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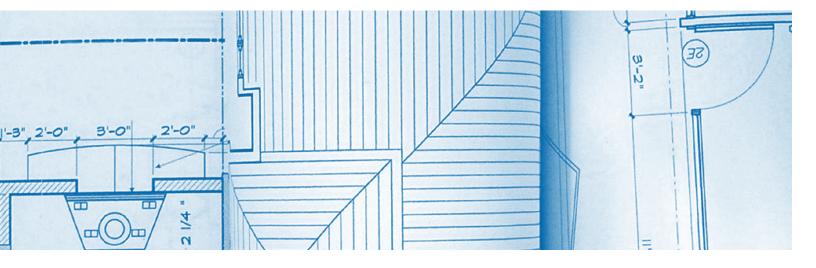
NPHHI

National Public Health
and Hospital Institute

ASSURING HEALTHCARE EQUITY

A Healthcare Equity Blueprint

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Letter from the Leadership
of Collaborating Organizations

The vision for *Assuring Healthcare Equity: A Healthcare Equity Blueprint* and the resources for its production were provided by the USDHHS/Office of Minority Health under the leadership of Dr. Garth Graham. Development of the *Blueprint* brought together national healthcare disparities experts and the experience and insight of members of the National Association of Public Hospitals and Health Systems, strategies for quality improvement designed by the Institute for Healthcare Improvement, and the research knowledge of The Disparities Solutions Center at Massachusetts General Hospital. We welcomed this unique opportunity for our organizations to work together on the critical issue of healthcare disparities. We expect that *Assuring Healthcare Equity: A Healthcare Equity Blueprint* will become a valuable resource for hospitals and providers to address healthcare disparities by offering strategies and interventions that can be adapted to individual organization settings and priorities.

In the 2007 *National Healthcare Disparities Report*, the Agency for Healthcare Research and Quality highlighted several activities that address the challenges in reducing healthcare disparities. The common elements of these activities are the focus on multiple stakeholders and the need for customized solutions for particular disparities and the patient populations involved. The strategies recommended in the *Healthcare Equity Blueprint* are grounded in both quality improvement techniques and in the involvement of patients and their communities.

It is our hope that this *Blueprint* will be used and further developed by hospitals and health systems across the country.

Sincerely,

Larry S. Gage

President

National Association of Public Hospitals

and Health Systems

Donald M. Berwick, MD, MPP, FRCP

President and Chief Executive Officer

Institute for Healthcare Improvement

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About The National Association of Public Hospitals and Health Systems (NAPH)

NAPH represents America's largest urban safety net hospitals and health systems. These facilities provide high-quality health services for all patients, including the uninsured, regardless of ability to pay. They also provide many essential community-wide services, such as primary care, trauma care, and neonatal intensive care and educate a substantial proportion of America's doctors and nurses. At the national level, NAPH advocates on behalf of its members on issues of importance to safety net health systems across the country. NAPH also conducts research on a broad range of issues that affect safety net hospitals.

About The National Public Health and Hospital Institute (NPHHI)

NPHHI is a private, nonprofit research and education organization established in 1988 to address the major issues facing public hospitals, safety net institutions, and underserved communities, as well as related health policy issues of national priority. NPHHI is an affiliate organization of NAPH. The Institute's membership includes the hospitals and health systems that comprise NAPH. The NPHHI board of directors includes public and nonprofit sector leaders in health policy and service delivery.

Acknowledgments

NPHHI Board of Directors 2007–2008

Contents

Tables

Executive Summary

In April 2007, the National Association of Public Hospitals and Health Systems (NAPH), through its research and education affiliate, the National Public Health and Hospital Institute (NPHHI), convened a meeting of national experts on healthcare disparities, quality improvement, and hospital administration. The purpose: to outline a framework for hospitals to address racial and ethnic disparities in healthcare.

NAPH represents America's largest urban safety net hospitals and health systems. Member hospitals provide inpatient and outpatient care to millions of uninsured and underserved patients across the county. These facilities serve a significantly higher percentage of individuals from diverse ethnic, racial, cultural, and linguistic backgrounds compared with hospitals nationally. Safety net organizations are a vital part of our nation's health delivery system: they increase access to care, provide vitally important specialty services, and help to educate the next generation of physicians.

The Institute of Medicine outlined six aims for quality improvement (QI): healthcare should be safe, effective, timely, patient-centered, efficient, and equitable.[1] This *Healthcare Equity Blueprint* focuses on strategies and practices that address equity in providing quality care. Quality and patient safety are an imperative and a challenge for all hospitals. Safety net organizations address

these requirements with the added pressures of financial constraints, huge patient volumes, and a substantial proportion of patients who do not speak English as their native language. In recognition of the importance of quality and patient safety, both as critical hospital values and for their financial impact, the NAPH Executive Committee adopted quality improvement as a major priority for the Association. The NAPH strategic plan for 2007-2010 includes the following language:

> *NAPH will enhance the quality of patient care in safety net hospitals to strengthen member performance and to underscore the need for continuing financial support.*

Implementation of this priority has been the principal responsibility of the NPHHI, which has undertaken a number of initiatives designed to build QI capacity of NAPH members. The U.S. Department of Health and Human

Services' Office of Minority Health (OMH), recognizing the importance of addressing disparities in the context of quality improvement, initiated the development of the *Blueprint* as a QI intervention tool.

The expert meeting held in April 2007 brought together more than 20 leaders in healthcare disparities and quality improvement from public hospital administration, government, foundations and the research community. The Institute for Healthcare Improvement (IHI) synthesized the expert group's input into practical strategies and approaches that hospitals, health centers, and individual providers can use to ensure that all patients receive the same high quality care. The Disparities Solutions Center at Massachusetts General Hospital provided expert review.

The genesis of this *Blueprint* stems from findings of the 2003 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, as well as insights from the *2007 National Healthcare Disparities Report,* produced by the Agency for Healthcare Research and Quality (AHRQ). The latter document highlights activities that address challenges in reducing healthcare disparities. The common element of such activities is the "focus on multiple stakeholders and the need for tailored solutions depending on the particular disparities issue and the populations involved."[2]

This *Blueprint* offers all U.S. hospitals and providers strategies to address dis-parities through interventions that can be tailored to the individual hospital setting. These strategies, developed with expert input have been grouped into the following five categories:

- Create Partnerships with the Community, Patients, and Families
- Exercise Governance and Executive Leadership for Providing Quality and Equitable Care
- Provide Evidence-Based Care for All Patients in a Culturally and Linguistically Appropriate Manner
- Establish Measures for Equitable Care
- Communicate in the Patient's Language—Understand and Be Responsive to Cultural Needs/ Expectations

Achieving healthcare equity is a daunting challenge for any hospital or healthcare system. Constrained hospital budgets, insufficient staffing, technology gaps, and the absence of patient data are critical barriers. The amount of information in this *Blueprint* may appear equally daunting. However, this document is intended as a comprehensive listing of approaches that hospital leaders and providers can implement on a piecemeal basis to achieve healthcare equity and to sustain this effort over time.

The *Blueprint* should be customized for a hospital's established systems of strategic planning, clinical services, patient care, administrative and infra-structure support, human resources management, and community relations.

A hospital may select categories of change around governance and leadership, clinical services, and/or language access to begin the process, and then subsequently take on other categories as the process of change develops and evolves within the hospital organization.

The *Blueprint* adds to the resource base for developing models to improve quality of care and to reduce the disparities in treatment and outcomes that persist for racial and ethnic minorities. Included in the *Blueprint* are a guide for its use, appendices addressing data collection and measurement, practical tools and resources for initiating change, an extensive reference list, and information regarding the 2007 NAPH Expert Working Group on Reducing Racial and Ethnic Disparities in Healthcare.

Introduction

Despite the long history of inequities in healthcare delivery, the scientific study of healthcare disparities is a relatively new field.[3] Publicity and public concern regarding healthcare disparities have increased dramatically in the last ten years.

