

**#123forEquity:**

# A Toolkit for Achieving Success and Sharing Your Story



Dear Colleague:

To meet the changing needs of our communities, hospitals and health systems are working hard to make sure that every individual receives the highest quality of care. To achieve that goal as our nation becomes increasingly diverse, we must redouble our efforts to identify and eliminate disparities in care.

That's why the AHA last year launched the **#123forEquity Pledge to Eliminate Health Care Disparities**. The [pledge campaign](#) urges hospital and health system leaders to begin taking action in the next 12 months on specific areas that can improve health equity; provide updates on their organization's progress; and share their success in promoting diversity and health equity with the public.

**To support your efforts, we have developed #123forEquity: A Toolkit for Achieving Success and Sharing Your Story.** The toolkit contains resources that can assist all hospitals – whether your organization is just beginning this journey or is already deeply ingrained in this work. It includes:

- [A checklist of resources to help you achieve the #123forEquity goals](#)
- [FAQs on the #123forEquity campaign](#)
- [A sample slide presentation for use with your board of trustees and community](#)
- [Content for social and digital media](#)
- [An Op-Ed/newsletter article you can customize to use with your local media](#)
- [Case examples from the field and best practices for success](#)

Please share this toolkit with your leadership and communication teams. Additional resources related to the #123forEquity campaign are available on [www.equityofcare.org](http://www.equityofcare.org).

If your hospital or health system has already signed the #123forEquity pledge, thank you for your efforts and leadership on this vital issue. If your organization has not signed the pledge, please consider [signing the pledge](#) today. It's not only the right thing to do ... it's the smart thing to do.

Sincerely,

Richard J. Pollack  
President and Chief Executive Officer  
American Hospital Association

M. Tomás León  
President and CEO  
Institute for Diversity in Health Management



## Checklist of Resources to Help You Achieve the Goals of the #123forEquity Pledge

Building on the work of the National Call to Action to Eliminate Health Care Disparities, the #123forEquity pledge campaign focuses on three areas that are critical to identifying and addressing disparities in care. Those include increasing the collection and use of race, ethnicity and language preference data; increasing cultural competency training; and increasing diversity in governance and leadership. Below is a checklist with links to resources that can assist your hospital or health system as you begin or continue your efforts to ensure equitable care is being provided to all patients in your community. Additional resources can be found on <http://www.equityofcare.org/resources/index.shtml>.

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

- Ensure that REAL data collection is systematic and reliable



[Health Research & Educational Trust Disparities Toolkit](#)



[Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders](#)

- Use the data to stratify quality metrics



[A Framework for Stratifying Race, Ethnicity and Language Data](#)

- Identify disparities or confirm none exist



[NEW: CMS Mapping Medicare Disparities Tool](#)



[NEW: CMS Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries](#)



[Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data](#)

### Focus Two: Increase cultural competency training

- Make cultural competency training a part of the orientation of all employees and ensure all clinical staff receive the training



[Building a Culturally Competent Organization: The Quest for Equity in Health Care](#)

- Include training on the following competency areas: language services; family / community interactions; religious beliefs affecting health care; languages spoken by patients; diverse health beliefs held by patient populations



[Becoming a Culturally Competent Health Care Organization](#)

- Continually assess training and impact to gauge success and identify opportunities for improvement



[Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned](#)

### Focus Three: Increase diversity in leadership and governance

- Communicate across the organization the business imperative of having a leadership team and board reflective the communities served



[Rising Above the Noise: Making the Case for Equity in Care](#)

- Develop chief diversity officer roles to elevate diversity as a strategic priority



[The Role of the Chief Diversity Officer in Academic Health Centers](#)

- Think long term to ensure a deep pool of qualified candidates



[Best Practices for Building Leadership Diversity Programs](#)

## Frequently Asked Questions on the #123forEquity Pledge to Eliminate Health Care Disparities

Thank you for your interest in the #123forEquity campaign. We have put together a list of Frequently Asked Questions (FAQs) to assist you with questions that may arise as you discuss the campaign with your staff, board, community members or others. For additional resources, please visit [www.equityofcare.org](http://www.equityofcare.org). If you have questions, please contact us at (312) 422-2820 or [equityofcare@aha.org](mailto:equityofcare@aha.org).

**Question:** What is the #123forEquity pledge campaign, and why is it important?

**Answer:** The American Hospital Association (AHA) in 2015 launched the [#123forEquity Pledge to Eliminate Health Care Disparities](#). Building on the work that began 2011 by the partners of [National Call to Action to Eliminate Health Care Disparities](#), the #123forEquity campaign urges hospital and health system leaders to pledge to take action on specific areas that can improve health equity; provide updates on their organization's progress; and share their success in promoting diversity and health equity with the public.

**Question:** Who are the National Call to Action Partners?

**Answer:** The National Call to Action was established in 2011 by the AHA, American College of Healthcare Executives, America's Essential Hospitals, Association of American Medical Colleges and Catholic Health Association of the United States.

**Question:** Is there an AHA video about the #123forEquity Pledge?

**Answer:** Yes, there is a short [video](#) from AHA leadership explaining the importance of the pledge and why hospitals should participate.

**Question:** What is the timeframe to do this work?

**Answer:** The timeframe for this work is 12 months from when pledge is signed; however, it can be modified based on the situation of each hospital or health system. The AHA suggests a timeline for each of the pledge's action steps. More details are available [here](#).

**Question:** I don't have a lot of racial and ethnic diversity in my community, so what does that mean for the pledge?

**Answer:** We still strongly encourage you to take the pledge, as diversity can come in many forms. You could start with race and ethnicity when examining your data. However, every community is different so you also can stratify data by language preference or other sociodemographic variables (such as income, disability status, veteran status, sexual orientation and gender, or other) that are important to your community's health. In addition to addressing disparities for people of color, you may identify other groups such as veterans; people with psychiatric disabilities; people living in poverty; the gay, lesbian and transgender population; and others who may be experiencing disparities in care and health.

**Question:** This work seems like it will take resources and time. Can we afford this at a time when both of these are at a premium?

**Answer:** In addition to being the right thing to do, eliminating health care disparities is vital as our health care system moves from a volume to a value-based payment structure. As payment becomes more dependent on outcomes, it is not financially viable to ignore persistent poor health outcomes in certain patient populations. Associated with health care disparities are increased costs of care due to excessive testing, medical errors, increased length of stay and avoidable readmissions. Pay-for-performance contracts are beginning to include provisions to address racial and ethnic disparities. Here are a few key things to know:

- Between 2003 and 2006, 30.6 percent of direct medical expenditures for African Americans, Asians and Hispanics were excess costs due to health care disparities (Joint Center for Political and Economic Studies, 2009).
- Eliminating health care inequities associated with illness and premature death would reduce indirect costs by \$1 trillion.
- Researchers estimate that eliminating disparities would reduce direct medical expenditures by as much as \$229 billion.
- Eliminating health care disparities gives hospitals and health systems a competitive marketing edge when trying to attract or retain patients and employees.

**Question:** When I submit data for the project, will it be kept confidential?

**Answer:** Yes. All hospitals and endorsers/supporters that sign the pledge will have their organization's name listed publicly on the campaign website at [www.equityofcare.org](http://www.equityofcare.org). However, any progress data a hospital submits is kept confidential and reported only in aggregate to the public.

**Question:** What is cultural competency training? How often should it occur and who should receive it?

**Answer:** Cultural competence refers to an ability to interact effectively with people of different cultures, backgrounds and experiences. Cultural competence training should include four components:

- Awareness of one's own cultural worldview;
- Attitude and biases toward cultural differences;
- Knowledge of different cultural practices and worldviews; and
- Cross-cultural skills.

Developing cultural competence and sensitivity results in an ability to understand, communicate with, and effectively interact with clinicians, patients, families and other health care providers. The goal is to make cultural competency training part of the orientation and practice improvement of all employees that are essential for the delivery of high quality and safe care. The amount and method of delivery should be determined by the resources available to your hospital.

**Question:** Why is cultural competency training to help providers treat people with disabilities not a part of the data collection and evaluation process for developing strategies?

**Answer:** The AHA understands that other groups of people, such as those with disabilities, experience barriers to care. The AHA suggests that the cultural competency training should be tailored to your organization and population needs based on the data collected and analyzed to identify if gaps in care and health exist. The AHA would expect disabilities, including psychiatric disabilities, to be in many cultural competency programs.

**Question:** How do we build a diverse leadership pipeline?

**Answer:** The AHA recommends developing a measurable and achievable goal for diversity in both top management and the board of trustees. Set clear expectations for human resources and talent search firms to include at least two minority candidates interviewed for every top management position. Create a mentoring program for management staff in which less experienced employees are

formally paired with a senior staff person to develop professional networks and skills. Consider identifying local community stakeholders and internal diverse staff to help recruit qualified candidates from outside the company to fill upper-level positions. The AHA's Institute for Diversity in Health Management has a number of additional resources and best practices available at [www.diversityconnection.org](http://www.diversityconnection.org).

**Question:** What role can the board play in this work?

**Answer:** The board of trustees plays a vital role in the efforts to eliminate health disparities and advance diversity and inclusion practices. It can encourage and support the CEO and leadership to set clear performance goals to tie to these efforts. It also can ensure that the organization's strategic plan reflects this work. In addition, board members can serve as great spokespeople when they interact with the community to highlight the important work your organization is doing in these areas.

