Cultural Competency 2.0: Health Equity and Quality

Cheri Wilson, MA, MHS, CPHQ
Director, Diversity and Inclusion
Robert Wood Johnson University Hospital

Amy Wilson-Stronks, MPP, CPHQ
Independent Healthcare Quality Advisor

December 7, 2015
8:30 am–4:00 pm

M12 Session Objectives

- Develop a basic understanding of culture, intersectionality, cultural competency, health equity and the relationship with patient safety and quality.

- Identify tools and strategies for reducing disparities in health and healthcare.
Today’s Agenda

- Introductions and Welcome Exercise
- Pre-work Discussion
- Health Equity: A Quality Issue
- Demographic Characteristics and Intersectionality
- Cultural Competence and Quality
- Organizational Culture and Individual Competence
- A Patient-Centered Model of the Triple Aim
  - Conclusion, Participant Reports, and Next Steps

Safe Space Confidentiality Statement

As a participant, I agree to abide by the following to support the collaborative learning environment and safe culture necessary for advancing our shared goal to improve care for our diverse population:

- Confidentiality
- Respect
- Transparency

I will hold in confidence the stories, personal, and organizational information shared by my peers in this forum.

I will not use the personal or organizational information shared by my peers in this forum to advance personal or professional agendas.

I will not record, in audio or visual format, any portion of this meeting without the express permission of all participants.

I will take the lessons learned from this experience and work to create a similarly open and transparent environment in my institution, organization, or workplace.
Introductions

NAME Exercise
State -
- Your first name.
- The meaning/significance of your name.
- The person who named you.
- Why are you attending this session?

The Triple Aim: How Can Cultural Competence Help?

The IHI Triple Aim
Population Health
Experience of Care
Per Capita Cost
Health Equity: A Quality Issue

CHERI C. WILSON, MA, MHS, CPHQ

Definitions
“A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”


What are Health Disparities?

Health Disparities Result from Complex Interactions among Multiple Factors

- Biologic factors
- Cultural factors
- Socioeconomic factors
- Environmental factors
- Psychosocial factors
- Health risk behavior
- Access to healthcare
- Quality of healthcare
Myths About Racial and Ethnic Health Disparities

- Caused by race differences in income/education
- Caused by lack of access to health care
- Caused by biological or genetic differences among race groups

What are Healthcare Disparities?

- “Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2003)
- “Differences or gaps in care experienced by one population compared with another population” (Agency for Healthcare Research and Quality, National Healthcare Disparities Report, 2009).
What is Health Equity?

“Attainment of the **highest level of health for all people**. Requires valuing everyone equally with focused and ongoing societal efforts to **address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities**.”

Healthy People, 2020

Patient Safety and Healthcare Quality

Of the IOM’s 6 Aims of Improvement

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- **Equitable** care has received the least attention.

Sample IOM Reports from the **Quality Chasm Series** (11 reports total)
- *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001)

Sample IOM Reports
- *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in Health Professions* (2001)
- *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (2009)
Changing U.S. and State Demographics: Race, Ethnicity, Language, Gender Identity, and Sexual Orientation

Race and Ethnicity
As of July 1, 2011, the U.S. Census Bureau estimated that 50.4% of the population younger than 1 was minority.
Changing U.S. and State Demographics

• In 2008, four states—Hawaii (77.1%), California (60.3%), New Mexico (59.8%), and Texas (55.2%)—plus the District of Columbia (64.7%) were already majority minority.
• In the rest of the U.S., minorities constitute 36.6% of the population.

Source: 2009 and 2013 American Community Survey; 2010 U.S. Census; 2011 U.S. Census Bureau

English Language Proficiency
Increased number of foreign born residents
- 16.0% (or 41,348,066 million) U.S. residents

Increased numbers speak a language other than English at home
- 20.8% (or 65,754,799 million) U.S. residents

Increased numbers speak English less than "very well" and are considered limited English proficient (LEP)
- 8.5% (or 26,870,951 million) U.S. residents

Source: 2013 American Community Survey

Between 1990 and 2010, the U.S. LEP population increased **80%**.

Between 1990 and 2010, the 10 states experiencing the greatest growth in their LEP populations were:
- Nevada (398.2%), North Carolina (395.2%), Georgia (378.8%), Arkansas (311.5%), Tennessee (281.4%), Nebraska (242.2%), South Carolina (237.2%), Utah (235.2%), Washington (209.7%), and Alabama (202.1%).

In 8 states, at least 10% of the overall population is already LEP. California (19.8%), Texas (14.4%), New York (13.5%), New Jersey (12.5%), Nevada (12.3%), Florida (11.9%), Hawaii (11.8%), and Arizona (9.9%)

Source: U.S English Foundation, 2009
http://www.usefoudnation.org/usefoudnation/sff/faresearch/top_languages_by_county.pdf
Sexual Orientation and Gender Identity

- Exact prevalence remains unknown
- Measurements vary widely by geography, race/ethnicity, education levels, suggesting strong influence of stigma
- The Social Organization of Sexuality (Laumann, 1994):

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<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
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<tbody>
<tr>
<td><strong>Same-sex Attraction</strong></td>
<td>7.5%</td>
<td>7.7%</td>
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<tr>
<td><strong>Same-sex Behavior</strong> since puberty</td>
<td>4.3%</td>
<td>9.1%</td>
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<tr>
<td><strong>Identity</strong> as homosexual or bisexual</td>
<td>1.4%</td>
<td>2.8%</td>
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Transgender Prevalence

No reliable data:
- 1:500-1:2000 TG identity
- 1:2000 TG hormones (Belgium)
- 1:2900 MtF surgery/hormones (Singapore)
- 1:11900 MtF surgery/hormones (Netherlands)
- 1:30400 FtM surgery/hormones (Netherlands)
- 1:30000 MtF surgery (USA)

Source: Drs. Jason Schneider and Gal Mayer, GLMA
In 2013, surveyed 34,557 adult respondents
- Asked questions about sexual orientation for the first time
- Although gender identity is not yet being collected, the National Center for Health Statistics is considering it.

