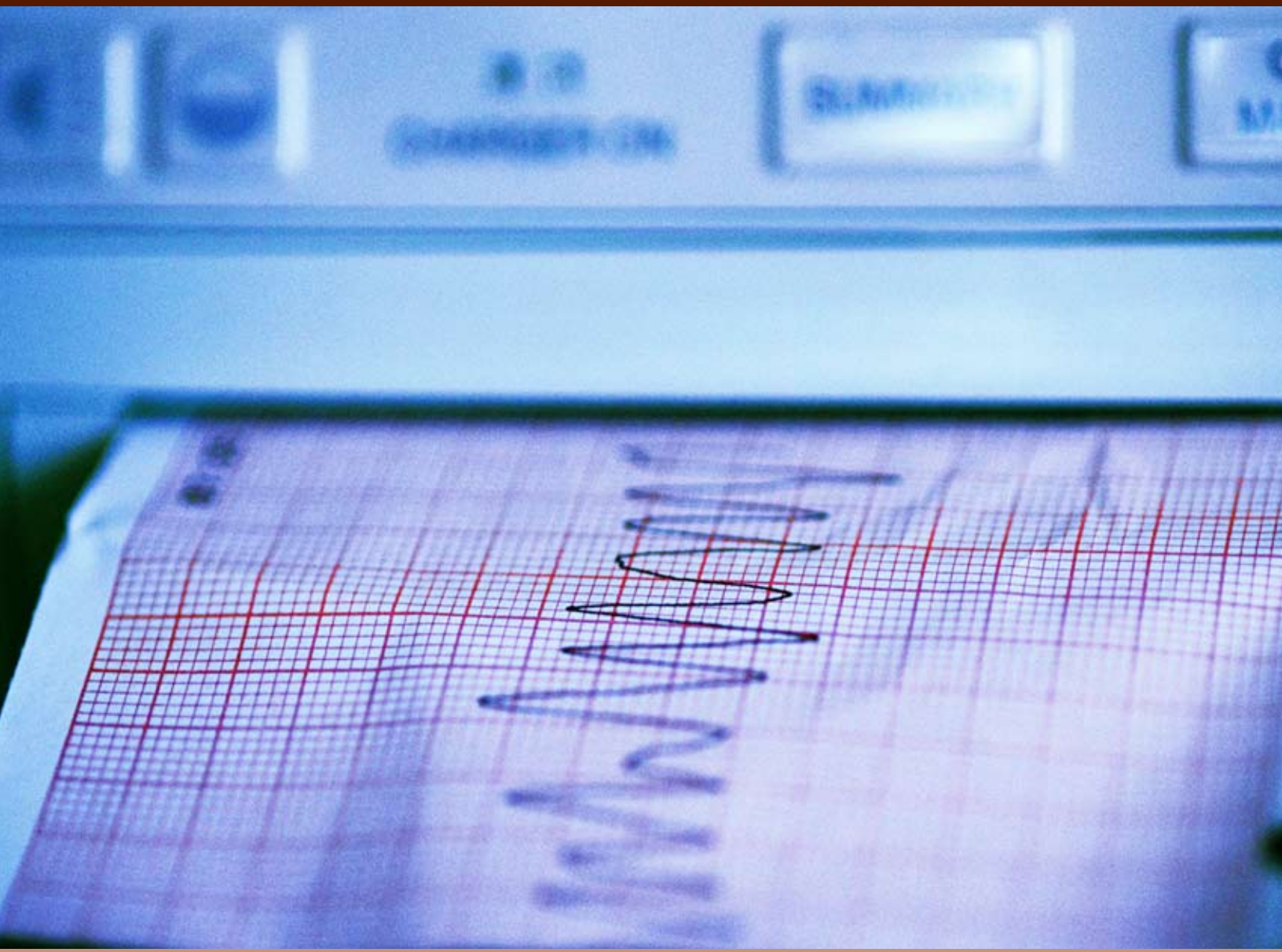
MASSACHUSETTS GENERAL HOSPITAL

Institute for Health Policy

Improving Quality and Achieving Equity:
A Guide for Hospital Leaders



THE DISPARITIES SOLUTIONS CENTER
at MASSACHUSETTS GENERAL HOSPITAL

Dedicated to eliminating racial and ethnic disparities in health care

Improving Quality and Achieving Equity: A Guide for Hospital Leaders

Acknowledgements

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Foreword by Peter L. Slavin, MD

The Institute of Medicine Report *Crossing the Quality Chasm* was truly transformative in that it presented our nation with a blueprint for achieving quality. The report urges us to focus on six key areas to deliver on our promise of high-quality care: efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity. Hospitals across the country have heeded the Institute of Medicine's call, and are actively engaged in trying to improve quality – yet, we would be remiss to view any one area of quality as less important than another. This brings me to the issue of equity.

The fact that racial and ethnic minorities in this country may receive poorer quality health care than their white counterparts in hospitals across the country – even when they have health insurance – is indisputable and undeniable. The evidence, so eloquently presented in another Institute of Medicine Report *Unequal Treatment,* clearly points to the fact that the issue of racial and ethnic disparities in health care is an *inequality in quality* that deserves our utmost attention. It is therefore no coincidence that equity is a key pillar of quality.

Although conceiving the notion of unequal treatment can be uncomfortable, and to some unimaginable, given the evidence, it is incumbent upon us to assume that we have disparities in our own institutions unless proven otherwise. The importance of collecting patient race and ethnicity data, developing monitoring and reporting tools, and creating interventions to address disparities when found – as *Unequal Treatment* recommends – cannot be overstated. At Massachusetts General Hospital, we have taken this issue very seriously. Equity receives equal attention to the other pillars of quality from the Board room to the exam room. Our leadership understands that we cannot improve quality without improving equity, and we have engaged in a process of building the systems and interventions necessary to make this a reality. Ultimately, we believe that improving quality, addressing disparities and achieving equity is our responsibility, and that these efforts will improve not just the care of minorities, but of all patients at our institution.

For those who are interested in better understanding the issue of disparities, and why it is a key component of quality, this *Guide for Hospital Leaders* will provide some concrete answers. In addition to presenting the evidence for disparities and the rationale for addressing them, it also gives a view from the field, as well as a guide on how to initiate a portfolio of action in this area. Built on research, real world experiences, and national examples and models, this first-of-a-kind guide is practical, respectful of competing interests and pressures, and strategic – a perfect resource for getting started. Whether you are a CEO and need some background and guidance, or an advocate in need of a tool to convince your leadership to care and act, this guide will meet your needs.

As we move ahead, we can see that there is a quality, safety, cost, and risk management case for addressing disparities. If that is not enough, the changing demographics of the U.S., new pay-for-performance efforts targeting disparities, and the Joint Commission and National Quality Forum's recent attention to these issues, clearly highlight that achieving equity isn't just the right thing to do, it's an important ingredient to business success in health care. This guide can help you map out a successful strategy to improve quality, achieve equity, and address racial and ethnic disparities in health care.

I urge my counterparts to take on this important area of work and join me and other hospital leaders across the country who are striving to meet the challenge of achieving equity and assuring high-quality care for all we serve.

Peter Slavin, MD
President
Massachusetts General Hospital

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Executive Summary

Introduction

The Institute of Medicine (IOM) Report *Crossing the Quality Chasm,* released in 2001, highlights that there is a significant gap between the quality of health care people should receive, and the quality of health care people do receive.[1] Just a year later, the IOM released another influential report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* highlighting an even larger quality chasm for racial/ethnic minorities in the United States.[2]

Crossing the Quality Chasm suggests that quality is a system property and that our current system of health care delivery is in need of redesign. To truly achieve quality care, health care systems must focus on six key elements – efficiency, effectiveness, safety, timeliness, patient-centeredness, and *equity. Equity* is achieved by providing care that does not vary in quality by personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status. Over the last few years, there has been an increased focus by hospital leadership on improving quality by responding to the six key elements proposed in *Crossing the Quality Chasm.* In regards to equity, research has shown that racial and ethnic disparities in health care have an impact on quality, safety, cost, and risk management. Addressing disparities has now been acknowledged by the National Quality Forum and the Joint Commission as an essential component of quality. Despite this, few hospital leaders have the issue of equity, and identifying and addressing disparities, prominently on their radar screen.

The Disparities Solutions Center at Massachusetts General Hospital, with support from the Robert Wood Johnson Foundation, has created *Improving Quality and Achieving Equity: A Guide for Hospital Leaders.* The goals of this guide are to:

- **Present the evidence for racial and ethnic disparities in health care and provide the rationale for addressing them – with a focus on quality, cost, risk management and accreditation.**
- **Highlight model practices – hospitals and leaders who are actively engaged in addressing disparities and achieving equity.**
- **Recommend a set of activities and resources that can help hospital leaders initiate an agenda for action in this area.**

This guide is constructed to be clear, concise, practical, and easy to read. It is targeted to hospital leaders - including CEO's, VP's, and others that focus on quality, safety, finance, and risk management. The guide was also designed to be used by individuals within hospitals who either would like to help convince their leadership to take action, or who are responsible for making the case for addressing disparities to other leaders in the hospital. It is applicable to all types of hospitals - rural, urban, public, private, and veteran's administration, among others. It was developed over the course of 2008, and includes a thorough review of the peer-reviewed literature, key informant interviews with hospital leaders, and case studies of innovative approaches that hospitals are undertaking to identify and address disparities, as well as to achieve equity. Guidance for the development of *Improving Quality and Achieving Equity: A Guide for Hospital Leaders* was graciously provided by our Sounding Board of health care leaders and experts (Appendix C), and the final draft was reviewed by a panel of leaders in the field of hospital quality and safety (Appendix D).

Equity is a key essential component of quality

- The Institute of Medicine Report *Crossing the Quality Chasm* suggests that quality is a system property, and that our current system of health care delivery is in need of redesign.
- To truly achieve quality of care, health care systems must focus on six key elements – efficiency, effectiveness, safety, timeliness, patient-centeredness, and *equity.*
- *Equity* is achieved by providing care that does not vary in quality by personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status.

Racial and ethnic disparities in quality of care exist

- The Institute of Medicine Report *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts.
- Racial and ethnic disparities have been found in the quality of care delivered to patients with cardiovascular disease (including acute myocardial infarction and congestive heart failure), diabetes, and cancer screening and management, among other conditions.

Achieving equity and addressing disparities has implications for quality, cost, risk management, accreditation, and community benefit

- Research has shown that racial and ethnic disparities in health care, and their root causes described below, have an impact on quality, safety, cost, and risk management. For example:
    - Patients with limited English proficiency (LEP) and racial/ethnic minorities are more likely than their English-speaking white counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.[3-5]
    - Communication problems are the most frequent cause of serious adverse events (as recorded in the Joint Commission database) and arise due to language barriers, cultural differences, and low health literacy, all of which are particularly important issues for racial/ethnic minority patients.[4]
    - In the presence of communication difficulties with patients (i.e. due to language barriers or cultural barriers) health care providers may tend to order expensive tests (such at CT Scans) for conditions that could have been diagnosed through basic history-taking.[6]
    - Patients with limited-English proficiency have longer hospital stays for some common medical and surgical conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement) than their white counterparts.
    - Minorities are more likely to be readmitted for certain chronic conditions,[7-9] such as congestive heart failure.[10] Moving forward, this issue might take on greater financial importance given that the Centers for Medicare and Medicaid Services will likely limit or refuse reimbursement for Medicare patients with congestive heart failure who are readmitted within 30 days of discharge.[11, 12]
    - Minorities, even when controlling for insurance status, may be at greater risk for ambulatory care sensitive/avoidable hospitalizations for chronic conditions (hypertension and asthma) than their white counterparts.
    - Pay-for-performance contracts have started including provisions that look to address racial and ethnic disparities in health care – and it is expected that this trend will become more widespread over time.
    - There are multiple liability exposures that arise when there is a demonstrated failure to address the root causes for disparities. These include patient misunderstanding of their medical condition, treatment plan, discharge instructions, (including how to identify complications and when to follow-up; ineffective or improper use of medications or serious medication errors; improper preparation for tests and procedures, and poor or inadequate informed consent).

- Disparities have also captured the attention of the Joint Commission who will soon likely release accreditation standards on this issue, as well as the National Quality Forum, who have recently developed quality measures on disparities and cultural competence.
- As the issues of community benefit and not-for-profit status takes on greater importance for hospitals across the country, addressing racial and ethnic disparities can become a valuable portfolio of work to meet these regulations.

There are many causes for disparities–no one suspect, no one solution

- The existence of racial and ethnic disparities in health care does not imply that a hospital or its providers are intentionally discriminating against certain groups of patients.
- Disparities are ubiquitous and multifactorial.
- Health system level factors (related to the complexity of the health care system and how it may be poorly adapted to disproportionately difficult to navigate for minority patients or those with limited-English proficiency), care-process variables (related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication), and patient-level variables (patient's mistrust, poor adherence to treatment, and delays in seeking care) all contribute to disparities.

Several hospitals across the country have distinguished themselves as leaders

- Several hospitals across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity.
- Activities have included the development of a strategic plan to address disparities, standardized collection of patient's race and ethnicity, stratification of quality measures by race and ethnicity, the development of quality measurement tools to monitor for disparities, community-based efforts to improve primary care services and create medical homes, development and expansion of interpreter services, and interventions to address disparities when found.
- These efforts have been motivated by the quality case and the business case for achieving equity.

Hospital leaders can develop systems to improve quality, address disparities and achieve equity

A recommendation checklist is included here in the executive summary, and more details on the recommendations can be found in Chapter 5.

- ***Getting Started***

  Create a multidisciplinary ***disparities committee*** of individuals representing quality, operations, patient registration, social services, human resources, nursing and physician-leaders from several clinical services to assess what is being done in the area of disparities at the hospital (such as whether patient race/ethnicity and language is collected), and to develop an initial strategic plan. Educate leadership team on the issue and the approach.

- ***Creating the Foundation***

  Develop a plan to ***collect patient race/ethnicity data*** (if not already done) and create medical policies to support this work. Assign an organizational leader as the key report for this work and engage in efforts to raise awareness of the issue among faculty and staff. Solidify community partnership and relationships in anticipation of future interventions.

- ***Moving to Action***

  Create a "disparities dashboard" composed of key quality measures stratified by race and ethnicity (i.e. National Hospital Quality Measures, HEDIS outpatient measures, patient satisfaction, etc.) that can be routinely presented to leadership and monitored. If disparities are found, create pilot programs to address them (examples include disease management programs with health coaches, navigators, or community health workers).

- ***Evaluate, Disseminate, Reengineer***

  Evaluate pilot studies and develop a dissemination strategy to post results; chart a new course and **reengineer** strategies from lessons learned. **Embed** successful practices into standard programs of care.

Frequently Asked Questions

The following is a set of frequently asked questions regarding the issues of quality, equity, and racial and ethnic disparities in health care.

1. Why is equity an important component of quality?

The Institute of Medicine Report *Crossing the Quality Chasm* suggests health care systems must focus on six key elements–efficiency, effectiveness, safety, timeliness, patient-centeredness, and equity. Equity is achieved by providing care that does not vary in quality by personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

2. Given all the competing interests and priorities our hospital is facing, why should we focus on equity?

Research has shown that racial and ethnic disparities in health care, and their root causes, have an impact on quality, safety, cost, and risk management. For example, patients with limited-English proficiency suffer from more medical errors with greater clinical consequences than their white counterparts; they have longer lengths of stay for the same clinical condition; they may undergo more high-priced diagnostic tests due to challenges related to communication; they have higher rates of readmission for chronic conditions and more avoidable hospitalizations. All of these situations may pose significant risk management issues as well. Furthermore, addressing disparities will likely soon become a key part of the Joint Commission's Accreditation Standards, the National Quality Forum's quality measures, a key aspect of pay-for-performance contracts, and a more central component of community benefit principles which are now under close federal scrutiny.

3. Is there evidence that hospitals may be providing care that is not equitable?

The Institute of Medicine Report *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation, and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts. Racial and ethnic disparities have been found in the quality of hospital care delivered to patients with cardiovascular disease (including acute myocardial infarction and congestive heart failure), diabetes, and cancer screening and management, among others. **Health-system level factors** (related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for minority patients or those with limited-English proficiency), **care-process variables** (related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication), and **patient-level variables** (patient's mistrust, poor adherence to treatment, and delays in seeking care) all contribute to disparities.

4. How do disparities apply to our hospital? We treat all our patients the same regardless of their race/ethnicity.

While most health care professionals and hospitals strive to provide the same level of quality of care to all patients, evidence shows this may not be the case. Research highlights racial/ethnic disparities in care across a wide range of institutions, geographic regions and services. The bottom line is that if you haven't looked at your quality data stratified by race and ethnicity, you can't assume that you don't have disparities.

Another key point is that treating everyone the same may not be enough. Patients may respond differently when presented with the same information from a clinician. Ensuring the highest quality of care possible to all patients requires understanding and adapting care to the patient's unique needs and perspectives, which are often influenced by their social and cultural backgrounds. Only then can high-quality care be achieved in a patient-centered manner.

5. Aren't racial and ethnic disparities in health mainly due to socioeconomic factors like poverty, poor education, and lack of insurance?

There is no doubt that socioeconomic status, education, and the environment – social determinants of health – as well as access to care, contribute to racial and ethnic disparities in health. However, the Institute of Medicine Report *Unequal Treatment* reviewed hundreds of articles that controlled for these factors and still found differences in quality of care based solely on the race and ethnicity of the patient. These are termed racial and ethnic disparities in health care. Efforts to improve quality and achieve equity should focus on the root causes of racial and ethnic disparities in health care.

6. New studies suggest that racial and ethnic disparities in health care are primarily due to where patients are seen, and by whom. Shouldn't disparities efforts focus on improving quality at predominately minority serving institutions?

Research has shown that racial/ethnic disparities are due not only to differences in care provided within hospitals, but also as a result of from whom or where minorities receive their care (i.e. specific providers, geographic regions, or hospitals that have limited financial resources, access to specialists, and as a result are lower performing in the area of quality).[13-15] In sum, research, including those studies presented in *Unequal Treatment,* show that racial and ethnic disparities in health care can happen anywhere,[16] and among patients cared for by any provider.[17] Efforts to address disparities should include quality improvement strategies in predominately minority-serving institutions, as well as institutions that serve a diverse patient population. The bottom line is that in order to assure equity, all hospitals need to collect data on patient race and ethnicity and stratify quality measures accordingly to determine if disparities exist – regardless of the size of the minority population being served.

7. Are there hospitals actively engaged in disparities work across the country?

Several hospitals across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity. Activities have included the development of a strategic plan to address disparities, standardized collection of patient's race and ethnicity, stratification of quality measures by race and ethnicity, the development of quality measurement tools to monitor for disparities, community-based efforts to improve primary care services and medical homes, development and expansion of interpreter services, and interventions to address disparities when found.

