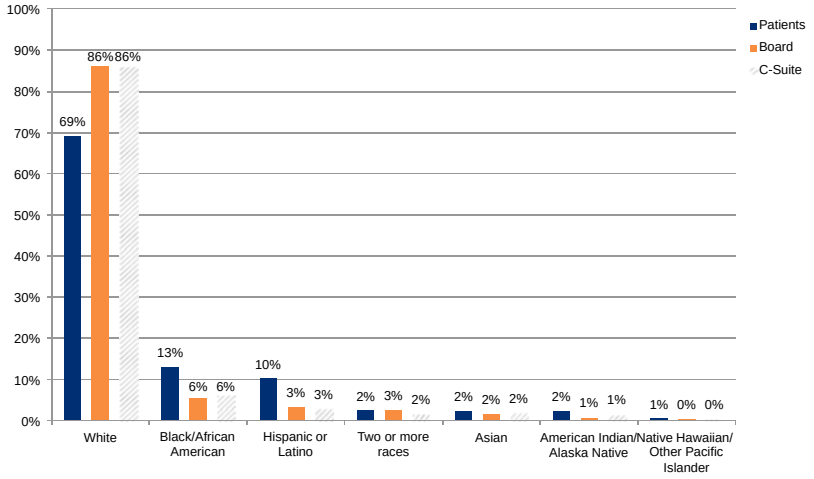
Cultural Competency Training



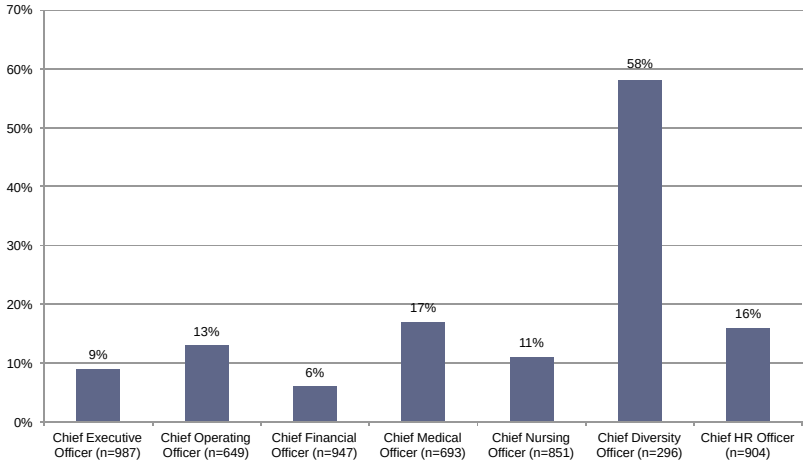


Leadership and Governance

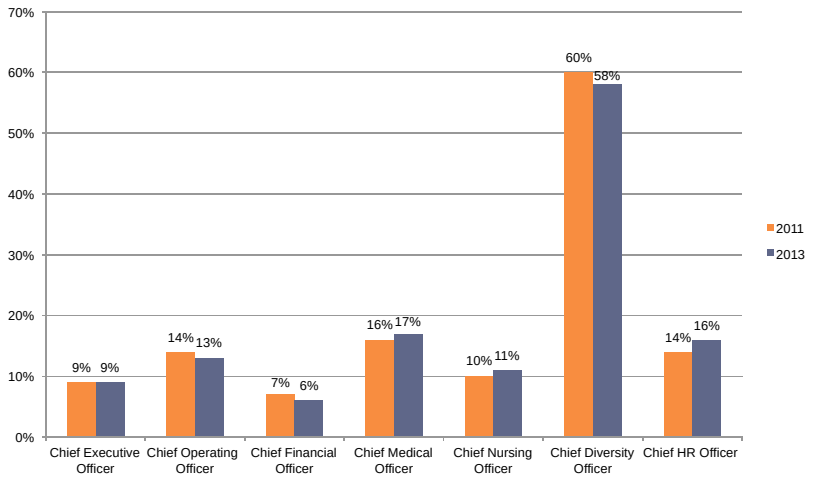




Minority Representation in Executive Leadership Positions – 2013

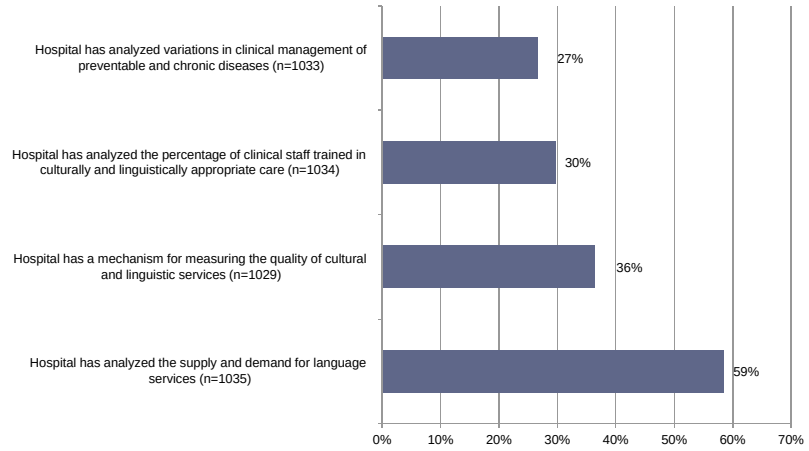


Minority Representation in Executive Leadership Positions

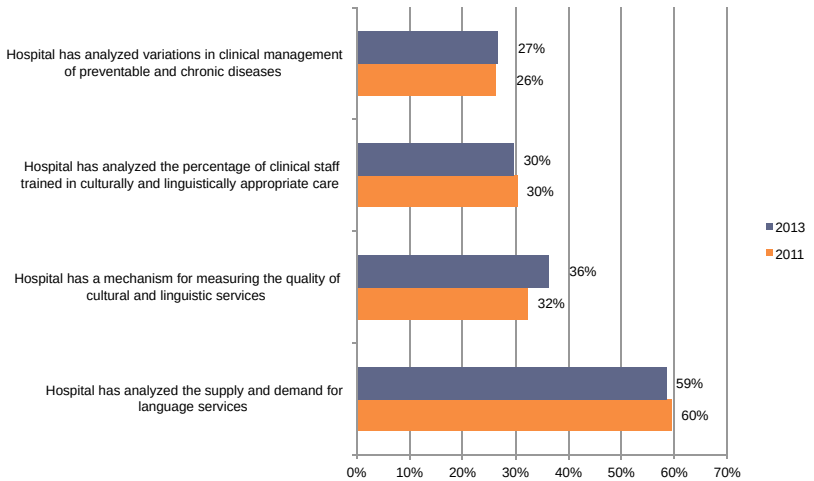


Appendix A: Data Utilization

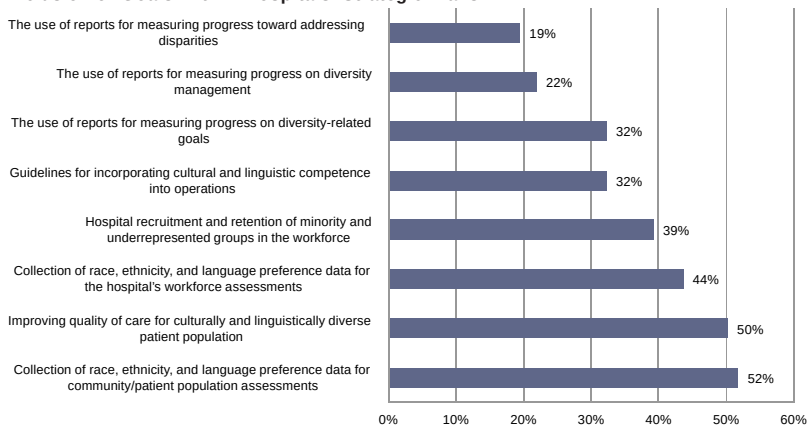
Hospitals' Utilization of Data to Address Health Care Disparities – 2013