- 2.3% identified as gay, lesbian, or bisexual
  - 1.6% - gay or lesbian
  - 0.7% - bisexual
  - 1.1% - "something else" or "I don't know the answer"
  - 0.6% - refused to answer

Federal and State Legislation, Mandates, and Regulatory Standards
Federal and State Legislation, Mandates, and Regulatory Standards

- Title VI of the Civil Rights Act of 1964
- American Recovery and Reinvestment Act (ARRA) of 2009 and Meaningful Use of Electronic Health Records (EHRs)
- The Joint Commission “Effective Communication, Cultural Competence, and Patient- and Family-Centered Care” Standards (effective 1/1/2011)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Experience Surveys
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<tr>
<td>• Patient Protection and Affordable Care Act of 2010 (PPACA)</td>
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<td>• Section 1557</td>
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National Initiatives to Reduce and Eliminate Health and Healthcare Disparities

State Legislation on Cultural Competency Training

Blue - denotes legislation requiring (WA, CA, CT, NJ, NM) or strongly recommending (MD) cultural competence training that was signed into law.

Red - denotes legislation that was referred to committee and/or is currently under consideration.

Yellow - denotes legislation that died in committee or was vetoed.

The Business Case: Economic Burden of Health Inequalities

- Direct Medical Care Costs $229.4 billion for the years 2003-2006.
- Indirect Costs of disability and illness $50.3 billion
- Cost of Premature Deaths were $957.5 billion
- Total $1.24 trillion (in 2008 inflation-adjusted dollars).
The Business Case: Influence on Healthcare Costs

- Poorer **patient experience** expressed on HCAHPS = reduced reimbursement

- **Avoidable readmissions** due to lack of culturally and linguistically competent, health literate care = reduced reimbursement

  - LEP patients often have **more (and often unnecessary) diagnostic tests** completed and longer **LOS** due to communication barriers

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Meaningful Use of Electronic Health Records (EHRs)

- During stage 1 of implementation, the minimum meaningful use standards enable a user to electronically record, modify, and retrieve patient demographic data including:
  - **preferred language**
  - insurance type
  - gender
  - **race**
  - **ethnicity**
  - date of birth
  - **date and cause of death** in the event of mortality

Hospitals and providers receive incentive payments for completing these fields. If the minimum percentage is not met (50% - Stage 1; 80% - Stage 2), the hospital or provider will not receive the incentive payment.
Since July 2007, CMS has required all hospitals (except critical access hospitals) that are subject to the Inpatient Prospective Payment System (IPPS) to collect and submit patient experience data using the HCAHPS survey.

Of the quality measures, patient experience (HCAHPS) accounts for 30% of the overall score, which impacts reimbursement.

- Note: Also does not apply to pediatric hospitals, psychiatric hospitals or other specialty hospitals.
- In the Patient Protection and Affordable Care Act of 2010, HCAHPS linked to value based purchasing (VBP).
- Penalty for non-participation (meaning not submitting quality measures including HCAHPS) equals reduction of 2% of annual payment update.

- Clinician & Group

Social Determinants of Health: Why is your zip code such a strong predictor of your health?
Social Determinants of Health

“The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.”

World Health Organization (WHO). “Commission on Social Determinants of Health: Key Concepts.”

A DOCUMENTARY SERIES & PUBLIC IMPACT CAMPAIGN
WWW.UNNATURALCAUSES.ORG

Produced by California Newsreel with Vital Pictures
Presented on PBS by the National Minority Consortia
Impact Campaign of Public Television
The Joint Center for Health Policy Institute
Documentary Trailer

Interactive Exercise: A Tale of Two Smokers
What is Unconscious Bias?

Where are you from?
In 1995, Anthony Greenwald and M.R. Benaji hypothesized that our social behavior was not entirely under our conscious control.

According to their study, the concept of **unconscious bias (hidden bias or implicit bias)** suggests that:

“Much of our social behavior is driven by learned stereotypes that operate automatically—and therefore unconsciously—when we interact with other people.”

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“Schemas are simply templates of knowledge that help us organize specific examples into broad categories. Schemas exist not only for objects, but also for people. Automatically, we **categorize** individuals by age, gender, race and role. Once an individual is **mapped** into that category, specific meanings associated with that category are immediately activated and influence our interaction with that individual.”


UCLA Law Professor, Jerry Kang
First Impressions Matter

How do we size people up?

How long do you have to make a first impression?

7 seconds

http://www.businessinsider.com/only-7-seconds-to-make-first-impression-2013-4
Hi, my name is Monica Soni.

Hi, my name is Sarah Oo.
Hi, my name is Nigel.

Hi, my name is Dr. Jean O’Brien.
How Does Unconscious Bias Work in Everyday Life?

How Does Unconscious Bias Work in Everyday Life?: The Homeless
How Does Unconscious Bias Work in Everyday Life?:
Media and Criminality

Before: Burglary Mugshots

After: Burglary Mugshots

How Does Unconscious Bias Work in Everyday Life?:
Loss of Innocence of Children and Criminality
What are Microaggressions?
How Does Unconscious Bias Work in Health Care?
Clinical Examples

Clinical Examples

Sickle cell is most common in people of ancestry from Africa, South or Central America, Caribbean Islands, India, Saudi Arabia and Mediterranean countries such as Turkey, Greece, and Italy.