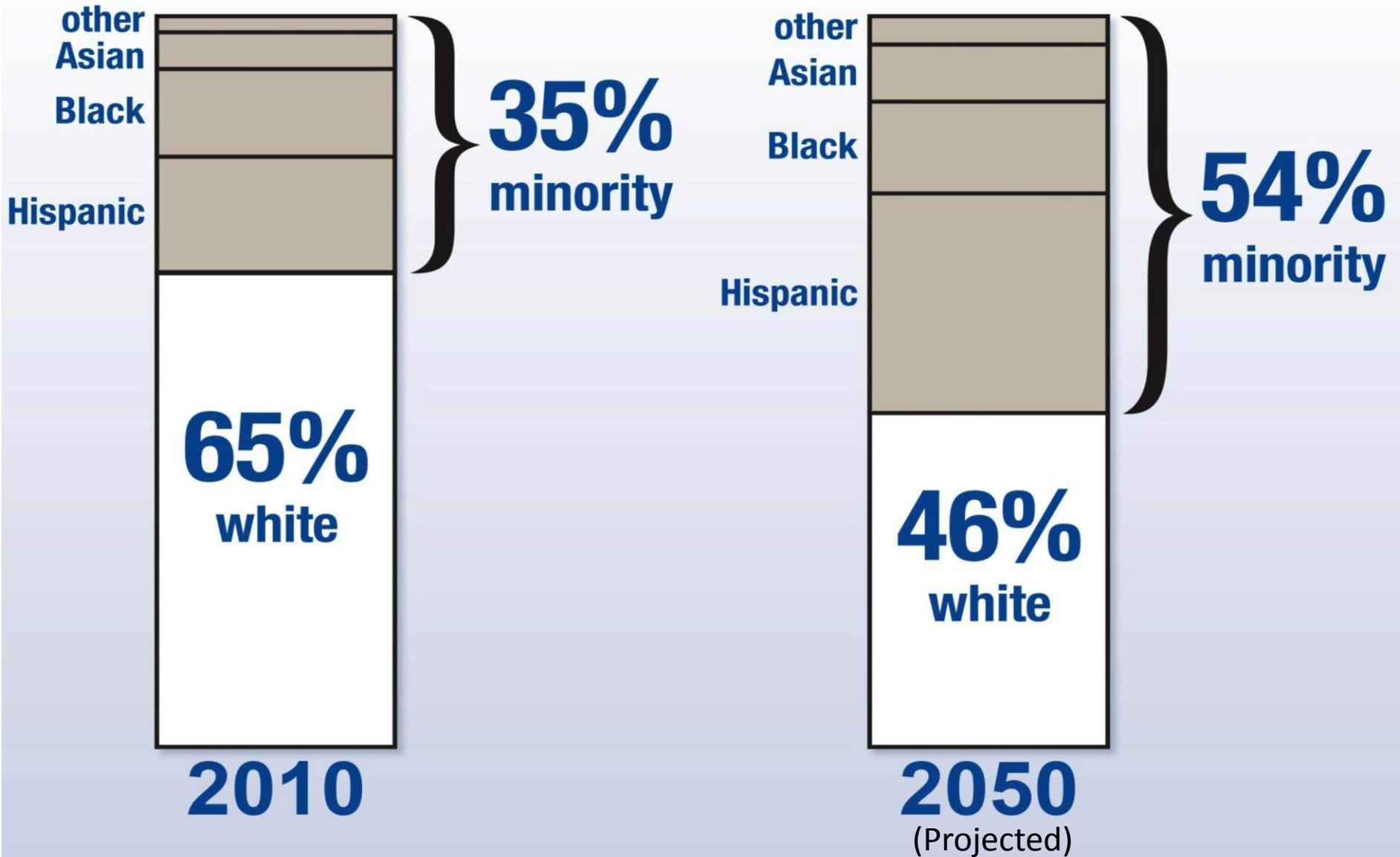
# #123ForEquity Pledge to Act Campaign to Eliminate Health Care Disparities

<Insert your name and title here>>

<<organization name here>

*Month, date , 2016*

# Diversity in the United States



# Disparities and Diversity

- **Health Disparities** can be defined as inequalities that exist when members of certain population groups do not benefit from the same health status as other groups.
- Evolving definition of **Diversity** is inclusive of disability, race, ethnicity, language, gender, sexual orientation, veteran and socioeconomic status.

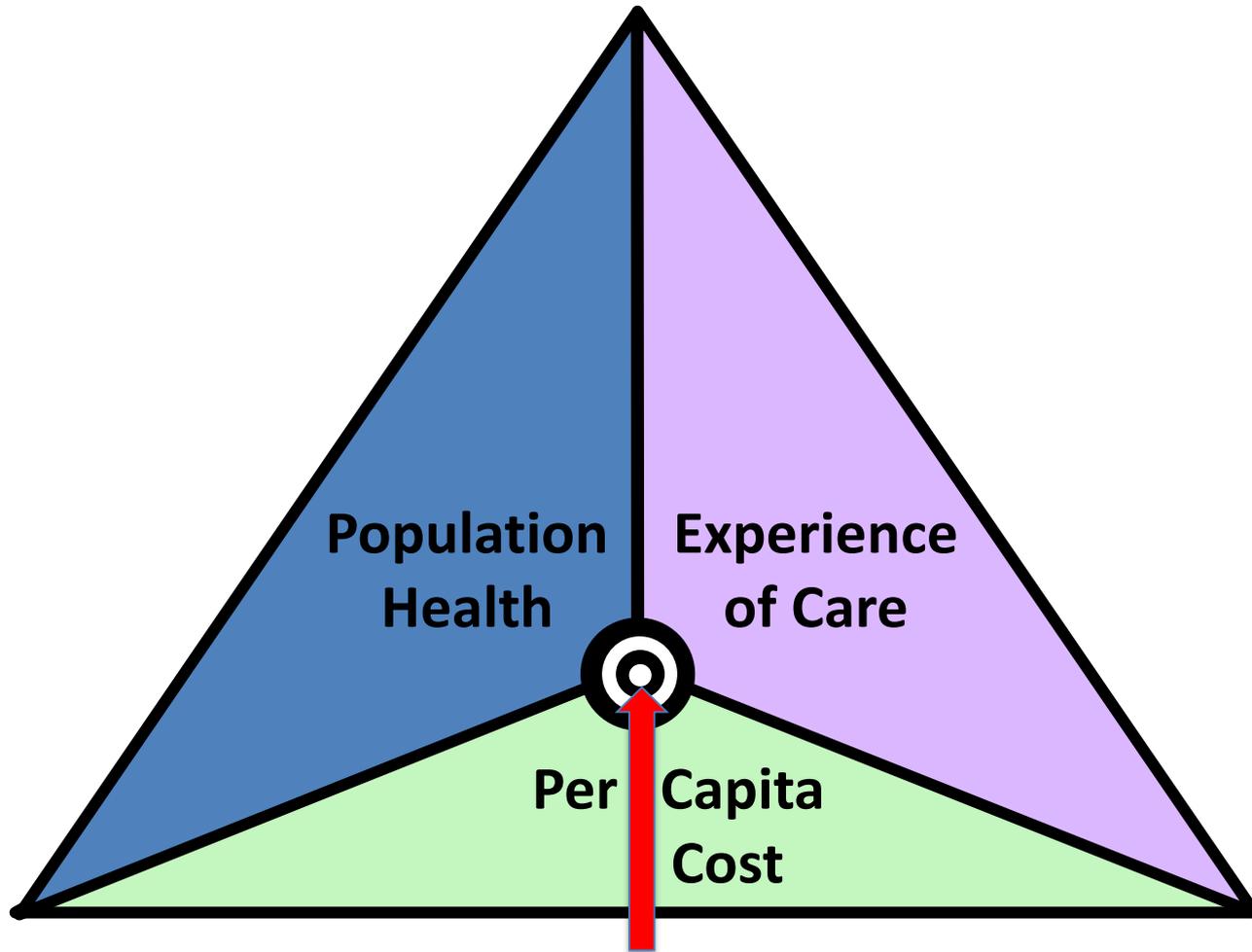
# Eliminate Disparities, Increase Diversity?



- ✓ Right thing to do
- ✓ Direct link to the Triple Aim, Performance Improvement, CHNA, CLAS, Meaningful Use, & other federal/state requirements.
- ✓ Meet changing needs/expectations of patients and communities



# The Goal: The Triple Aim



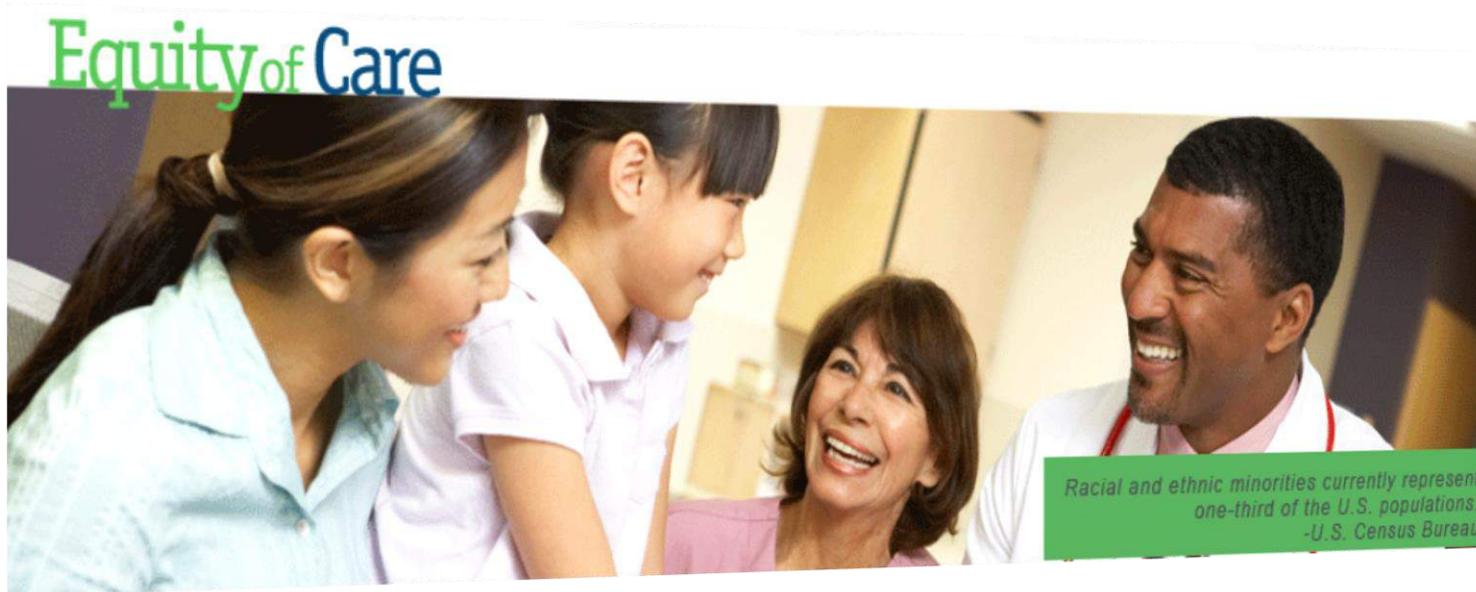
Health equity is the target.