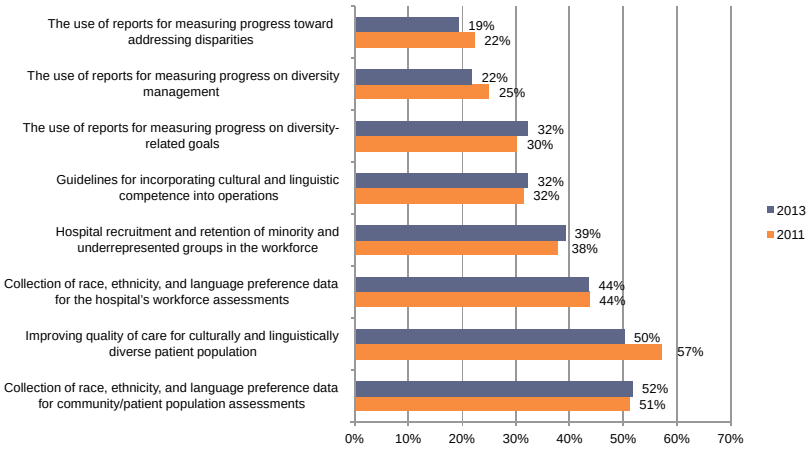


Hospitals' Utilization of Data to Address Health Care Disparities

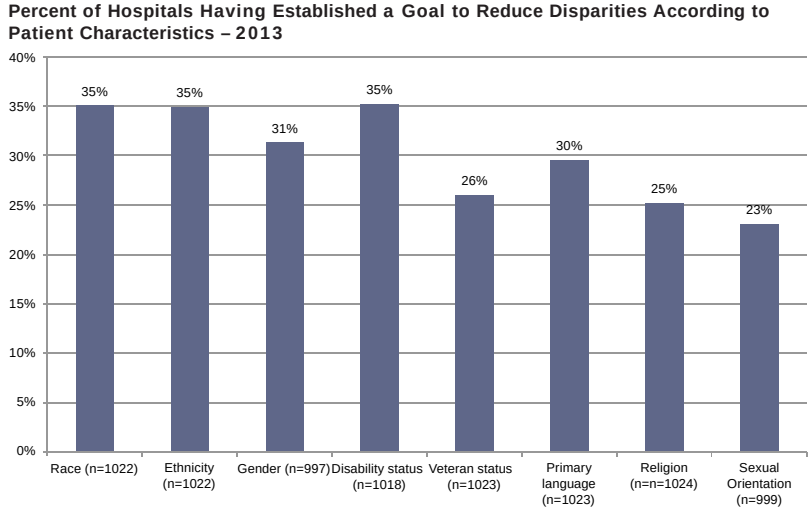


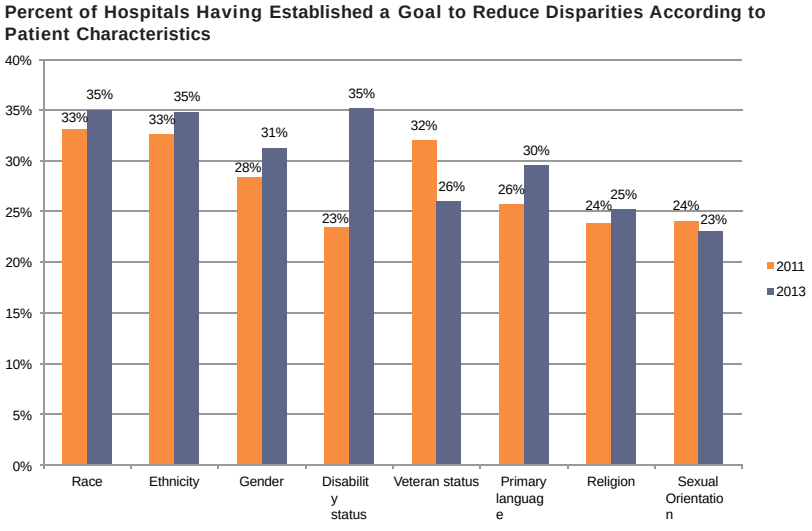
Appendix B: Strategic Goals





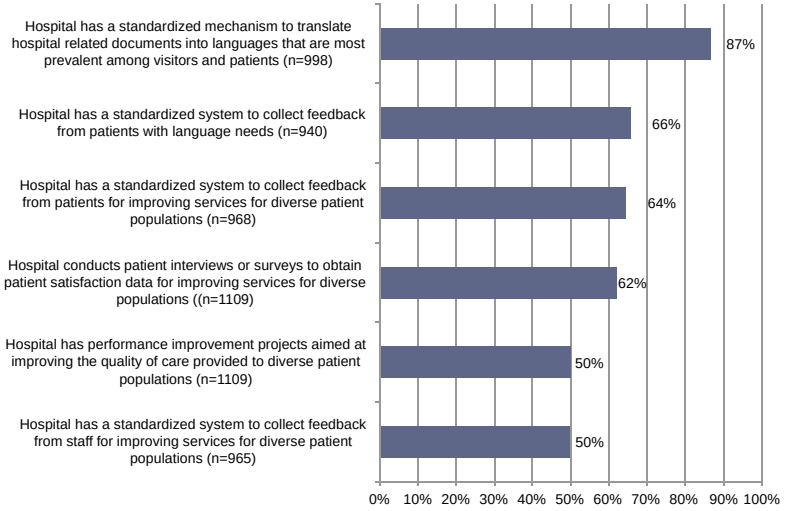
Appendix C: Strategic Goals



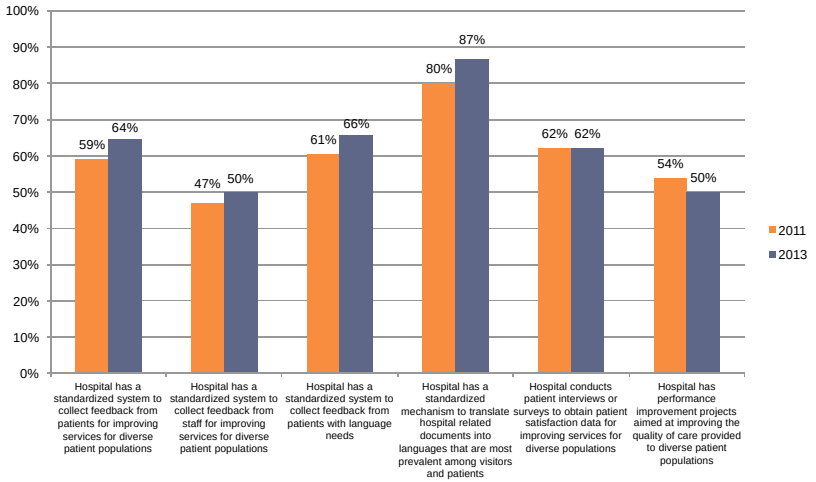


Appendix D: Reducing Disparities

