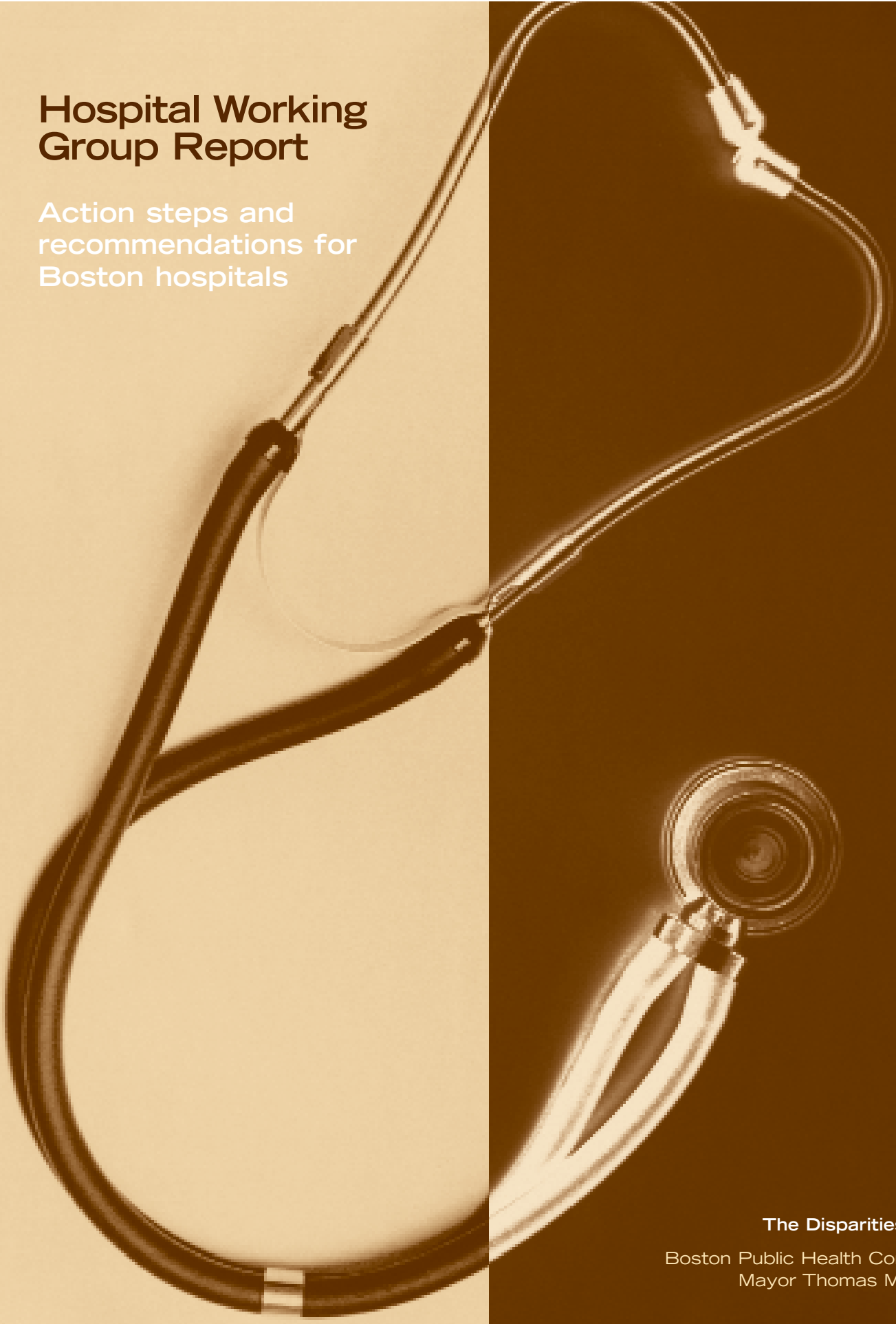
# Hospital Working Group Report

## Action steps and recommendations for Boston hospitals




**The Disparities Project**

Boston Public Health Commission
Mayor Thomas M. Menino

**The Disparities Project is an initiative of Mayor Thomas M. Menino and the Boston Public Health Commission.**

Its goal is to reduce disparities in health based on race and ethnicity.

This edition was printed April 2005. Visit **www.bphc.org/disparities** for our on-line toolkit full of tips, additional information and samples to get you going.

Other reports released by the Boston Public Health Commission as part of the Disparities Project:

***Data Report***
*A presentation and analysis of disparities in Boston*

***Mayor's Task Force Blueprint***
*A plan to eliminate racial and ethnic disparities in health*

The goal of these reports is to bring the City's institutions and organizations together to promote fairness, equality and good health for all Boston's residents.

Design by Boston Public Health Commission, Communications Department.

April 2005

Dear Fellow Bostonians,

I am both pleased and proud to see the results of the work of the Mayor's Hospital Working Group on Racial and Ethnic Health Disparities. I established this group, together with the Chief Executive Officers of the major hospitals of the City, more than a year ago. Our intent is and was to develop practical, effective activities that each hospital can undertake to reduce the inequities that contribute to poorer health for our residents of color.

Tragically, it is literally within the shadow of many of the nation's finest hospitals that we see the evidence of these race and ethnic-based health disparities. Black babies in Boston are almost 3 times more likely to die than white babies. Black adults are more likely to die of cancer and heart disease and Latino adults from diabetes and AIDS than whites. Asians in Boston experience higher levels of poverty which affects their ability to afford needed medical care. These outcomes occur in spite of the fact that individual hospitals have taken a number of steps already to reach at risk populations, develop specialized projects and train employees in cultural competence. The Working Group points the way to mobilize every institution to embrace the goal of the elimination of disparities and to move in a united and accelerated manner towards that end.