2005 SCIDAA Poster Child Giovanna Poli
Clinical Examples

How Does Unconscious Bias Contribute to Health and Healthcare Disparities?
National studies show significant racial/ethnic inequalities in access and quality of care

U.S. Progress on Healthcare Quality Measures

RWJF, “Reducing Health Disparities: Where Are We Now?” (March 2014)
Quality Disparities

- Largest number of quality disparities
  - Those in poor households
  - Blacks
  - Hispanics

Agency for Healthcare Quality and Research, National Healthcare Quality and Disparities Report, 2014
**Examples of Healthcare Disparities: Blacks/African Americans**

- Lower rates of cardiac surgeries
- Fewer hip and knee replacements
- Fewer kidney and liver transplants
- Diabetic and non-diabetic Blacks amputated more often.
- More likely to receive open surgeries than laparoscopic surgeries
- Less likely to receive lung cancer surgery
- Received less pain medication for same injuries and diseases

*Unequal Treatment, 2003.*

**Examples of Healthcare Disparities: Blacks/African Americans**

Even with same insurance as Whites:

- Black cardiac patients received
  - Less catheterization, less angioplasty, less bypass surgery
  - Less likely to receive beta blockers, anticlotting drugs or aspirin
- Black ER patients more likely referred to residents rather than attendings
- Black ER patients with long bone fractures less likely to receive opioids and other analgesics

*Unequal Treatment, 2003.*
### Examples of Healthcare Disparities: Latinos/Hispanics

- Less angioplasty and bypass surgery
- Less access to mental health care
- Don’t receive basic recommended preventive screenings
  - Mammograms, Pap smears, colonoscopies, cardiovascular screening, influenza vaccines, and diabetes screening
- Latino/Hispanic ER patients with long bone fractures less likely to receive opioids and other analgesics
- Less likely to receive pain medication for cancer pain
- Less likely to receive pain medication during childbirth, e.g., epidurals

*Unequal Treatment, 2003.*
Examples of Healthcare Disparities: Women

- Less angioplasty and bypass surgery
- Less aspirin, beta-blockers, cholesterol-lowering drugs after having a heart attack
- Can take significantly longer for EMS to get women with heart attacks to the hospital
- Fewer organ transplants after age 45
- Receive fewer joint replacements

Examples of Healthcare Disparities: LGBTQ Health

- Institute of Medicine Report on Lesbian Health conclusions (1999): Enough evidence to support more research; develop better methods of conducting that research
- Healthy People 2010 goal: Eliminate health disparities that occur due to differences in sexual orientation
- Institute of Medicine 2011 report: “Data on sexual orientation & gender identity should be collected in federally funded surveys and in electronic health records.”
- Healthy People 2020 goal: Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.
How Can We Combat Unconscious Bias in Everyday Life and in Health Care?

Implicit Association Test (IAT)
IAT: Understanding the Tool

- How does the IAT work?
  - The tool presents a method that demonstrates how the conscious-unconscious minds diverge.

- What is Project Implicit?
  - Project Implicit is a collaborative investigation effort between researchers at Harvard University, the University of Virginia, and University of Washington.
  - The studies examine thoughts and feelings that exist either outside of conscious awareness or outside of conscious control.

  - The goal of this project is to make this technique available for education (including self education and awareness).

IAT: What do the results tell you?

<table>
<thead>
<tr>
<th>Percent of web respondents with each score</th>
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<tr>
<td>Strong automatic preference for White people compared to Black people</td>
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<tr>
<td>Moderate automatic preference for White people compared to Black people</td>
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<tr>
<td>Slight automatic preference for White people compared to Black people</td>
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<tr>
<td>Little to no automatic preference between White and Black people</td>
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<tr>
<td>Slight automatic preference for Black people compared to White people</td>
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</tr>
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Click for detailed summary.
Findings Observed of the Project Implicit Study

- Implicit biases are pervasive.
- People are often unaware of their implicit biases.
- Implicit biases predict behavior.
- People differ in levels of implicit bias.

The Literature
Practical Tips to Combat Unconscious Bias in Health Care

1. Have a basic understanding of the cultures your patients come from.
2. Don’t stereotype your patients, Individuate them.
3. Understand and respect the tremendous power of unconscious bias.
4. Recognize situations that magnify stereotyping and bias.

Augustus White, MD, Seeing Patients: Unconscious Bias in Health Care, 2011
Practical Tips to Combat Unconscious Bias in Health Care

5. Know the CLAS Standards

Augustus White, MD, Seeing Patients: Unconscious Bias in Health Care, 2011
Practical Tips to Combat Unconscious Bias in Health Care

6. Do a “Teach Back”

7. Assiduously Practice “Evidence-Based Medicine”

Augustus White, MD, Seeing Patients: Unconscious Bias in Health Care, 2011

The Neural Basis of Implicit Attitudes

http://www.psych.nyu.edu/phelpslab/papers/08_CDPS_V17No2.pdf
Debiasing Techniques

State of the Science: Implicit Bias Review 2015

The key isn’t to feel guilty about our [implicit] biases—guilt tends toward inaction. It’s to become consciously aware of them, minimize them to the greatest extent possible, and constantly check in with ourselves to ensure we are acting based on a rational assessment of the situation rather than on stereotypes and prejudice.

- Training
- Intergroup contact
- Taking the perspective of others
- Emotional expression
- Counter-stereotypical exemplars

State of the Science: Implicit Bias Review 2015
Identify If You See an Element of Unconscious Bias in Health Care

In what ways did Mrs. Smith’s beliefs, biases, or behaviors influence her ability to treat the Holly?

CULTURAL COMPETENCE
OURS HARE DJOURNEY
Amy Wilson-Stronks

working collaboratively and acting collectively to improve healthcare™
CULTURAL COMPETENCE AND QUALITY CARE
A PERSONAL JOURNEY

CULTURAL COMPETENCE(Y)

Cultural Competency
Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, institution or individual and enable that system, institution or individual to work effectively in cross-cultural situations.

Terry Cross
Director, Pacific Islander Health Research"
CULTURAL COMPETENCE REQUIRES

LEARNING
- Active engagement with intent to understand
- Ongoing process
- Recognition of need to continually engage... culture is not stagnant
- Recognize role of bias and assumptions

BEHAVIOR
- Demonstrate value of diversity
- Assess individual, organizational
- Manage dynamics of difference
- Seek knowledge
- Adapt behaviors, processes, practices
- Manage bias and assumptions

CULTURAL COMPETENCE: LEARNING

“The active, intentional, and ongoing engagement with diversity to increase one’s awareness, content knowledge, cognitive sophistication, and empathic understanding of the complex ways individuals interact within systems and institutions”

CULTURAL COMPETENCE: BEHAVIORS

“the ability of healthcare providers and organizations to understand and respond effectively to the cultural and language needs brought by the patient to the healthcare encounter. Cultural competence is a process and requires organizations and their personnel to: (1) value diversity; (2) assess themselves; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of individuals and communities served.”