Hospitals' Efforts to Reduce Racial/Ethnic Health Care Disparities – 2013

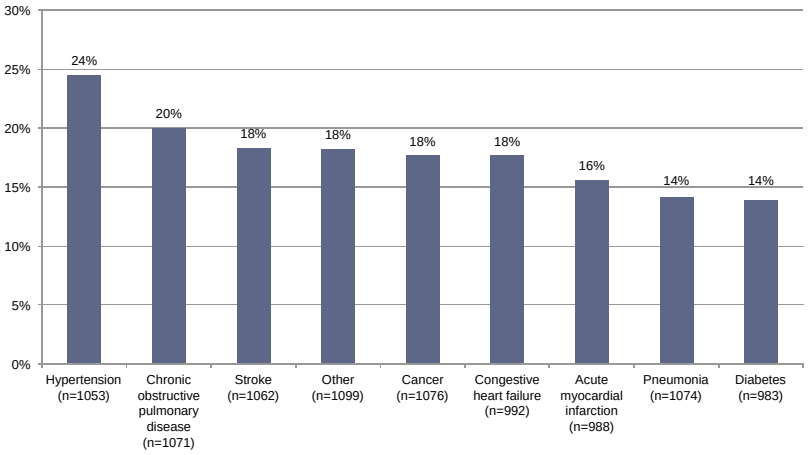


Hospitals' Efforts to Reduce Racial/Ethnic Health Care Disparities

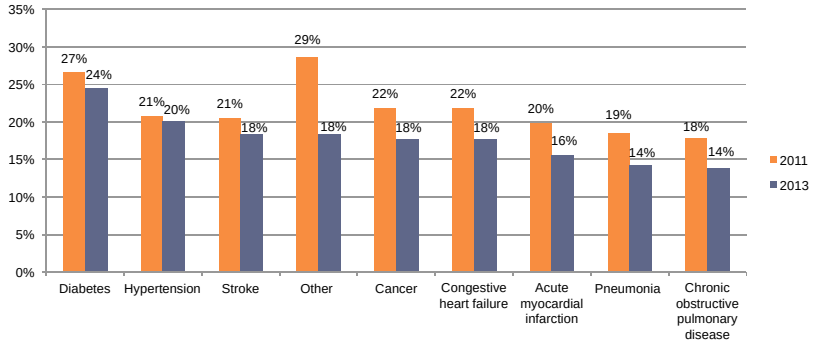


Appendix E: Reducing Disparities

Disease-Specific Interventions Planned or Implemented by Hospitals to Reduce Racial/Ethnic Disparities – 2013

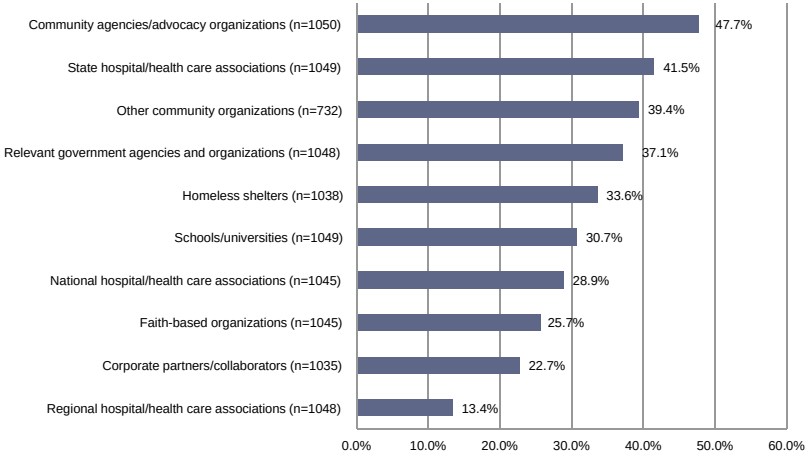