We are lucky to have had the cooperation and support of the leaders of the hospitals in acknowledging that the work thus far has not been enough. All Bostonians need to be concerned about these health trends, but the hospitals and the City have special roles. I hope and expect that every hospital in the City will take these recommendations to heart and develop an immediate implementation plan. The City, for its part, will make seed funding available in 2005 to support both hospital and non-hospital based initiatives.

The Working Group's recommendations fit into a larger, more comprehensive effort in Boston to tackle this problem. Its activities are coordinated with the Mayor's Task Force on Health Care Disparities, which has examined non-hospital (and for that matter, non-health care approaches) to improving health. The Task Force's report will include recommendations for health centers, academic and other training institutions, insurers, business and community residents of the most affected neighborhoods.

Together, we can make an important difference in this City and ensure that all Bostonians receive access to high quality, non-discriminatory care and to a healthier overall environment in which to live. Boston is proud to be a City of firsts - first public school, first health department, first public library. We also want to be the first to close the gap due to racial and ethnic disparities. By its work, the members of the Working Group have better prepared us for this role.

Sincerely,

Thomas M. Menino

Thomas M. Menino
Mayor

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# Acknowledgements

This report is the result of the work and dedication of many people. Foremost among them are the members of the Hospital Working Group who are listed beginning on page 3.

In addition, this report was informed by local and national experts, including ***Nancy Crehan,*** *Dana Farber Cancer Institute;* ***Katherine Flaherty****, Partners HealthCare Systems;* ***Tawara Goode,*** *Director of the National Center for Cultural Competence at Georgetown University Center for Child and Human Development;* ***Sarah Griffen,*** *Boston Health Care and Research Training Institute, Jamaica Plain Neighborhood Development Corporation;* ***Judy Kirim,*** *Beth Israel Deaconess Medical Center;* ***Rebekah Lashman,*** *Boston Private Industry Council;* ***Laverne Saunders****, Dorrington, Saunders and Associates;* ***Nancy Snyder,*** *Boston Private Industry Council;* ***Hope Worden,*** *Massachusetts General Hospital.*

Boston Public Health Commission staff were instrumental during the process and the writing of the report. They are ***Lisa Costanzo, Chuck Gagnon, Kristin O'Connor Golden, Stan McLaren, Debra Paul, Triniese Polk, and Lisa Scarlett .***

*"…we are implementing the HWG's recommendations for the categorization of race and ethnicity at registration. …we have set high standards for ourselves in workforce diversity. Over the past 3 years we have reached organizational goals to have at least 33% of all professional or technical positions filled by minority applicants. We celebrate this goal by having it on our organization-wide balanced scorecard."*

***Dr. John Chessare,***
*Boston Medical Center*

# About the Mayor's Hospital Working Group

Frustrated by the ongoing racial and ethnic disparities in the health of Boston's residents, in the summer of 2003 Mayor Thomas M. Menino brought together the Chief Executive Officers from the city's major hospitals and asked for their help in ensuring that all Bostonians have fair and equal access to quality health care. In a city that is home to the finest health care facilities in the world, the Mayor and hospital leaders realized they had a special duty to eliminate the health outcomes gap affecting Boston's residents of color. The Mayor was pleased to learn that hospital leaders shared his same commitment to developing solutions to tackle the problem of health disparities. Together, they established the Hospital Working Group - or the HWG as it came to be known - and appointed high-level, senior staff from each hospital to the group. This group met monthly from the Summer of 2003 through January 2005 to develop the hospital-based recommendations included in this report.

With the support of Chief Executive Officers from each institution and the commitment of Mayor Menino, HWG members have taken an important step toward ending health disparities in Boston.

Members of the Hospital Working Group (in alphabetical order):

**John Auerbach**
*Executive Director*
*Boston Public Health Commission*

**Joseph Betancourt, MD, MPH**
*Senior Scientist, Institute for Health Policy*
*Program Director for Multicultural Education*
*Massachusetts General Hospital*

**JudyAnn Bigby, MD**
*Director, Community Health Programs,*
*Brigham and Women's Hospital*
*Director, Harvard Medical School Center of Excellence in Women's Health*

**Laurie Cammisa**
*Vice President for Child Advocacy*
*Children's Hospital Boston*

**John Chessare, MD, MPH**
*Chief Medical Officer*
*Boston Medical Center*

**Richard Doherty**
*Senior Vice President, Public Affairs*
*Caritas Christi Health Care System*

**Sherry Dong**
*Associate Director, Community Health*
*Tufts New England Medical Center*

**Tom Dooley**
*Quality Improvement Specialist*
*Boston Medical Center*

**Patti Embry-Tautenhan**
*Vice President, Public Affairs & Marketing*
*Caritas St. Elizabeth's Medical Center*

**Barbara Ferrer, PhD**
*Deputy Director*
*Boston Public Health Commission*

**Matt Fishman**
*Director, Community Benefits*
*Partners HealthCare Systems*

**Ediss Gandelman**
*Director, Community Benefits*
*Beth Israel Deaconess Medical Center*

**Jessie Hood, MPH**
*Consultant*
*Boston Public Health Commission*

**Lisa Horowitz, PhD, MPH**
*Quality Improvement Consultant*
*Children's Hospital Boston*

**Anne Levine**
*Vice President, External Affairs,*
*Department of Patient Safety and Quality*
*Dana Farber Cancer Institute*