EFFECTIVE COMMUNICATION

- Successful joint establishment of meaning
- Patients and health providers exchange information
- Enables patient to participate actively in care from admission to discharge
- Ensures the responsibilities of both patients and providers are understood
- Expressive and receptive process
Communication Impacts Patient Safety

- Communication “vulnerable” patients are at Increased risk for:
  - Serious medical events (Cohen et al., 2005; Bartlett et al., 2008)
  - Poor medication compliance/adherence (Andrulis et al., 2002; Flores et al., 2003)
EFFECTIVE COMMUNICATION

“The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients, and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.”

Source: The Joint Commission, 2010

Multiple Factors Influence Communication

Adapted from M. Wynia, 2011
HEALTH LITERACY

- **Literacy**: 1.) Ability to read and write; 2.) knowledge that relates to a specific subject. Source: [http://www.merriam-webster.com/dictionary/literacy](http://www.merriam-webster.com/dictionary/literacy)

- **Health Literacy**: "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions." Source: [www.healthypeople.gov](http://www.healthypeople.gov)

HEALTH LITERACY

Nearly half of all American adults – 90 million people – have difficulty understanding and acting upon health information:

- 29% basic, plus 14% below basic literacy skills; 5% non-literate in English
- 21 million Limited English Proficiency (LEP)
- Quantitative skills: 33% basic plus 22% below basic
FACTORS INFLUENCING HEALTH LITERACY

<table>
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<tr>
<th>General</th>
<th>Physical</th>
<th>Social</th>
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<tr>
<td>Age</td>
<td>Vision</td>
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<td>Education</td>
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<td>Culture</td>
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<td>Language</td>
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Source: Addressing Patient’s Health Literacy Needs, Joint Commission Resources, 2009

STRATEGIES TO ADDRESS HEALTH LITERACY

- Raise awareness throughout healthcare organizations
  - train staff to recognize circumstances and respond
- Create patient-centered environments and culture; systems & services to meet needs
  - Simplify language (less jargon), instructions, forms, better signage
    - Target prescription bottles; pre-printed or pictures for instructions
    - Across care continuum, handoffs (home, med equipment, etc)
- Better communication and listening skills; more time for communication
  - Teach back, show back
- Reduce general functional illiteracy
  - Better basic skills, reading, writing, math
  - Practical math on drug dosages etc
What Happens When a Person Seeks Healthcare?

http://www.gofluently.com/fluency- PSA.htm

LANGUAGE ACCESS THROUGH THE EYES OF THE PATIENT

• What are your reactions to the video?
• Have you or someone you know had an experience like this?
• What does language access mean for patient experience improvement?
LANGUAGE AND LANGUAGE ACCESS

- **Language/preferred language/primary language**: The language (spoken/written) the patient is comfortable using to communicate health care information. This may differ from the patient’s native language.

- **LEP/Limited English Proficiency**: “Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.” OCR: [http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html](http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html)

- **Language Access**: “Language access services” is a term used to encompass a broad range of services designed to meet patient’s linguistic communication needs. Interpreting services, translations of written documents, bilingual signage are all examples of language access services.
BILINGUAL ≠ INTERPRETER

- Code of Ethics and Standards of Practice
- National Council on Interpreting in Healthcare (NCIHC)
- International Medical Interpreting Association (IMIA)
- American Translators Association (ATA)
- Registry of Interpreters for the Deaf (RID)
- National Board of Certification for Medical Interpreters
- Certification Commission for Healthcare Interpreters (CCHI)
- ASTM (formerly American Society for Testing and Materials)

Professional Interpreters

- Professional interpreters promote effective communication (Karliner et al., 2007; Flores 2005)
- An example: (Flores et al., 2003)

**Nurse Practitioner:** “And she’s going to have 1 teaspoon 3 times a day for 10 days.”

**Interpreter:** “Entonces para la amoxicilina por los oídos… entonces le vas a dar una cucharadita tres veces al día.”

**In the ears**... so you are going to give her 1 teaspoonful 3 times a day.”
INTERPRETING VERSUS TRANSLATING

Interpreting is the act of converting spoken language.

Translating is the conversion of written text from one language to another.

RESOURCES TO PROVIDE LANGUAGE ACCESS

Services Available 24 hrs/day

- Staff Interpreters: 54%
- Contract/Agency Interpreters: 93%
- Volunteer Interpreters: 28%
- Dual-Role Interpreters: 39%

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Use of Family and Friends as interpreters


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<tr>
<th>Whole Sample</th>
<th>Judgment Sample</th>
<th>Stratified National Sample</th>
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<tr>
<td>62%</td>
<td>55%</td>
<td>64%</td>
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<td>70%</td>
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Use of Family and Friends as Interpreters

Written Policy Against Use of Family/Friends†

A smile can always overcome the barrier of language.

"Keep the baby away from sick young goats."
LANGUAGES SPOKEN BY STATE

IDENTIFYING PATIENT LANGUAGE:
“ I SPEAK” CARDS
EFFECTIVE COMMUNICATION ACROSS THE CONTINUUM

FORMALIZE A PROCESS TO MANAGE PATIENT-PROVIDER COMMUNICATION AT THE PATIENT-LEVEL

1. Assess the Patient’s Communication Need
2. Refer to Communication Specialist
3. Select a Communication Intervention
4. Evaluate the Effectiveness of the Intervention
5. Monitor for Changes in the Effectiveness of the Intervention

Source: Patak et al. 2009
LANGUAGE ACCESS IS...

...the ability to communicate in complete, accurate, and timely fashion to assure meaningful access to equitable healthcare.

...a patient’s right

...a key to quality healthcare

...a hedge against risk

...a regulatory imperative

LANGUAGE ACCESS
3 PRIMARY GOALS

1.) Create a comprehensive Language Access Services Plan to guide appropriate allocation of resources and support compliance with law and regulation.

2.) Ensure that every patient with a language need receives timely effective language services in accordance with the Language Access Plan.

