

Diversity in Healthcare: Time to Get REAL!

**Frontiers of Health Services Management, Spring 2010 by
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http://findarticles.com/p/articles/mi_hb5871/is_201004/ai_n53082121/pg_2/?tag=content;coll

SUMMARY *

Cross-cultural healthcare involves three key issues: racial and ethnic disparities in the quality of healthcare provided to minority patients; cross-cultural value differences between immigrant patients and Western medical providers; and providing language access and assistance to limited English proficient (LEP) and disabled persons. Addressing these key issues represents a compelling diversity agenda for a new generation of healthcare executives. This article describes each of these challenges and the cutting-edge strategies that leading healthcare organizations are using to address them.

RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE

From now until the year 2050, over 90 percent of U.S. population growth is expected to come from people of color. If you think that 2050 is far off, consider that today, 48 of the 100 largest cities in the United States already have minority majorities. Five states - California, Texas, Hawaii, New Mexico, and Florida - also have minority majorities and five other states, including New York, are expected to become minority-majority soon.

In 2002, the Institute of Medicine released a report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare." The key conclusion from the report was that people of color receive lower-quality healthcare than whites do, even after adjusting for insurance status, income, age, and severity of conditions. Major disparities were found across a wide range of diagnostic areas including cardiovascular disease, cancer, stroke, kidney dialysis, HIV/ AIDS, asthma, diabetes, mental health and maternal and child health. Given the fact that over 80 percent of new private health insurance enrollees are people of color, the implications of disparities research suggests that the healthcare industry's fastest growing customers are receiving the worst care.

It has now been seven years since the Institute of Medicine issued its clarion call for improving the quality of healthcare for the nation's minorities. While some strides have been made, quality gaps continue. A recent Agency for Healthcare Research and Quality (AHRQ; 2008) report notes that over 60 percent of disparities in quality of care have stayed the same or worsened for blacks, Asians, and poor populations while nearly 60 percent of disparities, including but not limited to quality issues, have stayed the same or worsened for Hispanics.

In the meantime, new research has demonstrated dramatic difference between whites and people of color in terms of patient satisfaction. A Harvard School of Public Health/Robert Wood Johnson Foundation survey (Blendon et al. 2008) compared perceptions of the quality of physician care among 14 racial and ethnic groups with those of whites. On each measure

examined, the subgroups perceived their care to be significantly worse than care for whites – often by as much as 15 percentage points.

AHA EFFORTS TO ADDRESS RACIAL AND ETHNIC DISPARITIES

In December 2007, the American Hospital Association (AHA) convened the Special Advisory Group on Improving Hospital Care for Minorities as part of its ongoing efforts to ensure equitable treatment for all patients. This group has a dual mission: one, to study how to improve hospital care and eliminate disparities among minority populations; and two, to ensure that racial and ethnic minorities have a voice in the national debate on healthcare reform. The AHA also is bringing together tangible resources to help hospitals navigate the path toward disparities elimination. Through AHA's Center for Health Care Governance and Institute for Diversity in Health Management, the organization has developed trustee training programs to help hospitals expand the racial and ethnic diversity of their governing boards. The AHA's Health Research and Educational Trust (HRET) created the Disparities Toolkit, a Web-based toolkit to collect race, ethnicity, and primary language data in a uniform way.

Currently, 19 states have state-based mandates to collect race and ethnicity data in hospitals. While the AHA has not, as yet, taken a policy position on the collection of race, ethnicity, and language data, others have. In 2009, The Joint Commission, the National Committee on Quality Assurance, and the National Quality Forum all issued draft statements proposing new cultural competence standards for hospitals, health plans, and other healthcare organizations. All three sets of guidelines endorsed the collection of race, ethnicity, and language data.

HOSPITAL COLLECTION OF RACE, ETHNICITY, AND LANGUAGE (REAL) DATA

According to a 2006 study by the Robert Wood Johnson Foundation and the National Public Health and Hospital Institute, more than three-quarters (78.4 %) of non-federal acute care hospitals collect information on the race of their patients, and half the hospitals that collect race and ethnicity information do so at the point of registration for both inpatient (96%) and outpatient (93.5%) services provided at the hospital campus. The majority (89%) also collect this information in the emergency department and at affiliated same day surgery centers (79.7%). Only about half (55.6%) of hospitals that collect race and ethnicity information do so at doctors' offices or clinics located away from the hospital campus.

