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# **Patient-Centered Care for Underserved Populations: Best Practices**

## *A Case Study of Massachusetts General Hospital*

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*prepared for*

The W. K. Kellogg Foundation

*by*

Larry Stepnick  
Sharon Silow-Carroll

### **Economic and Social Research Institute**

2100 M Street, N.W., Suite 605  
Washington, DC 20037  
[www.esresearch.org](http://www.esresearch.org)

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## About the Authors

**Larry Stepnick**, MBA, is vice president of The Sevryn Group, a research, consulting, and communications firm that specializes in conducting qualitative and quantitative research, and writing and producing publications on a wide range of issues that span virtually all aspects of health care, including financing, management, delivery, and performance measurement. Mr. Stepnick can be contacted at [severyngroup@msn.com](mailto:severyngroup@msn.com).

**Sharon Silow-Carroll**, M.B.A., M.S.W. is Senior Vice President at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and meeting the needs of vulnerable populations. Her recent projects include: assessing state efforts to stretch limited health care dollars; reviewing community-based programs to expand health coverage to low-income workers; and examining local initiatives to enhance access to oral health care. She is author of numerous reports and articles analyzing public and private sector initiatives aimed at enhancing access, containing costs, and improving quality of health care. Ms. Silow-Carroll can be contacted at [silow@optonline.net](mailto:silow@optonline.net).

# Case Study: Massachusetts General Hospital

## Summary: Best Practices in Consumer/Patient-Centered Care (PCC)

Massachusetts General Hospital (MGH) is a large, academic medical center in Boston, MA. Through clinical practices, outreach, research, recruitment, and training/education at its main campus and five community-based health centers, MGH is pursuing consumer/patient-centered care (PCC) for underserved populations in a variety of ways.

Below are some “best practice” strategies undertaken at MGH that help achieve the core components of PCC, and that should be considered for replication or adaptation at other health care organizations:

### *Create a Welcoming Environment:*

- All signs are in multiple languages; staff wear name tags with welcoming message.
- Routine home visits from MGH’s community health centers are made to new refugee families to: welcome them; better understand family’s culture, environment, attitudes about health care, and needs; and jointly develop a family “plan” for their health.

### *Educate, Empower, and “Activate” Patients:*

- A highly visible, accessible, and well-staffed learning center offers educational materials in multiple languages; e.g., booklet defining common health/hospital terms in 18 languages, videos that can be piped into patient rooms.
- Health literacy workshops are geared to sixth- to eighth-grade level in languages most spoken.
- Group patient visits and seminars for community residents focus on specific issues most relevant to vulnerable populations such as asthma, breast cancer, nutrition (e.g., refugees taught about food and how to use food stamps), and financial literacy.

### *Promote Socio-Cultural Competence:*

- Initial request is made for patient’s preferred language, with interpreters arranged for scheduled visits and 24/7 access to interpreters for walk-ins and emergencies; a language card available in 19 languages explains how to access an interpreter.
- Staff for community health centers are recruited from local neighborhoods.
- Staff selected in part based on diversity and sensitivity regarding patients’ background, culture, individual preferences (see Workforce Recruitment and Development below).

### *Help Patients Navigate the System:*

- Wallet-sized “basic medical card” is specifically designed to help refugee and immigrant populations understand how to navigate the healthcare system.

- Specialized, “one-stop shop” clinics promote access for underserved populations at risk for specific diseases; bilingual navigator helps arrange appointments, follows up with “no shows,” and travels with patients on free shuttles from neighborhood to main campus clinic site; nurse practitioner runs support group for Spanish-speaking women with breast cancer.
- Computerized community resource center helps social workers link patients to needed services within their local community.

*Provide Physical and Emotional Support:*

- Social workers are integral part of patient care team, to support patients and families both in emotional and physical needs; e.g., adjusting to illness, coping with death and dying.
- Assistance is provided to low-income out-of-town families in finding affordable shelter if family member has extended stay at hospital.

*Promote Access to Care:*

- A pilot program informs low-income and minority cancer patients about potential enrollment in clinical trials.
- Under another pilot program, a Medicaid managed care plan reimburses outreach workers for “navigation” services (education and support in utilizing the health care system) for local, at-risk youth.
- “Open access” scheduling in MGH community health center allows for appointments in 7-10 days (versus months in advance) and sets aside patient slots for walk-ins, reducing need for long wait or advance planning.

*Reach Out to and Partner with Underserved Local Community:*

- MGH conducts community needs assessments and town hall-type meetings to ascertain the community residents’ health care priorities; programs are then developed to address those issues.
- Under a partnership with local police department, a social worker is called whenever a 911 call involves a child, and comes to scene to ensure child/family get needed support services.
- MGH partners with public schools to operate a school-based health center, an after-school drop-in program for teens, and an off-school teen clinic (for family planning services not permitted on school site); staff are trained to identify at-risk youth and refer or provide needed services.
- Certain supportive structures and processes in place at MGH have been essential for pursuing the above PCC activities. Other organizations interested in developing PCC should make great efforts to establish and/or build up these “ingredients” at their institutions:

*Passionate, Committed Leadership:*

- “Patient centeredness” is a priority in the institution’s strategic plan.
- Significant resources are allocated toward PCC-related departments and activities.
- PCC-related department heads report directly to CEO/President/Chief Medical Officer.