3.) Ensure that every patient with communication needs receives appropriate communication supports in accordance with Joint Commission standards and best practice.
LANGUAGE ACCESS OVERSIGHT

- Office for Civil Rights
- Department of Justice
- The Joint Commission
- Class Action
- Civil Suits
- Not covered by malpractice

DETERMINING THE NEED TO PROVIDE LANGUAGE ACCESS SERVICES:
THE FOUR-FACTOR ANALYSIS

1. # or proportion of LEP persons served or encountered in the eligible service population
2. Frequency with which the LEP persons come into contact with the organization
3. Nature and importance of program, activity or services provided by the organization
4. Resources available and costs to the organization

Source:
http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html
LANGUAGE ACCESS IS NOT...

...EVER, ONLY the Interpreter and Translation Services Department!

Language Access is a SHARED RESPONSIBILITY.

LANGUAGE ACCESS AND QUALITY HEALTHCARE

• Safe  • Patient-Centered
• Timely  • Efficient
• Effective  • Equitable
THE FIRST STEP TO COMPLIANCE
LANGUAGE ACCESS PLANNING

- Create a comprehensive Language Access Plan
- Establish team to inform plan development
- Gather appropriate data to establish need and plan for service provision
- Identify measures for ongoing improvement, establish reporting process for reporting
- Share plan – across organization, board, community, patients
- Review plan annually, make revisions as demographics, resources, and needs change.

ELEMENTS OF THE LANGUAGE ACCESS PLAN

- Language Needs Assessment
- Organization Resources for Language Access
- Interpreter Services
- Written Materials
- Signage and Wayfinding
- Notice of Language Access Services to Patients
- Quality Monitoring and Evaluation
- Sharing the Language Access Plan
HOW WILL YOU MANAGE THESE RISKS?

...AND HOW WILL YOU MANAGE THE COSTS?

PAY NOW...OR PAY LATER...

Cultural Competency: Race and Ethnicity

CHERI C. WILSON, MA, MHS, CPHQ
Discussion Questions about Race

- How would you define race? What does it mean to you?
- How many races do you think there are? What are they? How do you decide which race someone belongs to?
- Look around the room. Who do you think is likely to be most similar to you, biologically or genetically? Why?
- Where do your ideas about race come from? What are the sources of your information?

Sorting People by Race

Can You Tell Someone’s Race by Looking at Him or Her?
Is Race for Real?

Documentary: Race: The Power of an Illusion
Episode 1: The Difference between Us

Discussion Questions

 Did the video clip change or challenge any of your assumptions about race?

 Two weeks from now, what will you most remember from the video clip and why?
### Understanding Race vs. Ethnicity

<table>
<thead>
<tr>
<th>Race</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A human population that is believed to be distinct in some way from other humans based on real or imagined physical differences.</td>
<td>Refers not to physical characteristics but social traits that are shared by a human population.</td>
</tr>
<tr>
<td>Rooted in the idea of biological classification of humans according to morphological features such as skin color or facial characteristics.</td>
<td>Some of the social traits often used for ethnic classification include:</td>
</tr>
<tr>
<td></td>
<td>- nationality&lt;br&gt;- tribe&lt;br&gt;- religious faith&lt;br&gt;- shared language&lt;br&gt;- shared culture&lt;br&gt;- shared traditions</td>
</tr>
</tbody>
</table>


### Delineating Ethnicity in the U.S.

- **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.”

- **Non-Hispanic or Latino**

Delineating Race in the U.S.

- **American Indian/Alaska Native**: Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

- **Asian**: Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

- **Black/African American**: Having origins in any of the black racial groups of Africa. Terms such as “Haitian,” “Dominican,” or “Somali” can be used in addition to “Black or African American.”

- **Native Hawaiian/Other Pacific Islander**: Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- **White**: Having origins in any of the original peoples of Europe, the Middle East, or North Africa.


Ten Things Everyone Should Know about Race

1. Race is a modern idea.
2. Race has no genetic basis.
3. Human subspecies don’t exist.
4. Skin color really is only skin deep.
5. Most variation is within, not between, “races.”
7. “Race” and “freedom” were born together.
8. Race justified social inequalities as natural.
9. Race isn’t biological, but racism is still real.
10. Colorblindness will not end racism.
Cultural Competency: Religion and Spirituality

CHERI C. WILSON, MA, MHS, CPHQ

Worlds Apart: Justine Chitsena’s Story
According to a 2011 and 2012 Gallup poll:

- **92%** - I believe in God.
- **81%** - Religion is very important or fairly important in my life.
- **65%** - Religion is an important part of daily life.
- **55%** - I believe that religion can answer all or most of today’s problems.

Religious Diversity in the U.S.

Joint Commission Requirements

- **Standard PC.3.100:**
  - “The client’s spiritual orientation and religions are **OBTAINED** as part of [initial screenings and] assessment.”

- **Standard RI.01.01.01:**
  - “The hospital **RESPECTS** the patient’s cultural and personal values, beliefs, and preferences.”
  - The hospital **ACCOMODATES** the patient’s right to religious and other spiritual services.”
  - The hospital **PROHIBITS DISCRIMINATION** based on age, race, ethnicity, religion, cultural, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.”
<table>
<thead>
<tr>
<th>What do patients want?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many patients want their providers to ask about their religious needs.</td>
</tr>
<tr>
<td>- 41% of patients want to discuss religious concerns.</td>
</tr>
<tr>
<td>- Only half report having such a discussion and only 8% have this discussion with a doctor.</td>
</tr>
<tr>
<td>- 41% of patients can think of a time when religious beliefs influenced a healthcare decision they made.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>What are doctors doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>91% of physicians agree that it is appropriate to discuss religious issues when the patient brings them up.</td>
</tr>
<tr>
<td>55% feel it is appropriate to proactively address a patient’s religious concerns.</td>
</tr>
<tr>
<td>However...</td>
</tr>
<tr>
<td>- Only 10% of physicians report doing so on a regular basis.</td>
</tr>
</tbody>
</table>

Under the Affordable Care Act (beginning in FY2013):