Accuracy and the Use of Race and Ethnicity Data

The fact that 78 percent of American hospitals collect patient race data sounds impressive but becomes much less so under closer scrutiny. Research by the AHA and others has found serious reasons to doubt the accuracy of patient race data (Hasnain-Wynia, Pierce, and Pittman 2004). While most hospitals reported that the primary source of information about race/ethnicity is the patient or an admitting clerk obtaining information from the patient directly, 51 percent of responding AHA hospitals reported that admitting clerks determined the patient's race/ethnicity based on observation. (In short, they guess.) The researchers also asked hospitals to disclose the percentage of cases where data on race or ethnicity were missing or unavailable. Responses ranged from 0 to 100 percent.

NPHHI asked hospitals that collect race and ethnicity data whether they used it to assess and compare quality of care, utilization of health services, health outcomes, or patient satisfaction across their different patient populations. Sadly, less than 20 percent of surveyed hospitals

collect patient race and ethnicity information and tie it to patient outcomes and quality improvement.

Barriers and Concerns Regarding Data Collection

Research by the AHA's HRET shows that among hospitals that collected data on race/ethnicity, 70 percent did not see any drawbacks to collecting the data. Drawbacks reported by the remaining 30 percent included (Hasnain-Wynia, Pierce, and Pittman 2004):

- * discomfort on the part of the registrar or admitting clerk asking the patient for the information;
- * problems associated with the accuracy of the data collected;
- * a sense that patients might be insulted or offended, or resist answering questions about their race and ethnicity;
- * patients who did not "fit" the categories that were given;
- * a fear that data might not be kept confidential; and
- * the possibility that collecting data on race and ethnicity might be used to profile patients and discriminate in the provision of care.

Of these drawbacks, by far the biggest (though rarely discussed) issue is the concern among white admissions personnel that asking about patients' race will inevitably upset or offend people of color. Richard Pride, director of access management for the University of Mississippi Health Care initially shared these concerns when his organization launched a race/ethnicity data collection effort. The University of Mississippi launched its data collection effort after intensive training which offered admissions staff scripted answers to patients most frequently expressed questions. Prior to launch, Pride gave his staff his pager number and offered to be ready at a moment's notice to handle any racial concerns that came up. No one called. Pride did not receive one page or phone call during the first few weeks of the initiative. And the project is clearly generating quality data. According to Pride, the hospital had 350 Hispanic patients the year before the data collection initiative when race was largely determined by staff through patient observation. When the admissions staff asked patients about their race directly, they recorded 450 Hispanic patients the first month (AHA 2009).

HealthPartners based in Bloomington, Minnesota serves 1.25 million medical and dental health plan members nationwide. Since 2004, HealthPartners has collected race and language preference data from its patients and members. Today the organization has collected race data from nearly 90 percent of its primary clinic patients and language preference data on nearly 100 percent of its primary clinic patients. Regions Hospital, which is also part of HealthPartners, has collected race data on 84 percent of admitted patients and language data on 92 percent of admitted patients (Walker 2009).

Hospitals in the LeHigh Valley Health Network implemented a mandatory race/ethnicity data collection effort in October, 2008. Prior to launching the initiative, the organization was careful to communicate its intentions to minority community leaders and elected officials. The hospital even wrote an op-ed piece for the local newspaper discussing racial and ethnic

disparities in healthcare and describing the data initiative as one important step to address them. The result? Minimal disruption in the registration process for hospital staff and patients, according to Eric Gertner, MD, MPH, a hospital official who worked on the project (AHA 2009).

The Health Research and Educational Trust asked hospitals (n = 57) that do not collect data on race and ethnicity to give reasons why. Sixty-one percent stated that it was "unnecessary to collect data on patients' race and ethnicity." Smaller numbers of respondents stated that there was no reliable system for data collection (17 percent); there was no good classification system for race or ethnicity (16 percent); data were too costly to maintain (7 percent); and that collection of race/ ethnicity data was prohibited by law or external regulation (Hasnain-Wynia, Pierce, and Pittman 2004).