**Patrice MacCune**
*Director, Marketing*
*Caritas Carney Hospital*

**Wanda McClain**
*Administrative Director,*
*Office of the President*
*Brigham and Women's Hospital*

**Patricia McGovern**
*Executive Vice President, External Affairs*
*Beth Israel Deaconess Medical Center*

**Jennifer Morris**
*Director, Interpreter Services*
*Caritas Carney Hospital*

**Laurie Nsiah-Jefferson**
*Consultant*
*Boston Public Health Commission*

**Joan Quinlan**
*Director, Community Benefits*
*Massachusetts General Hospital*

**John Rich, MD, MPH**
*Medical Director*
*Boston Public Health Commission*

**Howard Spivak, MD**
*Chief, General Pediatric & Adolescent Medicine*
*Tufts New England Medical Center*

**Betsy Stengel**
*Executive Director*
*Conference of Boston Teaching Hospitals*

**Monica Valdes Lupi**
*Senior Health Policy Manager*
*Boston Public Health Commission*

**Ronald Wilkinson**
*Manager of Decision Support Systems,*
*Information Services Department*
*Children's Hospital Boston*

*"Boston's work on disparities truly stands to be a national model. Under the leadership of Mayor Menino and the coordination of the Boston Public Health Commission and the Conference of Boston Teaching Hospitals, key stakeholders have come together to have an open dialogue about how disparities affect people of color in our communities, and more importantly what we can do to address them. I am proud to say that the leadership of our hospitals are committed and actively engaged in taking the first steps to making disparities a thing of the past. I have to say that when I was on the Institute of Medicine Committee that released the report "Unequal Treatment" to further define this issue nationally, this is exactly the type of response we were hoping to see."*

***Dr. Joseph Betancourt,***
*Massachusetts General Hospital*

# Introduction

There has been a growing recognition of the severe health disparities that exist between people of color and white residents in Boston and in other urban centers nationwide. More than half of the city's residents continue to see wide-spread disparities in health and health care despite the fact that they live in a city that is home to world class hospitals, extraordinary community health centers and the very best academic programs. Black residents are more likely to have high blood pressure, diabetes, HIV, prostate cancer, asthma, and lead-poisoning than white residents. Latino adults are more likely to die from diabetes and AIDS than Whites. Asians in Boston experience higher levels of poverty which affects their ability to afford needed medical care.

The reasons for these disparities are complex and varied. Income, education and access to health care have historically been seen as the major factors contributing to differences in health. But more recent research suggests that differences also exist in the way that the public health and medical communities treat different races.

That's where the Hospital Working Group comes in. Working together for almost a year, senior personnel from Boston hospitals reviewed their policies and came up with realistic recommendations for improving institutional practices.

The issues specifically addressed in this report include:

1. Collecting Information on Race and Ethnicity
2. Measuring Health Disparities
3. Diversifying the Health Care Workforce
4. Improving Cultural Competence at Your Hospital
5. Including the Community in Institutional Decision-Making Processes

With more than 22 different recommendations included in this report, the Hospital Working Group highlights many issues that will get Boston going on the road to equality in health for all races and ethnicities.



[ Don't forget to visit **www.bphc.org/disparities** for our on-line toolkit. ]

## Goal

Hospitals should standardize the collection and reporting of data on health care access and utilization by patients' race, ethnicity, education, and primary language to enable them to analyze factors associated with health care disparities, to ensure the ability to analyze information across health care institutions, and to comply with federal reporting obligations.

## Background

The collection and reporting of data on race, ethnicity, and primary language are legal and authorized under Title VI of the Civil Rights Act of 1964. No federal statute prohibits this collection, and although very few require it, there is general agreement that racial, ethnic, and primary language data are critical to promoting health and quality health care for all Americans.

Both culture and language have a considerable impact on how patients access and respond to health care services. In order to ensure equal access to quality health care by diverse populations, it is important for health care organizations and providers to collect race and ethnicity data. In 2000, the Office of Minority Health (OMH) recognized the significance of measuring health disparities and published standards for the provision of culturally and linguistically appropriate services (CLAS) in health care.[1] CLAS standards include a guideline stating that health care organizations should ensure that data on patients' primary spoken language and self-identified race/ethnicity are included in the management information system and in any patient records used by staff.[2]

In 1997, the Office of Management and Budget (OMB) established revisions to the Statistical Policy Directive No.15 concerning the Race and Ethnic Standards for Federal Statistics and Administrative Reporting. The revised standards established five minimum categories for data on race: American Indian/Alaskan Native, Asian, Black or African-American, Native Hawaiian or Other Pacific Islander, and White. In addition, the OMB created two categories for data on ethnicity: Hispanic or Latino; and Not Hispanic or Latino. When self-identification of race/ethnicity is used, the revised OMB standards specify that individuals must be able to select more than one category of race. Two fields are required for race and ethnicity.

In its landmark report "Unequal Treatment," the Institute of Medicine (IOM) underscored the need for standardizing data collection to understand and eliminate racial and ethnic disparities in health care.[3] The IOM specifically recommended that health care organizations standardize data collected on the race, ethnicity, and highest level of education of their patients. Collection of data on patients' primary language was encouraged by the IOM Report.

## Guiding Principles

- Patient information should be collected in a setting that ensures privacy.
- Information must be collected in a timely fashion.
- Information must be collected in a way that patients can understand and respond accurately.
- Information collected should serve the primary goal of assessing racial/ethnic disparities and monitoring progress in addressing them. Collecting this data is not for broad research purposes, but instead to help hospitals monitor racial/ethnic disparities.
- Each institution should preface the collection of this information with a statement that is read to or by each patient. This script should state that disclosure is voluntary and will neither impact the delivery of services nor be used to discriminate in the provision of services.
- Whenever possible, health care institutions should collect this information prior to an appointment, either in a pre-visit or during phone registration. In situations where patients arrive at the hospital needing immediate attention, hospitals should establish protocols to facilitate the collection of this information as soon as possible after the initial treatment.
- Staff collecting this information should be appropriately trained and have an opportunity to voice concerns or ask questions. On-going support should be provided to address challenges in the collection of information as they arise.
- Providers and ancillary staff should also receive training/notification on the process and the importance of collecting this information.