1

Federal and state governments, leading healthcare foundations, and major employers have called attention to disparities in treatment and outcomes and to the urgent need to develop effective interventions. Some federal initiatives, such as *Healthy People 2010*, explicitly target reduction in disparities. Today, 13 of the nation's 48 state offices of minority health specifically identify "disparity reduction" or "equity" in their name,[4] and industries from hospitals to health insurance companies are working to ameliorate disparities by investing substantial resources in quality improvement efforts for all Americans.[5] Even with the increased attention and advances in the quality of care, persistent racial and ethnic health disparities continue to plague the U.S. healthcare system. Hundreds of studies have documented substantial gaps in access, quality of care and health outcomes by race, ethnicity, socioeconomic status, and gender.[6] Notable examples include surgical outcomes, access to ambulatory services, and outcomes for heart disease and certain cancers.[7] African American women are 67 percent more likely than White women to die from their breast cancer diagnosis;[8] Among those with HIV, Hispanics are almost 30 percentage points less likely to receive protease inhibitors during treatment than non-Hispanics;[9] poor individuals score lower on 63 percent of measures of quality care than their wealthier counterparts;[10] and African Americans wait twice as long as Whites for kidney transplantation.[11] Similarly women are less likely to receive evidence-based testing and treatment for heart disease than men.[12]

Poorer health outcomes also have an important financial impact that extend beyond the individual to the economy as a whole. For example, based on data for the year 2002, the economic cost of diabetes was $132 billion: $92 billion in direct medical costs and $40 billion in indirect costs, such as lost work days and restricted activity.[13] Because members of racial and ethnic minority groups are more likely to experience diabetes and its complications, the costs of the disease are disproportionately borne by already vulnerable populations and their employers. Similar statistics exist for other diseases that disproportionately impact minority populations, such as heart disease, premature births,

and HIV/AIDS, all of which are expensive to treat.

Given their commitment to provide care to all—regardless of ability to pay—NAPH members have long led the healthcare industry in providing quality care to diverse communities. Since the eighteenth century (New York City's Bellevue Hospital opened in 1736), U.S. public hospitals have been the "healthcare providers of first resort" for immigrant groups of virtually every ethnic and language background. Compared to other hospitals nationwide, NAPH members continue to care for a much higher percentage of individuals from ethnically and racially diverse backgrounds, as well as a greater percentage of individuals with limited English proficiency. More than one million discharges at NAPH member hospitals and health systems in 2006 were for patients who are members of racial and ethnic minorities, which represented more than 60 percent of these hospitals' total discharges.[14]

In *Crossing the Quality Chasm*, the Institute of Medicine called for a set of specific aims to ensure that healthcare is safe, effective, patient-centered, timely, and efficient, and equitable. NAPH responded to these aims and to the needs of its members by including quality and performance improvement among the major priorities in its 2007-2010 strategic plan. NAPH's efforts to build quality improvement in safety net hospitals are implemented primarily through NPHHI's research and education initiatives. Recognizing this, OMH helped to bring together NPHHI's focus on quality improvement and caring for diverse patients with IHI's expertise in building tools to effect lasting change.

In April 2007, NAPH gathered a group of national experts on disparities, hospital administrators, and other key stakeholders to identify strategies that help hospitals to reduce racial/ethnic disparities in healthcare. IHI synthesized the expert group's input into a set of specific steps hospitals can take to ensure that all patients receive the same high quality care. The Disparities Solutions Center at Massachusetts General Hospital provided expert review. This work was supported by funding from OMH.[15]

The *Blueprint* is a starting point for designing and implementing interventions tailored to the individual hospital. Aspects of this *Blueprint* apply to numerous healthcare settings, but the primary focus of the *Blueprint* is on hospitals. In addition, the *Blueprint* should be considered "a work in progress," to be improved and modified by hospitals that use it. Consequently, NPHHI plans to develop a system for capturing and disseminating feedback for future modifications to the *Blueprint*.

The proposed improvement strategies are grouped into the following five categories:

1. Create Partnerships with the Community, Patients, and Families
2. Exercise Governance and Executive Leadership for Providing Quality and Equitable Care
3. Provide Evidence-Based Care to All Patients in a Culturally and Linguistically Appropriate Manner
4. Establish Measures for Equitable Care
5. Communicate in the Patient's Language—Understand and be Responsive to Cultural Needs/Expectations

In addition to the change strategies, the *Blueprint* also provides:

- Guidance on using the *Blueprint*.
- Recommended tools and resources for implementing the *Blueprint* (Appendix A).
- Guidelines on the collection and measurement of data related to addressing healthcare disparities (Appendix B).
- A bibliography of key resources related to addressing disparities (Appendix C).
- A list of the participants in the expert working group on reducing racial and ethnic disparities in healthcare and the agenda from its April meeting (Appendix D).

How to Use this Blueprint

2

Executives and governing bodies may use this *Blueprint* to organize and prioritize the goals, strategies, expected outcomes, and performance benchmarks for addressing healthcare equity within their established strategic planning process.

Using the Healthcare Equity Blueprint

The *Blueprint* includes the following five categories:

1. Create Partnerships with the Community, Patients, and Families
2. Exercise Governance and Executive Leadership for Providing Quality and Equitable Care
3. Provide Evidence-Based Care to All Patients in a Culturally and Linguistically Appropriate Manner
4. Establish Measures for Equitable Care
5. Communicate in the Patient's Language—Understand and be Responsive to Cultural Needs/ Expectations

To understand how to use the *Blueprint*, review the first page of each table. The header identifies the **Category,** the column on the left lists a general idea for making improvements in care ("**General Change**"), and the column on the right offers more specific ideas ("**Specific Changes**") as a starting point for selecting strategies appropriate to each hospital.

Executives and governing bodies may use this *Blueprint* to organize and prioritize the goals, strategies, expected outcomes, and performance benchmarks for addressing healthcare equity within their established strategic planning process. Working groups within the hospital may identify specific ideas (from the column on the right) and identify changes in care and support operations that can be tested initially on a small scale within an organizational unit. The *Blueprint* categories are interrelated. Each category is part of an integrated system for providing quality care to a diverse patient population. Progress in one category will tend to have a positive effect on another. The key is to sustain this process of change over time throughout the organization while utilizing this *Blueprint* as a guide.

The Institute for Healthcare Improvement's *Model for Improvement*

As a principal collaborator in developing the *Blueprint*, IHI offers a *Model for Improvement* as a tool for implementing change strategies to achieve healthcare equity. IHI's process for developing a

set of recommendations to improve care delivery begins with high-level conceptual framework for a better functioning system of care. Rather than list a set of tasks that may not help drive improvement work, the IHI approach links each element in the conceptual framework to high-impact, testable, and actionable improvement ideas. Teams seeking to improve performance select change concepts that connect to their organization's strategic and operational priorities. IHI's approach to Plan–Do–Study–Act

(PDSA) cycles involve several key steps, such as planning improvement work, selecting interventions, studying (by measuring) the effect of the intervention, and adapting the intervention strategy to continually improve team or organizational performance.

Information on conducting PDSA cycle tests of change, are available at no cost on IHI's Web site (*www.ihi.org*). The *Improvement Methods* page is a helpful starting point and can be accessed at *www.ihi.org/IHI/Topics/Improvement/ImprovementMethods.*

Healthcare Equity Blueprint Categories

3

The *Blueprint* categories are interrelated. Each category is part of an integrated system for providing quality care to a diverse patient population. Progress in one category will tend to have a positive effect on another. The key is to sustain this process of change over time through– out the organization while utilizing this *Healthcare Equity Blueprint* as a guide.

Assess Community Needs and Develop Effective Community Engagement

GENERAL CHANGE	SPECIFIC CHANGES
The hospital understands that effective alliances and partnerships require an accurate assessment of community needs and productive community engagement. The hospital relates to the community as not just a recipient or consumer of healthcare, but as a partner in identifying needs, establishing priorities, developing programs, and promoting improved health status and effective healthcare for all.	■ Determine the resources both in the hospital and the community (formal and informal) that can be used to retrieve and update data on the needs of various racial, cultural, ethnic, linguistic, and socio-economic groups within the service area. ● Identify the sources of information that other organizations in the community use to determine the diverse factors related to patient needs, attitudes, behaviors, health practices, and concerns among the patient populations. ● Potential resources include: marketing enrollment, and termination data; census and voter registration data; school enrollment profiles; focus groups, interviews, and surveys; county and state health status reports; data from other community agencies and organizations; collaboration and consultation with faith-based and community organizations, providers, and leaders on conducting outreach, building provider networks, providing service referrals, and enhancing public relations; and community-member participation on hospital governing boards, advisory committees, ad hoc advisory groups, and hospital-community meetings. ■ Collaborate with other organizations to improve the capacity to obtain and update data for understanding the communities served and to accurately plan and implement services that respond to diverse needs. ● Use this information to plan, develop, and implement healthcare services that are responsive to the community served. ● Determine the costs involved in developing and implementing these services, the organizational barriers to be overcome, and strategies to overcome them.