The National Health Law Program (NHeLP) examined this question and issued a comprehensive report detailing its findings. In essence, the NHeLP found that the collection and reporting of data on race, ethnicity, and primary language are legal and authorized under Title VI of the Civil Rights Act of 1964. No state statutes bar hospitals from collecting race and ethnicity data, though some states restrict health plans from doing so (Hasnain-Wynia, Pierce, and Pittman 2004).

Lack of Executive Leadership

David Hunt is the president and CEO of Critical Measures, a leading consulting and training firm addressing racial and ethnic disparities in healthcare. Hunt believes that a key factor for the failure of some hospitals to collect race and ethnicity data is the lack of executive leadership. "It starts from the top," he says. "We've worked with a number of our hospital clients to stratify patient satisfaction data by race and language." Doing so showed dramatic differences in patient satisfaction rates. Patients of color were "twice as likely as whites not to have confidence in their doctors, two to three times as likely to rate the courtesy of doctors, nurses, and other staff as 'fair or poor' and substantially more likely to say that they were not treated with dignity and respect than white patients." Significantly, patients of color were also substantially more likely to say that they did not receive care in a timely manner and that staff did not do all they could to control their pain. Hunt notes that when he has presented this data to hospital CEOs during marketing presentations (with client's names deleted of course) "their reaction was - that data will never come out at my hospital as long as I'm the CEO" (Hubbard and Hunt 2009).

HOSPITAL CASE STUDY: HEALTHEAST CARE SYSTEM, ST. PAUL, MINNESOTA

It takes real courage and leadership for hospital executives to take on the lawyers, risk managers, and naysayers and demand that this data be examined. One hospital CEO who did just that is Tim Hanson, president and CEO of the HealthEast care system located in Saint Paul, Minnesota. With leadership from Hanson and the organization's Board of Directors, HealthEast (Anderson 2009):

- * Conducted a cultural competence organizational assessment based on the DHHS CLAS standards.

- * Took immediate steps to address issues identified in the assessment. In particular, HealthEast hired substantial numbers of qualified interpreters (including a full-time American

Sign Language (ASL) interpreter); improved written translated materials and hospital signage and way-finding resources; trained physicians and nurses to work with interpreters and to comply with federal and state language access laws; and began collecting patient race, ethnicity and language data.

- * Trained over 800 leading HealthEast executives, physicians, nurses, managers, and employees on the business, medical, and legal "cases" for diversity and cultural competence in healthcare.

- * Conducted a system-wide employee opinion survey on diversity issues (a Diversity Workforce Assessment); stratified the results by race, gender, and location; and took appropriate corrective action.

- * Trained emergency room physicians and nurses on Quality Interactions, the nation's first e-learning program on providing culturally competent medical care.

- * By becoming more intentional about providing high quality, culturally responsive patient care, HealthEast increased its inpatient Hmong market share by nearly 33 percent and saw ED usage by Hmong patients at one of its hospitals double within a six-month period. (The Twin Cities is home to one of the nation's largest communities of Hmong - people from the hills of Laos who fought on the American side during the Vietnam war.)

- * Finally, culturally responsive care has been positioned under the HealthEast Quality Institute; a new system director for cross cultural service has been hired who reports directly to HealthEast's chief medical officer; and leading HealthEast physicians are participating in a national program on reducing racial and ethnic disparities sponsored by Harvard's Disparities Solutions Center.

Hospitals can learn a lot from HealthEast's example. First, diversity at HealthEast has not been a simple "program" or "initiative." Rather, it has been embedded into the very fabric of the organization and institutionalized with its own staff and budget. Second, diversity has been tied to the achievement of larger organizational goals such as patient quality and safety and employee engagement and productivity rather than being an end in itself. Finally, paying attention to diversity factors played a significant part in accomplishing HealthEast's strategic goal of being the benchmark for quality in the Twin Cities by 2010. In 2009, HealthEast was named one of the top ten hospital systems in the United States, according to a study by Thomson Reuters. The study ranked hospitals based on their clinical performance.