## Recommendations

**H1-1: Hospitals should collect data on race, ethnicity, primary language and highest level of education by patient self-report.**

**H1-2: Hospitals should standardize the collection of data on both patient race and ethnicity.**

- In order to most easily comply with the OMB Revised Standards, information should be collected on the minimum five race categories. The suggested race categories in the sample survey can be included as part of a reporting system for OMB.
- Hospitals should also add a Latino/Hispanic category to the racial designation field. Without the inclusion of a Latino/Hispanic race category, the majority of Latinos may decline to select any race category.
- The ethnicity question should follow the question on race and should be asked of patients who have described themselves as Asian, Black/African American of Hispanic/Latino. In the sample survey included in the on-line toolkit,the proposed ethnic categories for each of the races above are from the U.S. Census and represent the top categories reported for Boston. Hospitals should modify the ethnic categories based on their patient population.

**H1-3: Hospitals should include a question to establish primary language.**

- Primary language information can serve both as a potential measure of acculturation and as a guide to the need for interpreter services.
- Information on primary language will also allow hospitals to study the quality of care delivered to non-English speaking patients.

**H1-4: Hospitals should include a question to establish the highest level of education. With children, hospitals should collect information on the mother or guardian.**

## Goal

Hospitals should collect and analyze information on access, utilization, treatment, and patient satisfaction by race and ethnicity to allow them to uncover disparities, monitor performance, identify and address discriminatory practices, and improve patient care.

## Background

Scientific studies provide extensive evidence that disparities exist in the delivery of health care across racial and ethnic groups. Given that differences in care may not be readily apparent to patients and providers in clinical settings, the IOM recommends that hospitals select a set of indicators that can be readily measured, analyzed and reported to better understand the nature of inequities in care. This information can help hospitals evaluate their own efforts to reduce disparities in care and develop strategies to serve an increasingly diverse patient population.

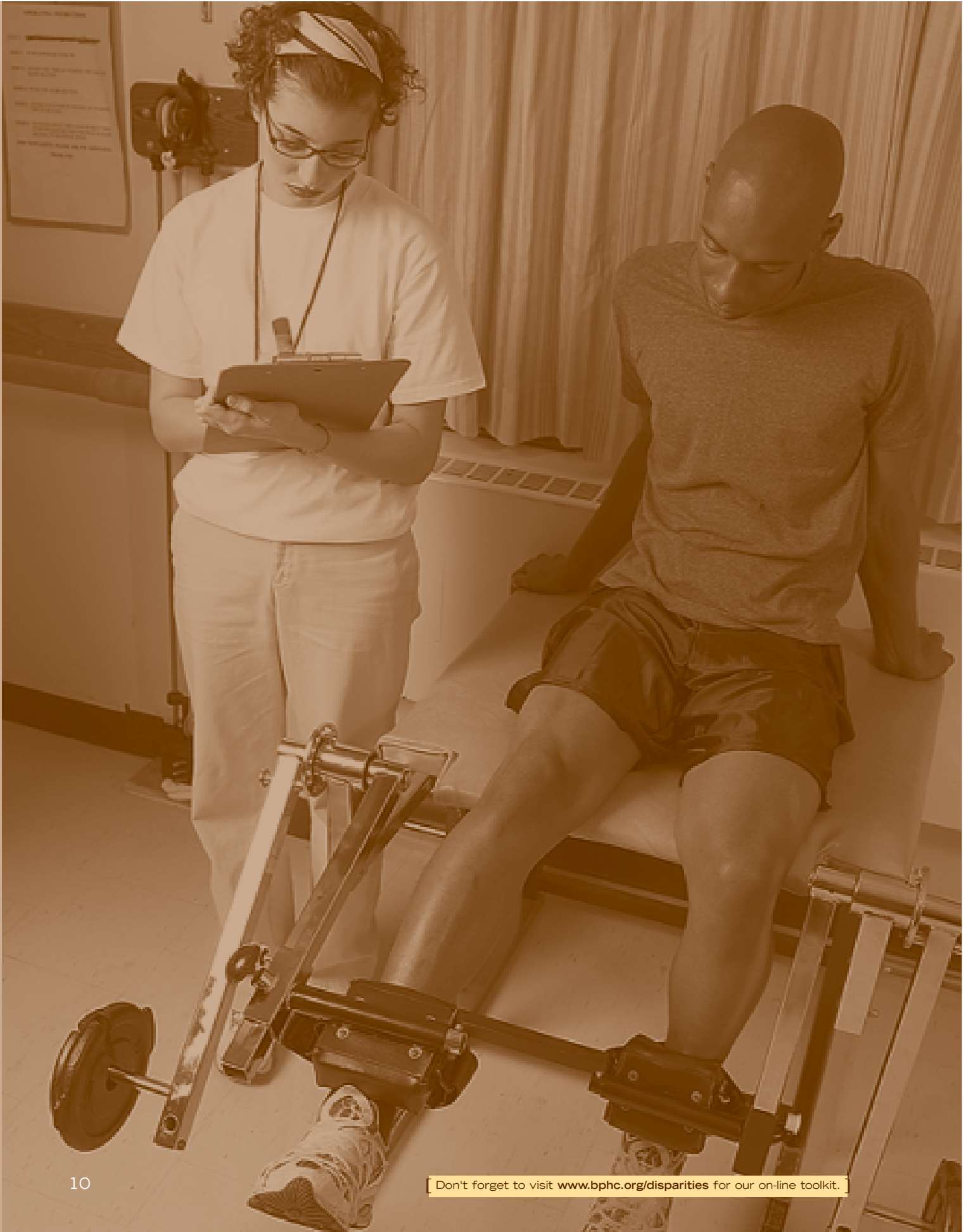
The Hospital Working Group formed the Disparities Measurement Sub-Committee to identify appropriate indicators and actions that could be used to assess differences in care. This sub-committee consisted of representatives from Boston teaching hospitals, with leadership provided by Dr. Joseph Betancourt from Massachusetts General Hospital. The following recommendations were informed by a review of the scientific literature, national activities, and local experience.