Institutions that have often achieved excellence in medicine, medical education, and research now need to enter into the community where they are no longer experts. They have to risk being the student and give up command and control and share resources to build a new accountability with the community.

Ron Anderson, MD, President and CEO, Parkland Health & Hospital System, *Report of the National Steering Committee on Hospitals and the Public's Health*, Health Research and Educational Trust, 2006.

I. Create Engagement and Partnerships with the Community, Patients, and Families

Assess Community Needs and Develop Effective Community Engagement

An organization should help its workforce engage all individuals, including those from vulnerable populations, through interpersonal communication that effectively elicits health needs, beliefs and expectations; builds trust; and conveys information that is understandable and empowering.

Improving Communication-Improving Care, An Ethical Force Program Consensus Report, American Medical Association, 2006.

GENERAL CHANGE	SPECIFIC CHANGES
The hospital establishes and maintains forums for meeting with the community to identify key concerns, strategies for improving the public's health, and available community resources.	■ Identify local leaders, as well as community resources. ● Form alliances and collaborative relationships with key leaders and organizations. ● Meet with these leaders to identify solutions for improving the provision of quality healthcare. ● Create alliances and collaborative relationships with local, state, and national hospital associations that are working to reduce disparities in healthcare.
The hospital identifies and establishes linkages to community resources for patients, families, and staff.	■ Form alliances and partnerships with community service providers and social service agencies to facilitate seamless, appropriate referral processes. ■ Form alliances and partnerships with homeless shelters, faith-based organizations, and other community advocates to promote the provision of quality healthcare. ■ Collaborate with community organizations and advocacy groups to provide access to quality language services for limited English proficient (LEP) populations (See Category V).

I. Create Engagement and Partnerships with the Community, Patients, and Families

Assess Community Needs and Develop Effective Community Engagement

GENERAL CHANGE	SPECIFIC CHANGES
The hospital engages patients and families as both a cornerstone and a catalyst for improvement in the organization.	■ Establish a patient and family advisory council that is representative of the community and institutionalizes healthcare equity issues as part of the regular agenda. ■ Create an ombudsman program to ensure that grievance resolution processes are culturally and linguistically appropriate and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
The hospital engages patients and families in their plan of care.	■ Establish a shared understanding between the clinician and patient about the clinical condition and the recommended plan of care, including tests, medications, diet, and activity recommendations, based on the application of cultural competency training. ■ Provide self-care support and engage in collaborative decision making with patients. ■ Develop a self-management care process for patients.

Build Diversity and Equity into the Governance and Leadership System

GENERAL CHANGE	SPECIFIC CHANGES
The hospital's governing bodies and executive leaders represent, and are responsive to, the diverse populations served by their organizations.	■ Commit to seeking opportunities for underrepresented racial and ethnic minority professionals to serve on boards and in executive positions. ■ Identify pools of talented individuals from diverse racial and ethnic groups through networking and proactive outreach to professional associations, chambers of commerce, corporations, community leaders, and advocacy groups. ■ Provide a support system that will help new hospital board members evolve and enhance their competency in board matters through education, training, and mentoring.

II. Exercise Governance and Executive Leadership for Providing Quality and Equitable Care

Build Diversity and Equity into the Governance and Leadership System

GENERAL CHANGE	SPECIFIC CHANGES

The hospital ensures that healthcare equity is integral to its strategic plan.	■ Incorporate equity into a hospital strategic plan that is accepted and promoted by both the executive leadership and the governance body.
	  ● State explicitly any organizational intent to close racial and ethnic quality gaps where they exist.
	  ● Develop a plan that is appropriate to the population served by the hospital.
	■ Include in the strategic plan specific strategies for ensuring that all patients have access to high-quality services and affordable medications.
	  ● Develop efforts to ensure that patients have access to continuous and high quality care.
	■ Establish equity as a standard of care equal to the other aims for improvement identified by the Institute of Medicine in *Crossing the Quality Chasm* (i.e., safety, effectiveness, patient-centeredness, timeliness, and efficiency).[16]
	  ● Develop a dashboard report on equity for presentation to the hospital's governance body and make it available to staff, patients, and the community.
	  ● Integrate an equity dashboard report and other quality indicators by race and ethnic group into the regular governance body and management reports, as well as on the balanced scorecard for the hospital.
	■ Identify key hospital leaders who can help build equity into the strategic goals of the hospital.
	  ● Create a matrix of key leaders within the hospital who are committed to decreasing disparities and who will detail activities and responsibilities to ensure that all patients receive the highest quality care, regardless of race or ethnicity.
	■ Ensure that diversity and cultural competence training programs integrate community context as part of the strategic planning process.

II. Exercise Governance and Executive Leadership
for Providing Quality and Equitable Care

Build Diversity and Equity into the Governance and Leadership System

GENERAL CHANGE	SPECIFIC CHANGES
The hospital's business planning includes an organizational assessment, strategic planning, implementation, and monitoring process to evaluate progress and results on interventions to ensure equity.	■ Include in the hospital's planning process strategic objectives that focus on equitable care, processes, and services, as well as a strategy to develop the necessary resources. ■ Incorporate healthcare equity into the hospital's budgetary planning and implementation process. ■ Commit to a plan to recruit and retain a hospital workforce that represents the diversity of the patient population. ■ Identify and develop a sustainable funding source for culturally and linguistically competent care, including provision of quality medical interpreters and translation services for all patients. ■ Collaborate with other hospitals and healthcare organizations in the community on developing strategies for leveraging available financial and infrastructure resources to improve culturally and linguistically competent care.

II. Exercise Governance and Executive Leadership for Providing Quality and Equitable Care

Build Diversity and Equity into the Governance and Leadership System

GENERAL CHANGE	SPECIFIC CHANGES
Equitable healthcare for diverse populations becomes part of the hospital's environment, policies, and practices and is supported with effective operational and administrative infrastructure supports.	■ Develop strategic goals to measure and increase workforce diversity in the hospital. ■ Establish cultural competence assessment teams to evaluate policies addressing the hospital's responsiveness to its diverse workforce and patient population. ■ Develop recommendations and implementation plans for culturally and linguistically appropriate services in accordance with the National Standards for Culturally and Linguistically Appropriate Services in Healthcare (*CLAS Standards*) developed by the U.S. Department of Health and Human Services' Office of Minority Health.[17] ■ Create accountability measures designed to improve customer service and quality of care. ■ Utilize technology to standardize the hospital's collection of race, ethnicity, language, and socio-economic status (SES) data; where possible, analyze data for quality measures by each of these factors to quantify the hospital's progress towards eliminating these demographic differences in quality of care. ■ Redesign the hospital's physical plant, including exterior and interior signage, to help LEP patients access services.[18]

When most of us think about the legacy of Martin Luther King, Jr., what comes to mind is his role in the real progress toward racial equity that this country has achieved over the 38 years since his death, in areas such as employment, voting rights, housing, and education. Despite the major racial and ethnic gaps that still exist in each of these areas, concrete, measurable gains have been realized, and as a nation we should be justly proud…We should be equally humbled and chagrined by the vast racial and ethnic disparities and inequities that continue—42 years after passage of the Civil Rights Act of 1964—in Americans' health status and access to healthcare.

Health Disparities and Martin Luther King Jr.'s Unfinished Civil Rights Agenda, George C. Halvorson, Chairman & CEO, Kaiser Foundation Health Plan and Hospitals, 2007.

Develop Evidence-Based Practice for Equitable Care

GENERAL CHANGE	SPECIFIC CHANGES
The hospital ensures that all patients receive high quality, evidence-based care.	■ Adopt standard order sets and/or treatment guidelines, with automated reminders for conditions, that have published as best practices for various conditions (e.g., acute myocardial infarction, congestive heart failure, community-acquired pneumonia, stroke, hypertension, diabetes, immunizations, as well as for preventive care). ■ Adopt a set of orders that provides evidence-based treatment guidelines to the provider. If a provider judges that the patient should not be offered a recommended treatment, test, or procedure, allow the provider to opt out of following that particular best practice only with documented justification. ■ Create systems to ensure that timely interpreter services are available at the bedside (See Category V).