HOSPITAL EQUITY REPORTS

The Disparities Solutions Center at Massachusetts General Hospital is a national thought leader in addressing disparities in healthcare. The Center has urged hospitals to create hospital equity reports. A hospital equity report is a tool that allows a hospital's executives, physicians, and staff to examine inequalities in the care provided to patients from different racial, ethnic, language, and socioeconomic groups. It can identify areas that are going well and those that could be improved, whether across the hospital, within a specific department, or for a specific patient group. The report can also help leaders monitor progress toward eliminating inequalities and providing the highest quality of care to all patients, regardless of their race, ethnicity, language, or socioeconomic status (Weinick, Flaherty, and Bristol 2008).

Again, however, executive leadership is key. When the idea of producing an equity report is first introduced, senior leaders, physicians, or staff may balk and raise concerns. Perhaps the most common objection focuses on the assumed lack of inequalities in the hospital, with the comment that "we treat everyone the same here," or that national or state-based inequalities may exist, but "not in my hospital." This may be true, but until a hospital looks at data on its performance, there is simply no way to tell.

PROVIDING LANGUAGE ACCESS TO LEP AND DISABLED PATIENTS

Addressing language access issues on behalf of limited English proficient (LEP) and disabled patients represents the second key hospital diversity issue. Fully 54 million Americans - roughly 20 percent of the population - do not speak English at home (U.S. Census Bureau 2000). In some states, such as California, Texas, and Florida, that number increases to over 43 percent of the population. Between 12 million and 23 million Americans are LEP. Accommodating the needs of deaf and hard of hearing persons adds another 20 million people to these totals (NCHS 1991). As with racial and ethnic disparities, the primary reason that this issue must be addressed relates to medical quality and safety. But there are compelling business and legal "cases" to be made as well.

The Diversity Medical Case for Language Access

Approximately 80 percent of American hospitals encounter LEP patients frequently: 43 percent of hospitals encounter LEP patients daily, 20 percent encounter them weekly, and 17 percent encounter them monthly. Yet only 33 percent of U.S. hospitals have quality improvement efforts underway to improve the quality of their language access programs (HasnainWynia et al. 2006). The evidence suggests that there is much to improve.

Language barriers are associated with poor quality of care in emergency departments; inadequate communication of diagnosis, treatment, and prescribed medication; and medical errors. According to Baker and colleagues (1996), no interpreter was used in 46 percent of emergency department cases involving patients with limited English proficiency. Few clinicians receive training in working with interpreters; only 23 percent of U.S. teaching hospitals provide any such training, and most of these make it optional. Perhaps the most damning evidence of all however, came from a 2007 report issued by The Joint Commission (Divi et al. 2007). According to the report, fully half of LEP patients who reported adverse events experienced some degree of physical harm - compared to less than a third of English speakers. The same report found that the rate at which LEP patients suffered permanent or severe harm or death was more than twice that of English-speaking patients.

The Diversity Business Case for Language Access

Hispanics are now the largest minority in the United States. Hispanic patients and their families frequently choose hospitals based primarily on the perceived quality of the hospital's language assistance services (Betancourt, Green, and Carrillo 2002). As a result, hospitals that fail to pay attention to the quality of their language services may be inadvertently denying themselves access to some of the fastest growing ethnic markets in the United States.

Aside from market growth, cost containment is another important business reason to consider the effectiveness of a hospital's language access program. When physicians cannot understand LEP patients, they frequently order more diagnostic tests or admit patients to the

hospital as a precautionary measure. Both options are costly. At least one study has shown that emergency room charges for LEP patients are \$38 higher than for other patients (Hampers et al. 1999). Other cost inefficiencies are less obvious. Take ambulance service for example. When emergency operators cannot understand what a caller is saying due to the caller's language or accent, many ambulance services respond with their highest level trauma ambulances, since they do not know how severe the case might be. If the case turns out to be minor, resources are wasted. Might an investment in trained medical interpreters have increased quality at lower cost?

The Diversity Legal Case for Language Access

Both LEP patients and disabled patients have language access rights under the law. Those rights may also extend to the parents of minor children and/or to spouses or family members in certain circumstances. Patients need not be U.S. citizens to have language access rights under American law.