## Guiding Principles

The HWG used three criteria to select the proposed indicators:

1. Indicators should be evidence-based.
2. Indicators should reflect health issues that are amenable to hospital quality improvement.
3. Data should be readily available and build on existing reporting obligations.

The following recommendations are intended to help health care organizations understand institution-specific issues that contribute to racial and ethnic disparities in care. These recommendations are meant to serve as a framework for each hospital and allow for flexibility in implementation. The recommendations address clinical indicators, patient satisfaction, quality improvement activities, and accountability.





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## Recommendations

**H2-1: Tertiary care hospitals should collect and analyze clinical treatment data by race and ethnicity for heart attack, congestive heart failure, pneumonia care, and diabetes. For those hospitals with a pediatric service clinical treatment data should be collected and analyzed for asthma and diabetes in children.**

- Most Boston hospitals already report quality indicators developed under the National Voluntary Hospital Reporting Initiative (NVHRI) launched by the Centers for Medicare & Medicaid Services (CMS). A public-private collaboration including the Joint Commission on Accreditation of Health care Organizations (JCAHO), the American Hospital Association (AHA), the American Medical Association (AMA) and the Agency for Health care Research and Quality (AHRQ) is working with CMS to support this initiative.
- In order to support national efforts and achieve consistency across institutions, hospitals should collect treatment data by race and ethnicity for the suggested indicators.

**H2-2: Hospitals should translate patient satisfaction surveys into multiple languages appropriate for their patient population. If surveys are not done over the phone, hospitals should provide patients with written surveys available in multiple languages at an appropriate reading level. (6th grade reading level is recommended.)**

- Working through vendors, hospitals routinely conduct patient satisfaction surveys with a sample of patients to measure how well patients perceive their experiences. National surveys have found that racial and ethnic minorities perceive that they receive a lower standard of care than white populations.
- To examine perceptions of care more closely within their facilities, all hospitals should include racial and ethnic categories in their patient satisfaction surveys and consider over-sampling certain racial and ethnic groups to get a sufficient number of responses.
- Surveys should also be conducted in languages appropriate for the patient population.

**H2-3: Hospitals should conduct patient satisfaction surveys to gather information on race, ethnicity, educational attainment, and primary language spoken.**

**H2-4: Hospitals should establish Quality Improvement Rounds with a disparities focus to obtain regular, ongoing feedback and concerns from front-line staff.**

**H2-5: In order to ensure accountability, hospitals should conduct an internal review of data at least annually. This review should highlight identified racial/ethnic disparities and spur the development of action plans for addressing challenges and improving care. Hospitals should establish a mechanism for reporting back information to the entire hospital community and setting benchmarks to measure progress.**

- The data collected through this process should guide changes in policy and practice that will lead to improvements in the quality of care for all patients.
- Appropriate stakeholders should review the data internally and amend operations as needed.

**H2-6: Hospitals should develop an implementation plan to track progress in decreasing identified racial/ethnic disparities in clinical indicators, patient satisfaction and quality improvement activities.**

- Institutional change resulting from this process should be documented and reviewed on an annual basis through an established monitoring system.

**H2-7: The Boston Public Health Commission and Conference of Boston Teaching Hospitals (COBTH) should establish an annual forum among hospitals to assess citywide progress toward the elimination of racial and ethnic disparities in health care.**




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## Goal

Hospitals should increase the proportion of underrepresented U.S. racial and ethnic people of color among health professionals.

## Background

As the U.S. population is becoming increasingly diverse and less white, racial and ethnic groups who were previously classified as "minority" will become the majority later this century. Yet, a recent study showed that while minorities make up more than 25 percent of the U.S. population they represent only 9 percent of the country's nurses, 6 percent of its physicians, and 5 percent of its dentists. Health professional schools show similar lack of diversity among faculty where people of color make up less than 10 percent of baccalaureate nursing faculty, 8.6 percent of dental school faculty, and only 4.2 percent of medical school faculty.

Why is having a racially and ethnically diverse workforce important? Diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for all health profession students. The Institute of Medicine (IOM) emphasizes that diversifying the health care workforce will require, "promoting public and private collaboration, reducing financial barriers to health professions training, improving the institutional climate for diversity, and applying community benefit principles to diversity efforts." The IOM recommendations are directed to Health Professional Educational Institutions (HPEI) and relevant public and private groups that include hospitals and other health care institutions.

## Guiding Principles

Diversifying the health care workforce is one strategy that can help improve the health of people of color. While patients receive health care services at Boston hospitals and community health centers, other stakeholders such as insurers, business and academia must play an important role in supporting efforts aimed at eliminating health disparities among city residents. Decreasing the gap among key health outcomes requires a coordinated, cross-sector approach.

The underlying goal for both recommendations in this section is to offer educational and career experiences to students and employees of color who have had fewer opportunities than their white counterparts to access these types of programs.

Hospitals have the flexibility to design specific implementation strategies based on their own unique organizational culture and current set of activities.

These recommendations can help hospitals diversify their workforce. The recommendations identify critical components in comprehensive youth pipeline programs for middle and high school students of color who are Boston residents, and career ladder programs for employees of color.