The benefits of evidence-based medicine, thus defined, have been immense. Patients today can count on a growing proportion of the tests, diagnostic processes, surgical procedures, and other costs and risks in care to have been subjected to proper systematic evaluation. The very definition of 'quality' in health care has now come to incorporate the use of scientific evidence in practice; that is what the Institute of Medicine meant in its call for improvement of 'effectiveness' as a key aim for improving care. Gaps between science and practice remain wide, but we seem increasingly committed to closing them. That is good.

Donald M. Berwick, MD, MPP, FRCP, President and CEO, IHI, *Broadening the View of Evidence-Based Medicine*, Quality and Safety in Healthcare, 2005.

III. Provide Evidence-Based Care for All Patients in a Culturally and Linguistically Appropriate Manner

Develop a Culturally and Linguistically Appropriate Care Model

GENERAL CHANGE	SPECIFIC CHANGES
The hospital's leadership and staff understand that equitable care for diverse populations requires that cultural and linguistic competence be an essential element in the design, administration, and delivery of effective services.	Administrators and clinicians need to identify: 1. Effects of cultural and linguistic differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative end-of-life care; 2. The impact of socio-economic status (SES), race and racism, ethnicity, and socio-cultural patient factors on access to care, utilization, quality of care, and health outcomes; 3. Differences in the clinical management of preventable and chronic diseases and conditions by differences in the race or ethnicity of patients; and 4. The effects of cultural differences between patients and staff, and develop strategies to address these within the design, administration, and delivery of services. Steps to implement the above might include the following: ■ Collaborate with other hospitals and healthcare training resources in the community to improve clinician training and capacity in this area. ■ Provide an environment in which patients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices when negotiating treatment options with their providers. ■ Engage consumer, family, and community participation in the planning and delivery of services. Establish effective linkages and partnerships with other healthcare providers and community resources. *Please Note:* Key resources related to this specific change can be found in Appendix A. In particular, see *Finding Answers: Disparities Research for Change Program* at the University of Chicago and *The Disparities Solutions Center* at Massachusetts General Hospital.

III. Provide Evidence-Based Care for All Patients in a Culturally and Linguistically Appropriate Manner

Provide Effective Workforce Training and Education Oriented Towards Providing Equitable Care

GENERAL CHANGE	SPECIFIC CHANGES
The hospital's administrative and clinical leadership implements staff development programs that support culturally and linguistically appropriate evidence-based care.	■ Determine what workforce training and education programs are needed for staff to achieve cultural and linguistic competence. ■ Organize the hospital's workforce training and education programs to ensure that they: ● Are tailored to the particular functions of the trainees and the needs of the specific populations served; ● Educate staff on the effects of cultural differences between staff and patients within clinical settings; ● Include the hospital's language access policies and procedures (e.g., relevant laws and how to access interpreters and translated written materials); ● Successfully train staff on the elements of effective communication between staff and patients of different cultures and languages (e.g., working respectfully and effectively with interpreters; improving awareness of cultural differences such as religion, diet, and male-female relations); and ● Educate staff on strategies and techniques for recognizing and resolving racial, ethnic, or cultural conflicts with patients and other staff. ■ Collaborate with other healthcare organizations to improve workforce training and education programs in the community.

III. Provide Evidence-Based Care for All Patients in a Culturally and Linguistically Appropriate Manner

Provide Effective Workforce Training and Education Oriented Towards Providing Equitable Care

GENERAL CHANGE	SPECIFIC CHANGES
At times of transitions in care, the hospital's leadership and staff ensure both that communication with patients, families, and caregivers and coordination with clinical providers are handled consistently and effectively.	■ Develop a treatment summary as part of the patient record and make it available to providers and patients, in the patient's language and at the appropriate level of health literacy, during every care interaction. ■ Provide and/or facilitate the use of culturally and linguistically competent patient advocates. ■ Provide training for clinical staff to understand which family or community members are appropriate to invite to family meetings or to be present at time of discharge. ■ Include information related to language, culture, literacy, and SES issues in treatment plans, transitions, and reports.

Implement Data Guidelines from The Institute of Medicine

GENERAL CHANGE	SPECIFIC CHANGES
The hospiatl acknowledges the need for data on patient race, ethnicity, and primary language.	Ensure that every patient is identified accurately by race/ethnicity and primary language by using standard definitions on admission and in contacts with hospital services. It is highly recommended that hospitals standardize: ■ Who provides information, patient (self-identification is best) ■ When data are collected, ■ Which racial and ethnic categories are used, ■ Why race/ethnicity data are being collected, ■ How data are stored, and ■ How patients' concerns are addressed. It is recommended that hospitals utilize the Health Research and Educational Trust's (HRET) *Disparities Toolkit*—a practical Web-based tool that provides hospitals, health systems, clinics, and health plans with resources for systematically collecting such data from patients. (*www.hretdisparities.org*) Specific changes for establishing measurement strategies are detailed in Appendix B.

Analyze and Monitor the Data

GENERAL CHANGE	SPECIFIC CHANGES
The hospital's focus on measurement in reducing disparities is to ensure that all patients receive the appropriate standard of care. If this standard is not met, the hospital ensures that data is available in a format that allows stratifying by race, ethnicity and language to determine if gaps in quality care are present.	Determine whether patients receive all recommended care in a timely fashion and how patients perceive their care: ■ Compare the hospital's service population by race, ethnicity, and language data with those of the catchment community to identify disparities in access or accessibility. ■ Analyze clinical quality indicators for all patients to determine if gaps in quality exsists by race, ethnicity, or primary language. ■ Link patient demographic information to patient satisfaction surveys and analyze grievances and complaints filed to determine if differences in satisfaction fall along racial or ethnic lines. ■ Analyze medical errors by patient race, ethnicity, and primary language to identify and address patterns.
The hospital analyzes performance in providing timely patient access to culturally and linguistically competent services.	■ Determine the percent of clinical staff trained in culturally and linguistically competent care. ■ Evaluate the percent of completed race, ethnicity, and language data fields completed. ■ Analyze the demand and supply of language services. ■ Analyze time to bedside for supplying language services when needed.

Standardized data collection is critically important in the effort to understand and eliminate racial and ethnic disparities in healthcare. Data on patient race, ethnicity, and primary language would allow for disentangling the factors that are associated with healthcare disparities, help plans monitor performance, ensure accountability to enrolled members and payers, improve patient choice, allow for evaluation and intervention programs, and help identify discriminatory practices.

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, Institute of Medicine, 2002.

Use the Analysis for Improvement

GENERAL CHANGE	SPECIFIC CHANGES
Feedback on performance is provided to the hospital's clinical and administrative leadership for needed design change or improvement activities.	■ Create a timely feedback and learning process to ensure that data on clinical quality and service performance are communicated to clinical and administrative leaders. ■ Consider using report cards or dashboards to measure organizational performance on eliminating disparities by applying evidence-based guidelines of care and language services. (See Massachusetts General Hospital's *Creating Equity Reports: A Guide for Hospitals* at *<www.mghdisparitiessolutions.org>*.) ■ Consider provider-level report cards on clinical quality indicators and appropriate utilization of language services that are stratified by patients' race, ethnicity, and language data. ■ Evaluate clinical quality and service performance data over time to measure the impact of process changes. ■ Use data to determine gaps in individual patient care (or experience of care) and study the process leading to gaps in care or service delivery or quality. Apply this knowledge to system redesign or improvement.
The hospital establishes a goal of no disparities in care based on race, ethnicity, language, or SES.	■ Use data to benchmark the gaps in care based on race, ethnicity, language, and SES. ■ Benchmark performance and goals on best known results nationally. ■ Undertake small-scale tests of change to improve process gaps identified above until performance goals are achieved. ■ Apply reliability principles to ensure that improved processes are spread reliably throughout the organization.