# National Call to Action Partners

*Started in 2011*



# National Call to Action Goals



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

# Benchmark Results and Projections

<b>Milestones by Year</b>	<b>Collection and Use of REaL Data</b>	<b>Cultural Competency Training</b>	<b>Increasing Diversity</b>
2011 (Baseline)	18%	81%	Governance 14% Leadership 11%
<b>2013 (Progress Data)</b>	<b>19.4%</b>	<b>86.4%</b>	<b>Governance 14% Leadership 12%</b>
2015 Goal	25%	90%	Governance 16% Leadership 13%
2017 Goal	50%	95%	Governance 18% Leadership 15%
2020 Goal	75%	100%	Governance 20% Leadership 17%

# #123forEquity Pledge to Act

- 1. Sign the Pledge** – Pledge to take specific actions in the next 12 months to begin achieving the three goals of the National Call to Action.
- 2. Take Action** – Implement strategies that are reflected in your strategic plan and supported by your board and leadership. Provide updates on progress to the AHA and your board in order to track progress nationally.
- 3. Tell Others** – Achieve the goals and be recognized. Tell your story and share your learnings with others in conference calls and other educational venues, including social media to accelerate progress collectively.

# Action Items for the #123forEquity Pledge

Here's what we are doing as part of our commitment to the pledge:

- Choose a quality measure to stratify by race, ethnicity or language preference or other sociodemographic variables (such as income, disability status, veteran status, sexual orientation and gender, or other) that are important to our community's health.
- Determine if a health care disparity exists in this quality measure. If yes, design a plan to address this gap.
- Provide cultural competency training for all staff or develop a plan to ensure staff receives cultural competency training.
- Have a dialogue with our board and leadership team on how our hospital reflects the community we serve, and what actions can be taken to address any gaps.

## #123forEquity Social and Digital Media Resources

By participating in the #123forEquity campaign, you are taking important steps to eliminate health care disparities for the patients and community you serve. It's also a good opportunity to show your community that this is a priority issue for your hospital. Below are some sample messages that you can use on Twitter, Facebook and other digital or social media platforms to highlight your organization's work.

### Content for Facebook and Twitter

#MyHospital signed the #123forEquity pledge because all individuals should reach their highest potential for #health <http://owl.li/ZGgJN>

Equitable care is essential for healthy communities - that's why [INSERT YOUR ORGANIZATION'S NAME OR SOCIAL MEDIA HANDLE] has pledged #123forEquity <http://owl.li/ZGgJN>

[INSERT YOUR ORGANIZATION'S NAME OR SOCIAL MEDIA HANDLE] is committed to providing culturally competent care to all patients #123forEquity <http://owl.li/ZGgJN>

#MyHospital is committed to making sure our leadership and board reflect the community we serve #123forEquity <http://owl.li/ZGgJN>

Increasing diversity and reducing disparities in care is a priority for [INSERT YOUR ORGANIZATION'S NAME OR SOCIAL HANDLE] #123forEquity <http://owl.li/ZGgJN>

## SAMPLE OP-ED/NEWSLETTER ARTICLE

[HOSPITAL NAME] took the #123forEquity pledge to better serve our patients and community

By [INSERT HOSPITAL NAME]

Every patient expects and deserves the highest level of care. To successfully provide that care and improve the community's overall health, we must reduce and eliminate health care disparities.

[INSERT HOSPITAL NAME] is committed to providing equitable care for all our patients. That's why we have signed the American Hospital Association's #123forEquity Pledge to Act Campaign to Eliminate Health Care Disparities.

As part of the #123forEquity campaign, our hospital has agreed to take specific actions over the next year to:

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

[INSERT SPECIFIC EXAMPLES OF WHAT YOUR HOSPITAL PLANS TO DO OR IS DOING IN THESE AREAS]

We believe that these actions will help us reduce health care disparities and increase the quality of care delivered to all of our patients. Our hospital's leadership team and board are deeply committed to this effort as we continue to look for ways to improve the health of our community.

# DIVERSITY IN HEALTH CARE: EXAMPLES FROM THE FIELD



July 2015

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**Accessible at:** [www.hpoe.org/diversitycasestudies](http://www.hpoe.org/diversitycasestudies)

**Contact:** [hpoe@aha.org](mailto:hpoe@aha.org) or (877) 243-0027

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## EXECUTIVE SUMMARY

Diversity is becoming a key word in health care. Hospitals and health care systems are focusing on providing care that addresses the diversity of their patient populations. To better care for diverse patient populations, hospitals are working to increase the diversity of their leadership team, board and staff. And many hospital teams are building a culture of diversity and inclusion, to better engage all employees and provide high-quality, equitable care for all patients.

Aligning health care quality and equity supports the Triple Aim: improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. As hospital teams work to meet the needs of diverse patient populations, pursuing and achieving these goals will be foremost as the health care field moves from a volume-based to value-based delivery system.

These examples from the field highlight diversity initiatives at six hospitals across the country.

- » CHRISTUS Health, a multistate health system in Texas, Louisiana and New Mexico, is building a culture that prioritizes diversity and inclusion.
- » Lucile Packard Children’s Hospital Stanford is improving health care access for its diverse patient population in Palo Alto, California.
- » Main Line Health in Philadelphia is increasing leadership diversity and actively addressing determinants of health beyond hospital walls.
- » NYU Lutheran in Brooklyn, New York, has developed staff training and education that ensures culturally competent care for its diverse patient population.
- » Robert Wood Johnson University Hospital in central New Jersey promotes diversity and inclusion through employee resource groups that engage its workforce.
- » Rush University Medical Center in Chicago has created a Diversity Leadership Council to increase the number of underrepresented minorities in executive leadership and board positions.

The American Hospital Association offers more field examples and resources through the [Hospitals in Pursuit of Excellence](#) strategic platform and the [Equity of Care](#) initiative. Visit both websites for more information about diversity in health care.

## CHRISTUS HEALTH—BUILDING A CULTURE THAT PRIORITIZES DIVERSITY AND INCLUSION

### BACKGROUND

Founded in 1999, CHRISTUS Health is a multistate, faith-based, not-for-profit health system with locations in Texas, Louisiana and New Mexico, as well as in Mexico and Chile. CHRISTUS is comprised of 350 hospitals, clinics and long-term acute-care facilities. In efforts to systematically emphasize the importance of diversity and inclusion, the Office of Diversity and Inclusion was established to focus on diversity in leadership, training and education, recruitment and retention, equity of care, community partnership and the supply chain.

### INTERVENTIONS

In 2011, demonstrating organizationwide commitment to diverse leadership and equity of care, CHRISTUS Health's chief executive officer, who is also the chief diversity officer, identified "a culture of diversity and inclusion" as one of the organization's top three key strategic objectives. The board-approved strategic plan also includes strategic objectives for asset growth and clinical integration. The executive leadership team reports on these three key areas every year. Furthermore, the CEO uses a scorecard to assess the performance of the organization's top 200 senior leaders in advancing these strategic objectives. Key components of the scorecard are the overall incentives that are tied to strategic objectives and effectively prioritize diversity and inclusion.

To further drive this strategic objective throughout the organization, CHRISTUS is reaching out to managers to promote diversity and inclusion through their direct reports. To achieve this, the Office of Diversity and Inclusion provides ongoing cultural competency training that focuses on unconscious bias, generational differences and talent development.

- » *The Unconscious Bias* workshop examines how unconscious bias develops and influences staff and efforts to promote diversity and culture change. The workshop combines psychological approaches such as stereotype threat, unintentional blindness and selective attention, along with other diversity approaches.
- » *Fierce Generations* is training to create a culture where employees of all ages are comfortable teaching and learning from each other by focusing on similarities, respecting differences and identifying and leveraging strengths.
- » *The Development Ladder* is an interactive simulation workshop for employees that involves friendly competition and exposure to opportunities, barriers, rewards and consequences typically experienced in career advancement.

Working toward improving the collection and reliability of race, ethnicity, language, gender and geography data, CHRISTUS implemented MIDAS in 2014 as its clinical data system. MIDAS collects and analyzes race, ethnicity and language (REAL) data in order to generate reports, thereby advancing organizational efforts to better understand the patient population. To strengthen the reliability and consistency of REAL data collection throughout the organization, CHRISTUS trains all patient registration staff in this process.

## RESULTS

Diversity and inclusion are an established value proposition for the organization. As of fiscal year 2014, diversity in leadership has increased from 13 percent to 23 percent, and diversity on the system-level corporate board has increased to 25 percent. All departments are accountable for advancing this strategic objective. For example, when considering candidates for a new position, the human resources department is responsible for finding diverse candidate pools, which will increase diverse representation within CHRISTUS. Furthermore, equity of care initiatives are overseen by the chief medical officer, and supplier diversity is managed by the supply chain department.

## LESSONS LEARNED

- » Increasing diversity and inclusion cannot be accomplished by one department or silo. It must be embedded in a systemwide manner so that all leaders are held accountable for driving and sustaining it.
- » A reliable infrastructure must be in place to successfully collect and analyze race, ethnicity and language data.

## CONTACT

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[CHRISTUS Health](#)

## LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD—IMPROVING HEALTH CARE ACCESS FOR A DIVERSE PATIENT POPULATION

### BACKGROUND

Established in 1991, Lucile Packard Children's Hospital Stanford is a not-for-profit, 311-bed hospital located in Palo Alto, California. As part of the Stanford University system and Stanford Children's Health, the hospital is dedicated solely to pediatrics and obstetrics and has six centers that provide comprehensive services. In addition to providing health care services for pregnant mothers and children, Lucile Packard Children's Hospital Stanford actively collaborates with local nonprofit organizations and community leaders to improve community health outcomes.