Clinical shortage areas such as nursing and other allied health professions are highlighted in these recommendations. Efforts to diversify the workforce can also include non-clinical management positions in order to effect change at all levels and within all departments at the hospital.

## Recommendations

**H3-1:** Each hospital should support between 10 - 25 Boston middle and high school students of color annually in a comprehensive health careers program.

**H3-2:** Each hospital should support the participation of 20 or more incumbent employees of color in career ladders focused on nursing and allied health professions such as medical imaging, surgical and pharmacy technicians.

*"…The four broad initiatives and the specific recommendations have become a guiding framework for the work at Dana-Farber…we were pleased to serve as a pilot site for the data collection effort and as a result of our collaboration, have established an Executive Committee on Health Disparities, recruited a Director of Health Disparities, and developed a patient navigation program."*

*Anne Levine*
*Dana-Farber Cancer Institute*



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**What is cultural competence? Among the multiple definitions of cultural competency are the following:**

- the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.
- the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group.
- the behaviors, attitudes, and policies that can come together on a continuum: that will ensure that a system, agency, program, or an individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among, and between groups. Cultural competency is a goal that a system, agency, program or individual continually aspires to achieve.

## Goal

Hospitals should improve institutional cultural competence by developing and implementing a cultural competence assessment tool and achieving consistency in cross cultural education and anti-racism training opportunities for hospital employees.

## Background

Racial disparities in health are the direct result of historical socioeconomic oppression of people of color. While legalized enslavement and the most overt forms of segregation - such as Jim Crow laws - are no longer legal, racism and ethnic prejudice continue to exist, sometimes blatantly and sometimes subtly. Because of this, deliberate steps need to be taken in order to eliminate persistent health disparities. The Institute of Medicine found that health care providers' bias and stereotyping were more important factors in reinforcing disparities than patient behavior. Racial and ethnic bias can affect health in a number of ways by limiting access to quality medical care and by creating physiological stress.

As the demographics of the U.S. population change, there is a growing racial and ethnic discordance between health professionals and the patients they serve. Health care providers will need the ability to provide culturally competent care regardless of their own racial and ethnic background.

Additionally, an increasing body of evidence demonstrates that there are differences in health services offered and provided to patients of color. Training health care providers to be culturally competent is a key strategy in ensuring that quality health care is provided regardless of a patient's race or ethnicity. Hospitals should link cultural competency training to quality improvement efforts.

Providers who are not trained to effectively communicate with patients from different racial/ethnic and cultural backgrounds can deliver poorer health care. For example, research has shown that miscommunication produces negative health consequences through diagnostic errors and poorer patient adherence to medical advice.

In "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine proposed that the health care system focus on six aims to improve the quality of care. Cultural competency training can be linked to the aims of delivering "patient-centered" and "equitable" health care. Culturally competent health care providers are in a better position to provide care that is both respectful and responsive to individual patient preferences, needs, values, and ensure that patient values guide all clinical decisions. Additionally, culturally competent providers are more likely to be conscious that the care they provide does not vary in quality because of personal characteristics like gender, ethnicity, geographic location and socioeconomic status.

## Guiding Principles and Definitions

Cultural competence should be part of every institution's efforts to eliminate longstanding racial and ethnic health disparities. Cultural competence programs should develop the capacity to (1) value diversity, (2) conduct-self assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of the individuals and communities served.

A critical component for all training is to give health care providers and non-clinical staff opportunities to reflect on their own biases and stereotypes and their potential impact on treatment and care decisions.

Having staff trained in cultural competency can also lead to better health outcomes and patient satisfaction by enhancing providers' ability to communicate respectfully with their diverse patient population.

## Recommendations

**H4-1: Each hospital should identify and utilize an institutional assessment tool to evaluate its ability to provide high quality effective, understandable, and respectful health care in a manner compatible with the diverse cultural health beliefs and practices of its patient population.**

- For the initial phase, hospitals could implement the diversity and cultural proficiency assessment tool for leaders developed by the American Hospital Association and American College of Health care Executives.
- This questionnaire may be a starting point for implementing a cultural competence organizational self-assessment. It is intended as a checklist to help hospitals initiate a dialogue with staff and community on diversity and cultural proficiency. The following topic areas are covered: (a) serving a diverse community, (b) providing culturally proficient care, (c) strengthening workforce diversity, and (d) expanding diversity of the hospital leadership team.
- Areas covered by the tool include organizational, systemic, and clinical cultural competence. It is intended to help organizations identify strengths and challenges in creating a culturally competent institution. Organizations are encouraged to select staff representing various job titles and diverse backgrounds to serve on a committee to direct the assessment process. For example, a quality improvement committee or multicultural advisory committee could guide the completion of the tool.
- Additional surveys that are to be completed by staff, patients, and community residents supplement the assessment tool.

**H4-2: Through senior management oversight and coordination, hospitals should identify high-level staff charged with implementing various cultural competence and anti-racism activities within the institution.**

- Among the activities that are important reflections of culturally competent care are health disparities initiatives, high-quality interpreter services, and cultural competence training and education. Additionally, staff should develop an action plan to address weaknesses and gaps identified during the assessment process. The institutional leader of these efforts should report directly to the hospital's Board of Directors.

**H4-3: Hospitals should commit to developing consistency in cultural competence training and promoting promising practices.**

- The Boston health care community is fortunate to have nationally recognized leaders in the areas of health disparities research and cultural competency. Each individual and institution's unique contributions in this field should be recognized, but also become part of a larger, city-wide effort to address health disparities.
- Achieving consistency in cultural competency training for staff at all levels (professional, clinical and non-clinical staff) requires a coordinated, cross-institutional effort.
- Much of the current training has been designed for physicians and nurses. However, training opportunities should also be developed and offered to non-clinical staff such as administrative and front-line staff.
- The activities of this group should build on current training efforts by identifying a common set of educational objectives, developing an inventory of available curricula and training materials, as well as identifying gaps in training.