- CMS will make value-based incentive payments based on the following quality measures:
  - Clinical process of care measures (70%)
  - Patient experience of care measures (30%)

A 2010 study found: Inpatients who discussed religious concerns were more likely to positively assess their care whether or not they initially indicated wanting such a discussion.

https://www.cms.gov/Hospital-Value-Based-Purchasing

Predictors and association with patient satisfaction. Journal of General Internal Medicine

July, 1 Published Online
**Trigger Topics**

- **Dress & Modesty:** A hospital in Maine discovers that Muslim women are not coming in for care due to the immodest gowns.
- **End-of-Life:** A young Jewish girl is declared brain dead but the parents refuse to withdraw care. They do not view brain stem death as death.
- **Dietary Requirements:** A son is horrified to discover that his mother, a Hindu and lifelong vegetarian who suffers from dementia, was served (and ate) a non-vegetarian meal.
- **Reproductive Health:** A Catholic mother refuses to consider allowing her daughter to use birth control pills as a treatment option for endometriosis.
- **Conscience Rules:** An Evangelical Christian physician refuses to provide fertility treatment for a lesbian couple.

**Litigation Avoidance**

- **A Muslim woman** suffering from chest pains asks for a female teach to conduct the electrocardiogram. She is left waiting in the emergency room for 5 hours. She sues the hospital and wins.
- **A woman with brain cancer asks to be removed from life support. Her Christian parents** go to court to prevent this. They believe this would be suicide and would condemn their daughter to hell.
- **A nurse cleans up an elderly patient, cutting his beard, eyebrows and moustache. She does not realize that his is Sikh, and that Sikhs are prohibited from cutting their hair. A lawsuit is brought.**
Addressing Disparities: A Case Example

**The Situation:** A hospital in the UK found that Asian patients, the largest percentage being Muslim, failed to attend 50% of appointments compared to 33% of Europeans.

**The Solution:** Several interventions were implemented including:
- Schedulers were given a list of dates for religious holidays.
- Staff were educated in certain religious/cultural practices that could impact scheduling.
- Hospital staff collaborated with faith community leaders.

**The Result:** Non-attendance dropped to 13.5% for Asians and 12% for Europeans.

Recommendations

- Track cultural and religious demographic changes within patient population and implement accommodations.
- Engage with faith community leaders to address challenges their community faces in accessing care.
- Develop a system for taking a spiritual history and ensuring that religious needs are assessed.
- Commit to ongoing education of all hospital staff in religio-cultural competence.
- Create integrated, cross-departmental responses.
- Be proactive, not reactive.
SEXUAL ORIENTATION AND GENDER IDENTITY
Amy Wilson-Stronks

“THE BEGINNING OF WISDOM IS THE DEFINITION OF TERMS.”
— SOCRATES

“Words are pale shadows of forgotten names. As names have power, words have power. Words can light fires in the minds of men. Words can wring tears from the hardest hearts.”
— Patrick Rothfuss, The Name of the Wind
LET'S START WITH “SEX”
- Attributes characterizing biological maleness or femaleness;
- Sex determining genes, sex chromosomes
- Sex hormones
- Internal and external genitalia
- Secondary sex characteristics

SEXUAL ORIENTATION
- Identification of physical and emotional attraction to others.
- Not related to GENDER IDENTITY
- May or may not reflect sexual behaviors
- Common labels:
  - Gay
  - Lesbian
  - Bisexual
  - Heterosexual
  - Straight
GENDER

“The attitudes, feelings, behaviors that a given culture associates with a person’s biological sex.”


GENDER IDENTITY

• Male
• Female
• Transgender
• Male to Female (MtF)
• Female to Male (FtM)
• Genderqueer/Queer
• Two-Spirit
• Cisgender
TERMS TO AVOID
• she-male
• he-she
• it
• tranny
• “real” woman or “real” man

• homosexual
• sexual preference
• gay lifestyle
• sex-change operation
• transgenders (noun) or transgendered (noun or adjective)

GENDER AFFIRMATION
• Behaviors or interventions to change gender expression or physical appearance to align with gender identity.
• May or may not include surgery, hormone therapy
• Transitioning
  • Social
  • Physical
  • Legal
DIFFERENCES OF SEX DEVELOPMENT

As many as 1/100 people
Born with atypical feature of sex chromosomes, gonadal development, or anatomical sex


EXPERIENCES WITH HEALTHCARE

4,916 healthcare consumers surveyed
More than half at one or more of the following experiences:
- being refused needed care;
- health care professionals refusing to touch them or using excessive precautions;
- health care professionals using harsh or abusive Language;
- being blamed for their health status; or
- health care professionals being physically rough or abusive.

Table 1: I was refused needed health care

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGB</td>
<td>7.7%</td>
</tr>
<tr>
<td>Transgender</td>
<td>26.7%</td>
</tr>
<tr>
<td>Living with HIV</td>
<td>19.0%</td>
</tr>
</tbody>
</table>

FEARS AND CONCERNS

Table 6: Fears and concerns about accessing health care

<table>
<thead>
<tr>
<th>Fear</th>
<th>LGB</th>
<th>Transgender</th>
<th>Living with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will be refused medical service because I am...</td>
<td>9.1</td>
<td>20.0</td>
<td>28.8</td>
</tr>
<tr>
<td>Medical personnel will treat me differently because I am...</td>
<td>20.0</td>
<td>30.5</td>
<td>28.8</td>
</tr>
<tr>
<td>Not enough health professionals adequately trained to care for people who are...</td>
<td>35.5</td>
<td>55.0</td>
<td>58.8</td>
</tr>
<tr>
<td>Not enough support groups for people who are...</td>
<td>49.0</td>
<td>89.4</td>
<td>85.7</td>
</tr>
<tr>
<td>Not enough substance abuse treatment for people who are...</td>
<td>48.0</td>
<td>50.5</td>
<td>52.4</td>
</tr>
<tr>
<td>Community fear/dislike of people who are...</td>
<td>24.3</td>
<td>31.0</td>
<td>31.1</td>
</tr>
</tbody>
</table>
ON SERVING AS A BEDSIDE PATIENT ADVOCATE FOR TRANSGENDER PATIENTS

“I SPEND MORE TIME MAKING SURE PEOPLE AREN’T MAKING UP REASONS TO COME INTO THE ROOM BECAUSE THEY ARE JUST CURIOUS THAN I DO ENSURING APPROPRIATE INFECTION CONTROL PRACTICES (WITH TRANSGENDER PATIENTS).”