### INTERVENTIONS

In its mission to integrate itself with the community to improve health, Lucile Packard has pursued several strategies. First, the hospital conducted a community health needs assessment that included Palo Alto and East Palo Alto, low-income areas with a diverse population. Although the hospital is located only a few miles away from East Palo Alto, patients needed two to three hours to get there by bus—an issue identified in the community health needs assessment. In response to the low accessibility of primary care in the area, Lucile Packard leaders served on a task force convened by the federal government. The task force worked to obtain a grant to designate and start a federally qualified health center in East Palo Alto. Committing itself as a long-term partner of the FQHC, Lucile Packard has provided annual grants, low-interest loans, donations and pediatricians to the FQHC. In addition, pediatricians at the FQHC have made it easier to refer children seeking specialty care to the hospital, thereby strengthening the continuum of care. To increase accessibility between the FQHC and other provider sites, the county of San Mateo—another FQHC partner—leased a bus shuttle that provided transportation between Lucile Packard, the FQHC, another clinic site and the Stanford Health System as the FQHC was being developed.

To help meet the needs of the medically underserved adolescent populations that are homeless or at risk of becoming homeless, Lucile Packard established the Adolescent Teens Clinic nearly two decades ago. This mobile clinic works with shelters, FQHCs in San Francisco and local school districts to identify and track homeless and at-risk youth. The clinic operates across three counties, at no cost to patients. Physicians provide comprehensive health services, including mental health, family planning, sexually transmitted disease testing and treatment, and substance abuse and social services. All mobile clinic staff, including physicians, nurses, technicians, psychologists, nutritionists and social workers, are required to be nonjudgmental and "teen-friendly." This is imperative for building trust with adolescent patients, promoting the mobile clinic as a medical home and maintaining relationships through medical records.

### RESULTS

In fiscal year 2014, Ravenswood Family Health Center, the FQHC in East Palo Alto, served 3,000 pediatric patients with more than 9,100 visits and served 2,500 pediatric dental patients with 5,400 dental visits.

In fiscal year 2014, the Adolescent Teens Clinic served 347 individual patients, ages nine and older. To these patients, the clinic provided 1,014 medical services; 1,288 individual and group dietician visits; and 679 individual and group social worker visits. The majority of youth served are Hispanic (74 percent) and/or female (77 percent).

Although more than 50 percent of patients in fiscal year 2014 were first-time visitors of the mobile clinic, approximately 30 percent of patients have maintained a relationship with the clinic for more than one year and have multiple visits per year. The services most frequently used by long-term patients are family planning and transgender services.

The mobile clinic uses several metrics to assess quality patient outcomes. Metrics include:

- » 70 percent of eligible patients receive all three immunizations in the Hepatitis B series.
- » 50 percent of sexually active patients increase condom or birth control use by at least one level on a 1-to-5 Likert scale.
- » 90 of patients meet one-on-one with social workers to use the Pediatric Symptom Checklist—Youth Report (standardized mental health screening). Patients who screen positive receive counseling, are referred for psychiatric services as needed and are monitored.

#### LESSONS LEARNED

- » It is imperative for hospital partners to treat community partners as equals and be good listeners in working toward the common goal.
- » When challenges occur in a health facility with limited resources, staff connections can make a big difference and help find alternative ways of providing care to vulnerable patients.
- » It is important to meet patients where they are and address the complex social determinants of their health.

#### CONTACT

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## MAIN LINE HEALTH—ADDRESSING DETERMINANTS OF HEALTH BEYOND HOSPITAL WALLS

### BACKGROUND

Main Line Health is a 1,348 bed, not-for-profit health system serving parts of Philadelphia and its western suburbs. Lankenau Medical Center, a member of Main Line Health, is a 331-bed teaching hospital and research institute located in Wynnewood, Pennsylvania. Main Line Health's strategic plan includes the goals of providing culturally competent and patient-centered care and eliminating ethnic and racial disparities.

### INTERVENTIONS

To cultivate a culture of diversity, inclusion and respect, Main Line Health has implemented multiple strategies, including an increased focus on talent recruitment and access to care.

- » *Enhancing diversity of the board.* Over the past decade, Main Line Health has emphasized creating a more diverse board. All board recruitment begins with marrying an extensive list of leadership and business competencies with the critical need to ensure representation from the region's diverse community. The board has experienced relatively strong gender diversity and increased the number of members from underrepresented minority groups, but it still seeks to grow its racial and ethnic minority representation.
- » *Bringing diversity to leadership.* The president and CEO of Main Line Health, as well as the board, recognized the importance of having a diverse team to foster an informed and culturally sensitive management team. Not only does the organization believe this diversification represents its core values, but several board members emphasized its importance as a strategic and business imperative. In addition, to provide development opportunities for the next generation of minority leaders, Main Line Health provides paid internships exclusively for summer interns recruited through the Summer Enrichment Program of the American Hospital Association's Institute for Diversity in Health Management.
- » *Addressing social determinants of access to comprehensive health care.* Led by the chief academic officer, interdisciplinary teams at Main Line Health conducted evidence-based assessments to identify disparities in patient treatment according to insurance status, gender, and racial and ethnic backgrounds. To date, 22 studies have been conducted. For example, a gastroenterology team assessed whether patients 50 years and older were referred for a surveillance colonoscopy as recommended. Although disparities in treatment were not found, disparities in outcomes, due largely to socioeconomic circumstances, were identified. For example, a patient did not follow up for a colonoscopy referral due to lack of transportation. To address these findings, the Health Care Disparities Colloquium was established in 2012, providing an opportunity for the community to collaborate on solving these complex problems and tracking improvements over time. To proactively address socioeconomic barriers to health care, Main Line Health has partnered with the Philadelphia College of Osteopathic Medicine to create the Medical Student Advocate program. Second-year PCOM students work with patients to address social barriers to positive health outcomes. These patients are at high-risk for readmission, delayed care and frequent ED utilization. The program aims to develop future medical professionals who are more cognizant of the key social determinants of health.

» *Addressing patient needs beyond hospital walls.* Lankenau Medical Center, situated at the intersection of two counties that rank first and last in the state's county health rankings, partners with community organizations to address health disparities. At Lankenau Medical Associates, patients who have a body mass index of at least 30 percent and/or are diabetic received prescriptions for Philadelphia Food Bucks, to use in local farmers markets. Philly Food Bucks are provided by a partnership between the Philadelphia Department of Public Health and the Food Trust. Lankenau Medical Center collaborates with Greener Partners to maintain a half-acre garden on campus. In addition, the medical center's Health Education Center draws more than 10,000 children annually and works to empower the next generation to make healthy choices. The Health Career Academy Main Line Health provides education outreach to local high school students who are at high risk for dropping out. The goal is to keep students in school by nurturing their interest in achievable health care professions. Ideally, this program will create a pipeline of promising new talent from the neighborhoods the health system serves.

## RESULTS

Although measures are not currently in place at Main Line Health to assess the impact of diversifying its board and leadership, the employees of Main Line Health have taken notice of these changes. The first class of the Medical Student Advocate program created a Wikipedia page that has nearly 500 socioeconomic and health care resources for patients. Thus far, the program has helped more than 300 patients and addressed more than 500 social needs (i.e., transportation, food, employment, utilities, etc). MSA is currently looking to partner with Spectrum Health, a federally qualified health center in West Philadelphia.

Health Career Academy has recruited four Philadelphia medical schools to oversee the program at five high schools. Over the past few years, HCA has received funding from Aetna and expanded its program to serve all high school grades. HCA also will be expanding nationally, starting with implementation in Atlanta in partnership with Morehouse and Emory Schools of Medicine. Future plans involve implementation in Houston.

Main Line Health has begun to track the impact of the Medical Student Advocate program and the Philly Food Bucks program through its electronic medical record system.

## LESSONS LEARNED

- » While the primary focus for Main Line Health is to create a diverse and inclusive environment, the real impact occurs at the program level and may take several years to yield measurable results.
- » Even at the most senior level of leadership in health care, mistakes will be made during the sensitive discussion of diversity. Therefore, it is imperative that the workplace environment encourages transparent discussions and empowers staff to hold each other accountable.
- » Leaders set the tone for promoting diversity and cultural competence within the organization by modeling respectful behavior and recruiting a diverse team.
- » It is critical to invest in the development and management of diverse talent, increasing the likelihood of retaining diverse employees.

## CONTACTS

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## NYU LUTHERAN—ENSURING CULTURALLY COMPETENT CARE FOR A DIVERSE PATIENT POPULATION

### BACKGROUND

NYU Lutheran is an academic, faith-based, community health care organization located in southwest Brooklyn, New York. The organization includes a medical center, a multisite health center network, home care, subsidized senior housing, and community development. The community served by NYU Lutheran has become increasingly diverse. Southwest Brooklyn is predominantly Hispanic, with residents from Puerto Rico, Mexico, the Dominican Republic and areas throughout Central and South America. The community is also home to the third largest Chinatown in New York City. In addition, NYU Lutheran serves the largest Arab-American community in New York City.

### INTERVENTIONS

NYU Lutheran has partnered with community-based organizations, faith-based organizations and other groups on many efforts to reduce health care disparities for the diverse communities it serves. For example, the health care system developed a successful asthma program for Latino patients who regularly used the emergency department for asthma treatment. The program focused on routine visits to monitor medication usage, and Spanish-speaking home health care workers and educators went to patient homes to teach patients how to manage their asthma in their home environment. The asthma program was so successful, emergency room utilization decreased dramatically and there is no longer a need for the program.