On the federal level, both Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act provide language access rights to LEP and disabled patients. On the state level, all 50 states now have language access laws. The Department of Health and Human Services' Culturally and Linguistically Appropriate Service (CLAS) standards mandate the provision of language access rights for LEP patients.

If a hospital or clinic receives Medicare or Medicaid, it has a legal duty to provide language assistance services. This legal duty escalates if (a) the hospital's primary market has a higher percentage of LEP individuals than surrounding areas, (b) it provides care to LEP patients frequently, (c) it provides both acute and particularly emergency care, and (d) the hospital has above average financial resources.

Failure to provide meaningful access to language assistance resources can be seen as a form of national origin discrimination under Title VI of the Civil Rights Act of 1964 and/or disability discrimination under the Americans with Disabilities Act. While the language access laws have not been vigorously enforced in the past, the Obama Administration is more aggressive about enforcement than the Bush Administration. In addition, state attorney generals have begun to actively enforce state language access laws. Significantly, hospitals have been the most frequent target of Office of Civil Rights enforcement actions and settlement decrees.

Finally, both the Joint Commission (2009) and the National Quality Forum (NQF 2009) have recently issued new cultural competence accreditation standards that require adherence to the language access laws as a means of improving patient quality and safety. In fact, since 2006, The Joint Commission has issued three major reports on language access in hospitals. In 2007, The Joint Commission began requiring hospitals to collect data on patients' primary oral language and preferred written language.

Improving Your Hospital's Language Access Programs

Here are a few of the actions that leading hospitals are taking to improve their language assistance programs:

- * Collect patient language data on or preferably prior to admission. (Without knowing patients' primary oral languages or their preferred written languages, hospitals will not know what resources to deploy to best communicate with patients.) Today, 67 percent of American hospitals collect patient language data (HRET 2009).
- * Conduct an organizational language access audit to determine whether hospital systems, policies, and practices for providing language access are in compliance with federal and state laws, the CLAS standards, and Joint Commission requirements.
- * Based on the results of the language access audit, develop a system-wide language access plan as required by federal law.
- * Train all physicians, nurses, and other credentialed providers on hospital policies and procedures for using qualified interpreters, how to use interpreters effectively, the quality and safety implications of using trained interpreters, and language access laws.
- * Take steps to ensure that the hospital has enough trained interpreters on staff (including American Sign Language interpreters) or on call via telephone interpreting services.
- * Establish formal criteria that describe the limited circumstances in which family members and friends may be used as interpreters. Minor children should rarely, if ever, be used as interpreters.
- * Test the clinical foreign language proficiency of supposedly bilingual doctors or nurses before allowing them to interpret for patients. Require proof from external contract interpreting agencies that they are testing the competency of their interpreters.
- * Take steps to ensure that all prescriptions and drug labels are translated and available in patients' preferred written languages.
- * Make sure that trained interpreters are present during all physician examinations and informed consent discussions and at discharge from the hospital.
- * Ask doctors to have their patients repeat back their treatment instructions to check for understanding.
- * Back-translate all "vital" documents to assure high-quality written translation.
- * Ensure that hospital signage and wayfinding materials appear in the most commonly used languages in your community.
- * Adopt national best practice quality assurance measures for language assistance such as those developed by the Robert Wood Johnson Speaking Together Project (Robert Wood Johnson Foundation 2008).

Ironically, the biggest challenge that hospitals face on the language access front may well be the most basic: getting physicians to use qualified interpreters once they are in place. Many physicians, overly stretched for time, will simply not wait for interpreters to arrive at a patient's bedside or will try to make do with their own limited command of a language or with patients' family members and friends, untrained bilingual staff, or even minor children as interpreters. In short, how do we get physicians to change their practice behaviors around language access?

Lee and colleagues (2006) suggest that teaching physicians about the law and patients' rights to interpreters can change practice behaviors. The article suggests that physicians' use of qualified interpreters increases (and use of children and family members decreases) when physicians are taught about LEP patients' legal right to language access resources. Critical Measures employs two strategic interventions with its hospital clients to change physician behavior in this area. First, it conducts an online physician cultural competence assessment that targets physicians' knowledge or lack of knowledge of the language access laws and documents whether physicians use trained interpreters, bilingual staff without formal training in interpreting, or family members, friends, or minor children to interpret for LEP patients. Based on the results, Critical Measures then trains providers who need it most on its comprehensive new e-learning program - Language Access and the Law: Caring for the LEP Patient. The course is offered for CME credit.