Disease-Specific Interventions Planned or Implemented by Hospitals to Reduce Racial/Ethnic Disparities

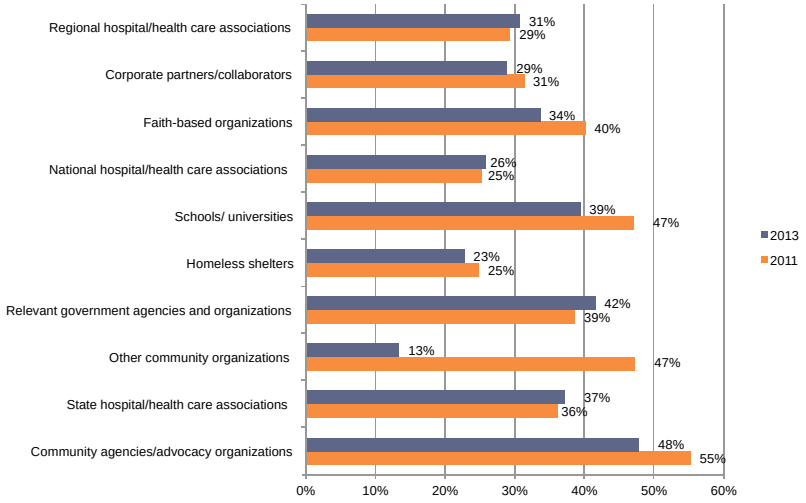


Appendix F: Reducing Disparities

Hospitals' Collaboration with External Organizations to Reduce Disparities – 2013

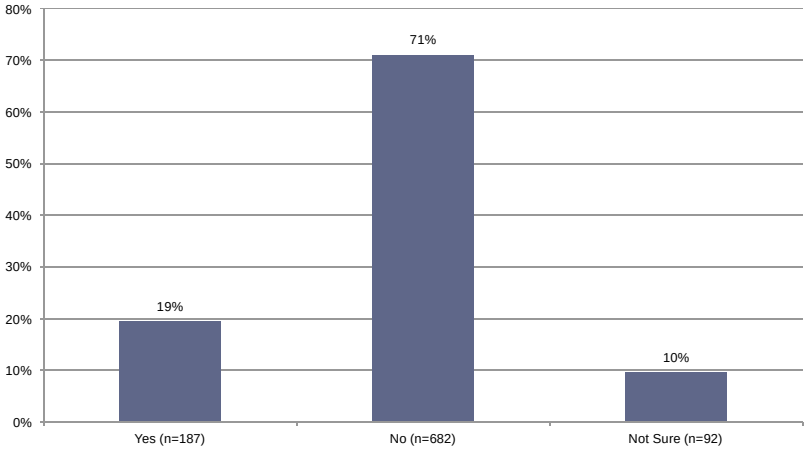


Organizations with which hospitals have collaborated with to reduce disparities over the last 3 years?