8. What are some basic things we should be doing to address the issue of disparities?

First, develop a system to routinely collect patient race and ethnicity data. Second, begin to stratify quality measures by race and ethnicity to assess equity; this should be formalized into a disparities dashboard or equity report that can be monitored routinely by the leadership. Third, if a disparity is identified, develop an intervention to address it. All of this work should be done in collaboration with, and supported by, the Board, hospital leadership, faculty and staff. Please reference our Resource Section which highlights several toolkits, web-based seminars and models for how to do this effectively.

9. Are there strategies that work to address disparities once they are found?

For the past decade, research has focused on documenting disparities, but new research is emerging that documents promising practices to address them as well. These include the use of culturally-competent disease management models,[18-21] bilingual health coaches,[22-25] as well as navigators,[26-30] and the implementation of community outreach programs.[22, 31-36] This Guide will provide an overview of what action leaders can take at their own organizations to move towards the elimination of healthcare disparities, including resources for identifying, monitoring, and developing interventions to address disparities.

Recommendation Checklist

Getting Started

- ☐ Create a Disparities Committee or Task Force.
    - A multidisciplinary team, charged with assessing what is being done to identify and address disparities, including whether patient's race and ethnicity data is being collected. Develop initial strategic plan.
- ☐ Educate leadership team on disparities, quality, equity via champion, local national expert.

Creating the Foundation

- ☐ Begin to build foundation to address disparities (including race/ethnicity data collection, stratification of quality measures, etc.).
- ☐ Develop medical policies to support all new work.
- ☐ Finalize a strategic plan of action with 1, 3 and 5 year goals.
- ☐ Assign an organizational leader who can liaison with Disparities Committee; align with other hospital champions.
- ☐ Engage in efforts to raise awareness of the issue among faculty and staff, and provide broad education on the issue.
- ☐ Develop any community-based relationships that are necessary.

Moving to Action

- ☐ Monitor for disparities by stratifying quality measures by race/ethnicity and presenting findings routinely to leadership via a disparities dashboard.
    - Examples include National Hospital Core Measures of congestive heart failure, acute myocardial infarction, community acquired pneumonia, surgical infection prophylaxis as well as other high-impact measures of interest, such as diabetes and breast, cervical, and colon cancer screening.
    - Standardize processes related to stratification of quality measures.
- ☐ Develop pilots to address them.
    - Coaching, navigators, community outreach workers.
- ☐ Expand measurement capabilities to other areas.

Evaluate, Disseminate, Reengineer

- ☐ Evaluate pilot interventions.
- ☐ Disseminate points of action and success.
- ☐ Reengineer efforts as necessary.

Resources

A. The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* *http://www.iom.edu/?id=16740*

B. *HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity and Primary Language from Patients.* *http://www.hretdisparities.org/*

C. *Creating Equity Reports: A Guide for Hospitals.* *http://www.massgeneral.org/disparitiessolutions/resources.html*

D. The Joint Commission's *Hospital, Language and Culture: A Snapshot of the Nation study.* *http://www.jointcommission.org/PatientSafety/HLC/*

   a. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*

   b. *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*

E. The Office of Minority Health. *www.omhrc.gov*

F. The Office of Minority Health's Final Report on *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* *http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf*

G. *Assuring Healthcare Equity: A Healthcare Equity Blueprint.* h*ttp://www.naph.org/Template.cfm?Section=Home&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9428*

H. National Quality Forum. *http://www.qualityforum.org/*

I. The MGH Disparities Committee at Massachusetts General Hospital. *www.mghdisparities.org*

J. The MGH Disparities Dashboard at Massachusetts General Hospital. *http://qualityandsafety.massgeneral.org/measures/equitable.aspx?id=4*

K. Hablamos Juntos, which has the latest information on interpreter services. *www.hablamosjuntos.org*

L. Robert Wood Johnson Foundation's *Speaking Together: National Language Service Network Toolkit* *http://www.rwjf.org/qualityequality/product.jsp?id=29653.* This toolkit provides advice to hospitals on improving quality and accessibility of language services.

M. Robert Wood Johnson Foundation's *Expecting Success: Excellence in Cardiac Care* *http://www.expectingsuccess.org/* aimed at improving quality of cardiac care while reducing racial, ethnic and language disparities and their toolkit available at *http://www.rwjf.org/pr/product.jsp?id=28433*

N. Robert Wood Johnson Foundation's *Finding Answers: Disparities Research for Change* awards and manages research grants totaling $6 million to healthcare organizations implementing interventions aimed at reducing disparities. *http://www.solvingdisparities.org/*

O. Hospitals interviewed for this guide

   a. Baylor Health Care System – *www.baylorhealth.com*

   b. Contra Costa Health Services – *www.cchealth.org*

   c. Cooper Green Mercy Hospital – *www.coopergreenmercyhospital.org*

   d. Duke University Health System – *www.dukehealth.org*

   e. Henry Ford Health System – *www.henryfordhealth.org*

   f. Los Angeles County and University of Southern California Healthcare Network – *www.lacusc.org*

   g. Massachusetts General Hospital – *www.massgeneral.org*

   h. Montefiore Medical Center – *www.montefiore.org*

   i. Seattle Children's Hospital – *www.seattlechildrens.org*

   j. University of Mississippi Medical Center – *www.umc.edu*

P. The Disparities Solutions Center's Archived Web Seminars *http://www.massgeneral.org/disparitiessolutions/web.html*

a. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders*

b. *Getting Started: Building a Foundation to Address Disparities through Data Collection*

c. *Getting it Right: Navigating the Complexities of Collecting Race/Ethnicity Data*

d. *Collecting Race and Ethnicity Data is Not Enough: Measuring and Reporting Disparities*

e. *Creating Equity Reports: A Guide for Hospitals*

f. *Using Multi-Disciplinary Teams to Address Disparities: Navigators, Health Coaches and Community Health Workers*

g. *QI and the EMR: Identifying and Addressing Disparities in Chronic Disease Management*

h. *Improving Quality and Addressing Disparities: Accreditation Standards, Market-Strategies and Levers for Action*

Q. PowerPoint presentations (See Appendices B, E and F)

a. Improving Quality and Achieving Equity: A Guide for Hospital Leaders

b. Disparities and Quality: Why Now and What Are We Doing About It?

c. Leading Change

R. Peer-reviewed Articles (See Appendix G)

Chapter 1: Racial/Ethnic Disparities in Health Care

The Institute of Medicine Report *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts.

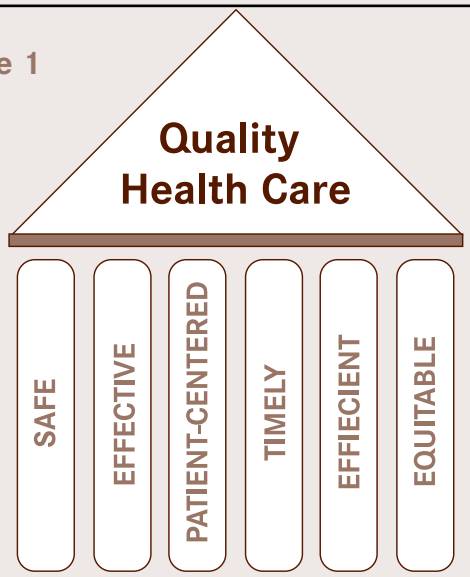
For instance, Table 1 lists several examples of where disparities are found.

Table 1

WHERE DISPARITIES ARE FOUND	EXAMPLES FROM RESEARCH
Utilization of cardiac diagnostic and therapeutic procedures in the Emergency Department	African-Americans being referred less than whites for cardiac catheterization[37] and bypass grafting[16, 38]
Administration of analgesia for pain control	African-Americans and Latinos receiving less pain medication than whites for long bone fractures in the Emergency Department[39] and for cancer pain on the floors[40, 41]
Surgical treatment of lung cancer	African-Americans receiving less curative surgery than whites for non-small cell lung cancer[42]
Referral to renal transplantation	African-Americans with end-stage renal disease being referred less to the transplant list than whites[43]
Treatment of patients hospitalized with pneumonia and congestive heart failure	African-Americans receiving less optimal care than whites when hospitalized for these conditions[44]
Outcomes of myocardial infarction	Elderly African-American women having the highest adjusted in-hospital mortality[45]

Our nation's annual *National Healthcare Disparities Report* released by the Agency for Healthcare Research and Quality further reinforces the persistence of these trends.[46] The examples provided here not only highlight lapses in quality of care, but also have significant clinical consequences and are directly linked to known racial/ethnic disparities in health outcomes. There is little doubt that social determinants – such as lower levels of education, overall lower socioeconomic status, inadequate and unsafe housing, racism, and living in close proximity to environmental hazards – disproportionately impact minority populations, and thus contribute to their poorer health outcomes.[47-53] Similarly, lack of access to care, a particular problem for minority populations, also takes a significant toll, as uninsured individuals are less likely to have a regular source of care,[54, 55] are more likely to report delaying seeking care,[56, 57] and are more likely to report that they have not received needed care.[58] This results in an increasing amount of avoidable hospitalizations, use of emergency hospital care, and ultimately adverse health outcomes for minorities in the US.[59, 60] Yet *Unequal Treatment* clearly stated that racial/ethnic disparities in quality of care contribute to disparities in health outcomes, and stressed the need for leaders of health care organizations nationwide to engage in activities to identify and address them.

Figure 1



Six Principles of Quality Health Care

SAFE Avoiding injuries to patients from the care that is intended to help them

EFFECTIVE Providing services based on scientific knowledge and avoiding underuse and overuse, respectively

PATIENT-CENTERED Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

TIMELY Reducing waits and harmful delays for both those who receive and those who give care.

EFFICIENT Avoiding waste, including waste of equipment, supplies, ideas, and energy.

EQUITABLE **Providing care that does not vary in quality because of personal characteristics such as ethnicity, gender, geographic location and socioeconomic status.**

Why Equity is an Essential Component of Quality

Crossing the Quality Chasm highlights that quality is a system property, and that our current system of health care delivery is in need of redesign. To truly achieve quality of care, health care systems must focus on six key elements – efficiency, effectiveness, safety, timeliness, patient-centeredness, and *equity* (see Figure 1).

Equity is achieved by providing care that does not vary in quality by personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status. Over the last few years, there has been an increased focus by hospital leadership on improving quality by responding to the six key elements proposed by *Crossing the Quality Chasm.* There is no doubt that significant gains have been made in this effort, particularly in the area of patient safety.[61, 62] However, one key pillar of quality – achieving equity – has remained elusive and garnered significantly less attention than the others. This is despite robust evidence that demonstrates the existence – and persistence – of racial and ethnic disparities in health care, and how the inattention to the root causes of these disparities can have a significant impact on quality, cost, and risk management.[63-65]

Despite this, few hospital leaders have the issue of equity, and identifying and addressing disparities, prominently on their radar screen. For example, preliminary results from an organizational assessment survey distributed to approximately 150-200 executives, physicians and hospital management at 10 hospitals across the country found that only 3% of executives agreed or strongly agreed that disparities in health care were a major problem in their hospital; 85% disagreed or strongly disagreed that disparities were a major problem (12% were neutral).[66]

So why might this be the case? Two primary hypotheses emerge:

- First, as reflected in research to date, health care leaders may be reluctant to believe that racial/ethnic disparities exist, and perhaps more importantly, that they do not exist in the institution they are overseeing. This perspective, referred to as the "not me!" phenomenon takes root in health care providers' reluctance to believe that patients might receive a different quality of care based on their race/ethnicity.[67] For example, when doctors were asked in a large survey: "Do you think people are treated unfairly in the health care system based on their race/ethnicity?" approximately 14% said

never, and 55% said rarely. In another Web-based survey of 344 cardiologists, only 12% felt disparities existed in their own hospital setting, and only 5% thought disparities existed in the care of their own patients.[68] This viewpoint, although inaccurate in the face of a breadth of evidence on disparities, is understandable as the concept of unequal treatment runs counter to what health care providers are taught (that they shouldn't treat people differently based on personal characteristics) and is conceptually anathema to them.

- Second, given the multiple competing interests on the leadership agenda, the issue of equity may have yet to bubble to the top. Whether it is an issue of limited resources, an uncertain business case, or lack of rigorous quality measures or accreditation standards, equity remains a lower priority in practice than safety, for example, where some of the aforementioned conditions (e.g. accreditation standards) are more mature.

No matter what the reason, the evidence is clear – equity has yet to take its place among the pillars of quality. However the tide is turning, as there is now a persuasive quality, business and risk management case to be made for identifying and addressing disparities, not to mention impending quality measures[69] and accreditation standards[70] that will move the issue of assuring equity from the "optional" to the "mandatory" column of hospital leaders' to-do list. Our *Improving Quality and Achieving Equity: A Guide for Hospital Leaders* provides leaders with the "case" for addressing disparities, as well as the knowledge and know-how to initiate a portfolio of activities related to improving quality and achieving equity. Ultimately, this guide will assure that hospital leaders can improve quality, achieve equity, and be responsive to the impending levers that will move this issue from the margins to the mainstream.

Chapter 2 – Why should you care?

> ***"I think the three major arguments for addressing disparities are the quality argument, the caring argument, and the financial argument."***
> – William Fulkerson, MD, Chief Executive Officer, Duke University Hospital

Racial and ethnic disparities in health care have an impact on quality, safety, cost, and risk management. Disparities can lead to increased medical errors, prolonged length of stay, avoidable hospitalizations and readmissions, and over and under-utilization of procedures. Addressing disparities is no longer just a moral or ethical imperative – it has now taken on greater importance with significant bottom line implications, and has been acknowledged by Joint Commission and the National Quality Forum as an essential component of quality of care, and as part of community benefit principles. We now present several major "cases" for addressing disparities and achieving equity that are of critical importance to hospital leaders.

The Quality Case: Addressing Disparities, Improving Quality and Achieving Equity

> ***"Health disparities and quality are two sides of the same coin…that's it in a nutshell. If you're going to provide quality care and services, then you need to address health disparities."***
> – Kimberlydawn Wisdom, MD, Vice President of Community Health, Education and Wellness, Henry Ford Health System

Crossing the Quality Chasm states that to achieve *equity,* systems should provide care that does not vary in quality because of personal characteristics such as ethnicity, gender, geographic location, and socioeconomic status. Equity is the only pillar of quality that was seen as 'cross-cutting', meaning that it has implications for safety, effectiveness, patient-centeredness, timeliness, and efficiency. A careful analysis of the pillars of quality provides several important examples of how the inattention to disparities can impede quality of care. The following section provides a summary of these key findings, with efficiency given special attention (see also the five mini-vignettes in Appendix A for practical clinical examples).

Safety

Patients should not be harmed by the care that is intended to help them, and they should remain free from accidental injury, misdiagnosis and inappropriate treatment. Ensuring patient safety also requires that patients be informed and participate as fully as they wish and are able – and that patients and their families should not be excluded from learning about uncertainty, risks, and treatment choices.

> ***"Addressing cultural and linguistic barriers is about saving lives. Any progressive leader can understand that communicating effectively with patients is essential to making healthcare delivery safer. The issue of disparities needs to be embedded in safety policies and procedures."***
> – Pete Delgado, CEO, Los Angeles County and University of Southern California Healthcare Network

Disparities and their Impact on Safety

Communication between patients and health care providers, and the barriers many racial/ethnic minorities face in this regard, has an important impact on patient safety. Communication difficulties may lead to misdiagnosis, inappropriate treatment, and limit the process of truly informed consent. We currently have both direct and circumstantial evidence to support the impact of the root causes of disparities on patient safety. For instance:

- Patients with limited English proficiency (LEP) and racial/ethnic minorities are more likely than their English-speaking white counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.[3-5]
- Communication problems are the most frequent cause of serious adverse events as recorded by the Joint Commission. Effective communication is compromised by language barriers, cultural differences, and low health literacy, all of which are particularly important issues for racial/ethnic minority patients.[4]

- True informed consent is not possible without effective communication, and according to the Institute of Medicine, "an informed patient is a safe patient."[1]

Exploring patient safety issues through the stratification of medical errors by race and ethnicity should yield improvement opportunities that will not only improve quality, but likely provide cost-savings and yield lessons that will help manage risk.

Effectiveness

Patients should receive care that uses evidence-based guidelines to determine whether an intervention (preventive service, diagnostic test, etc.) produces better outcomes. Included in this principle is the integration of research evidence with clinical expertise (skills to identify each patient's unique health state and diagnosis, individual risks and benefits of interventions, and personal values and expectations) and patient values (unique preferences brought by each patient to the clinical encounter and must be integrated into clinical decisions).

Disparities and their Impact on Effectiveness

There have been hundreds of carefully controlled studies showing that even when clinically appropriate, minorities tend to receive fewer key diagnostic and therapeutic procedures than their white counterparts. For instance:

- Racial/ethnic minority and limited-English proficient patients are less likely than others to receive some of the most effective, evidence-based treatments for certain conditions.[2] Racial/ethnic disparities exist in the use of thrombolysis for acute myocardial infarction,[38] curative surgery for early non-small cell lung cancer,[42] renal transplantation for end-stage renal disease,[43] and the management of patients with diabetes,[71-73] congestive heart failure and community acquired pneumonia,[44] among many other examples.[74-76]
- Differences in patient preferences never fully account for the observed racial and ethnic disparities in health care (placement of patients with end-stage renal disease onto the transplantation list is probably the best example in this regard).[2]

Several of the root causes of disparities (e.g. poor communication, stereotyping, mistrust) contribute to this problem and must be attended to if effectiveness is a priority. Stratifying quality measures by race and ethnicity (i.e. the National Hospital Quality Measures), at a minimum, will allow the opportunity to identify disparities that are amenable to intervention, and improve effectiveness overall.

Patient-Centeredness

The key dimensions of patient-centered care include respect for patient's values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support; and involvement of family and friends.

> ***"I think the key 'selling point' is patient-centered services. I don't think that there's a health care executive in the United States that isn't thinking about the concept of patient and family satisfaction. If you want to deliver patient-centered services, you have to think about issues of equity to make those services more patient-centered."***
> – Rohit Bhalla, MD, MPH, Chief Quality Officer, Montefiore Medical Center

Disparities and their Impact on Patient-Centeredness

The key aspects of patient-centered care are indelibly linked to the issues of provider-patient communication, stereotyping, and mistrust, among others that contribute to racial and ethnic disparities in health care. For example:

- Racial and ethnic minorities report more communication difficulties with their doctors, less involvement in clinical decisions, more difficulty understanding instructions on prescription bottles and instructions from their doctor's offices than their white counterparts.[77]
- Racial and ethnic minorities are more likely to feel like they will receive unequal treatment, than their white counterparts.[78]
- Racial and ethnic minorities feel less satisfied with the quality of care they receive than their white counterparts.[77]

Despite this, not only are routine patient satisfaction survey results (i.e. HCAHPS, Press-Ganey) not stratified at hospitals by race and ethnicity, but often are not administered in multiple languages, and do not include questions specific to issues that are connected to racial and ethnic disparities in health care. Stratification of these survey results by race and ethnicity, administering them in multiple languages, and minor improvements in their content would allow for greater sensitivity in identifying issues related to disparities in patient-centeredness.