**H4-4: In order to ensure accountability, information gathered by hospitals during the assessment process should guide changes in policy and practice that will lead to improvements in the quality of care for all patients. Appropriate stakeholders should review the information internally and amend operations as needed. Institutional change resulting from this process should be documented and reviewed on an annual basis through an established monitoring system.**

- Hospitals should convene an internal task force to review the results of the institutional assessment tool; this review should address the gaps identified in the responses and include action plans with next steps to address challenges and improve care.
- Hospitals should include cultural competency and anti-racism activities in their Quality Improvement Rounds in order to obtain regular, ongoing feedback and hear concerns from front-line staff.



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## Goal

Hospitals should develop opportunities for diversifying the racial and ethnic composition of governing boards and update the board regularly on its progress. As part of the process for ensuring institutional accountability, hospitals should also continue to provide support to community-based efforts that promote work to eliminate health disparities.

## Background

Governing boards of hospitals are important links to funders, patients, staff, beneficiaries, professional and industry groups, and the communities in which they are located. They are powerful structures that have the ultimate authority to interpret organizational mission, define goals, and allocate resources. Diversifying board membership, racially and ethnically, can serve to strengthen the hospital as an organization especially in light of the increasingly diverse patient populations they serve.

Board diversity is not only a social imperative, but also a strategic one. Boards that look more like the institution's employees, suppliers, and patients can help dispel negative stereotypes and catalyze efforts to recruit, retain, and promote the best people, including women and minorities. Prioritizing diversity and recognizing diversity efforts attracts the best and the brightest employees to a company. As the value of diversity continues to grow in the business and health care community, recruiting and retaining talented potential employees who enhance diversity is becoming even more important to organizational success.

Diverse boards offer broader perspectives and improve the quality of corporate deliberations and policymaking. An increasingly diverse workforce and marketplace demand that businesses address demographic changes and that these be reflected at all levels throughout the organization, including the governing boards. A diverse workforce will serve customers effectively, maintain market share, and attract and retain talent. Similarly, in order to remain competitive, institutions must both attract and retain a diverse workforce and offer supportive work environments where diversity is respected.

## Recommendations

**H5-1: Board chairs should submit a multi-year plan demonstrating their long term commitment to diversifying the racial and ethnic composition of their governing boards.**

- Plans should include the current racial and ethnic breakdown of governing boards and identify benchmarks for diversifying the racial and ethnic composition.
- In order to optimize the meaningful participation of board members who are people of color, plans should create a supportive environment for cooperation and communication to help prepare members of color for success.
- Each hospital could convene a Multicultural Advisory Committee to provide guidance as it develops plans for diversifying board membership.

**H5-2: Hospitals should add language to their mission statements that clearly articulates a commitment to eliminating racial and ethnic disparities in health.**

- An institution's mission statement identifies its overall goals and objectives for health care delivery. The hospital's mission statement should articulate that achieving optimal health for all patients, regardless of their racial or ethnic background, is a priority.
- The hospital mission statement should state the institution's commitment to developing leadership, policies and practices that ensure that all patients receive quality care including diverse populations, and aim to eliminate health disparities.
- Commitment at the highest levels should also be reflected in the institution's community benefits mission statement.

**H5-3: In addition to the routine reporting that is provided to governing boards on financial and programmatic matters, an annual report should be made to board members of the institution's health disparities activities and initiatives.**

- Staff charged with implementing health disparities activities at the hospital should be given an opportunity to provide an annual report on achievements and challenges. Programs or activities that could be highlighted in this report include: institutional cultural competency efforts; workforce diversity; interpreter services; health disparities data collection; patient satisfaction surveys, etc.
- Additional opportunities to engage board members in an active learning process around the impact of health disparities could occur through board subcommittees such as a "Community Benefits Board Committee," "Multicultural Community Advisory Committee," or "Patient Care Assessment Committee."

**H5-4: Community support is critical to developing effective programs and strategies that address racial and ethnic health disparities. Involving community residents in problem solving and decision making is essential to community change efforts. Therefore, hospitals should strengthen their participation in and support of community-based efforts to eliminate health disparities.**

- Through the years, hospitals have developed strong relationships with many community coalitions and organizations. Some of these organizations share a vision to eliminating health disparities, and hospitals should continue to participate in and support these existing community based efforts.
- In addition to resources, hospitals should create opportunities for community residents to take part in designing, implementing,and evaluating programs/services that address health disparities.

- Hospitals should also engage community partners such as religious, civic, and academic institutions that may not be focused on health disparities and build support for their efforts on the elimination of health disparities.

**H5-5: The information provided to a hospital's governing board and gathered through community-based efforts should guide changes in policy and practice that will lead to improvements in the quality of care for all patients.**

- The governing board should review and amend operations based on guidance and comments offered by community stakeholders.
- Institutional change resulting from this process should be documented and reviewed on an annual basis through an established monitoring system.
- The governing board and subcommittees should pay particular attention to improving cultural competence and measuring racial and ethnic disparities in health care.

*"Medical researchers and public health reports have documented disparities in health care for more than three decades. Eliminating health disparities in health and health care is a daunting task because of the long standing social and institutional factors that contribute to inequalities in health. The opportunity to work on a collaborative effort to address health disparities is in itself a unique opportunity."*

*Dr. JudyAnn Bigby*
*Brigham & Women's Hospital*

## Quick reference guide to recommendations from the Hospital Working Group

H1-1: Hospitals should collect data on race, ethnicity, primary language and highest level of education by patient self-report.

H1-2: Hospitals should standardize the collection of data on both patient race and ethnicity.