V Communicate in Patient's Language—Understand and Be Responsive to Cultural Needs/Expectations

Provide Sufficient, Well Trained Interpreter Services

GENERAL CHANGE	SPECIFIC CHANGES
The hospital communicates with patients and families in the patients' own language and is responsive to the patients' cultural needs. This may involve using interpreter services, offered by trained and competent staff, and distributing well-translated written materials.	■ Identify the primary language during interaction with patient (e.g., identify language preferences of patients using existing materials such as the "I Speak" card). ■ List in a visible and accessible manner the local options for culturally appropriate medical interpreters (e.g., telephone or in-person interpreters). ■ Create a language and interpretation plan that follows the patient through all healthcare interactions (e.g., assign a medical interpreter when diagnostic test, procedure, or family meeting is scheduled). ■ Inform patients of guidelines pertinent to their care in a culturally and linguistically appropriate manner. ■ Organize language access and interpreter services to ensure the availability of interpreters and translated materials as needed for safe and high quality patient care. ■ Assess and ensure the training and competency of interpreters. ■ Ensure that translated materials and signs accurately convey the meaningful substance of materials written in languages other than English. ■ Collaborate with other hospitals in the area to improve language access and interpreter services in the community. *See:* American Medical Association's (AMA) Institute for Ethics/Ethical Force Program organizational assessment toolkit for patient-centered communication, available at: *<www.ama-assn.org/ama/pub/category/ 18225.html>*.

Research documents how the lack of language services creates a barrier to and diminishes the quality of healthcare for limited English proficient (LEP) individuals. Over one quarter of LEP patients who needed, but did not get, an interpreter reported they did not understand their medication instructions, compared with only two percent of those who did not need an interpreter and those who needed and received one. Language barriers also impact access to care—non-English speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than do English speaking patients. Language access is one aspect of cultural competence that is essential to quality care for LEP populations.

LEP Language Access Coalition—Statement of Principles, Washington DC, 2004.

V. Communicate in Patient's Language—Understand and Be Responsive to Cultural Needs/Expectations

Ensure the Accuracy and Cultural Appropriateness of Translated Materials

GENERAL CHANGE	SPECIFIC CHANGES

The hospital provides oral and written educational and community resource materials in a culturally appropriate manner, in the appropriate language, and at the correct level of literacy.	■ Develop a process to create mass customization of written patient information, based on collected race, ethnicity, language, and socio-economic characteris-tic data of the hospital patient population.
	■ Provide opportunities to amend these prepared documents at the point of care (e.g., hospital ward, procedure room for consent).
	■ Establish written follow-up instruction and support as a standard part of every clinical interaction, including the patient verbalizing understanding and agreement with the plan.
	
	See: Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals, The Commonwealth Fund, August 2006, available at: <*www.cmwf.org/usr_doc/ Wynia_promisingpracticespatientcentered_947.pdf*>.
	    See: An Ethical Force; Program™ Consensus Report, Improving Communication—Improving Care, AMA Institute for Ethics, 2006, available at: <*www.ama-assn. org/ama1/pub/upload/mm/369/ef_imp_comm.pdf*>.
	    See: A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations, Office of Minority Health U.S. Department of Health and Human Services, September 2005, available at: <*www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf*>.

V. Communicate in Patient's Language—Understand and Be Responsive to Cultural Needs/Expectations

Develop Resources for Language Access

GENERAL CHANGE	SPECIFIC CHANGES
The hospital develops external and internal resources for healthcare language access.	■ Strategize within the hospital and advocate outside the hospital for improved healthcare financing of language access for LEP populations. ■ Hire appropriately-trained bi- and multi-lingual staff, including those fluent with American Sign Language. ■ Provide competency training for medical interpretation. ■ Ensure that all visual and written signs and materials are in the specified languages of the hospital's patient population. ■ Use *promotoras*, navigators, and care managers trained in the language and culture appropriate to the patient population. It is recommended that hospitals utilize the following premier resources in the area of health care language access: ■ *Hablamos Juntos <www.hablamosjuntos.org>*: Established with support from The Robert Wood Johnson Foundation, this program provides technical assistance and guidance on interpreter training, signage and print materials. Hablamos Juntos also seeks to raise visibility and understanding about language barriers nationally through dissemination of material, development of a science base, and production of a set of practice-oriented tools. ■ *Speaking Together <www.speakingtogether.org>*: Also supported by the Robert Wood Johnson Foundation, this project integrates quality improvement with language services, and brings together hospitals to pilot new performance measures and to test valuable techniques for reducing healthcare disparities associated with language barriers.

V. Communicate in Patient's Language—Understand and Be Responsive to Cultural Needs/Expectations

Ensure Smooth Transitions in Care

GENERAL CHANGE	SPECIFIC CHANGES
	■ The National Health Law Program (NHeLP) is an organization focused on national public interest law. It seeks to improve healthcare for America's working and unemployed poor, minorities, the elderly and people with disabilities. Language access is a key issue area for NHeLP, which has organized a coalition of national organizations to develop an agenda around improving access to health care for LEP individuals. The NHeLP Web site <*www.healthlaw.org*> contains many useful resources in the area of language access.
The hospital measures performance in communication at times of transitions.	■ Develop processes to communicate with ambulatory providers at clinical transitions (e.g., admission, discharge, and end of life). ■ Upon discharge, provide patients and families with written information on clinical status, follow-up plans, and who to call if clinical deterioration occurs. ■ Ensure that ambulatory follow-up visits are scheduled at time of discharge and included in the patient's follow-up plan. ■ Ensure that ambulatory providers receive a sufficiently detailed clinical summary to facilitate meaningful follow-up in the post-acute care setting. ■ Include information related to language, culture, literacy, and SES issues in treatment plans, transitions, and reports.

The following resources are recommended to assist in the use of the *Healthcare Equity Blueprint*:

The Health Research and Educational Trust Disparities Toolkit

The *Disparities Toolkit* produced by the Health Research and Educational Trust (HRET) is a practical, Web-based tool that provides hospitals, health systems, clinics, and health plans with information. It offers resources for systematically collecting race, ethnicity, and primary language data from patients. This toolkit is useful for educating key hospital staff about the importance of data collection, how to implement a framework to collect demographic data, and ultimately, how to use these data to improve quality of care for all populations. HRET's toolkit can be accessed at: <*www.hretdisparities.org*>.

Finding Answers: Disparities Research for Change

In 2005, The Robert Wood Johnson Foundation launched a national program at the University of Chicago, *Finding Answers: Disparities Research for Change*, to evaluate interventions and their potential for broad dissemination. Led by Marshall H. Chin, MD, MPH, Associate Professor of Medicine and Director of General Internal Medicine Research, the program describes best practices with respect to quality improvement strategies specifically targeted at minority patients. *Finding Answers: Disparities Research for Change* seeks to improve the quality of healthcare provided to patients from racial and ethnic backgrounds likely to experience disparities.

Through a systematic review of the racial and ethnic disparities intervention literature, the program found three strategies that are often part of successful interventions:

1. Implementing multifaceted programs with multiple components targeting different levers of change, such as providers, patients, and the community.
2. Ensuring a focus on cultural relevancy by creating intervention materials (e.g., posters, pamphlets) with culturally-congruent images and in languages other than English. This produces successful outcomes that increases patient knowledge and understanding of self-care, decreases barriers to access, and improves multiple areas of cultural competency for healthcare providers.
3. Establishing patient-centered interventions implemented by nurses, who often spend more time with patients and provide critical care coordination, affect systemic change within an organization.

Appendix A

Finding Answers: Disparities Research for Change offers useful tools, resource links, and models for implementing change in quality improvement strategies for addressing disparities. These include:

- *Finding Answers Intervention Research (FAIR) Database.* The FAIR Database contains journal article summaries from a systematic review of racial and ethnic healthcare disparities interventions. Diseases examined in this database are highly prevalent, cause significant morbidity and mortality, have clear standards of care, and have documented disparities in care (i.e., diabetes, depression, breast cancer, and cardiovascular disease). The FAIR Database is searchable by health topic, racial/ethnic population, organizational setting, and intervention strategy, and provides a customized list of interventions based on the categories selected.
- *Special Supplement of Medical Care Research and Review on Health Disparities—October 2007.* A review of the racial and ethnic health disparities intervention literature identifies successful strategies and provides healthcare organizations, providers, and payers with recommendations on how they can address disparities in their own organizations. This literature review examined more than 200 articles that outline interventions with the potential to reduce racial and ethnic disparities in the areas of cardiovascular disease, diabetes, depression, and breast cancer. Additionally, the research surrounding two specific approaches—cultural leverage and pay-for-performance incentives—were considered.

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Chien A, Chin M, Davis A, & Casalino L. "Pay for Performance, Public Reporting, and Racial Disparities in Healthcare: How Are Programs Being Designed?" *Med Care Res Rev*, 64: 283S –304S, 2007.