Timeliness

Patients should not experience harmful delays in receiving necessary services, and waiting times should constantly be reduced. Health systems must develop multiple ways to meet patient needs.

Disparities and their Impact on Timeliness

Several root causes for disparities have been shown to clearly impact timeliness, and the disparities literature provides several examples where lack of timeliness has led to differences in quality. Overall, minority and limited English proficient patients receive less timely care in a variety of scenarios than their white counterparts.[79-81] For example:

- Patients with limited-English proficiency have longer waiting times to see a physician in the emergency department[81] and delays in time to appendectomy and time to definitive breast cancer surgery.[82, 83]
- Minorities have longer door-to-needle time for community acquired pneumonia than their white counterparts; they also have longer door-to-balloon time for acute myocardial infarction.[84]
- African-Americans with end-stage renal disease on hemodialysis are less likely to be on the renal transplantation list than their white counterparts.[43]

Active measurement to assure equity in timeliness is critical to high-quality care for all patients. Systems should be developed to assure that the root causes of disparities do not disproportionately impact the ability of minorities to obtain critical health care services.

The Business Case: Disparities, Efficiency, and the Bottom Line

> ***"Baylor's focus on Health Equity emerged from its interest in improving quality. We have begun to understand that improving health care quality not only makes the hospital experience safer and more patient-centered, but by also focusing on the improvement of health equity we can simultaneously address avoidable causes of hospitalizations and improve health status for people experiencing disparities in health. As we have begun to address health inequity at Baylor, we have identified opportunities to reduce inefficiencies and waste in the systems of care for a number of minority sub-populations within our health care system. Initially, we have focused upon processes of care changes for low income populations who experience the most health disparities within our community, understanding that these actions were both good medicine and good business."***
>
> – James Walton, DO, VP and Chief Health Equity Officer, Baylor Health Care System

Efficiency is certainly one of the pillars of quality that garners special attention given its link to the financial wellbeing of hospitals, particularly in this time of tight budgets and a contracted health care dollar. New efforts and initiatives often have to either be budget-neutral or show a return-on-investment to justify the expenditure. The 'efficiency pillar' states that systems should use resources to get the best value for the money spent. This can be achieved by reducing quality waste and administrative and/or production costs. Some argue that efforts to address racial and ethnic disparities in health care are simply too costly in these challenging financial times–that there is no strong "business case". A large part of this viewpoint centers on the perception that addressing disparities requires significant cost outlays without clear cost savings. However, a more careful review of the evidence highlights how being inattentive to the root causes of disparities adversely impacts efficiency and the hospital bottom line.

Disparities and their Impact on Efficiency and Cost

- ***Medical Errors:***
  Patients with limited-English proficiency have more medical errors, with greater clinical consequences, than their white counterparts.[3, 85, 86] Line infections, falls, bed sores all may be more common with minority patients who may not be able to communicate effectively with their health care providers–whether it be due to limited-English proficiency, mistrust, or a cultural perception that clinicians are authority figures who shouldn't be questioned. These situations undoubtedly have an impact on efficiency and cost, likely leading to complications that require a prolonged length of stay, and tying up beds that could be used for other services. Even greater financial risk now exists with the Centers for Medicare and Medicaid Services non-reimbursable "never-events," many of which can be prevented by an empowered patient who can communicate clearly with their health care providers.[12, 87, 88] Devising systems to address the root causes of disparities, particularly those related to communication (through the implementation of interpreter services, training in cross-cultural communication for health care providers and staff, etc.), should certainly improve safety and provide both immediate and long-term cost savings.

- ***Inappropriate Test Ordering:***
  Communication difficulties (due to language barriers or cultural barriers) can lead health care providers to order expensive tests (such at CT Scans) for conditions that could have been diagnosed through basic history-taking.[6] This is particularly the case in the emergency setting. Interpreter services can assist health care providers in obtaining an accurate history that in turn prevents the knee-jerk ordering of high-priced tests. This can lead to significant cost-savings and reduction of risk of medical errors (i.e. contrast allergy, IV infection). Finally, limited resources, like CT Scans, will not be inappropriately tied-up and instead used more effectively for those patients who really require them. Investing in systems to assure that a history can be taken effectively in patients of diverse cultural and linguistic populations should decrease inappropriate utilization of potentially high-priced diagnostic procedures, and in turn improve safety and efficiency.

- ***Length of Stay:***
  Patients with limited-English proficiency have longer hospital stays than English-speakers for some common medical and surgical conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement) than their white counterparts.[89] There may be many reasons for these findings, but there is no doubt that addressing language and communication barriers can expedite the discharge process and thus decrease length-of-stay and increase efficiency. This issue takes on particular importance for hospitals that run at capacity, as they are often prevented from reliably scheduling high-revenue generating elective surgical procedures, and frequently need to go on emergency room diversion because of bed shortages. Developing strategies for case management (i.e. cross-cultural training, access to interpreter services) that are able to address the cultural and linguistic needs of patients may in turn improve the efficiency of the discharge process and decrease length of stay for these patients.

- ***Readmissions:***
  Minorities are more likely to be readmitted for certain chronic conditions[7-9] – such as congestive heart failure (CHF) – than their white counterparts.[10] This may be due to the fact that when a patient has limited-English proficiency, low literacy, or other communication barriers, they may be more likely to misunderstand discharge instructions. As a result, the risk for readmission may be higher, particularly for chronic conditions (e.g. CHF) in which diet, weight management and adherence to a complex medication regimen is essential. This issue will take on greater financial importance if the Centers for Medicare and Medicaid Services decide to limit or refuse reimbursement for patients with CHF who are readmitted within 30 days of discharge.[11, 12] Given that minorities suffer at greater rates from cardiovascular disease and congestive heart failure, collecting race and ethnicity data to identify patients-at-risk for readmission, and developing targeted discharge planning that addresses cultural and linguistic needs, should be a worthy investment that will improve efficiency and provide cost-savings.

- ***Ambulatory Care Sensitive/Avoidable Admissions:***
  Minorities may be at greater risk for ambulatory care sensitive/avoidable hospitalizations for chronic conditions (hypertension and asthma) than whites.[91] Contributing to this risk is the fact that minorities, even with health insurance, are less likely to have a medical home where these issues can be better managed in the outpatient setting. The issue of medical homes has garnered significant attention recently as a method of improving quality and it may also play a major role in addressing racial and ethnic disparities in health care. Targeted efforts to support systems that facilitate a medical home for all patients within hospital outpatient settings – including the development of strategies to address cultural and linguistic barriers to care – has the potential to improve quality, efficiency, and equity, as well as save costs.

- ***Pay-for-Performance:***
  Pay-for-performance is gaining traction as a method for addressing quality of care. For example, health plans are increasingly including pay-for-performance measures for conditions such as diabetes in their contracting with provider organizations, and public payors are also beginning to move in this direction. Some of these contracts have also started including provisions that look to address racial and ethnic disparities in health care – and it is expected this trend will become more widespread over time.[92] For example, in Massachusetts health care reform linked Medicaid hospital rate increases to various quality measures including the measurement and reduction of racial and ethnic disparities in health care.[93] As these initiatives become more evolved, hospitals will undoubtedly have to develop systems to track patients by race and ethnicity, monitor quality, and develop strategies to address disparities. From a financial standpoint this will be particularly important for conditions where pay-for-performance is taking root, such as diabetes.

> ***"With investing in reducing disparities comes fewer errors and this in turn reduces costs."***
> – Pat Hagan, MHSA Chief Operating Officer and President, Seattle Children's Hospital

In summary, there are several clear examples of how disparities, when left unattended can impact efficiency and cost. The development of initiatives in a variety of areas–as described above–can not only improve efficiency, but provide both financial gain and cost savings in the short and long-term, all the while improving quality.

The Risk Management Case: Addressing Disparities and Limiting Risk

Identifying areas that expose the hospital or its health care providers to liability is critical in managing risk. When such situations are identified, there is an opportunity to engage in a set of activities that can prevent tort and untoward settlements – which can be both costly as well as detrimental from a public relations standpoint. There are multiple liability exposures that arise when providing care to diverse patient populations. They include situations that relate to: [94]

- Patient comprehension of their medical condition, treatment plan, discharge instructions, complications and follow-up.
- Inaccurate and incomplete medical history.
- Ineffective or improper use of medications or serious medication errors.
- Improper preparation for tests and procedures.
- Poor or inadequate informed consent.
- Use of interpreters who are not properly trained, cannot accurately translate medical terms and conditions or are not adequately conversant in the patient's and physician's languages.

Many of these areas also constitute patient safety issues, and therefore take on added importance. For example, a patient's ability to read, understand and act on health information has a direct impact on the physician-patient interaction and patient safety. As it relates to prescriptions, a patient's ability to know if they have received the correct medication, or their ability to follow instructions regarding their medication (including dose, frequency and time), both constitute safety and risk management scenarios. Written communications, in the form of appointment slips (appropriate time, date, location), referral slips (reason for referral, name and location of provider, instructions regarding preparation), intake and discharge instructions, and most commonly, informed consent, are all fair game for liability.

Risk management experts have recently reviewed case law and settlements with an eye towards issues related to patients' race, ethnicity, culture, and language proficiency.[94] Communication issues represent a key component of claims filed

by patients whose culture, ethnicity, religion and/or English language ability differ from that of the physician or other healthcare provider. Hallmarks of poor communication leading to tort have included:

- insufficient explanations
- discounting pain and suffering
- failure to recognize or take into account the patient's cultural, religious, or ethnic beliefs
- the use of language suggesting abandonment

Settlements related to communication problems between the patient/family and provider have centered on lack of, or inadequate informed consent for surgical or invasive procedures as well as inadequate identification of provider and/or provider's professional designation; inadequate understanding of explanation, educational material, follow-up instructions and/or discharge instructions; inadequate information provided regarding adverse events and proposed corrective action; poor or negative rapport; and poor telephone communication.

In sum, identifying root causes for disparities that are centered on race, ethnicity, culture, or language proficiency may provide an opportunity to manage risk. As our patient population becomes increasingly diverse, settlements in the area of disparities will no doubt continue to emerge. Developing mechanisms to identify and address disparities will improve patient safety and minimize risk.

The Accreditation and Regulation Case: New Standards and Measures for Quality and Equity

> ***"Hospitals pay very close attention to Joint Commission and their upcoming requirements, goals, etc. and they really do set the stage and foundation for what hospitals try to become."***
> – California Hospital Quality Leaders: Views on Culturally and Linguistically Appropriate Services (CLAS) & the Potential Role of the Joint Commission: Summary of Key Findings

The previous sections provide a solid and compelling rationale for hospitals and other health care organizations to identify and address disparities in care. Improving quality, addressing efficiency and cost, and managing risk are powerful drivers. However, one of the true signs that the issue of addressing disparities and achieving equity is becoming mainstream is the attention the issue has received from the Joint Commission. The Joint Commission has published two reports based on its project *Hospitals, Language and Culture: A Snapshot of the Nation,* a national, qualitative study exploring how 60 hospitals across the country provide health care to culturally and linguistically diverse patient populations.[95, 96] This project is the first of its kind in the nation, and the fact that it has been taken on by the Joint Commission foreshadows the development of new accreditation standards in this arena. The most recent Joint Commission report, *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations* provides a set of recommendations for hospitals on how to effectively provide culturally and linguistically appropriate services to their patients, and includes items on measuring and addressing racial and ethnic disparities in health care.[96] The Joint Commission is now beginning a project to develop standards based on the findings above, which will be much more rigorous than their current standards for culturally and linguistically appropriate services. These will likely go into effect in 2010, yet hospitals will need to begin planning for these new measures well in advance.

Similarly, the National Quality Forum is working on a series of quality measures with particular attention to the provision of culturally and linguistically appropriate services.[69] These measures are being developed to guide hospitals on systems development in the area of disparities and equity, and will also serve for national benchmarking purposes. The planned release date for these measures is 2009.

Finally, as the issue of community benefit and not-for-profit status takes on greater importance for hospitals across the country, addressing racial and ethnic disparities can become a valuable portfolio of work to meet these regulations.[97] Based on findings from the Senate Finance Committee, hospitals with not-for-profit status are under greater scrutiny by the Internal Revenue Service, Congress and state officials, and will need to demonstrate what they do in return for their tax exemptions.[98] Community based efforts to address the root causes of disparities – such as the use of community health workers, navigators, and coaches – have successfully been reported as community benefit activities.[99]

Chapter 3: A Root Cause Analysis: Why Do Racial and Ethnic Disparities in Care Exist?

> ***"For hospital executives that don't think they have a problem with disparities, if you haven't looked at your data then you don't have any basis for saying that, unless you're in some kind of nirvana."***
> – William Fulkerson, MD, Chief Executive Office, Duke University Hospital.

The existence of racial and ethnic disparities in health care does not imply that a hospital or its providers are intentionally discriminating against certain groups of patients. Disparities are ubiquitous and multifactorial. Just as hospitals now work towards quality improvement and patient safety by emphasizing a culture of systems improvement rather than blaming individuals, we must begin to create the same environment for the issue of disparities. With this in mind, the following section describes what is known about the underlying causes of racial/ethnic disparities and builds a solid foundation for action.

The IOM's *Unequal Treatment* report provides an exhaustive overview of hundreds of studies documenting racial/ethnic disparities in health care across a wide range of services and disciplines, and health care organizations. Most of these studies focused on disparities between black/African-American and/or Hispanic/Latino patients compared to white patients, but new findings continue to emerge revealing disparities in different racial/ethnic populations, patients with limited-English proficiency and other vulnerable groups. Racial/ethnic disparities are due not only to differences in care provided within hospitals, but also as a result of where and from whom minorities receive their care (i.e. specific providers, geographic regions, or hospitals that are lower-performing on certain aspects of quality).[14, 100-102] That being said, it is incumbent on all hospitals to monitor quality by race/ethnicity, and address disparities and equity issues following the recommendations of both *Crossing the Quality Chasm* and *Unequal Treatment.*

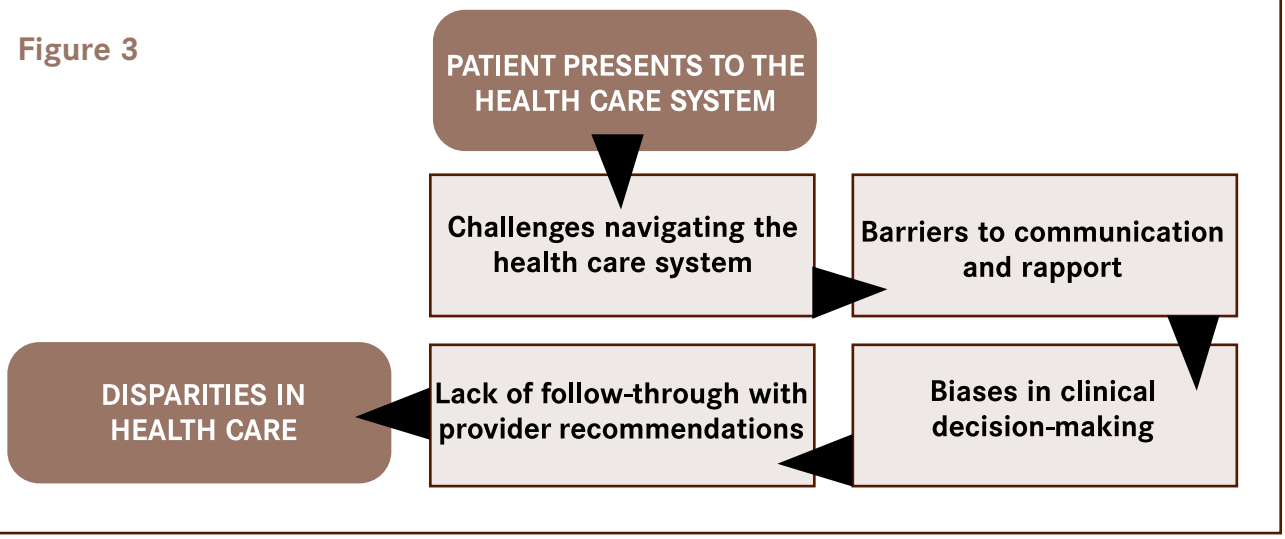
The root causes of disparities in care are complex and multifactorial. *Unequal Treatment* groups them into three basic areas (see figure 2):

Figure 2. IOM Unequal Treatment Classification of Root Causes of Racial/Ethnic Disparities

Health System-Level Factors	Care-Process Variables	Patient-Level Variables
These include issues related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for minority patients or those with limited-English proficiency.	These include issues related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication.	These include patient's mistrust, poor adherence to treatment, and delays in seeking care.

In order to illustrate the many factors that can contribute to racial and ethnic disparities in health care, we have developed a flow diagram (see figure 3) that follows a patient's experience with the health care system. This model is modified from work by Einbinder and Schulman on cardiac care, and cross-links with the three major areas highlighted above in *Unequal Treatment.*[103] Detailed evidence supports how each step of the model can lead to disparities in care. We have adapted and broadened this model to apply to disparities in all types of care, and to emphasize the role that health care leaders can play in eliminating disparities at their own organizations.

Figure 3



Challenges Navigating the Health Care System

Once a patient has recognized the need for medical care and has some form of insurance coverage (both potential sources of disparities outside the health care system), he or she must navigate through a very complex health care system to obtain needed care. Multiple barriers come into play in this first step in our model that may prevent immigrants, patients with limited-English proficiency or low health literacy, and minorities from getting timely, effective care, thus leading to disparities in care.

Patients may:

- Not trust the hospital or its providers.[104]
- Be afraid to seek care due to language barriers and embarrassment or cultural differences.[105-107]
- Not be familiar with the use of primary care services, relying instead on urgent care or emergency services.[104]
- May not understand how to prepare for a procedure, how to access specialty care, or where to go to follow up on an abnormal test result.[108]
- Have as their only accessible source of care hospitals with limited resources that serve a higher proportion of minority patients. These hospitals may have less availability of provider visits, less access to specific health care services, and lower quality of care.[14, 109]

Massachusetts General Hospital identified disparities between Hispanic/Latino patient and white non-Hispanics in colorectal cancer screening rates and diabetes control. Culturally competent coaching and navigator programs were implemented to help patients manage the complexities of their illness and of the health care system, and these have led to decreased disparities in these areas.

For these primarily health system-level factors, hospitals can play a major role in addressing disparities by improving their systems to provide more accessible, high quality care to diverse patient groups. Approaches include making the environment more culturally and linguistically responsive (translated signage, maps and other materials, diverse workforce, etc.), emphasizing "medical homes," educating patients on how to manage the system, and use of patient navigators to help patients with particularly complex conditions or procedures (see Chapter 5 "What Can You Do?").