DIVERSITY AND CULTURALLY COMPETENT CARE

During the 1990s, the United States took in 13 million new immigrants (Capps, Fix, and Passel 2002). Significantly however, the United States was on track to break that mark during the last decade, despite concerns about national security spawned by September 11. Beyond the sheer number of new immigrant arrivals, however, it's worth noting that the vast majority of today's immigrants no longer come from Western Europe. Instead, they are coming from Eastern Europe, India, China, Southeast Asia, Africa, Mexico, and South America - countries whose cultural traditions may be less familiar to today's providers.

The final major diversity issue for hospitals is providing culturally competent care. There are at least two compelling reasons hospitals should pursue this elusive goal. First, when immigrants and refugees arrive in the United States they frequently have a higher prevalence of infectious diseases, including intestinal parasites, as well as perspectives on health, illness, and disease that may be at odds with Western medicine. Providers may not be well prepared to deal with these issues. Second, as Americans travel to more remote parts of the world, they bring back exotic diseases with them. Unless physicians inquire about patients' recent travel history, they may overlook or fail to diagnose these diseases. Increasingly, the medical community is recognizing that the world is flat and that global is local.

Much has happened over the last ten years to put cultural competence on providers' radar. In 2000, the Department of Health and Human Services issued the Culturally and Linguistically Appropriate Service (CLAS) standards, the first national standards in the United States to proscribe standards specific to the health care industry. By 2004, the Association of American Medical Colleges required every American medical school to teach crosscultural medicine. By 2006, three states (New Jersey, California, and Washington) had changed their physician licensing laws to require physicians, as a condition of licensure, to take additional training in cross-cultural medicine. Most recently, The Joint Commission, the National Committee on Quality Assurance (NCQA), and the National Quality Forum have all issued

new draft cultural competence standards that address cultural and linguistic competence and urge additional training.

What is the goal of the cultural competence movement? According to Betancourt, Green, and Carrillo (2002):

The goal of cultural competence is to create a healthcare system and workforce that are capable of delivering the highest quality of care to every patient, regardless of race, ethnicity, culture, or language proficiency. Such a system would be equitable, of high quality, and free of disparities based on individual patient characteristics.

Betancourt and colleagues have identified three levels of cultural competence in healthcare:

- * Organizational cultural competence focuses on increasing the diversity of the healthcare workforce and leadership as a means of improving quality of care.

- * Systemic cultural competence focuses on strategies that address structural processes of care, including implementing racial/ethnic and language preference data collection (as a way of monitoring quality of care), developing specific culturally competent quality improvement projects to address disparities, ensuring interpreter services and culturally and linguistically appropriate health education materials and signage, and creating mechanisms for community assessment and input.

- * Clinical cultural competence focuses on educational and training strategies that highlight the importance of sociocultural factors on patients' health values, beliefs, and behaviors and equip providers with the tools and skills to effectively address these issues in the clinical encounter.

What skills and areas of expertise would a culturally competent provider need? Patricia F. Walker, MD, DTM&H, is the medical director of HealthPartners Center for International Health and an associate professor in the Department of Medicine, Division of Infectious Disease and International Health at the University of Minnesota. She has helped lead HealthPartners disparities efforts. According to Walker (2009), culturally competent physicians would need to be knowledgeable in three key areas:

1. Attitudes and awareness: Providers must begin by understanding their own implicit and explicit biases, the personal, cultural frames of reference they bring to their work, and the cultural framework of Western medicine. They must also work to understand the cultural frameworks and goals of their patients, in order to provide truly patient-centered care, as recommended by the Institute of Medicine. Examples include cultural differences around death and dying, delivering bad news, blood beliefs, surgery, organ transplants, and mental health.

2. Skills and abilities: Providers must have adequate skills and abilities to interact effectively across many cultures. Examples include conducting a culturally competent patient examination and medical history using the LEARN Model (Listen, Explain, Acknowledge, Recommend, Negotiate), managing cross-cultural conflict and negotiating treatment plans across cultures, and working effectively with LEP patients via qualified medical interpreters.