Ilene Corina, Patient Advocate and Founder of PULSE NY
www.pulseofny.org

LGBT PATIENT EXPERIENCES

“Although my doctor knew all about me, each encounter with new people—with blood draws, ultrasound, breast x-ray, etc.—had the basic anxiety of the procedure and layered on to that, the possibility of homophobia and having to watch out for myself.”

Source: Margolies L, Scout NFN. LGBT Patient-Centered Outcomes: Cancer Survivors Teach Us How To Improve Care For All. April 2013.

Online report available at: www.cancer-network.org/patient-centered_outcome
DEFINING FAMILIES

- “How would you describe your family?”
- “Who makes up the members of your family?”
- “Who do you consider your family of choice?” *if different than blood kin ties
- What role would you like these family members to have in your health care decisions?
- Are there legal POA/Healthcare proxy decision makers identified?

LGBT HEALTH CONCERNS

- Depression and Anxiety
- Suicide
- Tobacco Abuse
- Substance Abuse
- Cancer
- HIV/STIs
- Hepatitis
- Complications from Hormone Therapy
CREATING ENGAGED LGBT PATIENTS

10 Top Ten Issues to Discuss with Your Healthcare Provider

- LGBT people have unique health needs and concerns, yet many healthcare providers do not fully understand these issues.
- Take charge of your health by asking your healthcare provider about the health matters that may apply to you!
- Visit www.glma.org/top10 to download our free Top Ten List!

www.glma.org/top10

SOME RECENT ADVANCES

- DHHS National Prevention Strategy
- Health People 2020
- DHHS National Health Interview Survey
- Institute of Medicine Report 2011
- The Joint Commission Standards
- Centers for Medicaid and Medicare Services
- OMH CLAS Standards 2013
- SSA- Birth certificate gender change policy
THE JOINT COMMISSION NON-DISCRIMINATION
Standard RI.01.01.01 The hospital respects, protects, and promotes patient rights.

EP 29: The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
THE JOINT COMMISSION
ACCESS TO A SUPPORT PERSON
Standard RI.01.01.01 The hospital respects, protects, and promotes patient rights.

EP 28: The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.

Note: The hospital allows for the presence of a support individual of the patient’s choice, unless the individual’s presence infringes on others’ rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient’s surrogate decision maker or legally authorized representative.
CULTURAL COMPETENCE(Y)

SOME PRINCIPLES OF QUALITY HEALTH CARE

1. Quality healthcare is: Timely, Effective, Efficient, Safe, Patient-centered, and Equitable. (IOM definition)

2. Our healthcare system is stressed; medical errors and other factors inhibit quality.

3. Healthcare quality requires a shared responsibility among healthcare professionals, institutions, and patients.

4. Multiple factors—individual, system, environmental, social—impact quality and must be part of the solution.

5. If it doesn’t make noise, no one will listen.
PRINCIPLES: PATIENT-CENTERED QUALITY

1. All people deserve quality care.
2. All patients deserve to be treated with dignity and respect in a non-discriminatory environment.
3. Every patient is unique and brings his or her own set of healthcare values, beliefs, understanding, and expectations.
4. Differences in healthcare values, beliefs, understanding, and expectations between patients and providers— if not identified and managed— can cause stress and contribute to lower quality care.
5. “Patients” include the individual patient, the patient’s support person(s), and family members (as defined by the patient). Thus, when considering “patients” we necessarily must consider these players.
6. All patients need an advocate and/or support person 24/7 when in the healthcare environment or receiving healthcare services.
7. The patient/family/community is the fundamental core of healthcare delivery, yet is often not considered in the design of patient safety systems.

PATIENT SAFETY

“A discipline in the health care sector that applies safety science methods to the goal of achieving a trustworthy system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.”

Source: What Exactly Is Patient Safety? Linda Emanuel, MD, PhD; Don Berwick, MD, MPP; James Conway, MS; Martin Hatlie, JD; Lucian Leape, MD; James Reason, PhD; Paul Schyve, MD; Charles Vincent, MPhil, PhD; Merrilyn Walton, PhD Available: http://www.ahrq.gov/downloads/pub/advances2/vol1/advances-emanuel-berwick_110.pdf
PATIENT SAFETY

1. Organization and management factors.
2. Work environment factors.
3. Team factors.
4. Task factors.
5. Individual factors.
6. Patient characteristics.
7. External environment factors.


BARRIERS TO PATIENT SAFETY

- Time
- Resources
- Our manner of care delivery
- Physical environment
- Type of services
- Training and behavioral supports
WHAT DOES QUALITY MEAN TO PATIENTS?

Some questions to consider:

- What do you expect from your healthcare experience?
- What are your top concerns when you seek healthcare?
- How would you describe a good outcome/experience? A bad outcome/experience?
- Do you have any challenges or barriers to accessing care?
- How did you feel the last time you had a healthcare experience?

Everyone’s answers will be different— Patient-centered care
WHAT DO WE CARE ABOUT NOW?
- Shared decision making
- Value based purchasing
- Bundled payments
- Patient experience
- Population health
- Prevention/chronic disease management
- Readmissions
- Accountable care
- Integrated care systems

C&L IN ORGANIZATIONAL PLANNING

Figure 4-B: Hospitals Developing Formal Plans to Meet Cultural and Linguistic Needs of Patients (Aggregate)

CULTURAL SAFETY

“The main themes of cultural safety are that we are all bearers of culture and that we need to be aware of and challenge unequal power relations at the level of individual, family, community, and society.

Cultural safety draws our attention to the social, economic, and political position of certain groups within society…”

CULTURE OF SAFETY

“The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.”