Barriers to Communication and Rapport

Even once a patient is able to navigate through the health care system to reach the appropriate services, he or she may be more challenged to effectively communicate and build rapport with providers. Good communication and trust between patient and providers are essential to effective delivery of health care services. Several studies show that providers communicate less effectively with minority patients and those with language barriers, and are less likely to build

trusting relationships.[110, 111] For example, a national survey by the Commonwealth Fund showed that Hispanics were twice as likely as whites to report one or more communication problems such as not understanding their doctor, feeling their doctor did not listen to them, or feeling afraid to ask questions (a third of Hispanics and a quarter of African-Americans and Asian-Americans experience these communication problems).[104]

Poor communication and rapport due to language barriers or cultural differences can lead to:

- Dissatisfied, mistrustful patients when providers do not understand their unique perspectives and values.[112-114]
- Patients misunderstanding their illness and treatment plan.[115]
- Clinical uncertainty and misdiagnosis, or over-reliance on objective testing such as CT scans in the emergency department.[2, 6]

Seattle Children's Hospital has developed and integrated a health system-wide state-of-the-art interpreter services program for inpatient and outpatient services after finding higher hospital error rates for LEP patients.

These *care-process variables* are another important area for hospitals to focus on in order to make an impact on disparities in care.

- Improving the cultural competency of health care providers and other staff through ongoing training and feedback can improve their ability to communicate well with patients across cultures, improve rapport, and enhance patient understanding and follow-up.[2, 116]
- In addition, improving the cultural competency of the hospital's care delivery system more broadly, can make patients of all cultural backgrounds feel more satisfied with the care the hospital provides.

Biases in Clinical Decision-Making

Despite the best intentions of clinicians, research has shown that a wide range of non-medical factors may have as much influence on clinical decisions as the actual signs and symptoms of disease.[117, 118] Clinical decisions are influenced by characteristics of the patient (including age, gender, socioeconomic status, race/ethnicity, language proficiency, and insurance status), characteristics of the doctor (including the specialty, level of training, clinical experience, age, gender, and race/ethnicity) and features of the practice setting (including location, organization of practice, form of compensation, performance expectations, and incentives).[37, 103, 119-127] The challenge is that if left unchecked, stereotyping may lead to lower quality of care for certain groups of patients.[2]

- Conscious, or more likely unconscious stereotypes, judgments or preconceptions about patients based on personal characteristics can lead to disparities in care.
- Even when clinicians have the best intentions, unconscious biases may come into play about what a patient is capable of understanding, whether they would want a procedure or treatment, or how much effort it is worth spending to overcome communication barriers.
- For example: studies show that minority patients are:
    - Less likely to receive adequate pain medication in the emergency setting (potentially due to stereotypes that they are drug-seeking).[128]
    - Less likely to be treated with highly active antiretroviral therapy for HIV (due to stereotypes about inability to adhere to therapy).[120]

Duke University Hospital implemented a system-wide mandatory diversity training initiative for managers, providers and staff.

Hospitals can address issues of stereotypes and biases in clinical decision-making in at least two main ways.

- Cultural competence training for health care professionals and other staff can increase awareness of unconscious biases and the impact on clinical decisions.[2, 129] This must be done through a non-judgmental approach.
- Systems can be set up to minimize the impact of biases through enforcement of evidence-based practice guidelines and report cards to providers stratified by race/ethnicity, language, etc.[2, 130, 131]

Lack of Follow-Through with Provider Recommendations

Whether or not a patient will accept and follow through with a provider's recommendations depends on a balance of key factors:

Mistrust

A survey by the Kaiser Family Foundation found that 65% of African-Americans and 58% of Hispanics (compared to 22% of whites) were afraid of being treated unfairly when accessing health care services based on their race/ethnicity.[78] This lack of trust can result in inconsistent care, doctor shopping, self-medicating, and an increased demand for referrals and diagnostic tests by patients.[132]

Cultural beliefs

Sometimes patients have a completely different understanding of their condition or its treatment. For example, some patients are afraid to have surgery for cancer because of fear of spreading the tumor.[133] If these beliefs aren't explored and taken into consideration, patients may be less likely to follow through with recommendations.

Poor understanding of the management plan due to communication barriers

Patients with language barriers who are discharged from the emergency room are less likely to understand their diagnosis, prescribed medications, instructions, and plans for follow-up care.[134] Further, they are less likely to be satisfied with their care or willing to return if they had a problem; more likely to report problems with their care;[135] and less satisfied with the patient-provider relationship.[135]

Once again, both communication and trust are potentially amenable to approaches that aim to increase the cultural competence of health care providers. This should include clinicians at all levels, as well as hospital staff who interact with patients, and can contribute to an environment of acceptance and customer service for diverse patients. Innovative programs such as culturally and linguistically competent navigators, health coaches, and educators, as well as information technology-based interventions, can extend the influence of the medical system to help patients follow through with recommendations, improve health outcomes, and reduce disparities.

Given the multiple causes of disparities, it is clear that there are no simple solutions for addressing them, just as there are no simple solutions for improving health care quality overall. Although the relative contribution of each these factors has not been calculated, the overall model can provide some direction and areas of focus for potential interventions. Strategies to address disparities will require a multidisciplinary, multi-method, step-wise approach and will be discussed further in this guidebook.

A Tale of Two Patients

Just as the Joint Commission uses "patient tracers" to assess whether hospitals are meeting certain standards, we will use two simulated cases to walk through the various steps to obtaining high quality health care. At each step problems may arise, particularly for racial and ethnic minority patients that can lead to disparities. We will focus on two cases – Mr. P and Mrs. L – which exemplify these steps. We have intentionally left out the patient's race/ethnicity, given that these are cross-cutting issues that can affect any patients.

Disparities Simulation Case 1 – Mr. P

Mr. P is a 55 year-old man who has lived in the U.S. for 5 years and speaks just enough English to get by. He is college educated, works as a mechanic, and has insurance through his employer. He has type II diabetes and hypertension, both in poor control. He missed his last appointment with his primary care physician (PCP) and has been without medication since. When he developed a problem with his vision, he waited 6 weeks before going to an urgent care center.

Navigating the Health Care System

Mr. P was afraid to seek care due to language barriers and embarrassment. He was not familiar with how to access his PCP and instead relied on costly urgent care or emergency services.

Mr. P spoke to a nurse practitioner (NP) in English at the urgent care center and described his symptoms as best he could. The NP had a difficult time understanding him and did not have time to call an interpreter. Somewhat frustrated, he gave Mr. P a referral to an ophthalmologist and told him to follow up with his PCP. Two weeks later Mr. P presented to the Emergency Department with weakness of his right leg from a carotid territory stroke. In the hospital his PCP was able to get his diabetes and hypertension in fair control. However, their communication was limited due to the language barrier, and it wasn't clear how much he understood about the importance of tight control.

Communication and Rapport

- Mr. P was upset and embarrassed and was reluctant to return to see his PCP until after he already had suffered a stroke, a potentially avoidable medical error and liability issue.
- Mr. P didn't have an opportunity to learn about diabetes and hypertension management in a way he could understand. This may lead to poor adherence to medications, diet, etc. and poor quality care.

Mr. P's PCP did not believe that he was likely to adhere to the regimen. In her view, Mr. P didn't really understand the importance of managing his diabetes and hypertension, and she in turn didn't understand his motivations. She opted against starting him on insulin because she felt that he would not be able to manage the complexity of insulin administration and he wouldn't want it anyway. She maximized his oral medications and did not refer him to an endocrinologist.

Clinical Decision-Making

- Mr. P's doctor assumed many things about him that were unfounded. Had she been able to communicate with him better she may have understood that he is intelligent, well educated, and motivated to improve his health. He had no major concerns about taking insulin.

Mr. P did not fully trust his PCP, and also had difficulty affording co-payments for brand-name medications. When he began to develop some dizziness from the medications he called his PCP's office to report this and was told he should go to the emergency department given his stroke history. Fearing another hospitalization, he instead stopped taking the medication and missed his follow-up appointment.

Follow-Through with Provider Recommendations

- Mr. P never developed much rapport or trust with his PCP and did not feel comfortable with her recommendations.
- Mr. P didn't really understand the management plan due to his limited-English proficiency and thus he didn't follow through as he was supposed to.

Disparities Simulation Case 2 – Mrs. L

Mrs. L is a 53 year-old female with a past medical history of mild asthma and iron deficiency anemia who saw her doctor recently for some chest discomfort – or "atypical chest pain". She was thought to have gastroesophageal reflux (GERD), and was given a prescription for an antacid medication. Four weeks later her symptoms have worsened. She is scheduled for an upper endoscopy and is sent information on the procedure. However, she doesn't fully understand the printed materials as they are written in complicated language. When she shows up to get it done, she is sent home and told to reschedule because she ate breakfast. She gets the procedure done at a later date, and it is normal. Two days later she presents to the emergency room with a small myocardial infarction.

Navigating the Health Care System

- Mrs. L has trouble reading in general but especially the complicated language used to described health related concepts such as preparing for an upper endocscopy (low health literacy). This led to a delay in her receiving the endoscopy.

Clinical Decision-Making

- Patients from different cultural backgrounds may present their symptoms differently than what is described in medical textbooks, which generally base their descriptions of symptoms on white male patients. There is also a tendency to under-appreciate the risk of coronary artery disease in women. Understanding this may have heightened the physician's suspicion of coronary artery disease and led to a more timely work-up of her heart rather than her upper GI tract.

Mrs. L is admitted to the hospital and told she needs to have a cardiac catheterization. She says she wants to discuss this with her sister tomorrow when she arrives from out of town, but is told that the situation is urgent and she needs to decide. She has trouble understanding why this is the case, and feels particularly mistrustful of the hospital physician. The next day she speaks to her sister and agrees to get the procedure, but unfortunately she has missed her turn and ends up waiting two more days. On the night prior to the procedure she is found to be too anemic to undergo the catheterization (she has underlying anemia and had a significant amount of blood drawn) and she is told she needs a blood transfusion. When the doctor tries to get informed consent, he finds out she is a Jehovah's Witness and cannot accept blood products. She is treated with a red blood cell stimulation medication, blood draws are minimized, and she gets the catheterization five days later.

Communication and Rapport

- Like Mr. P, Mrs. L never developed much rapport or trust with the physician caring for her, though in this case there were no language barriers. She perceived a lack of respect for her concerns, which contributed further to this mistrust.
- Better communication with Mrs. L could have opened up a discussion about her religious restrictions on blood products. This may have improved her care and shortened her hospital stay.

Chapter 4 – What's being done out there?

In-Depth Case Studies

Several hospitals across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity. We had the opportunity to interview leaders from ten organizations across the country who were identified by their peers as having activities in this area. Interviews with leadership highlighted their perspectives and viewpoints on the issue of disparities, including why they think it is important to identify and address them, and what key pearls they would share with their peers in this regard. Of those ten organizations, we conducted site visits at three hospitals (Baylor Health Care System, Seattle Children's Hospital and Duke University Hospital) to develop in-depth case studies. Information gathered during the interviews and site visits helped shape and inform this Guide. Below are the three case studies that provide in-depth information about addressing disparities from three different organizational perspectives. In addition, we've included a table of all ten hospitals that provides a brief overview of these organizations, highlights what they are doing, the challenges and successes they have experienced, and the key ingredients for their progress to date. This diverse group of hospitals has made great strides towards addressing the issue of racial and ethnic disparities.

Baylor Health Care System Case Study

The Baylor Health Care System has a long history of improving the health of underserved communities, but it was in 2001, after the release of the Institute of Medicine's report, *Crossing the Quality Chasm,* that the institution began massive organizational transformation to improve quality of care and address health care disparities. Their service mission dates back to 1903, when the founder of Baylor, Baptist minister George W. Truett stated, "It is out and out time to begin erection of a great humanitarian institution, one in which men of all creeds and those of none may come with equal confidence." This philosophy has permeated Baylor's sense of institutional responsibility to provide equitable care to all who enter their doors – regardless of their background – and has been the foundation of a commitment to community health and improving the health of the people they serve.

Baylor Health Care System is a non-profit health care system. Baylor University Medical Center at Dallas serves as Baylor Health Care System's flagship hospital. The medical center is recognized as a major center for patient care, teaching and medical research throughout the Southwest. The Health Care System provides full-range, inpatient, outpatient, rehabilitation and emergency medical services through 15 owned, leased or affiliated hospitals and surgical services at six short-stay hospitals. Each year Baylor Health Care System medical centers provide community education, health screenings, and community health improvement and wellness initiatives to people throughout North Texas. For fiscal year 2007, Baylor will report $390 million in community benefit to the Texas Department of State Health Services.

The Catalyst

The release of the Institute of Medicine Report "Crossing the Quality Chasm" served as the impetus for Baylor to refocus its efforts on improving quality of care. Hospital leadership viewed this as an opportunity for "clinical transformation", which undoubtedly also required a cultural transformation. The six pillars of quality as delineated by the Chasm Report (trademarked as STEEEP by Baylor–Safe, Timely, Effective, Efficient, Equitable, and Patient-centered) presented the institution with a more formal framework to address equity in its delivery of services. The leadership began to develop efforts along each particular pillar of quality, and Dr. Jim Walton emerged as natural champion for the pillar of equity given his longstanding commitment to the underserved. Dr. Walton had become a fixture in the community as a physician dedicated to the care of those with limited access or ability to seek care in formal settings – particularly in the design and oversight of a home visiting program.

Tipping Point

As Baylor began to explore the ways in which it could both identify and address issues related to equity, two factors came together to create a natural tipping point for action and leadership in this area.

1. Chief Health Equity Officer and The Office of Health Equity

To both solidify its efforts in equity, as well as create a formal organizational home for this work, Baylor named Dr. Walton their Chief Health Equity Officer, a Vice-President level position. Along with this new appointment came the directorship of a new Office of Health Equity in 2006. This office was charged to:

- Identify opportunities where Baylor could improve in the area of equity.
- Reduce variations due to sociodemographic characteristics that may be seen in the areas of health access, health care delivery, and health outcomes. These were termed the "equity dimensions" and together formed the equity triangle.

It is important to note that the Office of Health Equity did not only focus on racial and ethnic disparities, but instead looked much more broadly at issues including disparities by payor status, socioeconomic status, and gender, among others – thus following the true definition of equity as defined in the *Chasm* report.

2. The South Dallas Initiative

Efforts to develop a health initiative in South Dallas received a major boost when a Board member, who grew up in the medically underserved area of South Dallas, helped secure $15 million to target diabetes in this predominately African-American community. Although in the planning phase, these funds will allow for a major partnership between Baylor and the city of Dallas to develop a health care center with primary care services to this underserved community.

The creation of the of Chief Health Equity Officer position and Office of Health Equity, combined with a major financial commitment to develop a significant equity initiative in the community, formed a tipping point which allowed equity to solidify its already present roots at Baylor.

Mitigating Factors and Barriers

Baylor has faced several barriers in its newly energized journey towards equity, ranging from the practical to the political.

- *Achieving Broad Acceptance:* As is the case in many institutions, although the Board and leadership are strong supporters of this effort, a critical task that remains is achieving buy-in among other leaders within the organization. This is an ongoing struggle that is strategically managed with the intent of developing supporters for this effort. Baylor has handled this by being proactive in engaging a diverse set of leaders, keeping them abreast of progress (without any surprises), and continuing to make the business case for equity.
- *Appropriate Messaging:* The measurement of equity always poses the risk of publicly disclosing areas of deficiency in the care provided by an institution. As such, this needs to be managed so as to not undercut support–both internal, as well as in the community.
- *Defining a Disparity:* A debate has emerged about what constitutes a disparity. Is it a 5% or 10% variation between groups? More? Less? This remains a challenge for measurement and reporting. Baylor continues to try to sort this out.
- *Identifying the Right Measures:* In addition to the stratification of existing measures, are there additional measures which can be sensitive markers of equity? As the portfolio of measurement expands, this question remains a barrier to progress and is currently being debated internally.

Sustaining Elements

The Office of Health Equity began by focusing on two areas: (1) measurement along the equity dimension of access and (2) health equity reporting. In terms of measurement along the equity dimension, the goal was to identify opportunities to improve access to preventive and primary care services in the community, particularly for underserved patients within their catchment area–among which racial/ethnic minorities were over-represented. Beyond the moral imperative of this initiative, the significant business case began to emerge for decreasing unnecessary emergency room visits, avoidable hospitalizations, cost, and utilization by patients with multiple chronic conditions who may be either under- or uninsured. Several important initiatives were developed such as:

- Increasing the number of primary care providers in community and alternative settings (including faith-based settings),
- Community care coordination (through the use of teams of doctors, nurses, social workers, and community health workers),
- Developing medical homes, and
- Continuing home visits to patients who are either disabled or who have chronic conditions and most heavily utilize health services. Initial analyses and financial models have shown this to be a cost-effective approach–and one that both improves equity and efficiency.

Next, the Office focused its sights on equity in health care delivery. The central target here was health equity reporting, which included stratification of the National Hospital Quality Measures, ambulatory care measures (i.e. mammography screening), and other care process measures by various sociodemographic characteristics. The first among these targets was surgical infection prophylaxis. Initial analyses showed variations in surgical infection prevention measures, particularly by payor status where statistically significant differences were identified between commercially-insured and self-pay (i.e. uninsured) patients. The Office of Health Equity worked with high and low-performing hospital facilities within BHCS to identify root causes of the observed differences and best practices that could be implemented to improve equity in SIP performance across the system. Again, in addition to the importance of this measure in terms of quality of care, there was also a business case for improvement. Efforts to standardize surgical infection prophylaxis and assure equity would in turn prevent unnecessary readmission or prolonged length of stay due to preventable, post-surgical infections. Plans exist to expand the set of equity measures Baylor will be routinely reviewing as part of its standard quality monitoring and reporting portfolio. Particular interest is emerging in the area of chronic disease, especially congestive heart failure, given the impending changes regarding payment for readmissions within 30 days of discharge currently being discussed at the Centers for Medicare and Medicaid Services.

Efforts are just beginning on the equity dimension of health outcomes–to assure that there are not variations by sociodemographic characteristics. The aforementioned successes in access and service delivery have served to sustain Baylor's efforts in equity, as well as convert skeptics among those who doubted the importance and financial viability of this work. Measurement and intervention have been the focal points of their approach to date.

Successes

Board support, leadership support, and the emergence of a champion have all contributed to the successes of Baylor to date. The view that high quality, equitable care is not only good medicine but good business further fortifies these efforts. Whereas measurement has been the foundation for this work, this phase hasn't been prolonged and interventions have been quick to follow. Equity, and disparities, have been defined broadly to not only include race/ethnicity as variables, but also socioeconomic status and payor status, to name a few. For Baylor's catchment area, minorities are over-represented among the underserved, so efforts that focus on class disparities have essentially encompassed racial/ethnic disparities as well.