3. Clinical knowledge base: There is a body of knowledge in cross-cultural healthcare and refugee/immigrant healthcare that providers should develop in order to provide competent clinical care in the global village. This includes diseases more commonly seen by race/ethnicity, as well as diseases endemic to different parts of the world.

Ethnopharmacology and its implications for current clinical practice and an understanding of how a lack of knowledge of epidemiological and pathophysiological differences may lead to unintended iatrogenic consequences should also be seen as fundamental to this clinical knowledge base. Finally, clinicians should understand the Law of Language Access and its implications for informed consent and other legal issues.

WHY SHOULD CEOS CARE, AND IF THEY DO, WHAT ACTIONS MAKE SENSE?

Eliminating racial and ethnic disparities in healthcare, providing language access to LEP and disabled patients, and achieving organizational, systemic and clinical cultural competence provide a daunting diversity agenda for today's executives. But why should CEOs commit their personal time and prestige to this agenda? What are the benefits to be gained and obstacles to be faced in doing so, and what initial steps make sense? Our thoughts and recommendations follow.

Face it. Demographics are destiny. America is becoming a minority-majority, multilingual, multicultural society. These trends are not going away. The incomes of people of color are growing faster than those of the white population, and they are driving the growth in the private health insurance market. The uncomfortable truth is that our present healthcare system serves precisely these patients least well. Employers and health plans have a vested interest in reducing disparities in order to keep people of color healthy and productive at work. Hospitals that fail to make progress on these fronts risk alienating their biggest institutional clients - not to mention the public sector. And speaking of the public sector, if federal health reform passes, patient diversity is likely to increase dramatically. Moreover, if access is the first step for federal health reform, can fiscal accountability be far behind? Soon after we provide insurance coverage for all, calls to tie reimbursement to patient satisfaction or patient outcomes will intensify. What effect will that have on hospital systems where people of color and LEP patients frequently have the highest levels of dissatisfaction and are the most frequent victims of health disparities?

Research shows that CEO involvement on diversity issues provides many crucial benefits to your organization. According to the Gallup Organization (2001), in companies where the CEO is clearly committed to diversity, more than twice as many employees expressed high job satisfaction (58% vs. 24%), and employees were substantially more likely to recommend their company to others (65% vs. 29%). Retention at CEO-supportive companies was almost a third higher (81% vs. 60%) than at other companies.

So what obstacles will a well-intentioned CEO face? Here's the problem. In the past, the diversity agenda has been driven by human resources types emphasizing workforce diversity, inclusion, and compliance with EEO and Affirmative Action requirements. HR professionals know diversity but may know nothing about medicine or the clinical issues associated with diversity (racial and ethnic patterns in disease incidence, disparities in clinical outcomes, and quality and safety issues associated with language access). Today, the diversity agenda is increasingly driven by clinical professionals concerned about patient equity, reducing disparities, and improving quality and safety to improve the patient experience. Clinicians have no gut-level, personal experience with the effect of white American hospital cultures on

people of color or those whose differences make them stand out from the majority culture. They may understand medicine, but they don't understand diversity or systemic bias.

The challenge for CEOs is to bring about communication between these two isolated portions of their hospitals. This will be difficult because most hospitals operate in silos. The workforce side of the hospital is not involved in patient care, and the clinical side of the hospital is not involved in workforce issues. Moreover, diversity practitioners are resentful that clinicians have "stolen" the diversity initiative. In fact, the last thing that most clinicians are interested in doing is taking the initiative for diversity. To clinicians, dealing with diversity means dealing with disparities, which means acknowledging that human bias could impair clinical objectivity. It is exceedingly difficult for a profession that worships competence to admit that there are areas where, professionally, cultural incompetence could endanger patients' lives. Plus, many African American healthcare professionals are more than a little annoyed at their white counterparts' sudden interest in foreign-born immigrants, cultural competence, and language access when they have been so disinterested in the medical problems created by two hundred years of racism. When, they ask, will we ever get to the real issue?

What steps should CEOs take to make meaningful progress in this simmering cauldron of issues? Here are our top five recommendations .