ACHIEVING CULTURAL COMPETENCE

M A K I N G I T A C T I O N A B L E

WILSON’S RULE:

“NOTHING IS IMPOSSIBLE FOR THE (PERSON) WHO DOESN’T HAVE TO DO IT.”
WHO ARE THE STAKEHOLDERS?

- Patients
- Physicians
- Insurers
- Hospital
- Government
- Generics
- Medical Devices
- Pharma
- Biotech
- FDA
- NIH
- KCI
- CARE

Our Challenge

- Compelling Interest
- Health Literacy
- Unequal Treatment
- Crossing the Quality Chasm
WHO IS RESPONSIBLE?

“All members of the health and healthcare team (p)rovide individuals with assurances that disrespect or discrimination of any kind is intolerable”

(Source: Source: US DHHS OMH National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice, page 45)

MAKING CULTURAL COMPETENCE ACTIONABLE

<table>
<thead>
<tr>
<th>VALUE</th>
<th>Diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSESS</td>
<td>Oneself, one’s organization</td>
</tr>
<tr>
<td>MANAGE</td>
<td>Individual and organizational interactions and relationships</td>
</tr>
<tr>
<td>ACQUIRE</td>
<td>Knowledge and information</td>
</tr>
<tr>
<td>USE</td>
<td>Knowledge and information to inform practice</td>
</tr>
<tr>
<td>ADAPT</td>
<td>To diversity and the cultural contexts</td>
</tr>
</tbody>
</table>
A FRAMEWORK FOR DISPARITIES REDUCTION

1. DETECTING DIFFERENCES DISPARITIES IN HEALTH CARE FOR DIFFERENT GROUPS
   - Define health care disparities
   - Define and identify vulnerable populations
   - Measure disparities in vulnerable pop.

2. UNDERSTANDING THE DETERMINANTS OF DISPARITIES IN HEALTH CARE
   - Patient-level characteristics
   - Clinical encounters
   - Health-care systems

3. DESIGNING INTERVENTIONS THAT REDUCE AND ELIMINATE DISPARITIES IN HEALTH CARE
   - Design interventions and implementation plans
   - Evaluate intervention outcomes
   - Translate and disseminate findings
   - Inform policy/practice
   - Change policy/practice

DISPARITIES MEASUREMENT LAGS BEHIND QUALITY MEASUREMENT

Not all organizations collect race/ethnicity data
- 78.4% collect race data
- 50.5% collect ethnicity data
- 50.2% collect language data

Half of hospitals "eyeball" or "earball" their patients
- Race/ethnicity and preferred language often assigned based on appearance or last name

Regenstein and Sickler, 2006

RACE AND ETHNICITY

At a minimum to comply with the Meaningful Use of EHRs Standards, use the Office of Management and Budget (OMB) Guidelines:

- Race (Since the 2000 U.S. Census, individuals can check all races that apply)
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - White
- Ethnicity (Note: One can be any race(s) AND Hispanic or Latino)
  - Hispanic or Latino


SECTION 4302 OF THE ACA: RACE AND ETHNICITY STANDARDS

PREFERRED LANGUAGE
GUIDANCE FROM HRET TOOLKIT

• What language do you feel most comfortable speaking with your doctor or nurse (patient’s primary language)?
  ▪ Include a list of locally relevant languages

• In which language would you feel most comfortable reading medical or health care instructions?
  ▪ Include a list of locally relevant languages

Would you like an interpreter?
  Yes, No, Don’t Know, Declined, Unavailable

SECTION 4302 OF THE ACA:
PRIMARY LANGUAGE

Data Standard for Primary Language:

1. Do you speak a language other than English at home? (5 years old or older)
   a. __ Yes
   b. __ No

   For persons speaking a language other than English (answering yes to the question above):

2. What is this language? (5 years old or older)
   a. ___Spanish
   b. ___Other Language (Identify)

RESOURCES FOR COLLECTING REAL DATA

HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients
  - http://www.hretdisparities.org/
Institute of Medicine – Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement
U.S. Department of Health and Human Services, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards)
  - A Blueprint for Advancing and Sustaining CLAS Policy and Practice (The Blueprint)
    - https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
America’s Essential Hospitals - Ask Every Patient: REAL – Interactive Course on Race, Ethnicity, Language

EQUITY OF CARE

A National Call to Action to Eliminate Health Disparities, which focuses on:

- increasing the collection and use of race, ethnicity and language preference data;
- increasing cultural competency training; and
- increasing diversity in governance and leadership.
NATIONAL INITIATIVES TO REDUCE AND ELIMINATE HEALTH AND HEALTHCARE DISPARITIES

The CMS Equity Plan for Improving Quality in Medicare

National Stakeholder Strategy for Achieving Health Equity

Centers for Medicare & Medicaid Services
Office of Minority Health
September 2016

HOSPITAL EQUITY REPORTS

Massachusetts General Hospital
Racial and Ethnic Disparities Report
2017

New England Center for Children
Equity Report
2018
WHAT IS THE ROI OF CULTURAL COMPETENCE?

“We feel the overall cost benefit...is there. We may not show it in direct dollars and cents...a lot of times (costs) just look like operating expense...but if we can get people established with primary care instead of using the ED...it is more cost effective...we are always looking at ways to demonstrate that.”

- Hospital CEO


CREATING A WELCOMING ENVIRONMENT

- Leadership/policies/mission
- Workforce/training/performance evaluation
- Care Practices/communication/sensitivity to unique clinical needs/creating trust
- Collecting and Using Data and Information/forms/confidentiality/aggregate vs. patient-level
- Engaging the Community/marketing/gathering feedback
MY SOAPBOX

"My head is bloody, but unbowed…
It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate:
I am the captain of my soul."

William Ernest Henley (1849-1903)

Contact Information

Cheri C. Wilson, MA, MHS, CPHQ
- Director, Diversity and Inclusion
- Robert Wood Johnson University Hospital
- cheri.wilson@rwjuh.edu
- 443-616-6170

Amy Wilson-Stronks, MPP, CPHQ
- Independent Healthcare Quality Advisor
- Wilson-Stronks LLC
- amy@wilson-stronks.com
- 312-671-1439