To date, successes in the access dimension have included:

- *Community Health Services Corps:* Doctors and nurses staff charitable clinics in the community focusing on the uninsured and underserved. The overarching goal of this program is to increase access to primary care and in turn decrease reliance on hospital care. To date, research has shown that emergency department use among individuals who use these services (compared to a control group) have similar Emergency Department use, but the average cost of the visit is significantly less; in addition, their hospital admission rate is significantly lower and the average length of stay is almost a day less.
- *Project Access Dallas:* This project encourages private physicians to accept 4 to 5 indigent patients into their patient panel, and is accompanied by specialist access and pharmacy benefits. Analyses of this program at participating hospitals throughout Dallas County have consistently shown decreases in emergency department visits, inpatient admissions, and related hospital costs when comparing patient utilization one year pre- and one year post-enrollment in Project Access Dallas.
- *Community Care Coordination:* Several programs focused on linking patients with services that might include those related to housing, transportation, health education.

The Vulnerable Patient Network Program focuses on patients with congestive heart failure who are frequent emergency department users and provides home visits to patients who have had neurological trauma. Research has shown a decrease in emergency department visits per patient, a decrease in average admission per patient, and a slight increase in average out-patient visits per patient.

On the health care services dimension:

- Development of the BHCS Health Equity Performance Analysis: As described above Baylor's Office of Health Equity successfully developed a methodology for stratifying quality performance indicators by patients' demographic characteristics in order to identify and track the presence of significant differences between patient groups. While the quantitative definition of "disparity" continues to be a topic of debate, the Health Equity Performance Analysis methodology has gained system-wide acceptance and serves as the primary tool for direction of Baylor's equity improvement efforts.

Seattle Children's Hospital Case Study

In 2004, Seattle Children's Hospital recognized the importance of addressing health care disparities within their institution. Faced with a rapidly changing demographic patient population, they were challenged in new ways to meet their organizational mission to "... prevent, treat, and eliminate pediatric disease ...". Seattle Children's journey to address health care disparities and improve the quality of care of all their patients led them down the "road" of patient safety. Their decision to frame addressing health care disparities as a safety issue for their patient population became the key driver of this organizational transformation.

Consistently ranked as one of the best children's hospitals in the country by *U.S. News & World Report,* Seattle Children's serves as the pediatric and adolescent academic medical referral center for the largest landmass of any children's hospital in the country (Washington, Alaska, Montana and Idaho). For more than 100 years, Seattle Children's has been delivering superior patient care and advancing new treatments through pediatric research. Seattle Children's is a 250-bed hospital and serves as the primary teaching, clinical and research site for the Department of Pediatrics at the University of Washington School of Medicine. Beginning in 2005, the hospital increased the rigor in which it collected data on race/ethnicity and language spoken. These efforts demonstrated the rich diversity of the patients and families served and disparities among them. It was this recognition that mobilized a group of internal champions to push initiatives that address the elimination of disparities.

The Catalyst

The initial push for the hospital to address the changing patient population was spearheaded by a Diversity Committee that was led by Pat Hagan, the Chief Operating Officer, and Susan Heath, the Nurse Executive. In these early years, the justification for the need of the Diversity Committee was primarily based on the moral imperative of addressing the needs of diverse communities. The initial work of the committee was focused on gathering data from minority patients about their perceptions of the hospital with the goal of exploring whether the data on perceptions could have some impact/effect on the way that care was being provided. Hospital leadership was also particularly interested in the hospital perception by the growing immigrant population.

Tipping Point

There were two critical events that helped to advance the disparities agenda for Seattle Children's Hospital:

- The early work of the Diversity Committee ultimately led to the formulation and adoption of a Diversity Strategic Plan by the Hospital Board of Trustees.
- The quest of the hospital leadership to better understand the perceptions of minority patients of the hospital led to the creation of a more rigorous quantitative study to address the research question of, "Does having a limited English proficiency impact the rate of errors observed in the hospital?" Led by their pediatric research fellow, Adam Cohen, the study focused on families with LEP and compared them to families that did not have LEP. The study found that for all participants, except for Spanish speakers, error rates were the same. There was, however, a clear disparity in error rates between those that spoke only Spanish and those that did not. This study was the key driver to begin the organizational shift to make health care disparities a patient safety focus, and equity integral to effective clinical care.

Mitigating Factors and Barriers

Systems typically are resistant to change and Seattle Children's faced several challenges in trying to advance the disparities agenda. There were several factors that played a critical role in making the case to address disparities and advancing the importance of improving quality of care as a patient safety issue. The key factors were:

- *Achieving Broad Acceptance:* There was a degree of cynicism from hospital staff (clinical and non-clinical) about the commitment of leadership to address issues of diversity and disparities. Many hospital employees saw these efforts as just the "flavor of the day".

- *Appropriate Messaging:* By making the link between patient safety and health disparities - driven by data - it made the issue of disparities apparent and its impact on patient safety very real.
- *Leadership:* There were key individuals to drive issues (champions): Pat Hagan, Susan Heath, Ben Danielson, Deb Gumbardo, Beth Ebel, and Sarah Rafton. However, once the hospital leadership committed to fully addressing health disparities, the challenge was finding the suitable individual(s) to formally lead this work. It took over 1.5 years for hospital leadership to fill a key diversity leadership position to drive this work.
- *Commitment:* A solid commitment from the Board of Directors (BOD): The BOD has become data driven, particularly the Board Chair.
- *Diversity:* There was an ongoing push to increase the diversity of clinical staff as a way to continue to build momentum for their disparity efforts, however, the institution has had difficulty attracting diverse residents, fellows and faculty staff to the hospital.
- *Research:* Although their research clearly delineated the association of language barriers and error rates for specific patient population, there still needed to be further exploration of root causes why other disparities existed. Many other unanswered questions existed about other population's perceptions of the hospital.

Sustaining Elements

For organizational change to be institutionalized the change needs to be sustainable. For Seattle Children's Hospital, there are three critical elements that continue to drive this work:

- Leadership - Key leadership roles are now major advocates:
    - Hospital President and COO, Pat Hagan is a big supporter
    - CMO - David Fisher, was recruited because of his passion and interest in this area
- Institutionalization of the work - Hospital leadership created a "Center for Diversity and Health Equity" and committed staff and financial resources
- Health Services Redesign:
    - Improved structure and delivery for interpreter services, and protocols instituted
- Strong and committed decision support department (Knowledge Management Dept) with direct access to an analyst with public health training /background (with a population health focus)

Successes

Board support, leadership support, and the emergence of a champion have all contributed to the successes of Seattle Children's Hospital. The driving force for change to address health care disparities in their health system was the universal understanding that high quality, equitable care is critical for patient safety.

To date, successes have included:

- Diversity Committee ultimately led to the formulation and adoption of a Diversity Strategic Plan by the Hospital Board of Trustees.
- Creation of the "Center for Diversity and Health Equity" and recently appointed Douglass L. Jackson as Chief of the Center for Diversity and Health Equity. Prior to joining Children's, Jackson was the Associate Dean of the Office of Educational Partnerships and Diversity at the University of Washington (UW) School of Dentistry. Jackson is also director of the Robert Wood Johnson Foundation funded grant "Pipeline Profession and Practice," and is co-director of the Robert Wood Johnson Foundation funded grant "Summer Medical/Dental Education Program" in partnership with the UW School of Medicine.
- State-of-the-art translational services that have been fully integrated into inpatient as well as outpatient care for the health care system.

Duke University Hospital Case Study

In 2003, Duke University Health System embarked on a process of organizational transformation to address the issue of diversity and disparities based on the critical business case that equitable quality of care improved the financial viability of their institutions. As the only major source of inpatient care and the majority of outpatient care in the county, Duke University Health System, which includes a large, previously public community hospital, Durham Regional Hospital, provides healthcare for a large minority population. Providing equal access and health care by identifying and eliminating disparity in treatment and outcomes for this population became a priority for the leadership from an ethical perspective as well as a business perspective.

Duke University Hospital (DUH) is a 946-bed not-for-profit hospital and the flagship hospital for the Duke University Health System, an academic medical center serving Durham, North Carolina. DUH is one of the primary providers of care for Durham County where almost half of the residents are either African American (40%) or Latino (8%).

The Catalyst

"***We are the only emergency rooms in town. So, patients that are underserved that wind up in emergency rooms with threatening illnesses are our responsibility ... If we're not out there, identifying and treating hypertension in the uninsured Latino patient, we're going to be taking care of him after he has a stroke***"

– William Fulkerson, MD, CEO of Duke University Hospital and Vice President for acute care division of Duke University Health System

In 2003, it was determined that racially and culturally based rifts between some staff members were compromising productivity and increasing turnover. DUH embarked on a process of organizational transformation, prompting a system-wide diversity training initiative, including self assessment, cultural competency training, and eventually, disparities initiatives. Addressing issues of diversity and culturally competent care delivery also played a significant role in Duke's success in achieving Magnet status by the American Nurses Credentialing Center.

Tipping Point

In 2003, William Fulkerson asked Kerry Watson to take the lead on strengthening the diversity initiative at Duke Health System.

In October, 2005, Duke received funding from the Robert Wood Johnson Foundation to participate as one of 10 centers around the country in the *Expecting Success: Excellence in Cardiac Care* program to address racial/ethnic disparities in the management of cardiovascular disease. *Expecting Success* helped Duke develop a platform internally for identifying, understanding and addressing disparities. This initiative extended Duke's ongoing diversity and cultural competency efforts into directly measuring and addressing racial/ethnic disparities in care. For DUH that meant improving the collecting and tracking of patient data by race, ethnicity and spoken language, and using accurate patient demographic data to identify possible areas of disparities in care.

Mitigating Factors and Barriers

Achieving Broad Acceptance - Achieving buy-in from physicians was critically important to developing an organizational-wide transformation process. Feedback from a group of physician leaders indicated the need for published research data to make the case.

"From my perspective, … the biggest challenge is to get this in front of our physicians and to get them interested and engaged, not only in the health system's diversity issues, but also into the disparity issues."

– William Fulkerson, MD, CEO of Duke University Hospital and Vice President for acute care division of Duke University Health System

Sustaining Elements

Early on Duke brought together a diverse group of leaders from different parts of the health care team to brainstorm and develop strategies for addressing diversity, cultural competency and disparities. This group has provided ongoing direction and has helped to sustain the effort.

Leadership

William Fulkerson, MD, MBA, is the CEO and the executive sponsor of Duke's participation in the *Expecting Success* program. In 2003, William Fulkerson asked Kerry Watson to lead the diversity initiative at Duke Health System.

Eric Velazquez, MD, is a cardiologist and Program Director of Duke's *Expecting Success* program. He has led the charge for Duke to systematically collect patient-reported race/ethnicity data and use this to stratify quality measures for cardiovascular disease and identify disparities in readmission rates for African Americans and Latinos. Presenting real data on disparities has helped to achieve buy-in for cultural competency initiatives among physicians.

Kerry Watson is the CEO of Durham Regional Hospital and was previously the Senior Associate Operating Officer for Duke Hospital. He has led the effort to implement diversity training for managers, including a mandatory eight hour module for all leadership and a four hour module for all staff.

Successes

By developing and monitoring balanced score cards for Duke Heart Center's Center for Excellence and DUH, they were able to identify that African Americans and Latinos were more likely to be readmitted after treatment and discharge for heart failure. DUH developed several strategies to ensure proper discharge process, including:

- Improving technology to schedule follow-up appointments.
- Implementing culturally sensitive patient education materials.
- Evaluating heart failure patients for appropriateness for patient disease management.
- Ensure discharge medications are appropriately available at locations where patients access their pharmacy.
- Improving patients' access to follow-up cardiac care by providing advanced consultative services in the community.

ORGANIZATION	WHO THEY ARE	HOW ARE THEY ADDRESSING DISPARITIES?	CHALLENGES	SUCCESSES	KEY INGREDIENTS
1. Baylor Health Care System Dallas, TX	A non-profit, faith-based health care system providing health care, educational, research, and community services throughout North Texas	Stratify data by race/ethnicity, payer proxy, and gender Create the Office of Health Equity to address disparities in health access, health care delivery, and health outcomes Business case: address disparities by identifying inefficiencies and waste	Embed disparity issues in the quality and patient-centered frameworks Ensure accurate data collection Measure and report data: identify disparities within the data and develop appropriate quality improvement programs	Within Office of Health Equity improved access (charitable clinics, link high risk patients to community health worker), delivery (reporting and monitoring disparities), and outcomes (diabetes coaching program) Restructure registration system for collecting patient information	Following the IOM's *Crossing the Quality Chasm,* a system-wide cultural transformation to adopt the six pillars Getting senior level buy-in and proactive leadership that understands how inequity impacts overall quality Develop the business case to address disparities
2. Contra Costa Health Services Martinez, CA	A comprehensive and integrated county health system that provides health care services, community improvement, and environmental protection	Developing a system-wide goal to reduce health disparities via the Reducing Health Disparities (RHD) Framework: Key components include: enhancement and development of organizational supports, linguistic access, staff education and development, and community engagement and partnerships	Creating change across the entire organization to address disparities Establishing understanding of RHD framework, and how core principles are critical to providing culturally and linguistically appropriate services Influencing key CCHS decision makers to integrate RHD principles into their existing efforts Providing resources to assist in RHD efforts Establishing benchmarks to measure the success of RHD efforts	Creating the Reducing Health Disparities 5-year plan Creating the Reducing Health Disparities Unit Partnering in a multi-county live Health Care Interpreter Network Equipping Contra Costa Regional Medical Center and 8 Health Centers with interpretation equipment & training for staff Launch of training for all CCHS managers and supervisors to promote Service Excellence standards Creation and distribution of Community Health Indicators highlighting population health and disparities Promulgation of formal policies for Linguistic Access, Service Excellence and Reducing Health Disparities Monthly highlights of RHD efforts in employee newsletter	Identifying key senior-level champions Marrying RHD efforts with division interests/needs Committing resources Identifying disparities through accurate data Developing RHD measures of success and benchmarks Developing organizational supports for data collection, linguistic access, end user and staff feedback mechanisms End user engagement Developing local partnerships Implementing cultural competency and communication training for staff Developing a shared vocabulary and understanding

ORGANIZATION	WHO THEY ARE	HOW ARE THEY ADDRESSING DISPARITIES?	CHALLENGES	SUCCESSES	
3. Cooper Green Mercy Hospital Birmingham, AL	Only county hospital in metro area providing inpatient and outpatient services, without regard for a patient's ability to pay	Diversifying leadership Developing and implementing community-based disparities initiatives (e.g. African-American Health Initiative) Implementing programs to train their own community health workers Monitor outcomes through their IT systems	Addressing and embedding disparities in a quality framework Addressing disparities in communities where there are no primary care providers Securing funding for interpreter services Addressing social factors that influence health (e.g. transportation, education)	Development of partnerships: Interpreter services via collaboration with university and a mechanism to train community health workers via Minority Health Program at University of Alabama (UAB) Developing IT system to measure and report disparities Having specialty care facilities in communities lacking services Creation of Wellness Centers (online health and prevention resources for patients)	Developing partnerships with UAB, other hospitals, and local faith-based groups Educating leadership about patients' diverse backgrounds and experiences Identifying key senior-level champion Getting staff buy-in Explanation of business case to leadership and staff (e.g. makes daily jobs of staff easier)
4. Duke University Health System Durham, North Carolina	An academic health care system comprising of three main hospitals including the Duke University Medical Center, and several primary and specialty care clinics throughout North Carolina	Participating as one of the hospitals in RWJF's Expecting Success: Excellence in Cardiac Care Program Stratifying performance scorecards by race and ethnicity Implementing extensive organization-wide training on culturally competent care delivery and workplace diversity	Getting physician buy-in Collecting of reliable and accurate patient information Addressing disparities in a large complex comprehensive healthcare delivery system with multiple locations	Re-structuring registration system for collecting patient information: shift to patient self-identification Comprehensive education and training program for all staff addressing workplace diversity and conflict Interactive Grand Rounds professional development /cultural competence care delivery for clinical staff and faculty	Identifying senior- and clinician-level champions Identifying disparities through strong and accurate data Integrate disparities efforts with existing performance improvement infrastructure

ORGANIZATION	WHO THEY ARE	HOW ARE THEY ADDRESSING DISPARITIES?	CHALLENGES	SUCCESSES	KEY INGREDIENTS
5. Henry Ford Health System Detroit, MI	Nonprofit integrated health system which includes six hospitals, medical centers, health plan, community services, and community partnerships	Developing and implementing wellness efforts in minority communities Support from senior leadership to do research that identifies disparities and gaps in care	Integrating disparity efforts into the entire system Proving to leadership that disparities exist	Establishing the Institute on Multicultural Health: focus on clinical guidance and community outreach Establishing the Health Disparities Research Collaborative to identify opportunities for research and collaboration	Getting key senior-level buy-in and champions Having a critical mass of influential investigators interested in disparities Identifying disparities through strong and accurate data Developing partnerships with other organizations
6. Los Angeles County and U of Southern California Healthcare Network Los Angeles, CA	Partnered with the Keck School of Medicine of USC One of the largest teaching and acute care hospitals in the country servicing central Los Angeles County	Focusing on improving communication with emphasis on cultural and linguistic issues Collecting data on race and ethnicity, country of origin, and language Training bilingual staff and develop collaborations	Embedding disparities issues in the quality and patient safety frameworks Securing leadership buy-in Educating leadership about patients' diverse backgrounds and experiences Demonstrating that disparities issues are addressable and solvable	Developing and implementing rigorous data collection methods	Identifying disparities through rigorous data collection methods Getting senior-level buy-in Developing Collaborations

ORGANIZATION	WHO THEY ARE	HOW ARE THEY ADDRESSING DISPARITIES?	CHALLENGES	SUCCESSES	KEY INGREDIENTS
7. Massachusetts General Hospital Boston, MA	A private, non-profit, academic health center providing health care, education, research, and community services throughout the greater Boston area	Collecting patient race/ethnicity data Stratifying quality measures by race/ethnicity Monitoring for disparities through routine release of a Disparities Dashboard for hospital leadership Developing interventions to address disparities in diabetes management and colon cancer screening Creating several efforts to raise awareness and educate hospital faculty and staff about disparities	Developing additional measures to identify disparities Better monitoring of patient experience by race/ethnicity	Developing Disparities Committee Developing Disparities Dashboard Reporting equity measures publicly available on web Developing and implementing Chelsea Diabetes Management Program Developing and implementing Colorectal Cancer Screening Navigator Program	Following the IOM's *Crossing the Quality Chasm* Having senior level buy-in and proactive leadership that understands how disparities impacts overall quality Using an action-oriented approach Seeding money for interventions Identifying and having champions, expertise, and cross-institutional support
8. Montefiore Medical Center Bronx, NY	An integrated healthcare delivery system of hospitals, primary care sites, home health, post-acute, and community programs throughout the Bronx The university hospital for the Albert Einstein College of Medicine	Participating as one of the hospitals in RWJF's Expecting Success: Excellence in Cardiac Care Program Implementing standardized training and IT mechanisms for collecting patient demographics Developing and implementing community-based programs in an ethnically and culturally diverse community Focusing on conditions prevalent in the community, such as diabetes and cardiovascular disease	Extending and integrating quality improvement efforts into post-acute and community settings	Implementing extensive changes to registration systems to collect patient race, ethnicity, and language information Improving cardiovascular care Physician leadership and engagement Interdisciplinary teamwork	Senior Executive stewardship Collecting input from "front-line" staff at an early stage Involving a broad number of disciplines in the implementation design process Embedding a cognizance of disparities into quality and service improvement efforts

ORGANIZATION	WHO THEY ARE	HOW ARE THEY ADDRESSING DISPARITIES?	CHALLENGES	SUCCESSES	KEY INGREDIENTS
9. Seattle Children's Hospital Seattle, WA	A leading children's academic hospital that offers advanced in-patient, surgical, emergency, and, specialty care and child advocacy programs	Evaluate hospital goals, family satisfaction, and clinical outcomes by race/ethnicity and language Creation of The Center for Diversity and Health Equity Creation of Patient and Family Relations Program Participant in RWJF's Speaking Together: National Language Services Network	Getting physician- and staff-level buy-in: shifting provider behavior to engage in active communication with patients and family Identify key leaders in disparities to spearhead efforts at the hospital Diversify leadership, faculty, and staff	Center for Diversity and Health Equity has increased diversity, improved linguistic services, and mandated cultural competency training Extensive interpreter services Strategic Plan for Diversity approved by board and institutionalized a long-term commitment to diversity	Getting buy-in from key leadership champions Having the commitment from the Board of Directors Institutionalized Initiatives Identifying disparities through rigorous data collection methods Developing partnerships between data analysts and clinical champions
10. University of Mississippi Medical Center Jackson, MS	As the health sciences campus of the University of Mississippi, the Medical Center focuses on teaching, research, service, and leadership in the health sciences	Participating as one of the hospitals in RWJF's Expecting Success: Excellence in Cardiac Care program Participating in the AMA's Patient-Centered Communication Program Participating in Jackson Heart Study in collaboration with Jackson State Univ., Tougaloo College, and NIH Participating in the Delta Health Alliance: partnerships with universities to improve access and availability of care	Creating a continuity between educational and hospital-centered disparities initiatives	Enhancing research resources at minority institutions, and increased opportunities for minority students in health sciences through the Jackson Heart Study, which is the largest investigation of cardiovascular disease (CVD) in African-Americans Continuation of the Patient-Centered Communication Program at the hospital Organization-wide priority and goal to increase underrepresented minorities at the medical school	Getting key senior-level buy-in and support Developing partnerships and collaborations such as the Mississippi Institute for the Improvement of Geographic Minority Health and Delta Health Alliance

Chapter 5 – What can you do?