   The Finding Answers: Disparities Research for Change program's web site can be accessed at: *<www.solvingdisparities.org>*.

Appendix A

Key Healthcare Language Access Resources

HABLAMOS JUNTOS

Hablamos Juntos (Spanish for "We Speak Together") is designed to connect health-care providers and the rapidly growing Latino health market. As a national pro-gram of The Robert Wood Johnson Foundation, *Hablamos Juntos* established ten demonstration sites around the country. These sites, ranging from health plans and large hospital systems to small nonprofit community organizations, have worked to improve communication between healthcare providers and Latino patients and to eliminate language barriers that can lead to medical errors and compromise the quality of care.

Program sites have tested model approaches, including using tools to assess existing language and interpreter services. These demonstration sites also have iden-tified organizational policies that promote affordable language services. Resources available on the *Hablamos Juntos* Web site <*www.hablamosjuntos.org*> fall into the following categories:

- The state of healthcare for LEP
- Population change and language data
- The business case for language access
- Legal requirements and government policy related to language access
- Organizational approaches to language access
- Interpreters and interpreting
- Translation and quality written materials
- Signage
- Ethics and culture

SPEAKING TOGETHER

Speaking Together: National Language Services Network <*www.speakingtogether.org*>, also funded by the Robert Wood Johnson Foundation, is a national program aimed at identifying, testing and improving the ways that hospitals provide language services to LEP patients. Through a learning collaborative of ten hospitals, strategies for improving the quality and availability of language services are assessed and shared with hospitals throughout the nation. *Speaking Together* integrates "quality improve-ment techniques with hospital-based language services activities to reduce healthcare disparities faced by patients across America."

The core component of *Speaking Together's* work is a 16-month collaborative process that allows ten acute care hospitals to pilot interventions using quality improvement tools in three specific areas:

- Improving the quality and accessibility of language services for patients with LEP;
- Using quality performance measures to monitor improvements in the delivery of language services to patients; and
- Focusing on quality improvement in cardiovascular disease, depression, or diabetes mellitus in order to demonstrate how quality of care can be affected by improvements in language services and communication.

THE NATIONAL HEALTH LAW PROGRAM

The National Health Law Program (NHeLP) is an organization that focuses on national public interest law. It seeks to improve healthcare for America's working and unemployed poor, minorities, the elderly and people with disabilities. NHeLP serves legal services programs, community-based organizations, the private bar, providers, and individuals who work to preserve a healthcare safety net for the millions of uninsured or underinsured low-income people.

Language access is a key issue area for NHeLP, which has organized a coalition of national organizations to develop an agenda around improving access to healthcare for individuals with limited English proficiency (LEP). NHeLP's Web site *<www.healthlaw.org>* contains many useful resources in the area of language access. For example, see: *<www.healthlaw.org/library/folder.56882-Language_Access_Resources>.*

DIRECT LINKS TO KEY LANGUAGE ACCESS PUBLICATIONS

- *Language Access in Healthcare Statement of Principles: Explanatory Guide* (revised November 2007). See: *<www.healthlaw.org/library/item.121215>*
- *Language Services Resource Guide for Healthcare Providers* (October 2006). See: *<www.healthlaw.org/library/item.118835>*
- Issue Brief—*Patients with Limited English Proficiency: Results from a National Survey* (October 2006). See: *<www.healthlaw.org/library/item.118641>*

Appendix A

The Disparities Solutions Center at Massachusetts General Hospital

- *Creating Equity Reports: A Guide for Hospitals* provides a detailed framework for equity reporting and sharing lessons learned from experience. It also includes information on the *Massachusetts General Hospital's Disparities Dashboard* and on measures that have been used in hospital–based research studies of healthcare equity. The guide can be found at: *<www.mghdisparitiessolutions.org>.*
- The *Disparities Leadership Program* is a year–long executive education program designed for leaders from hospitals, health plans, and other healthcare organizations to develop a strategic plan or to advance a project to eliminate racial and ethnic disparities in healthcare, particularly through quality improvement. The program is jointly sponsored by the National Committee for Quality Assurance and is supported by Joint Commission Resources, an affiliate of The Joint Commission.
- The Disparities Leadership *Toolkit* focuses on making readily available to hospital executives and leaders the evidence needed for addressing disparities. The toolkit presents key data about health disparities as well as basic strategies to monitor and address them. Released in June 2008, the toolkit is available at: *<www.mghdisparitiessolutions.org>.*

Race/Ethnicity Data Collection

Many hospitals routinely collect data on race, ethnicity, and language, but many find it challenging. Ensuring equity in healthcare requires that such data are collected. To assist in achieving this aim and to standardize the use of the data, the Health Research and Educational Trust (HRET) has recommended a structure to help hospitals uniformly collect patients' race, ethnicity, and primary language data.[19] Key elements are as follows:

1. **Hospitals should standardize who provides information.** Patients or their caretakers are more likely to provide accurate information about patients' race, ethnicity, and language than an admitting clerk or healthcare provider based on observation.
2. **Hospitals should standardize when data are collected.** Collection of data on patients' race, ethnicity, and language upon admission or registration will ensure that appropriate fields are completed when a patient begins treatment at the hospital.
3. **Hospitals should standardize which racial and ethnic categories are used.** Hospitals should use the Office of Management and Budget (OMB) categories (see Table 1). Additionally, hospitals might also use more specific categories for Hispanic or Asian groups, for example, that could then expand to broader U.S. Bureau of the Census categories, as needed.
4. **Hospitals should standardize how data are stored.** Race, ethnicity, and language data should be stored in a standard format that is compatible across hospitals and health systems. Many of the newer data systems have separate fields for race, ethnicity, and primary language that facilitate exporting and importing this data merging with clinical data files.
5. **Hospitals should standardize their responses to patients' concerns.** Prior to collecting the information, hospitals should address patients' concerns about the ways in which data on race, ethnicity, and language will be used. Hospitals should also offer a uniform rationale to all patients before asking them to identify their racial/ethnic background.

Appendix B

To help the user of this *Blueprint* analyze data for developing appropriate equity measures, the Institute for Healthcare Improvement has outlined the various types of measures and offers examples with explanatory charts and tables. They include:

1. **System Measures** (Hospital Level)—These focus on whether all patients receive the standard of care that matches their needs. Patients who do not meet the standard of care are then stratified by the race/ethnicity categories standardized by the Federal Office of Management and Budget (See Table 1).
2. **Structure Measures**—These help to indicate if a particular hospital has the existing structure to ensure high-equity outcomes (see Table 2). Examples of structure measures include:
   - Percent of staff with diversity training;
   - Percent of staff that represent the demographics of the patient population; and
   - Number of training hours per staff member on equity issues.
3. **Balancing Measures**—These give an indication of the effect of the tested changes on the overall system. They provide insight into the possible unintended effects of the changes on equity. Examples include:
   - Patient satisfaction relative to equity;
   - Number of complaints per 100 patients related to equity issues;
   - Costs due to equity issues such as training; and
   - Costs per patient for lawsuits and malpractice.

Summary

Strategies for collecting and utilizing data for measurement are suggested here to support the overall aim of the *Healthcare Equity Blueprint* and can be summarized as follows:

- The focus of the effort to reduce disparities is to ensure that all patients receive the appropriate standard of care.
- If this standard is not met, data should be stratified to determine if quality gaps are present for affected patients based on race, ethnicity, or language.
- While direct measures are important to ensure equity, important "structure measures" should also be tracked to achieve sustainability.
- "Balancing measures" are also important; with any effort, questions will be raised about the effect on patient satisfaction and the impact on costs to achieve gains.