In its ongoing commitment to meet community health needs, NYU Lutheran continues to develop community health needs assessments, focus groups and programs that are culturally and linguistically accessible, appropriate and competent. Collection of patients' race, ethnicity and language preference data, in addition to census data, has provided detailed information on the demographics and needs of the patient population. The health care system now has a mosque, Bikur Cholim Yad Yaakov room, Sabbath elevators, and an interfaith chapel – all on-site. Chinese, Halal and Kosher meals are served throughout the system. A patient guide and other documents are written at a sixth-grade reading level and available in five languages: English, Spanish, Chinese, Russian and Arabic. After successfully developing a Chinese unit in the hospital, the organization recently opened a Chinese unit in its nursing home/short-term rehabilitation facility. NYU Lutheran actively works with community organizations, staff and physician partners for input and fundraising for all of these initiatives.

Cultural competency training also is a core function of NYU Lutheran's equity of care efforts. All staff members receive cultural competency training during new employee orientation. In addition, nurses, physicians, house staff and medical students receive additional training on cultural competence within their disciplinary training. Special trainings open to all staff have been conducted on Chinese and Latino values and health beliefs; Ramadan; homelessness; gender; domestic violence; mental health; palliative care; working with Muslim families; working with patients with disabilities; and many other topics.

## RESULTS

Ensuring leadership, governance and staff diversity also is a priority for NYU Lutheran. The human resources department, together with staff, leadership and the community, work diligently to recruit staff members who are representative of the community. Fifty-nine percent of NYU Lutheran's staff is bilingual, which helps the health system care for its patient population. At NYU Lutheran, 39 percent of patients prefer not to speak English when receiving medical care. Leadership also ensures that all shifts at each health center include culturally and linguistically diverse staff members. These efforts have resulted in an increase in the number of patients from these various communities who use the hospital. In the 10-year period from 2004 to 2014, Hispanic patients have increased from 15 percent to 21 percent of all patients, Arabic-speaking patients have increased from 1 percent to 2 percent, and Chinese-speaking patients have increased from 4 percent to 6 percent of all patients at the hospital. The Chinese unit was expanded to the entire hospital, and Chinese staffing has increased throughout the hospital.

## LESSONS LEARNED

- » Ongoing partnerships with community organizations provide guidance and support in delivering culturally appropriate care.
- » It is important to recruit staff members who are representative of the community served.
- » Cultural competency training should be part of orientation for all employees; additional training in relevant topics and by specialized disciplines also should be provided.

## CONTACT

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## ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL—PROMOTING DIVERSITY AND ENGAGING EMPLOYEES

### BACKGROUND

Robert Wood Johnson University Hospital is a 965-bed hospital with campuses in New Brunswick and Somerville in central New Jersey. Together, RWJUH's New Brunswick and Somerset campuses serve as the flagship hospital of the 1,733-bed health care system.

### INTERVENTIONS

In 2012, RWJUH identified diversity and inclusion as a key strategic commitment and implemented the first board-approved diversity and inclusion plan. To begin this process, the hospital reached out to the American Hospital Association's Institute for Diversity in Health Management. One component of the diversity and inclusion plan was creating employee-led business resource groups, also known as employee resource groups. RWJUH now has seven business resource groups:

- » Advancing Women through Advocacy, Recognition and Empowerment (AWARE)
- » Asian Society for Impact and Advocacy Network (ASIAN)
- » Black Professionals Network (BPN)
- » Emerging Leaders Network (ELN)
- » Promoting Respect, Outreach, and Dignity (PROUD) for LGBT employees
- » Service and Advocacy for Latinos United for Development (SALUD)
- » Veterans Engaging Through Service (VETS)

RWJUH's business resource groups have helped advance the hospital's business objectives through improving employee and patient engagement, community outreach, and diversity and cultural competency education. The groups lead business impact projects that are linked to key organizational metrics, including financial performance, employee and patient engagement, and market-place positioning. RWJUH works with the business resource groups to engage and develop the next generation of leaders. For example, business resource group leaders are mentored by executive sponsors and frequently interact with leaders across the system.

### RESULTS

In a recent survey of RWJUH's business resource group members about their level of engagement, 70 percent said the business resource groups added value to the employee experience. Furthermore, because of RWJUH's support of business resource group involvement, employees believe that "RWJUH is committed to [their] overall growth and development." As a result, employees are more satisfied with RWJUH as an employer. The return on investment for engaged employees and for the organization has been measured in the number of promotions among business resource group leaders, expanded job roles and responsibilities, enhanced business acumen, and visibility as the next group of leaders at RWJUH. Since the program began in 2012, more than 30 percent of business resource group leaders have received a promotion within RWJUH.

The health care system's 2014 engagement survey found that diversity is a major driver of employee engagement and employer satisfaction. An example of a business impact project that promotes diversity is the Black Professionals Network's Project R.E.D. (Reach. Educate. Donate), which partnered with RWJUH's blood donor services to respond to a shortage of African-American blood donors. This initiative provided education and outreach in African-

communities on the importance of blood donation and reduced the costs associated with shortages of unique blood types in RWJUH's internal blood bank. The Black Professionals Network also led the development of community blood drive donor cards, which add potential donors to the RWJUH donor database.

#### LESSONS LEARNED

- » Employee business resource groups can support business objectives, including education and outreach and patient and employee engagement.
- » Effectively aligning employee business resource groups to organizational operations and performance adds value to the business case for increasing and advancing workforce diversity.
- » Engaging staff through business resource groups can provide opportunities for staff growth, including developing the next generation of leaders.

#### CONTACT

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## RUSH UNIVERSITY MEDICAL CENTER—CREATING A DIVERSITY LEADERSHIP COUNCIL

### BACKGROUND

Rush University Medical Center is a not-for-profit, 664-bed academic medical center located in Chicago. The mission of Rush is to provide the best health care for the individuals and diverse communities it serves through the integration of outstanding patient care, education, research and community partnerships. Rush's core values are innovation, collaboration, accountability, respect and excellence (I CARE).

### INTERVENTIONS

In response to an ad hoc committee's 2006 review of Rush's challenges on increasing diversity in leadership, senior leaders established the Diversity Leadership Council. This council is chaired by the vice president of corporate and external affairs, and the executive sponsor is the president of Rush University Medical Center. The council is composed of members from all sectors of the medical center. The council reviews organizational successes and areas for improvement regarding diversity and develops programs to promote organizational diversity.

Since the creation of the Diversity Leadership Council, Rush has implemented numerous policies and practices to promote diversity and inclusion within leadership and governance roles, with its initial focus on hiring more women and underrepresented minorities and encouraging their leadership development. The executive leadership council attends formal diversity training and at least two Rush diversity events annually. Furthermore, all staff and faculty complete online diversity training annually. As part of their performance appraisal process, managers must include at least one goal on diversity, which in some cases is tied to their annual compensation incentives. Rush also has a diversity scorecard that assesses whether leaders are making progress toward completing their goals. Rush hired an associate vice president in human resources to ensure there is a diverse pool of candidates for all open positions.

To understand and meet the needs of the medical center's patients and employees, the Diversity Leadership Council also created a LGBT advisory panel that includes allies and members of the LGBT community. The council and advisory panel identified goals in five areas: access; resources and visibility; health records; education and training; and transgender-specific goals. In addition, Rush hosts an annual Diversity Week with activities that are designed to break down barriers to effective communication among colleagues and create a culture of inclusion and increased cultural competence.

### RESULTS

Since 2007, representation of women in senior executive positions at Rush University Medical Center has increased from about 53 percent to 57 percent, along with an increase of underrepresented minorities from 11 percent to 17.9 percent of those positions. Twenty-five percent of board members are women, an increase from 21 percent, while minority representation increased from 11 percent to 20 percent.

Furthermore, Rush has revised its health records to allow patients to indicate whether their current gender identity differs from the gender they were assigned at birth and the gender shown on documents used in admitting or registration. In 2014, Rush provided six days of staff training on LGBT health-related topics and plans to continue it, along with developing additional LGBT resources for patients and employees.

## LESSONS LEARNED

- » Creating a culture of diversity should be consistent and deliberate, integrating patient care, education, research, and community partnerships.
- » Establishing a Diversity Leadership Council can help to increase the diversity of senior executive staff and board members.
- » It is important to understand and meet the needs of underserved patients and employees, including those who are LGBT.

## CONTACT

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## #123forEquity Toolkit Case Example: NYC Health + Hospitals

# The Roadmap to Improving Health Equity at NYC Health + Hospitals

### Organization and Team

#### NYC Health + Hospitals New York, NY



OFFICE OF CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS/LEP)  
BRIDGING THE LANGUAGE AND CULTURE DIVIDE



From left: Matilde Roman, Senior Director, CLAS/LEP Office; Evelyn Plaza, Executive Secretary; Caroline M. Jacobs, Chief Patient Safety Officer and Senior Vice President, Safety and Human Development; Camellia Mortezaezadeh, Associate Director, Cultural Competency; Anne-Marie Bumbalo, Associate Director, Language Access

### Problem Description

- HHC, the largest municipal health care delivery system in the country, serves over 1.2 million patients annually.
- Nearly forty percent (40%) of New Yorkers were born outside of the United States. Over 200 languages and dialects are spoken by city residents. Fifty percent (50%) of all New Yorkers speak a language other than English at home, and approximately 1.8 million residents are limited English proficient (LEP).<sup>1</sup>
- HHC is uniquely positioned at the forefront of issues related to health equity and access and addressing health care disparities, given the racial, ethnic and linguistic diversity of patients served.
- There is an identified need for an organizational strategy to enhance equity principles and promote cultural and linguistic competence throughout the Corporation, and to further tie these issues to key patient satisfaction and quality improvement measures.