> ***"As it relates to disparities, we need to get beyond just diagnosing the problem – we need to start treating it."***
> – Peter Slavin, MD, CEO, Massachusetts General Hospital

Several recommendations emerged from our research, leadership interviews and case studies in regards to how to begin the process of developing an action portfolio to improve quality, address disparities, and achieve equity. This guidance is built on real-world experience. The recommendations are meant to provide an overall outline for how to move forward on this issue, and are in no way exhaustive. Included here are the basic themes, in step-wise fashion, along with resources to assist in the process. All these resources listed below can be found in Chapter 6 – Resource Section.

> ***"[It's] Important to engage leaders on the issue ... challenges are the attention span is short, time is limited; the content needs to be powerful, and it needs to be almost indisputable."***
> - William Fulkerson, MD, Chief Executive Officer, Duke University Hospital

Getting Started

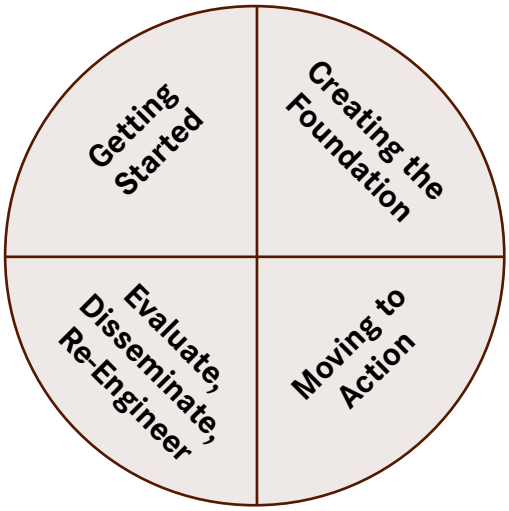
Create a Disparities Committee or Task Force

Creating a committee or task force to both conduct an assessment of where the hospital is in terms of identifying and addressing disparities can be an important first step. This group can also develop an initial plan of action using guidance from the Creating a Foundation section below.

Resource: The MGH Disparities Committee website has highlights of how this was done, as well as meeting minutes and organizational information that can be helpful.

- Committee should be composed of leaders in a variety of disciplines, including patient registration, quality and safety, nursing, patient advocacy, human resources, social services, as well as the leadership of clinical services, among others
- The committee should be tasked to:
  - Create a rapid self-assessment of what is being done in area of disparities, quality, equity, including whether the following are being done:
    1. Data collection of patient race/ethnicity
    2. Stratifying of the following measures by race/ethnicity: National Hospital Quality Measures; HEDIS Outpatient Measures; Patient Satisfaction (assess if done in multiple languages and if questions include issues related to race, ethnicity, culture, language); and Patient safety/medical errors
    3. Education and awareness of faculty, staff and patients: Cross-cultural communication for doctors, nurses, staff; overall awareness of disparities among all staff, patients; and training of registrars in data collection

Figure 3



> ***"In addition to physician and clinical leadership, you need support from the heads of IT, medical records, and other areas you may not typically work with in clinical improvement efforts."***
> – Rohit Bhalla, MD, MPH, Chief Quality Officer, Montefiore Medical Center

4. Efforts to address language barriers such as use of and training of interpreters
5. Efforts in development of medical homes/access
6. Interventions targeted at disparities, both community-based programs and hospital-based programs

- Develop an initial strategic plan of action to develop, solidify, or improve on and/or expand any of the aforementioned efforts

> ***"You need to do a fairly good assessment of where you're at."***
> – William Walker, MD, Director and Health Officer, Contra Costa Health Services

- *Educate leadership team on disparities, quality, equity via local champion or local or national expert*
  Either before or during the process of convening a committee as described above, it is helpful to begin to educate the leadership team about the issue of disparities, quality, and equity. This can be accomplished via internal or external means.

  Resource: The Institute of Medicine's Report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* has an Executive Summary that is very helpful in this regard. We have provided a PowerPoint presentation as well that can help achieve this goal if the decision is made to do this internally.

> ***"We have to build a shared vocabulary among the people who do this work. And I think that's really key ... everyone has different ideas and definitions about ... this terminology, ... it's critical for people to have a shared vocabulary about the meaning of all these different words."***
> – William Walker, MD, Director and Health Officer, Contra Costa Health Services

Creating the Foundation

Begin to build foundation to address disparities.

There are several key efforts that are essential to identifying and monitoring for racial and ethnic disparities in health care. These include:

Race/Ethnicity Data Collection

Resource: *The Health Resource and Education Trust Race and Ethnicity Data Collection Toolkit* is the standard in the field. There are several web seminars that can be helpful in developing these efforts (DSC Webinars: *Getting Started: Building a Foundation to Address Disparities through Data Collection* and *Getting it Right: Navigating the Complexities of Collecting Race/Ethnicity Data)*

Disparities and Equity Measurement and Monitoring Tools

Resource: The premier tool in the field is *Creating Equity Reports: A Guide for Hospitals,* with two accompanying web seminars *Collecting Race and Ethnicity Data is Not Enough: Measuring and Reporting Disparities* and *Creating Equity Reports: A Guide for Hospitals.*

Interpreter Services

Resource: The Hablamos Juntos/We Speak Together projects have detailed state-of-the-art information on the creation of interpreter services, as well as highlight cutting edge technology in the field. The International Medical Interpreters Association is also an excellent resource for ideas and consultation and we reference these in our resource section.

Medical Homes

Resource: Medical homes have been deemed a key initiative to address disparities and facilitate equity. The Commonwealth Fund has created an issue brief which can be helpful *(http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=506814).*

Develop medical policies to support all new work.

As new efforts develop, it is important to go through a process of formalizing them through the development of medical policy. This may include policies on the collection of patient race/ethnicity data, the stratification of quality measures by race/ethnicity, etc.

Finalize a strategic plan of action with 1, 3 and 5 year goals.

A formal strategic plan can be essential in charting a course of action. This can take on either a targeted set of issues (e.g. quality of care) or a broader set of issues (e.g. diversity training for staff, etc.).

Resource: The National Association of Public Hospitals, the Office of Minority Health, the Institute for Healthcare Improvement and the MGH Disparities Solutions Center recently released *Assuring Healthcare Equity: A Healthcare Equity Blueprint* which covers a range of activities that can serve as a template for developing a strategic plan.

Assign an organizational leader who can liaison with Disparities Committee; align with other hospital champions.

The leadership of the Disparities Committee should have a direct report from the hospital leadership (e.g. Vice-President of Quality and Safety, Vice-President of Clinical Affairs, etc.), as well as be aligned or supported by other champions within the hospital.

Engage in efforts to raise awareness of the issue and secure support among the Board, faculty and staff, Senior Leadership, Medical Staff Leadership, and faculty, and provide broad education on the issue.

Engaging the Board of Trustees early to garner their support, as well as disseminating the plan of action to Senior Leadership, Medical Staff Leadership, and faculty, is essential along the path of mainstreaming these efforts, creating cultural transformation, and assuring success.

Develop any community-based relationships that are necessary.

Efforts to monitor or address disparities can be evaluated and supported by community advisory boards or community leaders so it is essential that these relationships be solidified in anticipation of efforts in this area.

Moving to Action

Routine monitoring for disparities.

Once an initial plan and template to identify disparities and measure equity has been developed, a portfolio of measures can be stratified and presented to leadership routinely, including the National Hospital Core Measures (congestive heart failure, acute myocardial infarction, community acquired pneumonia, surgical infection prophylaxis) as well as other high-impact measures of interest, such as diabetes and breast, cervical, and colon cancer screening.

Develop pilot interventions to address disparities when found.

When disparities are identified, there are various models that can be used to address them. They can incorporate the standard tools of quality improvement and disease management with specific components targeted at addressing the root causes of disparities (language barriers, cultural barriers, literacy issues, etc.).

- Programs developed with this goal in mind have included the use of health coaches, navigators, community outreach workers to address diabetes, cancer screening, congestive heart failure and other conditions.

  Resource: A web seminar describes these interventions in detail (DSC Webinar: *Using Multi-Disciplinary Teams to Address Disparities: Navigators, Health Coaches and Community Health Workers)*.

> ***"It's tempting to sit in a conference room and draw out a battle plan and say, 'this is what we're going to do, because other organizations have been successful.' But I think it is important to sit down with staff and share with them what you're THINKING of doing, and the broad direction that you want to go in, and try to engage them in the process. Because ultimately then, when you get to the point of implementation, you're more effective because you've listened to the staff, and are moving forward together."***
> – Rohit Bhalla, MD, MPH, Chief Quality Officer, Montefiore Medical Center

Expand measurement capabilities.

Stratifying existing quality measures by race/ethnicity is perhaps the easiest first step in monitoring for disparities. Once this is done, additional measurement capacities can be developed to further assure equity. These can include:

- The development of disparities-specific measures that link to research, such as pain management in the emergency room, referral to cardiac procedures, etc.
- Additional ways to get at patient experience besides stratification of patient satisfaction. This may include targeted surveys of minority patients regarding their experience with care, for instance.
- The incorporation of questions about disparities into Quality Rounds in addition to standard questions about quality and safety.
- Surveying the staff about disparities-related issues as this may be helpful in identifying additional issues of importance.

Evaluate, Disseminate, Reengineer

Evaluate pilot interventions to address disparities.

Once pilot interventions are developed, they should be formally evaluated and modified if necessary to achieve their stated goals.

Disseminate points of action and success.

As successful strategies are developed, it can be helpful to disseminate these internally and externally to further garner support. This should include routine presentations to the Board and to the leadership team regarding progress in this area.

Reengineer efforts as necessary.

Mid-course adjustments should be expected and occur routinely.

Chapter 6 – Resource Section

A. The Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Http://www.i*om.edu/?id=16740*

B. *HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity and Primary Language from Patients. http://www.hretdisparities.org/*

C. *Creating Equity Reports: A Guide for Hospitals. http://www2.massgeneral.org/disparitiessolutions/resources.html*

D. The Joint Commission's *Hospital, Language and Culture: A Snapshot of the Nation* study. *http://www.jointcommission.org/PatientSafety/HLC/*

   a. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*

   b. *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*

E. The Office of Minority Health. *www.omhrc.gov*

F. The Office of Minority Health's Final Report on *National Standards for Culturally and Linguistically Appropriate Services in Health Care. http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf*

G. *Assuring Healthcare Equity: A Healthcare Equity Blueprint. http://www.naph.org/Template.cfm?Section=Home&Template=/ContentManagement/ContentDisplay.cfm&ContentID=9428*

H. National Quality Forum. *http://www.qualityforum.org/*

I. The MGH Disparities Committee at Massachusetts General Hospital. *www.mghdisparities.org*

J. The MGH Disparities Dashboard at Massachusetts General Hospital. *http://qualityandsafety.massgeneral.org/measures/equitable.aspx?id=4*

K. *Hablamos Juntos,* which has the latest information on interpreter services. *www.hablamosjuntos.org*

L. Robert Wood Johnson Foundation's *Speaking Together: National Language Service Network Toolkit http://www.rwjf.org/qualityequality/product.jsp?id=29653.* This toolkit provides advice to hospitals on improving quality and accessibility of language services.

M. Robert Wood Johnson Foundation's *Expecting Success: Excellence in Cardiac Care http://www.expectingsuccess.org/* aimed at improving quality of cardiac care while reducing racial, ethnic and language disparities and their toolkit available at *http://www.rwjf.org/pr/product.jsp?id=28433*

N. Robert Wood Johnson Foundation's *Finding Answers: Disparities Research for Change* awards and manages research grants totaling $6 million to healthcare organizations implementing interventions aimed at reducing disparities. *http://www.solvingdisparities.org/*

O. ***Hospitals interviewed for this guide***

   a. Baylor Health Care System – *www.baylorhealth.com*

   b. Contra Costa Health Services – *www.cchealth.org*

   c. Cooper Green Mercy Hospital – *www.coopergreenmercyhospital.org*

   d. Duke University Health System – *www.dukehealth.org*

   e. Henry Ford Health System – *www.henryfordhealth.org*

   f. Los Angeles County and University of Southern California Healthcare Network – *www.lacusc.org*

   g. Massachusetts General Hospital – *www.massgeneral.org*

   h. Montefiore Medical Center – *www.montefiore.org*

   i. Seattle Children's Hospital – *www.seattlechildrens.org*

   j. University of Mississippi Medical Center – *www.umc.edu*

P. The Disparities Solutions Center's Archived Web Seminars
http://www.massgeneral.org/disparitiessolutions/web.html

a. *Improving Quality and Achieving Equity: A Guide for Hospital Leaders*
b. *Getting Started: Building a Foundation to Address Disparities through Data Collection*
c. *Getting it Right: Navigating the Complexities of Collecting Race/Ethnicity Data*
d. *Collecting Race and Ethnicity Data is Not Enough: Measuring and Reporting Disparities*
e. *Creating Equity Reports: A Guide for Hospitals*
f. *Using Multi-Disciplinary Teams to Address Disparities: Navigators, Health Coaches and Community Health Workers*
g. *QI and the EMR: Identifying and Addressing Disparities in Chronic Disease Management*
h. *Improving Quality and Addressing Disparities: Accreditation Standards, Market-Strategies and Levers for Action*

Q. ***PowerPoint presentations*** *(See Appendices B, E and F)*

a. Improving Quality and Achieving Equity: A Guide for Hospital Leaders
b. Disparities and Quality: Why Now and What Are We Doing About It?
c. Leading Change

R. ***Peer-reviewed Articles (See Appendix G)***

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Appendix A

Mini Vignettes on Disparities and Quality

Safety Example

A 39 year-old Mexican-American woman presents to the emergency department with chest pain that seems to be musculoskeletal in nature. She speaks enough English so that an interpreter is not called in. She is discharged, but returns the next day with shortness of breath and is found to have multiple pulmonary emboli.

In this case poor communication led to misdiagnosis. Similarly, it may result in overutilization of procedures (with their associated risks) as a substitute for lack of an effective history, or to lack of understanding of medication instructions and subsequent adverse medication events.

Effectiveness Example

A 63 year-old African-American man is diagnosed with stage 1 non-small cell lung cancer and is offered surgery, but is reluctant to have it done. The surgeon gives him some information, tells him to think about it and return to discuss it further, but he misses the follow-up appointment. What the surgeon did not learn is that the patient believes that surgery could spread the tumor throughout his body, and since he did not have great trust in the surgeon anyway, he opted against the operation.

Here, a myth about lung cancer surgery that is prevalent among many patients, and even more so among African-Americans,[133] led to a missed opportunity for effective, evidence-based care. Had the surgeon developed a more trusting relationship with the patient and inquired further about his reluctance, the problem may have been avoided.

Patient-Centeredness Example

A hospital learned that its satisfaction scores were very low for its relatively large Chinese-American community. The hospital held focus groups with community leaders and learned that the environment did not feel welcoming to Chinese-Americans due to lack of signage in Chinese, poor representation of Chinese-Americans among the staff, slow interpreter services, and several cultural taboos.

In this case, stratifying satisfaction data led to focus groups, and eventually allowed for effective systems interventions.

Timeliness Example

A Haitian family brings their 10 year-old boy to the emergency department because of a cough. The triage nurse assesses the story without the use of an interpreter. She is upset that they came to the emergency department rather than to their pediatrician for care as the cough does not seems serious. The boy waits 6 hours to be seen by the physician with an interpreter and is eventually found to have pneumonia. The “door to needle” time for antibiotic administration is significantly delayed.

Here, a professional interpreter or even telephonic interpretation could have helped the triage nurse recognize the seriousness of the child’s condition and expedited the time to treatment. A stereotype of minority and/or immigrant patients overusing the emergency department for primary care may also have contributed to this delay.

Efficiency Example

A 58 year-old Native American (Navaho) man is discharged from the hospital after a 5-day stay for congestive heart failure. He is given a handout on dietary modification and medication adherence, but little time is spent going over his own culturally based diet and beliefs and fears about medications. He is readmitted 5 days later with another exacerbation.

Proper discharge planning, and ensuring the patient understand the dietary modifications they needed to make within their culturally based diet, as well as a more thorough review of the medications might have prevented this readmission.