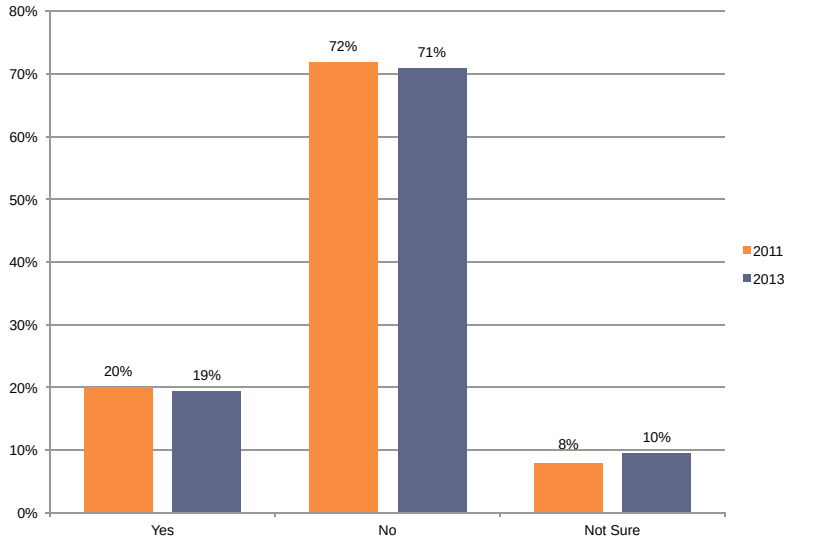


Appendix G: Reducing Disparities

Does Your Organization Have a Community-based Diversity Advisory Council or Committee? – 2013

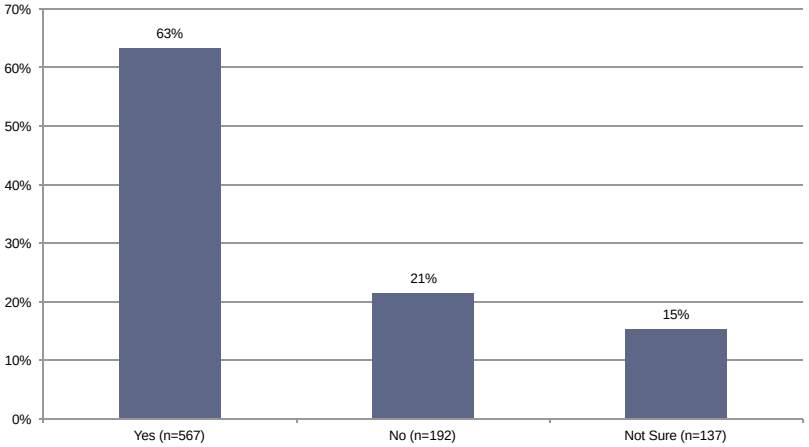


Does Your Organization Have a Community-based Diversity Advisory Council or Committee?

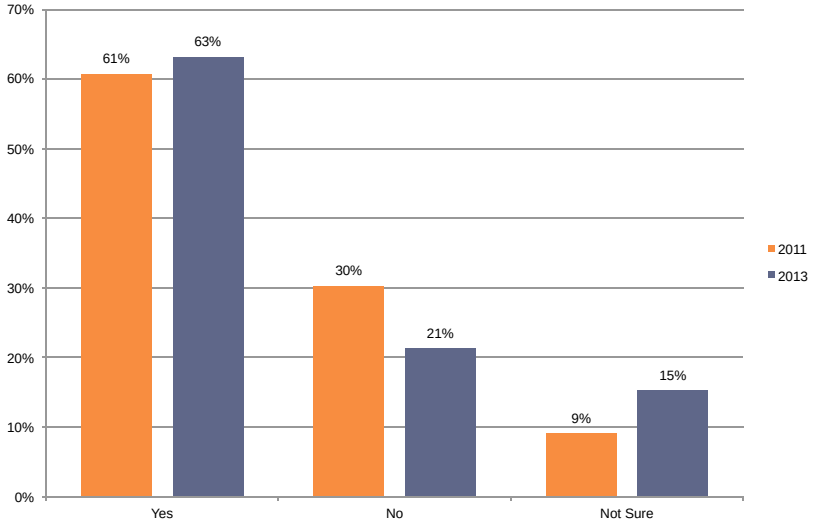


Appendix H: Cultural Competency

Has Your Hospital Conducted an Assessment of the Racial and Ethnic Demographics of Your Community in the Past Three Years – 2013

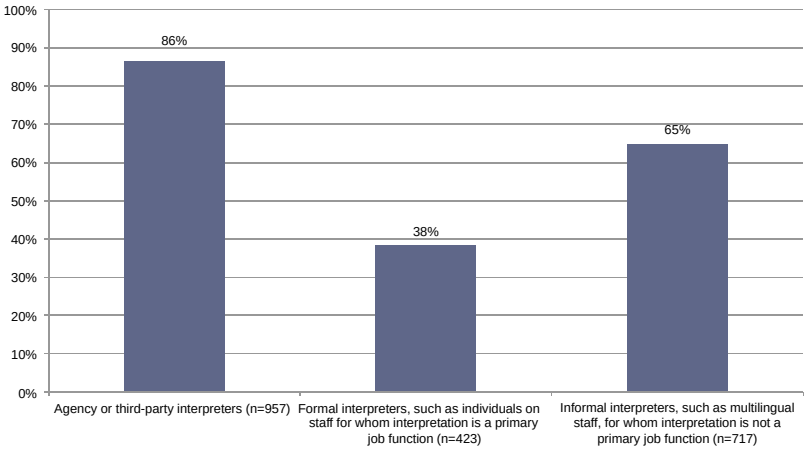


Has Your Hospital Conducted an Assessment of the Racial and Ethnic Demographics of Your Community in the Past Three Years