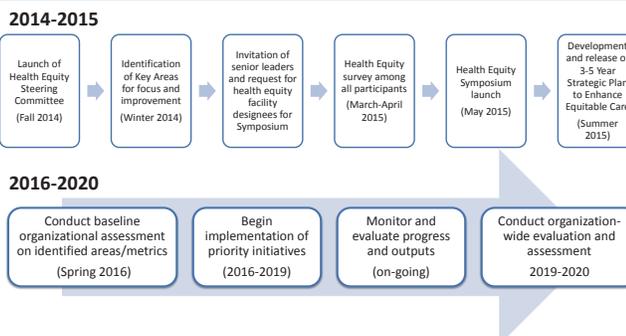
<sup>1</sup> U.S. Census Bureau. 2012 American Community Survey 1-Year Estimates. Population Division – New York City Department of City Planning (Jan. 2014)

### Deliverables & Measures

Patient Experience and Engagement	Workforce Strategy for Capacity Building and Long-Term Planning	Health Literacy
<p><b>Proposed Deliverables</b></p> <ul style="list-style-type: none"> <li>Development of real-time patient experience and feedback reports, disseminated to all layers of staff</li> <li>Utilization of REAL data to provide tailored, personalized care and services; ensure ongoing, updated training of all staff</li> <li>Development of patient-centered, standardized code of conduct and training</li> <li>Standardization of employee evaluations to incorporate patient experience and health equity goals</li> </ul> <p><b>Proposed Measures</b></p> <ul style="list-style-type: none"> <li>Improvements in HCAHPS scores, stratified by language, race, ethnicity</li> <li>Incorporation of code in hiring and performance evaluations</li> <li>Percentage of staff evaluated on new evaluation metrics</li> </ul>	<p><b>Proposed Deliverables</b></p> <ul style="list-style-type: none"> <li>Development of new target competencies for new and existing staff</li> <li>Development of ongoing professional development, CME and learning opportunities related to health equity goals and principles and patient demographics</li> </ul> <p><b>Proposed Measures</b></p> <ul style="list-style-type: none"> <li>Train and measure staff awareness on HHC patient demographics</li> <li>Percentage of staff evaluated on core competencies</li> <li>Number of staff enrolling in courses and certifications received</li> </ul>	<p><b>Proposed Deliverables</b></p> <ul style="list-style-type: none"> <li>Organizational health literacy assessment</li> <li>Launch and regular convening of Health Literacy Task Force</li> <li>Development of health literacy policy and best practices</li> <li>Deployment of educational training on health literacy and plain language best practices among staff</li> </ul> <p><b>Proposed Measures</b></p> <ul style="list-style-type: none"> <li>Incorporation of policy and standards into existing and new Corporate-wide documents</li> <li>Percentage of staff trained and aware of practices</li> </ul>

Note: deliverables and measures still in development

### Results



### Project Goals

- Goals:** Identify areas across the New York City Health and Hospitals Corporation (HHC) to improve the delivery of equitable, patient-centered and culturally responsive services.
- Objectives:** HHC's inaugural Health Equity Symposium convened senior leadership and key stakeholders for a full-day strategic planning session to develop measurable goals and objectives for health equity improvement.
- Strategies:** Develop a comprehensive organizational roadmap to reduce disparities in health and health care outcomes, and ultimately improve the quality of care for our diverse patients, inclusive of LGBTQ patients, the elderly, disabled, individuals possessing limited health literacy, veterans and other populations with unique needs.
- Implementation and Results:** Embed the roadmap within HHC's current organizational goals and priorities. Implement strategies and monitor progress and results.

### Improvement Strategies

- HHC identified six critical areas for planning and quality improvement:
  - Patient Experience and Engagement
  - Workforce Strategy for Capacity Building and Long-Term Planning
  - Health Literacy
  - Governance of Race, Ethnicity and Language (REAL) Data
  - Internal and External Communications
  - Governance and Leadership
- Convened HHC's inaugural Health Equity Symposium in May 2015
- Over 95 senior leaders, designees and key stakeholders convened for full-day strategic planning to develop broad goals, measurable strategies and deliverables for the six health equity improvement areas
- Recommendations and work plans will inform development of HHC's Strategic Plan to Enhance Equitable Care
- Plan will serve as a comprehensive roadmap for HHC to reduce disparities, improve patient experience, and enhance provision of quality culturally and linguistically responsive services



### Deliverables & Measures

Governance of Race, Ethnicity and Language (REAL) Data	Internal and External Communications	Governance and Leadership
<p><b>Proposed Deliverables</b></p> <ul style="list-style-type: none"> <li>Development of education campaign and training for patients and staff on importance of REAL data collection</li> <li>Launch pilot among facilities to improve REAL data collection</li> <li>Collect baseline data on gaps in REAL data across Corporation; identify metrics to measure progress and/or new fields to monitor (e.g., disability status, LGBT status, multi-racial identities, veterans status)</li> </ul> <p><b>Proposed Measures</b></p> <ul style="list-style-type: none"> <li>Decrease in 'missing' or 'unknown' demographic fields from baseline, pre- and post-pilot training and campaign</li> </ul>	<p><b>Proposed Deliverables</b></p> <ul style="list-style-type: none"> <li>Development of broad communications and marketing campaign to staff and patients</li> <li>Standardize policies and guidelines for patient communication materials, signage, forms, etc., incorporating plain language, health literacy and standardized transition practices</li> <li>Assessment of patient perceptions and preferred means of communication through focus groups</li> <li>Development of tailored messaging based on patient feedback</li> </ul> <p><b>Proposed Measures</b></p> <ul style="list-style-type: none"> <li>Number of new campaigns launched annually</li> <li>Staff knowledge on health equity, diversity, disparities and culturally and linguistically competent care</li> <li>Adherence to standardized policy and guidelines in new materials produced</li> </ul>	<p><b>Proposed Deliverables</b></p> <ul style="list-style-type: none"> <li>Increased transparency between HHC, its patients and their communities</li> <li>Development of concrete definitions and expectation on health equity priorities, goals and principles</li> <li>Increased opportunities for staff to take on community relations roles</li> <li>Increased utilization of Community Health Needs Assessment and findings in planning</li> </ul> <p><b>Proposed Measures</b></p> <ul style="list-style-type: none"> <li>Incorporation of health equity concepts into existing organizational policies, initiatives, grants and programs</li> <li>Measure engagement among external stakeholders and patients in HHC planning and program development</li> </ul>

### Lessons Learned

- Beginning phase of multi-year journey towards incorporating health equity goals into existing organizational functions and structures
  - Dr. Ram Raju's 20/20 Vision
  - HHC's Guiding Principles
- Continued engagement and leadership commitment across organizational divisions, facilities and various levels of staff is needed to ensure success and buy-in
- Baseline assessments of organizational readiness across critical health equity areas necessary to measure progress pre and post-implementation
- Next phase: Ongoing engagement with patients and additional external stakeholders to refine strategic plan and support implementation



## #123forEquity Toolkit Case Example: Massachusetts General Hospital Strategies and Tools to Identify and Address Disparities in Care for Patients with Limited English Proficiency

### Organization and Team

**Massachusetts General Hospital**  
Boston, MA



**The Disparities Solutions Center**  
Joseph Betancourt – Director (not pictured)  
Aswita Tan-McGrory – Deputy Director  
Karey Kenz – Project Manager  
Adriana Lopera – Research Assistant  
**Center for Quality & Safety**  
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Syrene Reilly – Sr. Director of Quality Management  
Andrea Tull – Director of Reporting & Analytics  
Bijay Acharjay – Fellow in Patient Safety & Quality  
Bob Malin – Sr. Data Analyst

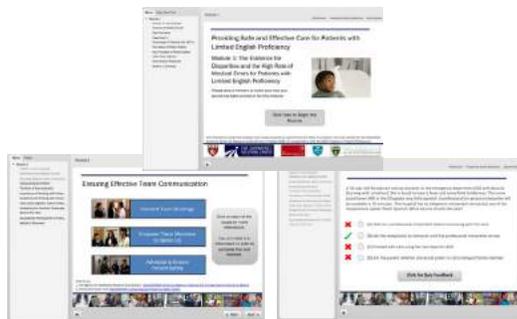


### Problem Description

- The role of language barriers and their impact on adverse events is now receiving greater attention. Recent research suggests that adverse events that affect patients with limited English proficiency (LEP) are more frequently caused by communication problems and more likely to result in serious harm, compared to English speaking patients.<sup>1</sup> Language barriers also lead to longer length of stay and higher readmission rates.<sup>2</sup>
- Data from the 2014 Annual Report on Equity in Healthcare Quality (AREHQ) revealed disparities between English-speaking and limited English proficient patients in several quality metrics including patient satisfaction, well-child visits, and administration of intrapartum antibiotic prophylaxis for Group B streptococcus.

1. Divi C, Koss RG, Schmalz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot. *International journal for quality in health care: journal of the International Society for Quality in Health Care / ISQua*. Apr 2007;19(2):60-67.  
2. Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. *J Gen Intern Med*. Oct 2012;27(10):1294-1299

### LEP E-Learning Program

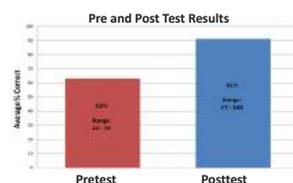


### Results

#### OB Pilot of LEP E-learning Program

- 52 out of 58 physicians and midwives in OB (90%) completed the course.
- 68% rated the overall learning experience above average/excellent.
- 82% agree/strongly agree that the course provided useful information regarding safe care for patients with LEP.
- 76% would recommend the program to other providers.

Maternity Measures	Race				Primary Language			
	White	Other	English	Other	White	Other	English	Other
Intrapartum antibiotic prophylaxis for GBS	N	%	N	%	N	%	N	%
2008 Q1 - 2010 Q4	36	82.7	167	88.0	83	100.0	128	100.0
2009 Q1 - 2011 Q4	40	97.6	130	80.8	69	86.6	100	100.0
2010 Q1 - 2012 Q4	56	98.2	178	91.6	108	97.2	126	100.0
2011 Q1 - 2013 Q4	71	84.4	217	93.6	140	95.3	184	93.0



### Project Goals

Analyze key quality measures stratified by race, ethnicity and language in an effort to identify existing disparities and implement quality improvement initiatives to address them.

### Improvement Strategy

The DSC worked with the Department of Obstetrics and Gynecology to pilot test its e-learning program, Providing Safe and Effective Care for Patients with Limited English Proficiency, with physicians and midwives. The pilot included two, 15-minute modules that address the evidence of disparities in care for patients with LEP and concrete skills for working with professional interpreters.