Appendix B

Improving Quality and Achieving Equity

A Guide for Hospital Leaders

Improving Quality and Achieving Equity
A Guide for Hospital Leaders

- The Goals of this Guide are to:
  - Present the evidence of racial and ethnic disparities in health care and provide the rationale for addressing them—with a focus on quality, cost, risk management and accreditation
  - Highlight model practices—hospitals and leaders who are actively engaged in addressing disparities and achieving equity
  - Recommend a set of activities and resources that can help hospital leaders initiate an agenda for action in this area

Improving Quality and Achieving Equity
A Guide for Hospital Leaders

- This presentation will:
  - Highlight the link between quality, equity and racial and ethnic disparities in health care
  - Present the evidence of the impact of disparities on quality, cost, safety, and accreditation
  - Recommend a set of activities that can help hospital leaders initiate an agenda for action

Equity is an Essential Component of Quality

- The Institute of Medicine Report *Crossing the Quality Chasm* suggests quality is a system property, and that our current system of health care delivery is in need of redesign.
- To truly achieve quality, health care systems must focus on six key elements—efficiency, effectiveness, safety, timeliness, patient-centeredness, and *equity.*
- ***Equity*** is achieved by providing care that does not vary in quality by characteristics such as ethnicity, gender, geographic location, and socioeconomic status.

Racial and Ethnic Disparities in Quality of Care Exist

- *Unequal Treatment* found that even with the same insurance and socioeconomic status, and when comorbidities, stage of presentation and other confounders are controlled for, minorities often receive a lower quality of health care than do their white counterparts.
- Racial and ethnic disparities have been found in the quality of care delivered to patients with cardiovascular disease (including acute myocardial infarction and congestive heart failure), diabetes, and cancer screening and management, among others.

Many Causes for Disparities
No one suspect, No one solution

Disparities are ubiquitous and multi-factorial. Causes include:

- *Health system level factors*, related to the complexity of the health care system and how it may be poorly adapted to and disproportionately difficult to navigate for minority patients or those with limited-English proficiency,
- *Care-process variables,* related to health care providers, including stereotyping, the impact of race/ethnicity on clinical decision-making, and clinical uncertainty due to poor communication, and
- *Patient-level variables,* related to patient's mistrust, poor adherence to treatment, and delays in seeking care.

Achieving Equity and Addressing Disparities

Implications for quality, cost, safety and risk management

Research has shown that racial and ethnic disparities in health care have an impact on quality, safety, cost, safety and risk management. For example:

- Patients with limited English proficiency (LEP) and racial/ethnic minorities are more likely than their English-speaking white counterparts to suffer from adverse events, and these adverse events tend to have greater clinical consequences.
- Communication problems are the most frequent cause of serious adverse events as recorded by the Joint Commission, and arise due to language barriers, cultural differences, and low health literacy, all of which are particularly important issues for racial/ethnic minority patients.

Achieving Equity and Addressing Disparities

Implications for quality, cost, safety and risk management

Continued

- In the presence of communication difficulties (i.e. due to language barriers or cultural barriers) health care providers may tend to order expensive tests (such at CT Scans) for conditions that could have been diagnosed through basic history-taking.
- Patients with limited-English proficiency have longer hospital stays for some common medical and surgical conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement).

Achieving Equity and Addressing Disparities

Implications for quality, cost, safety and risk management

Continued

- Disparities have also captured the attention of the Joint Commission who will soon likely release accreditation standards on this issue, as well as the National Quality Forum, who recently have developed quality measures on disparities and cultural competence.
- As the issues of community benefit and not-for-profit status takes on greater importance for hospitals across the country, addressing racial and ethnic disparities can become a valuable portfolio of work to meet these regulations.

Achieving Equity and Addressing Disparities

Implications for quality, cost, safety and risk management

Continued

- Pay-for-performance contracts have started including provisions that look to address racial and ethnic disparities in health care—it is expected this trend will become more widespread over time.
- There are multiple liability exposures that arise when there is a demonstrated failure to address the root causes for disparities, such as:
  - Patient comprehension of their medical condition, treatment plan, discharge instructions, complications and follow-up;
  - Ineffective or improper use of medications or serious medication errors;
  - Improper preparation for tests and procedures, and
  - Poor or inadequate informed consent

Achieving Equity and Addressing Disparities

Implications for quality, cost, safety and risk management

Continued

- Minorities are more likely to be readmitted for certain chronic conditions—such as congestive heart failure. Moving forward, this issue might take on greater financial importance given that the Centers for Medicare and Medicaid Services will likely limit or refuse reimbursement for Medicare patients with congestive heart failure who are readmitted within 30 days of discharge.
- Minorities—even when controlling for insurance status, though worse with public health insurance—may be at greater risk for ambulatory care sensitive/avoidable hospitalizations for chronic conditions (hypertension and asthma) than their white counterparts.

Several Hospitals have distinguished themselves as Leaders in the Field

- Several hospitals across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity.
- Activities have included:
  - Development of a strategic plan to address disparities,
  - Standardized collection of patient's race and ethnicity,
  - Stratification of quality measures by race and ethnicity,
  - Development of quality measurement tools to monitor for disparities,
  - Community-based efforts to improve primary care services and medical homes,
  - Development and expansion of interpreter services, and
  - Interventions to address disparities when found (using health coaches, navigators, community health workers, for example)
- These efforts have been motivated by the quality case and the business case for achieving equity.

Hospital Leaders can develop Systems to Improve Quality, Address Disparities, and Achieve Equity

Getting Started

- Create a multidisciplinary ***disparities committee*** of individuals representing quality, operations, patient registration, social services, human resources, nursing and physician-leaders from several clinical services to assess what is being done in the area of disparities at the hospital (such as whether patient race/ethnicity is collected), and to develop an initial strategic plan.
- ***Educate leadership team*** on the issue and approach.

Hospital Leaders can develop Systems to Improve Quality, Address Disparities, and Achieve Equity

Creating the Foundation

- Develop a plan to ***collect patient race/ethnicity data*** (if not already done) and create medical policies to support this work.
- Assign an ***organizational leader*** as the key report for this work and engage in efforts to raise awareness of the issue among faculty and staff.
- ***Solidify community partnership*** and relationships in anticipation of future interventions.

Hospital Leaders can develop Systems to Improve Quality, Address Disparities, and Achieve Equity

Moving to Action

- ***Create a "disparities dashboard"*** composed of key quality measures stratified by race and ethnicity (i.e. National Hospital Quality Measures, HEDIS outpatient measures, patient satisfaction, etc.) that can be routinely presented to leadership and monitored.
- If disparities are found, ***create pilot programs*** to address them (examples include disease management programs with health coaches, navigators, or community health workers).

Hospital Leaders can develop Systems to Improve Quality, Address Disparities, and Achieve Equity

Evaluate, Disseminate, Reengineer

- ***Evaluate pilot studies*** and develop a dissemination strategy to post results;
- Chart a new course and ***reengineer*** strategies from lessons learned.
- ***Embed*** successful practices into standard programs of quality of care.

Improving Quality and Achieving Equity A Guide for Hospital Leaders

Resources

- Strategic Planning on Disparities
  - *Assuring Healthcare Equity: A Healthcare Equity Blueprint* – www.naph.org
  - The Disparities Solutions Center – www.mghdisparitiessolutions.org
- Collecting Race/Ethnicity Data
  - HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity and Primary Language from Patients - http://www.hretdisparities.org/
- Monitoring and Reporting Disparities
  - Creating Equity Reports: A Guide for Hospitals www.mghdisparitiessolutions.org
- Developing Interventions
  - Expecting Success: Excellence in Cardiac Care – www.expectingsuccess.org
  - Finding Answers: Disparities Research for Change - www.solvingdisparities.org

Improving Quality and Achieving Equity A Guide for Hospital Leaders

Summary

- Equity is a key component of quality; addressing disparities will help achieve this goal
- Failure to address equity and disparities has significant implications for quality, safety, cost, risk management, and soon may affect accreditation
- There are hospitals around the country who are engaged in this work
- There are a basic set of activities that can help hospital leaders initiate an agenda for action to achieve equity

Appendix C

Sounding Board Members

Emilio Carrillo, MD, MPH
Vice President of Community Health Development
New York-Presbyterian Hospital.

Arthur Chen, MD
Chief Medical Officer
Alameda Alliance for Health

Crystal Clark, MD, MPH
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Appendix D

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Appendix E

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Disparities and Quality: Why Now and What Are We Doing About It?

Gregg S. Meyer, MD, MSc
Senior Vice-President for Quality and Safety, MGH/MGPO
28 May 2008

Reality #1: Crossing the *Quality Chasm*

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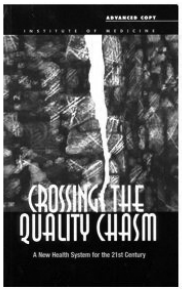

- "The Rest of the Iceberg"
- There are serious problems in quality
  - *Between the health care we have and the care we could have lies not just a gap but a chasm.*
- The problems come from poor systems…not bad people
  - *In its current form, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves.*
- We can fix it… but it will require changes

Clarifying National Aims for Improvement

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- Safety -- As safe in health care as in our homes
- Effectiveness -- Matching care to science; avoiding overuse of ineffective care and underuse of effective care
- Patient Centeredness -- Honoring the individual, and respecting choice
- Timeliness -- Less waiting for both patients and those who give care
- Efficiency -- Reducing waste
- Equity -- Closing racial and ethnic gaps in health status

The "no defect" approach to quality

Supporting Efforts

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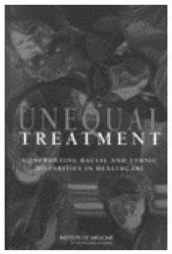

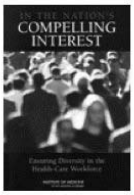

Reality #2: Cost Pressures – the 2½% Rule

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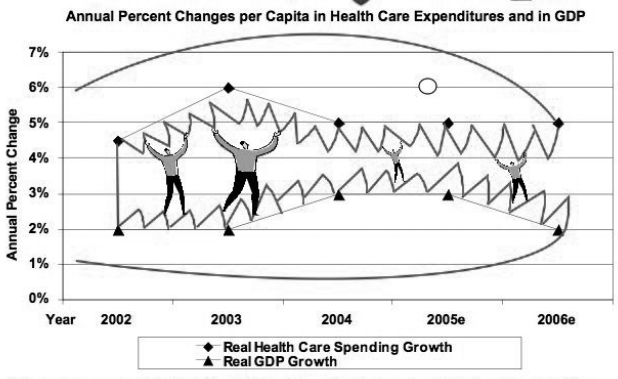

Data from Borger et al, *Health Affairs Web Exclusive*, "Health Spending Projections Through 2015: Changes on the Horizon," 2/2006. Dental work by Dr. Milstein.

What type of evolutionary era are we in?

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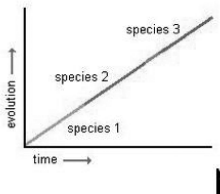

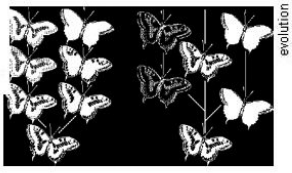

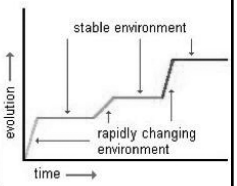

- Gradualism versus punctuated equilibrium
  - Environmental assessment as the key to what we will look like
  - Technical Revolution **and** Cultural Revolution

Synergy Among The Winds of Change

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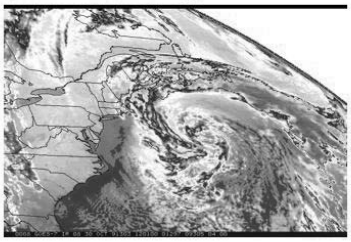
- Creation of the Perfect Storm
  - Focus on quality as the means for navigating through it
    - Leveraging the tempest to break logjams



The "5 Stages" of Getting Involved in Equity

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- Denial
- Anger
- Bargaining
- Depression
- Acceptance

You need a plan to get through the stages

One Plan

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- Talk About It
- Think Broadly
- Measure It (WELL)
  - then share
- Do Something About It

(repeat)

MGH Mission Statement 2007

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Guided by the needs of our patients and their families,

we aim to deliver the very best health care in a safe, compassionate environment; we advance that care through innovative research and education; and, we improve the health and well-being of the diverse communities we serve.

Is Talk Cheap? Mass General Board Focus on Quality & Safety Accelerates

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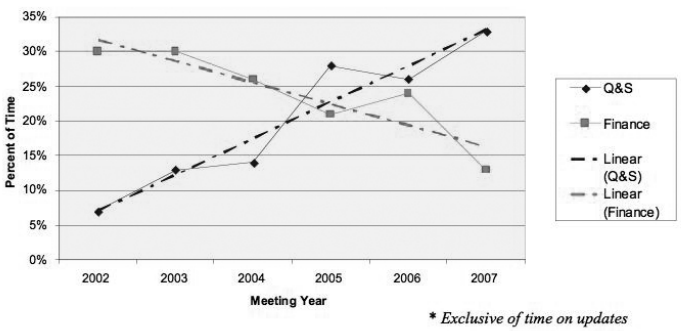
MGPO BOT % time spent on Q&S v. Finance



** Exclusive of time on updates*

Think Broadly: "VOLTAGE DROPS" IN QUALITY (*writ large*)

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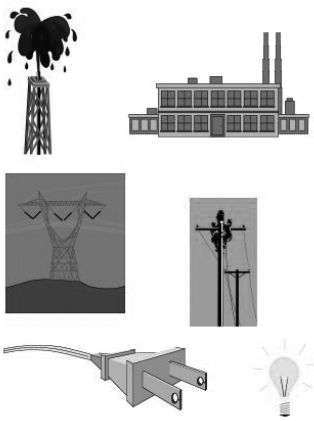

- Access to coverage
- insurance enrollment
- access to covered services and providers
- access to a consistent source of primary care
- access to referral services
- quality of care

- **lowering "resistance" at any of these "drops" will improve quality**

Measure It (WELL)

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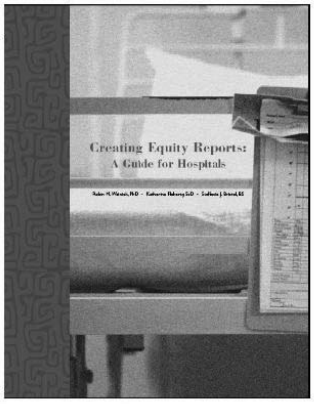
Massachusetts General Hospital
Racial and Ethnic Disparities Dashboard
2007

Massachusetts General Hospital Committee on Racial and Ethnic Disparities
Joseph R. Betancourt, M.D., M.P.H.
Joan Quinlan, M.P.H.
Co-Chairs

Massachusetts General Hospital Committee on Racial and Ethnic Disparities Quality Subcommittee
Elizabeth A. Mort, M.D., M.P.H.
Chair
Sarah K. Lenz



Then Share

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www.massgeneral.org

Then Share

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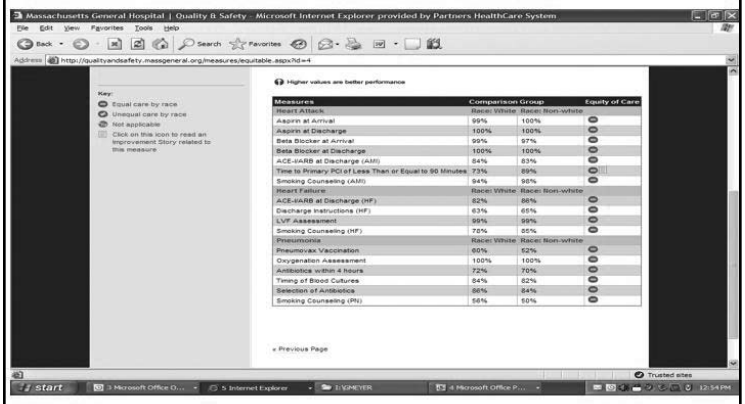

Don't Just Document…

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- Do Something
  - ? The end of the beginning
    - Example of patient safety

Do Something About It: Iron Laws of Improvement

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- **B Teams with A Systems always beat A Teams with B Systems**
  - It's the systems stupid…
  - Converting A individuals to A teams is essential to beating well developed B teams
  - Our goal is getting our A teams A systems to support their work

  GOAL Make doing the right thing easy (or easier)
- **It's not the seed, it's the soil**
  - Culture trumps all
  - Innovation must be balanced with Spread
  - The political is much more challenging than the technical

  GOAL Take advantage of opportunities to impact the culture (from wherever they come) and focus on your workforce
- **Data + Anecdote = Action (with some modest help from incentives)**
  - You need both

  GOAL Make the investment and tell the story (right)

Where Are We On The Healthcare Equity Journey?

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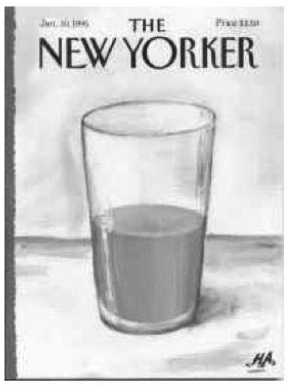
- Optimism as a force multiplier



Appendix F

Leading Change

Roderick K. King, MD, MPH
Senior Faculty, MGH Disparities Solutions Center
Instructor, Dept of Global Health and Social Medicine
Harvard Medical School

Learning Objectives

- Provide a framework for leading change around disparities within health care organizations.
  - Eight Steps for Driving Change…what does it take? *John Kotter Model*
- Assist organizations in understanding where they are in the process of identifying and addressing disparities.
- Develop goals for transforming organizations and advancing their particular work on disparities.

Driving New Initiatives and Change in the Organization

Eight Steps to Driving Change *:

1. Establish a Sense of Urgency
   Building the Case ~ Resistance to change
2. Build a Coalition
   Identify stakeholders and build alliances
3. Create a Shared Vision
4. Communicate Vision Repeatedly
5. Empowering Others to Act on the Vision
6. Planning for and Creating Short Term Wins
7. Reinforce the Change
8. Institutionalizing New Approaches

Leading Change, John P. Kotter, HBS Press, 1996
The Heart of Change Field Guide, Dan S. Cohen, John P. Kotter, HBS press, 2005

Leading Change Model

1. Establish a Sense of Urgency
   - *Examining market or demographic realities*
   - *Identifying and discussing crises, potential crises or major opportunities*
   - *Why might people fail here:*
     - ***Underestimating how hard it can be to drive people out of their comfort zones***
     - ***sometimes grossly overestimate how successful they have already been in increasing urgency***
     - ***sometimes lack the patience***

Leading Change Model

2. Forming a Powerful Guiding Coalition
   - *Assembling a group with enough power to lead the effort*
   - *Can be as small as 3-5 individuals, work as a team*

Leading Change Model

3. Creating a Shared Vision
   - *Picture of the future, easy to communicate, and appeals to staff, leaderships and stakeholders*
   - *Developing strategies for achieving that vision*

(e.g. HRSA's100 % Access, 0% Disparities (100/0 Campaign))

4 Question Individual Change Test

1. How does it relate to my job and what is in it for me?
2. Do I agree with the change?
3. Am uncomfortable with or afraid of the change?
4. Tell me again what is in it for me?