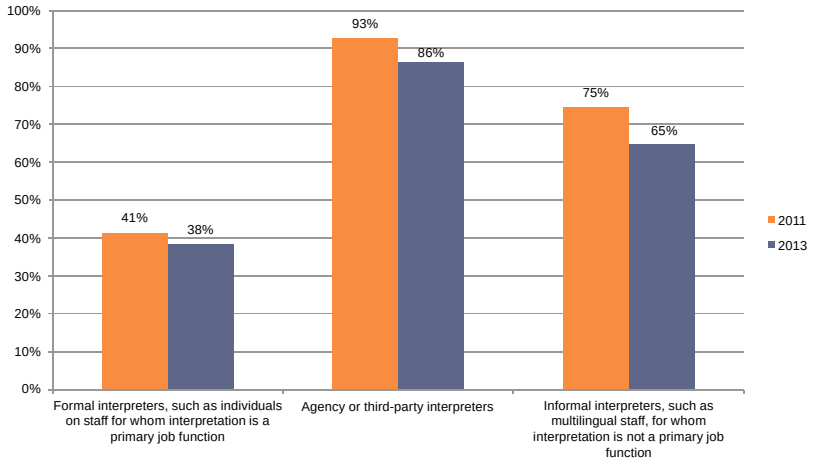


Appendix I: Cultural Competency

Types of Interpreters Used by Hospitals – 2013

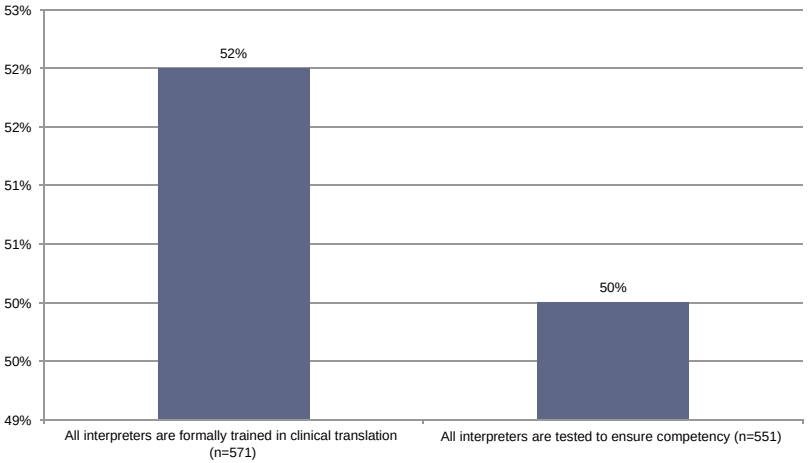


Types of Interpreters Used by Hospitals

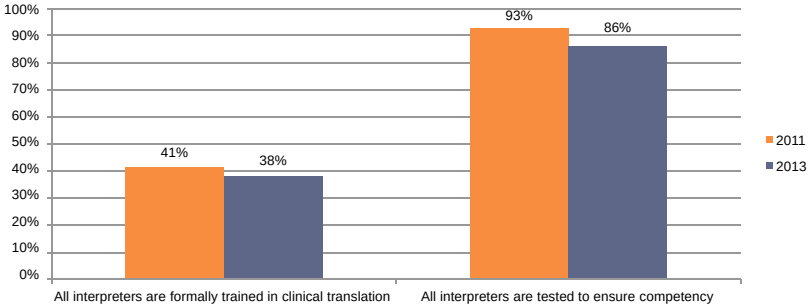


Appendix J: Cultural Competency

Hospitals' Verification of Interpreter Quality – 2013

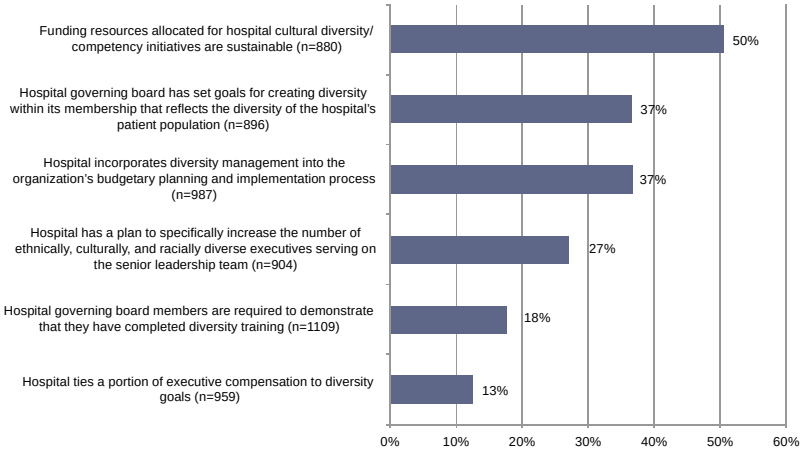


Hospitals' Verification of Interpreter Quality

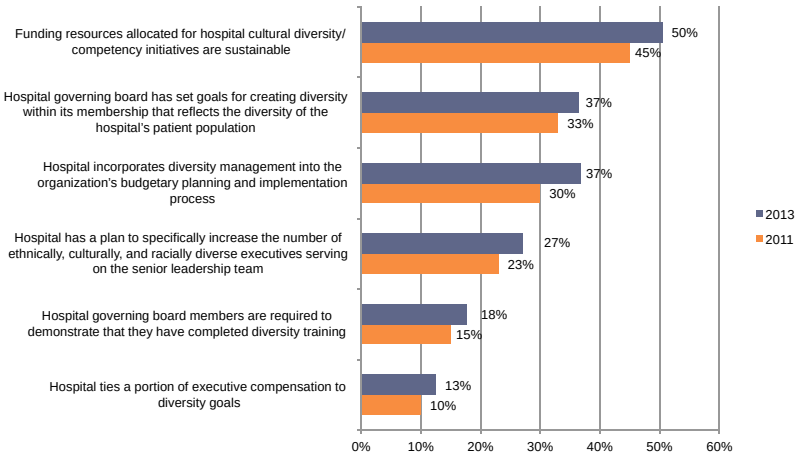


Appendix K: Leadership

Hospitals' Leadership Goals – 2013

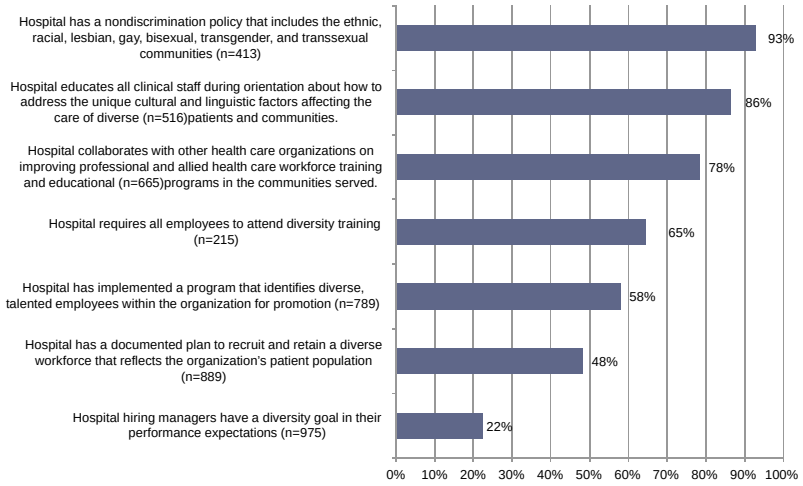


Hospitals' Leadership Goals

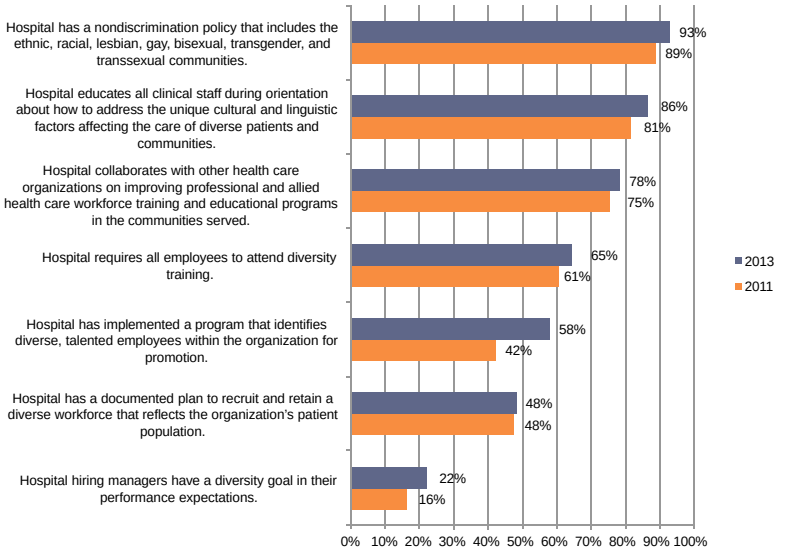


Appendix L: Diversity Management

Percentage of Hospitals Participating in Diversity Improvement Plans – 2013