TABLE 1	Categories for Classification of Race and Ethnicity

Race and ethnicity mandated by the Federal Office of Management and Budget for use by the Census Bureau:

Race

White

Black or African American

American Indian or Alaska Native

Asian

Native Hawaiian or Other Pacific Islander

Some Other Race

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

SOURCE U.S. Bureau of the Census Internet Release date: October 1997 and updated *www.census. gov/population/www/socdemo/race/racefactcb.html.*

Note: Hospitals that wish to use more refined classifications of race and ethnicity should consult the *Health Research and Educational Trust Disparities Toolkit* **that can be accessed at** *<www.hretdisparities.org>*. **The toolkit will guide the user in utilizing the Centers for Disease Control and Prevention's National Center for Health Statistics recommended classifications.**

Appendix B

TABLE 2	Measures, Definitions, Sources of Data, and Sampling Plan		
Measures	**Definition**	**Source of Data**	**Sampling Plan**
1. Percent of patients who do not receive a prescribed standard of care for specific clinical issues.	Collect data for all patients who have been given care. Compare the actual care given to the established standard of care. Classify patients into one of two groups: 1) Care given matched the standard, and 2) Care given did not match the standard.	Patient Database/ registry	Weekly or Monthly. On the last workday of each week or month, search the clinical information system for all patients who received the identified care plan and classify patients according to the standard of care.
2. Variation (gap measure) for all patient groups for specific clinical issues collected over time.	Given Measure 1, divide patients into racial, ethnic, or language groupings. Measure the gap between these groups relative to the percentage of patients receiving the prescribed standard of care.	Patient Database/ registry	Weekly or Monthly. Stratify the data from Measure 1 into the categories provided in Table 1.
3. Percent of staff with diversity training.	Percent of the staff of the hospital or clinic that has received diversity training for race, ethnicity, or language.	Human Resources	Monthly or Quarterly. This depends on size of employee population and turnover. Less frequent sampling may be more useful.
4. Percent of staff that represent the demographics of the patient population.	Identify staff race, ethnicity, and language and compare with the demographics of the patient population served.	Human Resources	Monthly or Quarterly. This depends on size of employee population and turnover. Less frequent sampling may be more useful.
5. Number of training hours per staff member on equity issues.	Total hours in training divided by total staff.	Human Resources	Monthly or Quarterly. This depends on size of employee population and turnover. Less frequent sampling may be more useful.
6. Patient satisfaction relative to equity.	Questions related to race, ethnicity and language are integrated into patient satisfaction surveys.	Patient Surveys	Weekly or Monthly. Collect survey data when patient and family are discharged from the hospital.
7. Number of complaints per 100 patients related to equity issues.	Complaints are collected by staff and reported through a formal system.	Formal Complaint System	Weekly or Monthly
8. Costs due to equity issues (training, etc.).	Resources dedicated to ensuring equity are tracked and reported.	Accounting	Monthly or Quarterly
9. Dollars per patient for lawsuits and malpractice per patient.	Total dollars allocated to lawsuits and malpractice divided by patient population served.	Accounting	Monthly or Quarterly

SOURCE **Institute for Healthcare Improvement**

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Appendix C

Web Links

Agency for Healthcare Research and Quality
www.ahrq.gov
www.qualityindicators.ahrq.gov

American Medical Association—Ethical Force Program
www.ethicalforce.org

California Healthcare Safety Net Institute
www.safetynetinstitute.org

Center for Health and the Social Sciences
http://chess.bsd.uchicago.edu

Community Voices: Healthcare for the Underserved
http://www.communityvoices.org

Cross Cultural Healthcare Program
www.xculture.org

Diversity Rx
www.diversityrx.org

EthnoMed
www.ethnomed.org

Expecting Success: Excellence in Cardiac Care
www.expectingsuccess.org

Finding Answers: Disparities Research for Change
www.solvingdisparities.org

Greater New York Hospital Association—Center for Trustee Initiatives and Recruitment
www.gnyha.org

Hablamos Juntos—Language Policy and Practice in Healthcare
www.hablamosjuntos.org

Health Disparities Collaboratives
www.healthdisparities.net/hdc/html/home.aspx

Health Research and Educational Trust
www.hret.org

Institute for Healthcare Improvement
www.ihi.org

Kaiser Permanente—National Linguistic & Cultural Programs
www.kphci.org

National Committee for Quality Assurance
www.ncqa.org

National Council on Interpreting in Healthcare
www.ncihc.org

National Minority Quality Forum
www.nmqf.org

National Public Health and Hospital Institute
www.npphi.org

National Quality Forum
www.qualityforum.org

Robert Wood Johnson Foundation
www.rwjf.org

Speaking Together: National Language Services Network
www.speakingtogether.org

The California Endowment
www.calendow.org

The Commonwealth Fund
www.commonwealthfund.org

The Disparities Solutions Center
www.massgeneral.org/disparitiessolutions

The Joint Commission—Hospitals, Language, and Culture
www.jointcommission.org/PatientSafety/HLC

The National Health Law Program
www.healthlaw.org

USDHHS—Office of Minority Health Resource Center
www.omhrc.gov

University HealthSystem Consortium
www.uhc.edu

University of California, San Francisco—The Network for Multicultural Health
http://futurehealth.ucsf.edu/TheNetwork

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Appendix D

National Association of Public Hospitals and Health Systems/National Public Health and Hospital Institute

Expert Working Group on Reducing Racial and Ethnic Disparities in Healthcare

April 11, 2007
Jurys Washington Hotel, Washington, DC

AGENDA

9:00 a.m.   **CONTINENTAL BREAKFAST AND REGISTRATION**

10:00 a.m.   **WELCOME AND INTRODUCTIONS**
Moderator: Linda Cummings, PhD, Vice President of Research/Director of NPHHI
Speakers: Larry S. Gage, JD, President, NAPH; Garth Graham, MD, Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services; M. Rashad Massoud, MD, Senior Vice President, Institute for Healthcare Improvement

10:30 a.m.   **CURRENT STRATEGIES FOR REDUCING DISPARITIES IN HEALTHCARE**
Content Leader: Bruce Siegel, MD, MPH, Research Professor in the Department of Health Policy, The George Washington University Medical Center, School of Public Health and Health Services

Topics:
- Current issues in reducing disparities
- Best known methods/known interventions
- Promising outcomes
- Measurements

WHAT HOSPITALS AND PROVIDERS CAN DO TO REDUCE DISPARITIES?
Group Workshop/Exercise: Will, Ideas and Execution
Facilitators: Sue Leavitt Gullo, RN, MS, Director, Institute for Healthcare Improvement; Clifford L. Norman, BS, Consultant, Associates in Process Improvement, Senior Fellow, Institute for Healthcare Improvement

Objectives:
- Defining the scope (which interventions apply)
- Identify the gap between what's known and what's practiced
- Designing a good system of care

1:30 p.m. REVIEW IDEAS GENERATED IN THE MORNING SESSION

Facilitators: Sue Leavitt Gullo, RN, MS; Clifford L. Norman, BS

Objectives:
- Identify any missing ideas from the morning's exercise
- Identify promising ideas that are achievable

2:00 p.m. GOALS AND MEASUREMENT RECOMMENDATIONS

Facilitator: Clifford L. Norman, BS

Objectives—Given the current state of knowledge:
- Identify ambitious but achievable targets
- Define what measures work best

3:00 p.m. BREAK

3:10 p.m. NEXT STEPS: TESTING AND DISSEMINATION

Moderator: Bernice Bennett, MPH, CHES, Assistant Vice President for Quality and Performance Improvement, NAPH
Facilitators: Bruce Siegel, MD, MPH; Garth Graham, MD

Discussion:
- How the meeting results will be used
- Dissemination strategies
- Closing gaps in the research
- Questions, discussion, and closing remarks

4:00 p.m. MEETING ADJOURNED

Notes

1. Committee on Quality of Healthcare in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press, 2001.

2. Agency for Healthcare Research and Quality. National Healthcare Disparities Report, 2007. Rockville, MD. Available at: *www.ahrq.gov/qual/qrdr07.htm*

3. It was only in 1999 that Schulman et al published the groundbreaking study that brought the issue into public consciousness. Schulman KA, et al. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *NEJM*, 340: 618-626, 1999

4. "Minority Health Laws: Commissions and Offices of Minority Health." National Conference of State Legislatures. Last updated June 2007. Available at: *www.ncsl.org/programs/health/mhcommissions.htm* (last accessed: May 7, 2008).

5. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare, Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, Institute of Medicine. Washington, DC: National Academy Press, 2002.