### Measures

- Effectiveness of the e-learning modules was measured by assessing change in the pre-post test scores of physicians and midwives who completed the program. Participants also rated the course and provided qualitative feedback via an end-of-course evaluation.
- Success of the pilot has led the institution to adopt the e-learning program for all physicians at MGH, and the module on working with interpreters will be rolled out as part of mandatory annual training requirements in fall 2015. As with the pilot, we will track the number of physicians who complete the program, along with changes in pre-post test scores and evaluation ratings.
- MGH will continue to monitor for disparities between English-speaking and LEP patients in the Annual Report on Equity in Healthcare Quality.

### Lessons Learned

- Leadership and accountability are critical**
  - Routine reporting to Board, leadership
- Socializing the concept early is essential; high quality for all**
  - Aspirational and tied to mission
- Integration within departments is key**
  - E.g., Quality and Safety should be responsible and accountable
- Incremental progress is progress**
  - Strategic, deliberate, tactical, practical
- Transparency demonstrates commitment; commit to action**

## #123forEquity Toolkit Case Example: KentuckyOne Health Health Connections Initiative: An Interdisciplinary Care Team Approach to Improved Care Coordination for the Low Income Vulnerable Patient Population

### Organization and Team



**KentuckyOne Health™**  
Jewish Hospital

#### Health Connections Initiative Team

Alice Bridges – Vice President for Healthy Communities, KentuckyOne Health

Dan Borrage, PT, MBA – Area Operations Director for VNA Nazareth Home Care

Tammy Schuley, RN, MS, ACM – Care Management Market Leader for KentuckyOne Health – West

Ginger Florence, RN – Health Connections Initiative Lead RN, VNA Nazareth Home Care

Bev Beckman, RN, CPHQ, ACM – Health Connections Initiative Project Manager



### Addressing Disparities & Health Equity

- People at the highest risk for emergency care and hospitalization are often tangled in a complex web of issues related to the social determinants of health.
- Limited access to educational, economic and job opportunities often result in poverty, social isolation, depression and multiple chronic medical conditions with a high utilization of healthcare services.
- The Health Connections Initiative Program is an interdisciplinary care team approach to improving care coordination for the low income vulnerable patient population in Louisville, KY.
- The Health Connections Initiative is grounded in strong evidence that a large number of ED visits and hospital admissions of “super-utilizing” patients can be prevented by relatively inexpensive and coordinated interventions.

### Strategy to Improve Quality

- Potential participants are identified while they are hospitalized at one of the three participating hospitals using an evidence based readmission risk assessment tool known as LACE; a scoring tool that calculates the risk for readmission based on length of stay, acuity, number of co-morbidities and number of ED visits within the previous six months.
- Those who score 11 or higher, live in one of the low-income neighborhoods, and have Medicare, Medicaid or are uninsured are invited to enroll in the free 90 day program.
- An outreach team including an RN, LPN, Social Worker and Community Health Worker provides in home visits over the 90 day program.
- As needed, the team draws on the services of a Registered Dietician for dietary coaching and a Peer Support Specialist for behavioral needs such as depression, social isolation or substance abuse.
- The team works with the patient to set patient centered goals for health improvement focusing on both the medical and social needs as well as transition to a medical home.

### Evidence Based Tools & Programs

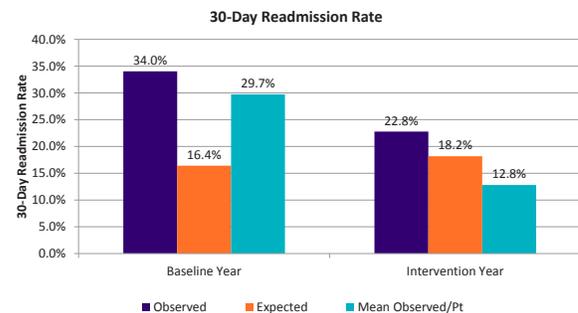
**Evidence based tools** are used for participant identification, measuring outcomes, performing a root cause analysis on all 30 days hospital readmissions and improving the quality of care for the low income patient population.

- Ottawa **LACE** tool for readmission risk assessment
- **Personal Health Questionnaire 9 (PHQ9)** for depression screening
- **Stanford Self Efficacy Survey** for assessment and measurement of self-efficacy
- **Client Perception of Care Coordination (CPCQ)** for assessment of satisfaction and coordination of care
- **IHI Starr Root Cause Analysis Survey** for review of hospital readmissions
- The **Camden Coalition of Care Intervention** was used as a benchmark in the development of this program.
- This project originated during participation in the Disparities Leadership Program operated by the **Disparities Solution Center**.

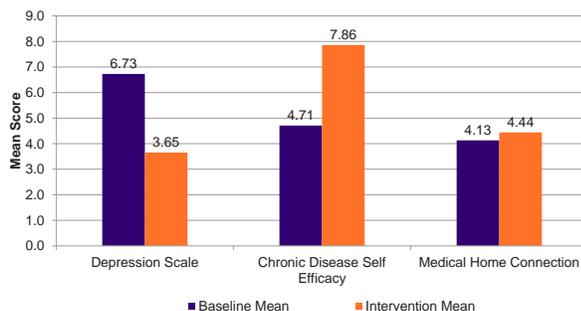
### Success Measures - The Triple Aim

- Evaluation is built on the **Institute for Health Improvement's Triple Aim** framework with measures tracked monthly on three dimensions: Better Health, Better Experience of Care, and Lower Cost Per Capita. The study includes 124 “graduates” between October 2013 and February 2015.
- The 30-day unplanned readmission rate dropped from 34% in the base year (12 months prior to enrollment in the program) to 22.8% in the intervention year (begins with discharge date of referring inpatient admission). A key finding is that there are some participants for whom behavior change seems nearly impossible, illustrated by a single patient who represents 27% of the readmissions.
- Depression rates, as measured by the Personal Health Questionnaire Depression Scale (PHQ-9), have been substantially reduced from a mean of 6.73 at enrollment to 3.65 at graduation.
- Participants reported significant improvement in their ability to manage their health as measured by the Stanford Chronic Disease Self-Efficacy 6-Item instrument: from a mean of 4.71 to 7.86.
- The number of participants who perceive their care is well coordinated improved from a mean of 4.10 to 4.64. This is measured by the Client Perception of Care (CPCQ) question: “In the past 3 months, how often did you feel the care you received was well coordinated?”
- The rate of patients returning to the ED within 7 days of an inpatient admission fell from 8.7% to 6.8%.

### Readmission Rate Improvements



### Quality Metric Improvements



### Lessons Learned

- The Health Connections Initiative Program piloted in Louisville, KY, demonstrated success and has been deployed to other CHI facilities in Little Rock, AR, Seattle, WA and Houston, Texas.
- The program demonstrates the value of collaboration between the acute care hospitals, community based organizations and local medical homes.
- Performance improvement methodologies and “lessons learned” have been used to build a sustainable model that can be shared for use by other organizations.
- A **toolkit** is available to assist those interested in the program.
- Future plans include the addition of tele-health, a mental health RN, Chaplaincy and extended health coaching using a volunteer community health worker.
- This program has demonstrated improvement in healthcare quality, utilization and patient experience.

## #123forEquity Toolkit Case Example: Baptist Health Medical Center Patient Satisfaction: Diversity Management

### Organization and Presenter

**Baptist Health Medical Center**  
Heber Springs, Arkansas

Charmaine Allen, RN  
Nursing Operations Manager



### Project Goals

- Identify age-specific disparities pertaining to patient satisfaction
- Develop action plan for process improvements toward quality of care
- Set specific goals that impact increasing outcomes
- Implement new care model

### Problem Description

- Decreased patient satisfaction scores can cost hospitals millions of dollars
- Hospitals across the nation are tracking patient satisfaction outcomes
- Reimbursement rates are tied to patient satisfaction ranking
- Scores are based off the patient perception of their hospital visit

### Patient Age Influences Scores

Demographic Characteristics, by age, from the Press Ganey website on returned surveys:

18-34 years	35-49 years	50-64 years	> 65 years
(6)	(60)	(415)	(475)

**Improvement strategy started with collecting data on who had returned the surveys**

### Measures: Overall HCAHPS Score by Age

Age Groups	Nurses	Pain	ER Wait Time	Response of Staff	D/C Info	Comm w/Doctors
18-34	88.6	80.9	50.0	80.1	85.4	86.4
35-49	91.6	80.0	33.3	84.1	85.2	87.0
50-64	93.7	87.1	65.3	90.1	90.6	89.5
>65	93.4	89.3	79.1	90.1	88.6	90.3

**Next we measured how each age group scored the specific HCAHPS domains**

### Age Specific Impact

- Age 18 – 34 didn't feel the physician spent enough time with them, didn't feel ready for discharge, had pain control issues and response to calls was scored low, ER wait time second lowest of all groups. **Comments pertained to patient/staff relationship behaviors.**
- Age 35-49 didn't feel ready for discharge, pain not controlled and ER wait time was lowest scored of all age groups. **Comments geared towards same as above age group.**
- Age 50 – 64 didn't feel physician spent enough time, pain not managed and ER wait times low. **Comments pertained to skill of staff and environment.**
- Age >65 didn't feel pain was managed, ER wait times low and ready for discharge low. **This group's comments pertained to care of spouse during stay.**

### Measures

- Improvement strategies will be measured utilizing the HCAHPS age specific report.
- This is a new process and we are currently collecting data, as seen on previous slides.
- Reports will be run monthly to track improvements.

### Lessons Learned

- Age-specific care planning impacts patient satisfaction outcomes.
- It is important to identify specific patient expectations prior to action planning.
- Building relationships with the patient and family is important to all age groups.
- Patient Care Associate added to staffing model to assist with increasing outcomes related to Response to Calls.

## #123forEquity Toolkit Case Example: Rancho Los Amigos National Rehabilitation Center Ask Patients to Estimate Adherence

### Organization and Team



Rancho Los Amigos National Rehabilitation Center  
Downey, CA  
Department of Health Services, County of Los Angeles

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### Problem Description

We designed the project to focus on the *Sustain* step of the Medication Self-Management Model at Rancho Los Amigos National Rehabilitation Center.