Jeff Oxidine, UC Berkeley

Leading Change Model

4. Communicate Vision Repeatedly
   - Leading change is usually impossible unless large numbers of people are willing to help
   - How? Organizational newsletters, Quarterly management meetings…
   - Use every possible channel, especially those that are being wasted on non-essential information
5. Enable Your Team to Achieve the Vision
   - Getting rid of obstacles
   - Changing systems or structures that undermine vision

Leading Change Model

6. Planning for and Creating Short Term Wins
   - Planning for visible performance improvements
   - Creating the improvements
   - Recognizing and rewarding employees involved in the improvement
7. Reinforce the Change…Producing still more change
   - Using increased credibility to change systems, structures and policies that don't fit
   - Hiring, promoting, and developing employees who can implement the vision
   - Reinvigorate process with new projects and themes

Driving Change in Health Disparities

8. Institutionalizing New Approaches

   "…the way we do things around here."
   - Articulating the connections between the new behaviors and organizational progress/success
   - Developing the means to ensure leadership development and succession

Weave into the Fabric of the Organization

- eliminate the perception of "add on"
- establish the business case
- link to quality of care
- legitimize in policy, structures, practices, procedures, & resources
- set bench marks & measure progress at regular intervals
- assure it is woven into the "culture" of the organization

Slide Source: The National Center for Cultural Competence, 2004

Persuading a group… Aim for the Middle

- 5 categories
  - Champions of an issue
  - Allies of an issue
  - Fence-sitters (neutral)
  - Mellow opponents
  - Hard core opponents
- Moderates: "hard information", evidence reports, material proof and other facts
- Using this same information to persuade everyone is too hard. Rely on the newly convinced moderates to convert the remainder of the group

Democracy Center, SF, CA
Bernard Caillaud & Jean Tirole, American Economics Review, Dec 2007

Where are you in the change process?

- From the perspective of your disparity initiative…
  - Determine where you are in the 8 step leading change process
  - Are there additional things you can do to in your current stage (before moving to the next)?
  - What are some strategies and actions for your next step in your change process?

Appendix G

Suggested Reading

1. ***Article: Leading Change: Why Transformation Efforts Fail.***

   By: Kotter JP.
   Published by: *Harvard Business Review.* 1995;73(2):59-67.

   Abstract: In the past decade, the author has watched more than 100 companies try to remake themselves into better competitors. Their efforts have gone under many banners: total quality management, reengineering, right sizing, restructuring, cultural change, and turnarounds. In almost every case, the goal has been the same: to cope with a new, more challenging market by changing how business is conducted. A few of those efforts have been very successful. A few have been utter failures. Most fall somewhere in between, with a distinct tilt toward the lower end of the scale. The lessons that can be learned will be relevant to more and more organizations as the business environment becomes increasingly competitive in the coming decade. One lesson is that change involves numerous phases that, together, usually take a long time. Skipping steps creates only an illusion of speed and never produces a satisfying result. A second lesson is that critical mistakes in any of the phases can have a devastating impact, slowing momentum and negating previous gains. Kotter's lessons are instructive, for even the most capable managers often make at least one big error.

2. ***Book: The Heart of Change Field Guide: Tools and Tactics for Leading Change in Your Organization***

   By: Dan S. Cohen
   Published by: HBS Press

   Description: In 1996, John P. Kotter's Leading Change became a runaway best seller, outlining an eight-step program for organizational change that was embraced by executives around the world. Then, Kotter and co-author Dan Cohen's The Heart of Change introduced the revolutionary "see-feel-change" approach, which helped executives understand the crucial role of emotion in successful change efforts. Now, The Heart of Change Field Guide provides leaders and managers tools, frameworks, and advice for bringing these breakthrough change methods to life within their own organizations. Written by Dan Cohen and with a foreword by John P. Kotter, the guide provides a practical framework for implementing each step in the change process, as well as a new three-phase approach to execution: creating a climate for change, engaging and enabling the whole organization, and implementing and sustaining change. Hands-on diagnostics — including a crucial "change readiness module" — reveal the dynamics that will help or hinder success at each phase of the change process. Both flexible and scaleable, the frameworks presented in this guide can be tailored for any size or type of change initiative. Filled with practical tools, checklists, and expert commentary, this must-have guide translates the most powerful approaches available for creating successful change into concrete, actionable steps for you and your organization. Dan Cohen is the co-author, with John P. Kotter, of The Heart of Change, and a principal with Deloitte Consulting, LLC.

3. ***Article: The Effect of Race on the Referral Process for Invasive Cardiac Procedures.***

   By: Einbinder LC, Schulman KA.
   Published by: *Medical Care Research and Review.* 2000;57 Suppl 1:162-180.

   Abstract: Coronary artery disease is the leading cause of death in the United States. Blacks are more likely than whites to experience premature disease, and they have poorer prognosis after acute myocardial infarction. Multiple studies have demonstrated that blacks are less likely to be referred for certain invasive cardiac procedures. Few studies have examined the effect of race on physician and patient decision making in referrals for cardiac procedures. The authors present a framework for the complex series of steps involved in obtaining invasive cardiac care. Patient race can affect each of these steps, and differences in physician and patient race may be a particular impediment to effective communication about symptoms and preferences and to the establishment of a therapeutic partnership. The potential role of communication in race-discordant physician-patient relationships suggests a need for more research in physician decision making and for efforts to promote cultural competency as a core component of medical education.

4. ***Article: Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care.***

   By: Fiscella K, Franks P, Gold M, Clancy C.
   Published by: *JAMA.* 2000;283(19):2579-2584.

   Abstract: Socioeconomic and racial/ethnic disparities in health care quality have been extensively documented. Recently, the elimination of disparities in health care has become the focus of a national initiative. Yet, there is little effort to monitor and address disparities in health care through organizational quality improvement. After reviewing literature on disparities in health care, we discuss the limitations in existing quality assessment for identifying and addressing these disparities. We propose 5 principles to address these disparities through modifications in quality performance measures: disparities represent a significant quality problem; current data collection efforts are inadequate to identify and address disparities; clinical performance measures should be stratified by race/ethnicity and socioeconomic position for public reporting; population-wide monitoring should incorporate adjustment for race/ethnicity and socioeconomic position; and strategies to adjust payment for race/ethnicity and socioeconomic position should be considered to reflect the known effects of both on morbidity.

5. ***Article: Health care organizations' use of race/ethnicity data to address quality disparities.***

   By: Nerenz D.
   Published by: *Health Affairs.* 2005;24(2):409-416.

   Abstract: Health care organizations–health plans, hospitals, community health centers, clinics, and group practices – can play an important role in the elimination of racial/ethnic disparities in health care. There are now a number of examples of organizations that have been successful in reducing or eliminating disparities, and a number of published examples of how quality improvement initiatives can improve care for members of targeted minority groups, thereby contributing to the elimination of disparities.

6. ***Article: Improving Quality and Achieving Equity: The role of cultural competence and quality in reducing racial/ethnic disparities in health care.***

   By: Betancourt JR.
   Published by: The Commonwealth Fund; 2006.

   Abstract: This report reviews key principles of quality (as it relates to the overall quality of the health care system and individual approaches to quality improvement); reviews evidence of the existence and root causes of racial and ethnic health disparities and recommendations to address them; and discusses strategies by which the quality and cultural competence movements could be linked. In particular, it focuses on the Institute of Medicine's six principles for designing a high-quality health care system to identify areas where aspects of cultural competence would be central to achieving high quality. It then presents a framework outlining both hypothetical and proven strategies for delivering high-quality, culturally competent care.

7. ***Article: Eliminating Racial and Ethnic Disparities in Health Care: What Is the Role of Academic Medicine?***

   By: Betancourt JR.
   Published by: *Academic Medicine.* 2006;81(9):788-792.

   Abstract: Research has shown that minority Americans have poorer health outcomes (compared to whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, and cancer. In addition to racial and ethnic disparities in health, there is also evidence of racial and ethnic disparities in health care. The Institute of Medicine Report Unequal Treatment remains the preeminent study of the issue of racial and ethnic disparities in health care in the United States. Unequal Treatment provided a series of general and specific recommendations to address such disparities in health care, focusing on a broad set of stakeholders including academic medicine. Academic medicine has several important roles in society, including providing primary and specialty medical services, caring for the poor and uninsured, engaging in research, and educating health professionals. Academic medicine should also provide national leadership by identifying innovations and creating solutions to the challenges our health care system faces in its attempt to deliver high-quality care to all patients. Several of the recommendations of Unequal

Treatment speak directly to the mission and roles of academic medicine. For instance, patient care can be improved by collecting and reporting data on patients' race/ethnicity; education can minimize disparities by integrating cross-cultural education into health professions training; and research can help improve health outcomes by better identifying sources of disparities and promising interventions. These recommendations have clear and direct implications for academic medicine. Academic medicine must make the elimination of health care disparities a critical part of its mission, and provide national leadership by identifying quality improvement innovations and creating disparities solutions.

8. ***Article: Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?***

   By: Casalino LP, Elster A, Eisenberg A, Lewis E, Montgomery J, Ramos D.
   Published by: *Health Affairs.* 2007;26(3):w405-414.

   Abstract: Pay-for-performance (P4P) and public quality-reporting programs can increase the quality of health care for the services being measured. However, unless carefully designed, these programs may have the unintended consequence of increasing racial and ethnic disparities. This paper describes ways in which P4P and public reporting programs may increase disparities and suggests ways in which programs might be designed that will make them likely to reduce, or at least not increase, disparities.

9. ***Article: Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients.***

   By: Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, Banaji MR.
   Published by: *J Gen Intern Med.* 2007 Sep;22(9):1231-8.

   Abstract: CONTEXT: Studies documenting racial/ethnic disparities in health care frequently implicate physicians' unconscious biases. No study to date has measured physicians' unconscious racial bias to test whether this predicts physicians' clinical decisions. OBJECTIVE: To test whether physicians show implicit race bias and whether the magnitude of such bias predicts thrombolysis recommendations for black and white patients with acute coronary syndromes. DESIGN, SETTING, AND PARTICIPANTS: An internet-based tool comprising a clinical vignette of a patient presenting to the emergency department with an acute coronary syndrome, followed by a questionnaire and three Implicit Association Tests (IATs). Study invitations were e-mailed to all internal medicine and emergency medicine residents at four academic medical centers in Atlanta and Boston; 287 completed the study, met inclusion criteria, and were randomized to either a black or white vignette patient. MAIN OUTCOME MEASURES: IAT scores (normal continuous variable) measuring physicians' implicit race preference and perceptions of cooperativeness. Physicians' attribution of symptoms to coronary artery disease for vignette patients with randomly assigned race, and their decisions about thrombolysis. Assessment of physicians' explicit racial biases by questionnaire. RESULTS: Physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness. In contrast, IATs revealed implicit preference favoring white Americans (mean IAT score = 0.36, $P < .001$, one-sample t test) and implicit stereotypes of black Americans as less cooperative with medical procedures (mean IAT score 0.22, $P < .001$), and less cooperative generally (mean IAT score 0.30, $P < .001$). As physicians' prowhite implicit bias increased, so did their likelihood of treating white patients and not treating black patients with thrombolysis ($P = .009$). CONCLUSIONS: This study represents the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity. Results suggest that physicians' unconscious biases may contribute to racial/ethnic disparities in use of medical procedures such as thrombolysis for myocardial infarction.

10. ***Article: A Plan for Action: Key Perspectives from the Racial/Ethnic Disparities Strategy Forum***

    By: King RK, Green AR, Tan-McGrory A, Donahue EJ, Kimbrough-Sugick JK, Betancourt, JR.
    Published by: *Milbank Q.* Jun 2008;86(2):241-272.

    Abstract: Racial and ethnic disparities in health care in the United States have been well documented, with research largely focusing on describing the problem rather than identifying the best practices or proven strategies to address them. In 2006, the Disparities Solutions Center convened a one-and-a-half-day Strategy Forum composed of twenty experts from the fields of racial/ethnic disparities in health care, quality improvement, implementation research, and organizational excellence, with the goal of deciding on innovative action items and adoption strategies

to address disparities. The forum used the Results Based Facilitation model, and several key recommendations emerged. The forum's participants concluded that to identify and effectively address racial/ethnic disparities in health care, health care organizations should: (1) collect race and ethnicity data on patients or enrollees in a routine and standardized fashion; (2) implement tools to measure and monitor for disparities in care; (3) develop quality improvement strategies to address disparities; (4) secure the support of leadership; (5) use incentives to address disparities; and (6) create a messaging and communication strategy for these efforts. This article also discusses these recommendations in the context of both current efforts to address racial and ethnic disparities in health care and barriers to progress. The Strategy Forum's participants concluded that health care organizations needed a multifaceted plan of action to address racial and ethnic disparities in health care. Although the ideas offered are not necessarily new, the discussion of their practical development and implementation should make them more useful.

11. ***Article: Language proficiency and adverse events in US hospitals: a pilot study.***

By: Divi C, Koss RG, Schmaltz SP, Loeb JM.
Published by: *Int J Qual Health Care.* 2007 Apr;19(2):60-7.

Abstract: OBJECTIVE: To examine differences in the characteristics of adverse events between English speaking patients and patients with limited English proficiency in US hospitals. SETTING: Six Joint Commission accredited hospitals in the USA. METHOD: Adverse event data on English speaking patients and patients with limited English proficiency were collected from six hospitals over 7 months in 2005 and classified using the National Quality Forum endorsed Patient Safety Event Taxonomy. RESULTS: About 49.1% of limited English proficient patient adverse events involved some physical harm whereas only 29.5% of adverse events for patients who speak English resulted in physical harm. Of those adverse events resulting in physical harm, 46.8% of the limited English proficient patient adverse events had a level of harm ranging from moderate temporary harm to death, compared with 24.4% of English speaking patient adverse events. The adverse events that occurred to limited English proficient patients were also more likely to be the result of communication errors (52.4%) than adverse events for English speaking patients (35.9%). CONCLUSIONS: Language barriers appear to increase the risks to patient safety. It is important for patients with language barriers to have ready access to competent language services. Providers need to collect reliable language data at the patient point of entry and document the language services provided during the patient-provider encounter.

12. ***Article: The effect of English language proficiency on length of stay and in-hospital mortality.***

By: John-Baptiste A, Naglie G, Tomlinson G, Alibhai SM, Etchells E, Cheung A,
Kapral M, Gold WL, Abrams H, Bacchus M, Krahn M.
Published by: *J Gen Intern Med.* 2004 Mar;19(3):221-8.

Abstract: BACKGROUND: In ambulatory care settings, patients with limited English proficiency receive lower quality of care. Limited information is available describing outcomes for inpatients. OBJECTIVE: To investigate the effect of English proficiency on length of stay (LOS) and in-hospital mortality. DESIGN: Retrospective analysis of administrative data at 3 tertiary care teaching hospitals (University Health Network) in Toronto, Canada. PARTICIPANTS: Consecutive inpatient admissions from April 1993 to December 1999 were analyzed for LOS differences first by looking at 23 medical and surgical conditions (59,547 records) and then by a meta-analysis of 220 case mix groups (189,119 records). We performed a similar analysis for in-hospital mortality. MEASUREMENTS: LOS and odds of in-hospital death for limited English-proficient (LEP) patients relative to English-proficient (EP) patients. RESULTS: LEP patients stayed in hospital longer for 7 of 23 conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement), with LOS differences ranging from approximately 0.7 to 4.3 days. A meta-analysis using all admission data demonstrated that LEP patients stayed 6% (approximately 0.5 days) longer overall than EP patients (95% confidence interval, 0.04 to 0.07). LEP patients were not at increased risk of in-hospital death (relative odds, 1.0; 95% confidence interval, 0.9 to 1.1). CONCLUSIONS: Patients with limited English proficiency have longer hospital stays for some medical and surgical conditions. Limited English proficiency does not affect in-hospital mortality. The effect of communication barriers on outcomes of care in the inpatient setting requires further exploration, particularly for selected conditions in which length of stay is significantly prolonged.

13. ***Article: Language barriers and resource utilization in a pediatric emergency department.***

By: Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE.
Published by: *Pediatrics.* 1999 Jun;103(6 Pt 1):1253-6.

Abstract: BACKGROUND: Although an inability to speak English is recognized as an obstacle to health care in the United States, it is unclear how clinicians alter their diagnostic approach when confronted with a language barrier (LB). OBJECTIVE: To determine if a LB between families and their emergency department (ED) physician was associated with a difference in diagnostic testing and length of stay in the ED. DESIGN: Prospective cohort study. METHODS: This study prospectively assessed clinical status and care provided to patients who presented to a pediatric ED from September 1997 through December 1997. Patients included were 2 months to 10 years of age, not chronically ill, and had a presenting temperature >/=38.5 degrees C or complained of vomiting, diarrhea, or decreased oral intake. Examining physicians determined study eligibility and recorded the Yale Observation Score if the patient was <3 years old, and whether there was a LB between the physician and the family. Standard hospital charges were applied for each visit to any of the 22 commonly ordered tests. Comparisons of total charges were made among groups using Mann-Whitney U tests. Analysis of covariance was used to evaluate predictors of total charges and length of ED stay. RESULTS: Data were obtained about 2467 patients. A total of 286 families (12%) did not speak English, resulting in a LB for the physician in 209 cases (8.5%). LB patients were much more likely to be Hispanic (88% vs 49%), and less likely to be commercially insured (19% vs 30%). These patients were slightly younger (mean 31 months vs 36 months), but had similar acuity, triage vital signs, and Yale Observation Score (when applicable). In cases in which a LB existed, mean test charges were significantly higher: $145 versus $104, and ED stays were significantly longer: 165 minutes versus 137 minutes. In an analysis of covariance model including race/ethnicity, insurance status, physician training level, attending physician, urgent care setting, triage category, age, and vital signs, the presence of a LB accounted for a $38 increase in charges for testing and a 20 minute longer ED stay. CONCLUSION: Despite controlling for multiple factors, the presence of a physician-family LB was associated with a higher rate of resource utilization for diagnostic studies and increased ED visit times. Additional study is recommended to explore the reasons for these differences and ways to provide care more efficiently to non-English-speaking patients.

14. ***Book: The Heart of Change: Real-Life Stories of How People Change Their Organizations***

By: John P. Kotter, Dan S. Cohen
Published by: HBS Press

Description: For individuals in every walk of life and in every stage of change, this compact, no-nonsense book captures both the hear t — and the "how" — of successful change. Organizations are forced to change faster and more radically than ever. How are companies faring in meeting these challenges — and what can we learn from their experiences? In this powerful follow-up book — organized around Leading Change's revolutionary eight-step change process — Kotter and co-author Dan Cohen reveal the results of their research in over 100 organizations in the midst of large-scale change. What they found may surprise you. Although most organizations believe change happens by making people think differently — Kotter and Cohen say the key lies more in making them feel differently. They introduce a new dynamic — "see-feel-change" — that sparks and fuels action by showing people potent reasons for change that charge their emotions. Through true stories from real people, the authors present a play-by-play of challenges encountered, mistakes made, and lessons learned through each of the eight steps of change — and offer tips and tools readers can apply within their own organizations.