Percentage of Hospitals Participating in Diversity Improvement Plans



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.

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

Call to Action Partners

American Hospital Association

AAMC
Tomorrow's Doctors, Tomorrow's Cures

American College of Healthcare Executives
for leaders who care

CHA
Catholic Health Association of the United States

AMERICA'S ESSENTIAL HOSPITALS

www.equityofcare.org

Equity of Care Platform

www.equityofcare.org

Offers free resources for the health care field:

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

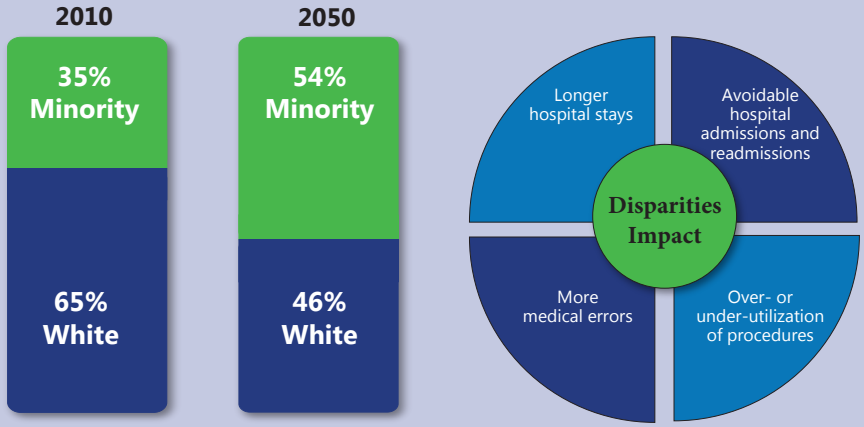
hospitals in pursuit of excellence™
Accelerating Performance Improvement