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7. Agency for Healthcare Research and Quality. *National Healthcare Disparities Report*, 2007. Rockville, MD. Available at: *www.ahrq.gov/qual/qrdr07.htm*

8. Joslyn S & West M. "Racial Differences in Breast Carcinoma Survival." *Cancer*, 88(1): 114–123, 2000.

9. Stone V, Steger KA, Hirschhorn LR, Boswell SL, et al. "Access to

treatment with protease inhibitor (PI) containing regimens: is it equal for all?" *Int Conf AIDS*, 12: 834, 1999. Available at: *http://gateway. nlm.nih.gov/MeetingAbstracts/ma?f=102231103.html*

10. Agency for Healthcare Research and Quality. *National Healthcare Disparities Report*, 2007. Rockville, MD. Available at: *www.ahrq.gov/qual/qrdr07.htm*

11. Louis O, Sankar P, Ubel P. "Kidney Transplant Candidates' Views of the Transplant Allocation System." *J Gen Intern Med*, 12(8): 478–484, 1997.

12. Kim C, Hofer TP, Kerr EA. "Review of evidence and explanations for suboptimal screening and treatment of dyslipidemia in women: a conceptual model." *J Gen Intern Med*, 18: 854–63, 2003.

13. Report from the American Diabetes Association: Reviews/Commentaries/Position Statements. *Diabetes Care* 26:917–932, 2003. Also: *http://spectrum.diabetesjournals.org/cgi/content/full/19/4/221*

14. National Association of Public Hospitals and Health Systems. *Annual NAPH Hospital Characteristics Survey*, 2006. Washington, DC: 2008.

15. Reasons for producing this *Blueprint* are described in the Institute of Medicine's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, as well as in the 2007 *National Healthcare Disparities Report* (NHDR) produced by the Agency for Healthcare Research and Quality (AHRQ), which highlights three key points regarding healthcare services for all Americans:
■ Overall, disparities in healthcare quality and access are not getting smaller;

■ Progress is being made, but many of the biggest gaps in quality and access have not been reduced; and
■ Persistent uninsurance remains a major barrier to reducing disparities.

The 2007 NHDR also highlights a number of activities at AHRQ that address the challenges in reducing healthcare disparities. The common element of these activities is the "focus on multiple stakeholders and the need for tailored solutions depending on the particular disparities issue and the populations involved."

16. Institute of Medicine, *Crossing the Quality Chasm.*

17. US PHHS, OPHS, Office of Minority Health, *National Standards for Cultural and Linguistically Appropriate Services in Health Care.* March 2001. Available at: www.omhrc.gov/assets/pdf/checked/finalreport.pdf.

18. Please note that the following civil rights statutes also apply to this category:
■ Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin by recipients of Federal financial assistance.
■ Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability by recipients of Federal financial assistance.

The Americans with Disability Act of 1990 prohibits discrimination on the basis of disability by covered entities. Title II applies to public entities; Title III applies to places of public accommodation.

19. *Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals*, Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman, The Commonwealth Fund, May 2004.

NAPH Members

Alameda County Medical Center Oakland CA

Arrowhead Regional Medical Center Colton CA

Boston Medical Center Boston MA

Broadlawns Medical Center Des Moines IA

Broward Health Fort Lauderdale FL

    Broward General Medical Center Fort Lauderdale FL

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    Broward Health Imperial Point Medical Center Imperial Point FL

    Broward Health North Broward Medical Center Deerfield Beach FL

Cambridge Health Alliance Cambridge MA

Carolinas HealthCare System Charlotte NC

Central Georgia Health System Inc. Macon GA

Community Health Network of San Francisco San Francisco CA

    Laguna Honda Hospital & Rehabilitation Center San Francisco CA

    San Francisco General Hospital Medical Center San Francisco CA

Contra Costa Regional Medical Center Martinez CA

Cook County Bureau of Health Services Chicago IL

    The John H. Stroger, Jr. Hospital of Cook County Chicago IL

    Oak Forest Hospital Oak Forest IL

    Provident Hospital of Cook County Chicago IL

Cooper Green Mercy Hospital Birmingham AL

Denver Health Denver CO

Erlanger Health System Chattanooga TN

Grady Health System Atlanta GA

Halifax Health Daytona Beach FL

Harborview Medical Center Seattle WA

Harris County Hospital District Houston TX

    Ben Taub General Hospital Houston TX

    Lyndon Baines Johnson General Hospital Houston TX

Hawaii Health Systems Corporation Honolulu HI

    Hale Ho'ola Hamakua Hospital Honokaa HI

    Hilo Medical Center Hilo HI

    Ka'u Hospital Pahala HI

Kauai Veterans Memorial Hospital Waimea HI

Kohala Hospital Kapaau HI

Kona Community Hospital Kealakekua HI

Kula Hospital Kula HI

Lana'i Community Hospital Lanai City HI

Leahi Hospital Honolulu HI

Maluhia Honolulu HI

Maui Memorial Medical Center Wailuku HI

Samuel Mahelona Memorial Hospital Kapaa HI

Healthcare District of Palm Beach County West Palm Beach FL

    Glades General Hospital Belle Glade FL

The Health and Hospital Corporation of Marion County Indianapolis IN

    Wishard Health Services Indianapolis IN

Hennepin County Medical Center Minneapolis MN

Howard University Hospital Washington DC

Hurley Medical Center Flint MI

Jackson Health System Miami FL

JPS Health Network Fort Worth TX

Kern Medical Center Bakersfield CA

Lee Memorial Health System Fort Myers FL

Los Angeles County Department of Health Services Los Angeles CA

    Harbor/UCLA Medical Center Torrance CA

    Martin Luther King Jr. Multi-Service Ambulatory Care Center Los Angeles CA

    LAC+USC Healthcare Network Los Angeles CA

    Olive View—UCLA Medical Center Sylmar CA

    Rancho Los Amigos National

    Rehabilitation Center Downey CA

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    Bogalusa Medical Center Bogalusa LA

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    LSU Interim Hospital New Orleans LA

    University Medical Center Lafayette LA

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Maricopa Integrated Health System Phoenix AZ

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    Joe DiMaggio Children's Hospital at Memorial Hollywood FL

    Memorial Hospital Miramar Miramar FL

    Memorial Hospital Pembroke Pembroke Pines FL

    Memorial Regional Hospital South Hollywood FL

    Memorial Hospital West Pembroke Pines FL

    Memorial Regional Hospital Hollywood FL

Memorial Hospital at Gulfport Gulfport MS

The MetroHealth System Cleveland OH

Nashville General Hospital at Meharry Nashville TN

Nassau University Medical Center East Meadow NY

Natividad Medical Center Salinas CA

New York City Health and Hospitals Corporation New York NY

    Bellevue Hospital Center New York NY

    Coler-Goldwater Specialty Hospital and Nursing Facility Roosevelt Island NY

    Coney Island Hospital Brooklyn NY

    Cumberland Diagnostics & Treatment Center Brooklyn NY

    Dr. Susan Smith McKinney Nursing and Rehabilitation Center Brooklyn NY

    East New York Diagnostics & Treatment Center Brooklyn NY

    Elmhurst Hospital Center Elmhurst NY

    Gouverneur Nursing and Diagnostic & Treatment Center New York NY

    Harlem Hospital Center New York NY

    Jacobi Medical Center Bronx NY

    Kings County Hospital Brooklyn NY

    Lincoln Medical and Mental Health Center Bronx NY

    Metropolitan Hospital Center New York NY

    Morrisania Diagnostics & Treatment Center Bronx NY

    North Central Bronx Hospital Bronx NY

    Queens Hospital Center Jamaica NY

    Renaissance Healthcare Network Diagnostics & Treatment Center New York NY

    Sea View Hospital Rehabilitation Center & Home Staten Island NY

    Segundo Ruiz Belvis Neighborhood Family Health Bronx NY

    Woodhull Medical and Mental Health Center Brooklyn NY

The Ohio State University Hospital Columbus OH

Parkland Health & Hospital System Dallas TX

Regional Medical Center at Memphis Memphis TN

Riverside County Regional Medical Center Moreno Valley CA

Safety Net Hospital Alliance of Florida Tallahassee FL

San Joaquin General Hospital Stockton CA

San Mateo Medical Center San Mateo CA

Santa Clara Valley Health & Hospital System San Jose CA

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    Roy Lester Schneider Hospital St. Thomas VI

    Myrah Keating Smith Community Health Center St. John VI

Shands HealthCare Gainesville FL

Sinai Health System Chicago IL

Stony Brook University Medical Center Stony Brook NY

Tampa General Hospital Tampa FL

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    TMC Hospital Hill Kansas City MO

    TMC Lakewood Kansas City MO

    TMC Behavioral Health Kansas City MO

UMass Memorial Healthcare System Worcester MA

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