H1-3: Hospitals should include a question to establish primary language.

H1-4: Hospitals should include a question to establish the highest level of education. With children, hospitals should collect information on the mother or guardian.

H2-1:Tertiary care hospitals should collect and analyze clinical treatment data by race and ethnicity for heart attack, congestive heart failure, pneumonia care, and diabetes. For those hospitals with a pediatric service clinical treatment data should be collected and analyzed for asthma and diabetes in children

H2-2: Hospitals should translate patient satisfaction surveys into multiple languages appropriate for their patient population. If surveys are not done over the phone, hospitals should provide patients with written surveys available in multiple languages at an appropriate reading level. (6th grade reading level is recommended.)

H2-3: Hospitals should conduct patient satisfaction surveys to gather information on race, ethnicity, educational attainment, and primary language spoken.

H2-4: Hospitals should establish Quality Improvement Rounds with a disparities focus to obtain regular, ongoing feedback and concerns from front-line staff. (Please refer to Appendix for model questions and suggestions for increasing attendance.)

H2-5: In order to ensure accountability, hospitals should conduct an internal review of data at least annually. This review should highlight identified racial/ethnic disparities and spur the development of action plans for addressing challenges and improving care. Hospitals should establish a mechanism for reporting back information to the entire hospital community and setting benchmarks to measure progress.

H2-6: Hospitals should develop an implementation plan to track progress in decreasing identified racial/ethnic disparities in clinical indicators, patient satisfaction and quality improvement activities.

H2-7: The Boston Public Health Commission and Conference of Boston Teaching Hospitals (COBTH) should establish an annual forum among hospitals to assess citywide progress toward the elimination of racial and ethnic disparities in health care.

H3-1: Each hospital should support between 10 - 25 Boston middle and high school students of color annually in a comprehensive health careers program.

H3-2: Each hospital should support the participation of 20 or more incumbent employees of color in career ladders focused on nursing and allied health professions such as medical imaging, surgical and pharmacy technicians.

H4-1: Each hospital should identify and utilize an institutional assessment tool to evaluate its ability to provide high quality effective, understandable, and respectful health care in a manner compatible with the diverse cultural health beliefs and practices of its patient population.

H4-2: Through senior management oversight and coordination, hospitals should identify high-level staff charged with implementing various cultural competence and anti-racism activities within the institution.

H4-3: Hospitals should commit to developing consistency in cultural competence training and promoting promising practices.

H4-4: In order to ensure accountability, information gathered by hospitals during the assessment process should guide changes in policy and practice that will lead to improvements in the quality of care for all patients. Appropriate stakeholders should review the information internally and amend operations as needed. Institutional change resulting from this process should be documented and reviewed on an annual basis through an established monitoring system.

H5-1: Board chairs should submit a multi-year plan demonstrating their long term commitment to diversifying the racial and ethnic composition of their governing boards.

H5-2: Hospitals should add language to their mission statements that clearly articulates a commitment to eliminating racial and ethnic disparities in health.

H5-3: In addition to the routine reporting that is provided to governing boards on financial and programmatic matters, an annual report should be made to board members of the institution's health disparities activities and initiatives.

H5-4: Community support is critical to developing effective programs and strategies that address racial and ethnic health disparities. Involving community residents in problem solving and decision making is essential to community change efforts. Therefore, hospitals should strengthen their participation in and support of community-based efforts to eliminate health disparities.

H5-5: The information provided to a hospital's governing board and gathered through community-based efforts should guide changes in policy and practice that will lead to improvements in the quality of care for all patients.

## References


1. Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda, U.S. Department of Health and Human Services, Office of Minority Health, Federal Register: December 22, 2000 (Volume 65, Number 247) [Page 80865-80879]

2. Ibid.

3. Smedley, B., Stith, A., & Nelson, A. (Eds.). (2002). Unequal Treatment Confronting Racial and Ethnic Disparities in Health care. Washington, D.C.: Institute of Medicine/The National Academy Press.

4. The Sullivan Commission (2004). Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Workforce.

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9. Institute of Medicine (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Committee on Quality of Health Care in America. Washington, D.C.: The National Academy Press.

10. Ibid.

11. According to the IOM Quality Chasm Report, health care in the 21st Century should aim to be 1) safe, 2) effective, 3) patient-centered, 4) timely, 5) efficient, and 6) equitable.

12. Cross, T., Bazron, B., Dennis, K., and Isaacs, M. (1989). Towards a culturally competent system of care volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

13. Betancourt, J., Green, A., and Carrillo, J. (2002). Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches. Field Report, The Commonwealth Fund.

14. U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA). Definitions of Cultural Competence.

15. Ibid.

16. Strategies for Leadership: Does your hospital reflect the community it serves? A Diversity and Cultural Proficiency Assessment Tool for Leaders, accessed at http://www.diversityconnection.org/userdocs/uploads/5_leadership_ifd.pdf.

17. The Boston Consortium on Cultural Competence Training in Health Care led by Dr. JudyAnn Bigby and Brigham and Women's Hospital has made progress in various training components including those activities mentioned along with the following: developing cross-institutional needs assessment and evaluation tools/programs and tools to describe patient's assessment of the cultural competence of health care providers. Additionally, the Manhattan Cross Cultural Group (MCCG), a training and research organization committed to improving health care to diverse patient populations and eliminating health disparities has developed an e-learning program called Quality Interactions: A Patient-Based Approach to Cross-Cultural Care, an additional training resource for hospitals.

18. Governing boards can encompass the following types of structures: Board of Directors, Board of Trustees, etc.

19. "Workplace Diversity," (1999). Society for Human Resource Management.

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## Notes

[ Don't forget to visit **www.bphc.org/disparities** for our on-line toolkit. ]