Equity of Care

INSTITUTE FOR DIVERSITY in Health Management
An affiliate of the American Hospital Association

Hospitals Making Progress on Health Care Disparities

Changing U.S. Demographics and the Impact of Health Care Disparities

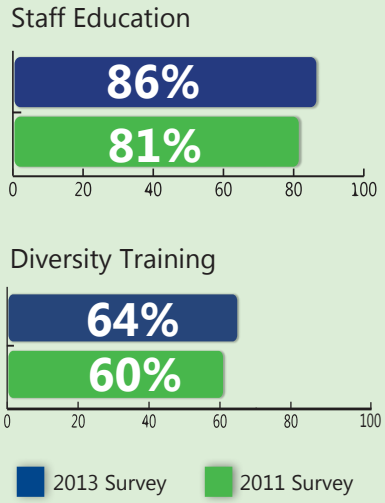


2013 Diversity and Disparities Survey

The survey highlights advancements made in cultural competency training, working with diverse patient populations and the collection of race, ethnicity and language (REaL) data.

For a copy of the full survey results, go to HPOE.org

Increased Cultural Competency Training



More Work Needed in Leadership Diversity

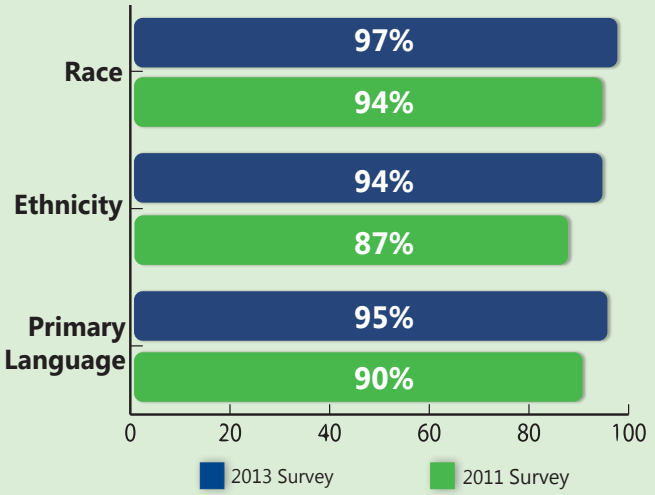
Progress Toward Working with Diverse Patients

64% Collecting feedback from diverse patient populations.
Up from 59% in 2011

87% Translating health-related documents into different languages.
Up from 80% in 2011

66% Collecting patient language needs.
Up from 61% in 2011

Collection of REaL Data Is Increasing



Equity of Care Resources

Resource	Description	Address
American College of Healthcare Executives	The American College of Healthcare Executives has developed a number of initiatives to further diversity within ACHE and the health care management field.	http://www.ache.org/policy/diversity_resources.cfm
American Hospital Association	The American Hospital Association offers resources, case examples and tools for hospitals to eliminate health care disparities.	http://www.aha.org/advocacy-issues/disparities/index.shtml
America's Essential Hospitals	America's Essential Hospitals initiates, advances and supports programs and policies that help hospitals ensure access to high-quality health care for all, including the most vulnerable populations.	http://essentialhospitals.org/
Association of American Medical Colleges	The Association of American Medical Colleges' commitment to diversity includes embracing a broader definition of "diversity" and supporting members' diversity and inclusion efforts.	https://www.aamc.org/initiatives/diversity/
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.	http://www.chausa.org/disparities/overview
Disparities Solutions Center	The Disparities Solutions Center offers many resources for hospital leaders interested in promoting equity and reducing health care disparities.	http://www2.massgeneral.org/disparitiessolutions/resources.html
Equity of Care	Equity of Care offers free resources for the health care field, including best practices, newsletters, blogs, case studies, guides, webinars and current research in health care equity.	http://www.equityofcare.org/
Health Research & Educational Trust Disparities Toolkit	The HRET Disparities Toolkit is a web-based tool that provides hospitals, health care systems, clinics and health plans with information and resources for systematically collecting and using race, ethnicity and language data from patients.	www.hretdisparities.org/

Hospitals in Pursuit of Excellence	The American Hospital Association's strategic platform to accelerate performance improvement and support delivery system transformation in the nation's hospitals and health systems, HPOE provides free evidence-based guides, case studies and other resources for hospital quality improvement efforts aimed at reducing health care disparities.	http://www.hpoe.org/resources?topic=91
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
The Joint Commission	In "Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals," the Joint Commission offers a series of resources to enhance cultural competency and communication.	www.jointcommission.org/Advancing_Effective_Communication/
U.S. Department of Health & Human Services	The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards), from the U.S. Department of Health & Human Services, 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.	https://www.thinkculturalhealth.hhs.gov/Content/clas.asp

Visit the Resources section of the Equity of Care website at http://www.equityofcare.org/resources for additional resources.