1. Cultivate a clinical leader who can champion the cause of patient equity. You will need a physician who is well respected by his or her peers to drive this agenda within your hospital's medical staff, as it may mean changes in how physicians relate to patients, families, interpreters, and each other.
2. Conduct a CLAS -based organizational assessment. According to Janice Dreachlin, hospitals that focus on complying with the CLAS standards end up improving care and patient satisfaction for all patients - not merely racial or ethnic minorities (WeechMaldonado et al. 2008). Use the assessment to identify key issues, then appoint a hospital-wide task force made up of leaders with enough clout to produce lasting change.
3. Collect patient race, ethnicity, and language data. How can you know what your patients need if you don't know who they are? Collect this data and follow it wherever it leads - to examining differences in patient satisfaction by race and language, for example. Although growing numbers of their patients were Hispanic, one hospital discovered that all their bills were sent out in English. After translating these communications into Spanish and hiring community workers to educate patients on how to pay their bills, this hospital's collections improved dramatically.
4. Focus on improving the quality and safety of hospital language access systems. Tackling this issue before racial disparities makes sense because it can open new markets, improve quality and safety, and help to avoid accreditation problems with The Joint Commission. Legally, violations of federal language access laws are regarded as civil rights violations. As most medical malpractice policies do not cover civil rights violations, hospitals and physicians would be wise to take prompt corrective action on this issue.
5. Keep racial and ethnic disparities on your hospital's management dashboard. If you want your hospital to be in the top 20 percent of American hospitals, rigorously collect patient race and ethnicity data and tie it to patient outcomes. A disparities dashboard or an annual hospital

equity report prepared by your clinical leaders will give these issues the attention they deserve on an ongoing basis.

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Armada, Anthony A "[Diversity in Healthcare: Time to Get REAL!](#)". Frontiers of Health Services Management. FindArticles.com. 11 Aug, 2010.

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Cross-cultural healthcare involves three key issues: racial and ethnic disparities in the quality of healthcare provided to minority patients; | Find, read and cite all the research you need on ResearchGate. Patient populations are rapidly increasing in diversity in today's healthcare environment worldwide. An important aspect of any profession is to accurately reflect the makeup of the general population (Armada & Hubbard, 2010; Birk, 2012; Douglas et al., 2014; Farmer, 2015; Fustis, Alexander Jr., & Plaster, 2010; Health Research & Educational Trust, 2013; McNair & Hegarty, 2010; Seeleman, Essink-Bot, Stronks, & Ingleby, 2015). Diversity in Healthcare and The Importance of Representation. In the United States today, there is a persistent lack of diversity among healthcare professionals. It's critical that healthcare organizations improve diversity to ensure that people of all socioeconomic backgrounds, races, ethnicities, sexual orientations, and genders are represented in the healthcare workforce. Diversity in healthcare has measurable benefits for both healthcare professionals and the communities they serve. Some of the key advantages of increasing the diversity of healthcare organizations include: Interested to learn more? Get in touch with our Enrollment Advisors. Request Information. Latest Stories. Diversity is important in any field, and the nursing industry is an exceptional example of why. The patient demographic is as diverse as this country's population. An ethnically and culturally diverse applicant pool leads to more diverse and culturally sensitive healthcare providers and happier, healthier patients. What's more, study after study has shown that diverse groups are better problem solvers and are more prepared, which is very important in healthcare! Check out our admissions page for information about our process to get started. The Importance of Diversity in Healthcare Programs. 5 years ago. Don't Miss a Post! Get news and tips from the Ameritech Blog direct to your inbox. Enter Your Email. Subscribe. Learn how increased diversity and representation in our healthcare system leads to safer, healthier, and stronger communities. And how you can help make it all happen. Those who saw black doctors were 56% more likely to get a flu shot, 47% more likely to agree to diabetes screening, and 72% more likely to accept a cholesterol screening. This doesn't mean the non-black doctors provided inadequate or inferior care. When rated, the black and non-black doctors actually received equal scores for quality of care. While you may not start in a leadership role, sustained commitment over time will help build organizational trust and lead to more opportunities for taking on responsibilities and leadership positions. How We Can Help: Support Inclusive Schools.