#### Model of Medication Self-Management\*



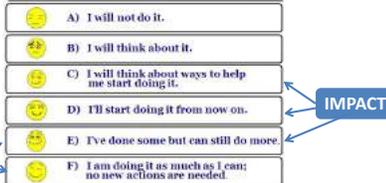
\*Bailey, Oramasionwu, & Wolf, (2013) Rethinking Adherence: A Health Literacy-informed Model of Medication Self-Management

### Measures

- Survey questions based on the aim of each PDSA cycle:
  - Any suggestion to make this page easy for you to use?
  - Please tell me in your own words what "refill your medicine is."
- Ranking different versions
- Estimate the impact and adherence using ETAC:

"Please stop and think about this. You are at your own place. You only have a few days of medicine left. Please tell me, how do you see yourself using the phone refill?"

#### Empowered To Act Consistently



**Impact:** Because of the PE, learners estimate that they will move toward adherence.

### Results

#### June 2015 Field-testing (N=118)

##### Improvement Cycle 1:

- To have bigger fonts; to include label on a vial graphic.

##### Improvement Cycle 2:

- 8% cannot locate the 10-digit prescription number:
  - English-speaking patients: 8% (6/78)
  - Spanish-speaking patients: 8% (3/37)
- 2.5% (3/118) didn't understand "Refill Your Medicine" and they happened to be Spanish-speaking

Latest Version



patients	I will not do it.	I'll think about it.	I'll think about ways to help me start doing it.	I'll start doing it from now on.	I have done some but can still do more.	I am doing it as much as I can; no changes are needed.
Spanish	8 (68%)	2 (17%)	1 (8%)	3 (24%)	2 (16%)	16 (68%)
English	6 (8%)	2 (3%)	8 (10%)	8 (10%)	8 (10%)	87 (97%)
Other	2 (87%)	0 (0%)	0 (0%)	0 (0%)	1 (5%)	1 (5%)
All	15 (12%)	4 (3%)	9 (7%)	9 (7%)	9 (7%)	94 (78%)

Estimated Impact: 12%  
Estimated Adherence: 72%

- Estimated impact improved 12% (from 27% to 39%) and estimated adherence improved 21% (from 51% to 72%) comparing 2013 & 2015.
- The refill PE had more impact in English-speaking patients.

### Project Goals

- It is a significant patient safety concern that patients often appear in the outpatient clinics or pharmacy out of their medications when they could have used the phone refill system. This is a problem of the *sustain* step of the medication self-management. It was implied that Spanish-speaking patients had more challenges with medication adherence.
- The goals of conducting the field-testing (usability test) are to:
  - Ensure a patient education information page (PE) is user-friendly and patient-centered;
  - Estimate the impact and adherence of PE use; and
  - Explore potential differences in using phone refill by English- and Spanish-speaking patients.

### Improvement Strategies

#### Two waves of field-testing: 2013 & 2015

##### June 2013 Field-testing



##### June 2015 Field-testing



PDSA: Plan, Do, Study, Act improvement cycle  
ETAC (Empowered-To-Act Consistently) to estimate **impact** and **adherence**

### Results

#### June 2013 Field-testing (N=83)

##### Improvement Cycle 1:

##### Which PE version?



##### Improvement Cycle 2:

"Refill Your Medicine" is preferred (p<.001)  
Clinicians: 68% (35/53); Patients: 75% (62/83)

##### Incorporating graphic?

Yes: 65% (89/136)  
Neutral: 18% (25/136)  
No: 16% (22/136)  
(p<.001)

##### Which graphic is preferred?

Action- or item-graphic? Item-graphic!



Asking patients to rate 4 versions of PE resulted in nebulous findings.

#### Patients' response: "How do you see yourself using the phone refill?" (2013)

patients	I will not do it.	I'll think about it.	I'll think about ways to help me start doing it.	I'll start doing it from now on.	I have done some but can still do more.	I am doing it as much as I can; no changes are needed.
Spanish	8 (24%)	4 (12%)	3 (9%)	0 (0%)	2 (6%)	16 (48%)
English	7 (14%)	8 (16%)	5 (10%)	6 (12%)	6 (12%)	18 (36%)
All	15 (18%)	12 (14%)	8 (10%)	6 (7%)	8 (10%)	34 (42%)

Estimated Impact: 27%  
Estimated Adherence: 51%

### Lessons Learned

- Think "action" - always ask patient to estimate adherence for any PE.
- Employ the ETAC methodology to estimate **impact** and **adherence** for the desirable action of patients.
- Conduct **field-testing** to address patient-centeredness for PE.
- We may need to ensure that patients know:
  - What "refill your medicine" is
  - Where to find the prescription number
- The use of the "phone refill" PE had a **higher impact** on English-speaking patients consistently.

## #123forEquity Toolkit Case Example: Connecticut Hospital Association CHA's Statewide Asthma Initiative

### Advancing Health Equity: CHA's Statewide Asthma Initiative



**Connecticut Hospital Association**  
Wallingford, CT



### Project Goals

The goals of CHA's Statewide Asthma Initiative are to improve access and appropriate care by partnering with the community; reduce asthma hospitalizations and ED visits; and significantly advance progress toward health equity for asthma care and outcomes by 2017.

We have assembled a broad-based project group of clinical experts, care providers, and community advocates who are working to develop a culturally sensitive model for asthma care to be implemented statewide. Model development will include evidence-based interventions, informed by the voices of patients and families in communities in which health disparities for asthma care are evident.

### Problem Description

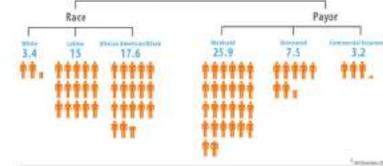
#### ASTHMA remains a problem in Connecticut

More kids and adults in CT have asthma than the US average.

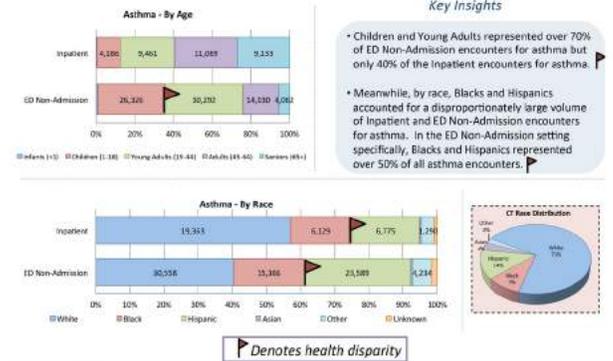


Asthma disproportionately affects children, women, the elderly, the economically disadvantaged, and urban residents. African Americans, Blacks and Latinos are more likely to end up in the hospital for asthma.

#### Asthma ED visits per thousand people in Connecticut



#### Chronic Disease: Asthma



### Improvement Strategies

- Mobilize hospitals in collaboration with community partners to identify barriers and challenges in continuum care for adults and children with asthma.
- Develop population-specific models of intervention that utilize the partnerships created for asthma care.
  - Focus groups conducted with parents of children with asthma and adults with asthma from African American/Black and Latino communities in 3 urban areas.
  - Interventions include culturally sensitive care, medication/inhaler use staff training, and patient teaching with patient teach-back before discharge, provision of standardized discharge plans and promotion of asthma action plans, and "warm hand-off" to a primary care provider.
- Identify, share, and implement national and statewide best practices.
  - Intervention set developed with clinical experts and academic partners to reduce variation, strengthening care for all served regardless of race, ethnicity, age, gender, etc.
- Identify and foster strategies for sustainability.

### Measures

- Emergency Department visits for asthma (stratified by age, race, and ethnicity)
- Hospital admissions for asthma (stratified by age, race, and ethnicity)
- Deaths due to asthma
- Process Measures
  - Establishment of Hospital-Community partnership.
  - Implementation of direct care staff inhaler education training.
  - Percent of patients discharged from the ED with PCP appointment and follow-up.

#### Key Process Steps Extracted from CHA's Statewide Asthma Initiative Work Plan/Timeline

- January 2015**
  - Meet with thought leaders in asthma and reach out to community coalitions.
  - Coordinate with Department of Public Health (DPH) for integration of efforts.
  - Research Connecticut asthma initiatives and participating agencies.
- February 2015**
  - Seek feedback/input on initiative from key CHA meeting groups: Quality Managers, ED Physician and Nursing Directors, Chief Nursing and Medical Officers, others.
  - Confirm asthma as a priority for work with DSH/ONH for the Medicaid population.
  - Identify hospital asthma key contacts.
- March 2015**
  - Kickoff asthma initiative meeting on March 3, 2015.
  - Identify national programs and best practices asthma care.
  - Review initiative plans with ED Nursing and Physician Directors at joint meeting.
- April 2015**
  - Convene Asthma Advisory Group to review plan and provide feedback.
  - Convene Asthma ED Work Group to develop ED-specific input regarding barriers and best practices.
  - Begin recruitment for part-time asthma initiative coordinator.
- May 2015**
  - Focus group planning for Black and Latino populations with Hispanic Health Council.
  - Convene Asthma Advisory Group to identify best practice interventions.
  - Convene asthma initiative meeting with Connecticut presenters/asthma programs and practices (May 13, 2015).
- June 2015**
  - Convene Asthma ED Work Group to finalize ED-specific input.
  - Convene asthma initiative meeting for further exploration of asthma programs and practices (June 26, 2015).
  - Hispanic Health Council recruitment for focus groups.
- July 2015 through January 2016**
  - Identify/confirm key initiative metrics.
  - Hospital engagement of asthma community partners.
  - Completion of focus groups report.
  - Convene asthma initiative meeting to confirm model and implementation plan (October 12, 2015).
  - Kickoff hospital implementation through Hospital-Community Partnerships (January 14, 2016).

### Lessons Learned

- Coordination and communication are key.
- Lack of knowledge statewide with regard to partners and resources.
- Social determinants of health must be considered/addressed for success.