- Top leadership express directive to assess community service operations and adopt/emulate best practices.

*Committees and Departments devoted to PCC-related issues:*

- Multicultural Affairs Office – dedicated to recruit, develop, and retain minority physicians.
- Patient Care Service Diversity Steering Committee- supports programs and events that promote diversity of nursing workforce, professional development of minority employees, student outreach, culturally competent care, and patient education materials tailored to a diverse population.
- Committee on Racial and Ethnic Disparities - charged with identifying racial disparities in care at MGH, developing solutions, coordinating with mayor’s citywide initiative. Includes president of hospital. Subcommittees collect and analyze data, hold forums, publish articles, raise awareness, etc.
- Disparities Solution Center – devoted to studying why disparities exist and how to address them, training medical professionals and building leadership, identifying and promoting best practices in reducing disparities in health care.
- Multicultural Community Advisory Committee - informs MGH about minority patients’ experiences with and perceptions of their care, and recommends ways to address issues identified.

*Workforce Recruitment and Development dedicated to Diversity and Cultural Competence:*

- On-site BSN and MSN programs support foreign-born and minority nurses.
- A physician “pipeline” targets for recruitment “underrepresented minority” college students, medical students, and residents. Outreach includes invitations for internships, clerkships, and registration dinners; minority faculty are included in interview team.
- Formal training in culturally competent care includes:
  - A full-day workshop for new and current staff focused on understanding and assessing the individual patient rather than using stereotypes;
  - Periodic sessions on topics such as caring for Muslim, Haitian, gay/lesbian patients; integration of disparities issues into mandatory orientation for new employees;
  - Training of physician faculty members to lead teaching sessions (for other staff physicians) in culturally competent care;
  - Development and use of curriculum for training physician residents about PCC and cultural competency (includes interactive, case-based work, 4-part video series, e-learning module);
  - Introduction of new, “medicine and society” concentration for medical students and other efforts to expose medical students to PCC and community-based care.

### *Input from Patients, Families, and Community in Program Design*

- Community leader, patients, and families from various racial and ethnic minorities comprise the Multicultural Community Advisory Committee, helping MGH understand minorities' perspective, problems, and possible solutions.
- Public meetings in health center communities solicit input into health priorities that is central to MGH programming.
- Focus groups with community members promote understanding of how local needs can be better met.

### *Measurement and Feedback*

- MGH uses a system for tracking patient satisfaction rates by ethnic or racial group.
- Patient satisfaction surveys are translated into Spanish; MGH plans to translate into other languages most common among patients.
- Oversampling of minority patients in telephone patient satisfaction survey used to better compare minority and white patients' scores.
- Patient satisfaction surveys assess perception about receiving "fair and equal" treatment, and whether patients felt they were treated with respect.
- Response to negative patient feedback has included focus groups with front-line support staff, training about cultural competency, and efforts to improve relationship between front-line and clinical staff.

### *Supportive Information Technology*

- Longitudinal electronic medical record system provides ready access to a patient's health care records, test results and patient education materials at all MGH sites.
- E-learning module was added to cross-cultural competency curriculum for residents.
- "Ambulatory Practice of the Future" project focuses on the use of technology and other tools to make outpatient care more patient-centered; MGH is exploring potential use of video or web-camera-based interpretation that would allow patients and providers to see the interpreter without requiring him or her to be there in person.
- New corporate funding supports development and creation of a multilingual digital online and CD ROM resource guide for women with cancer.
- Collaborative decision-making tool for patients with diabetes and health providers is under development; facilitates mutual goal-setting and assessment of progress toward goals.

The pursuit of PCC has not always been an easy, smooth process, and MGH continues to face challenges in retaining minority clinicians, recruiting and drawing appropriate boundaries for outreach workers, gauging and rewarding PCC-related performance, and obtaining adequate resources for PCC-related endeavors. Yet MGH appears to have the key supports necessary to continue being a leader in PCC for underserved populations in coming years.

## Background

Massachusetts General Hospital (MGH) is a large academic medical center in Boston, MA that has historically been committed to providing patient-centered care (PCC) to underserved communities and patients in the greater Boston area. MGH operates five community-based health care centers in and around Boston. MGH is a founding member of Partners HealthCare system, which was formed in 1994 with the merger of Brigham and Women's Hospital and MGH. Partners is a not-for-profit, integrated health care system that offers patients a continuum of coordinated care. In addition to the two founding academic medical centers, the system includes primary care and specialty physicians, community hospitals, specialty facilities, community health centers, and other health-related entities.

The race and ethnicity of MGH inpatients is roughly similar to that of the state of Massachusetts (with somewhat fewer African Americans and Asians, and slightly more Hispanics). The community health centers, however, see a significantly more diverse population than does the hospital. In particular, the centers care for many more Hispanic patients, who comprise 32 percent of the overall health center population (compared to less than 8 percent of the MGH inpatient population), and many fewer White patients, who comprise only 55 percent of the health center population (compared to 80 percent of the inpatient population at MGH).

MGH was selected to be highlighted in this study because it is involved in numerous programs and research studies related to the key components of patient-centered care. MGH is active, for example, in community partnerships, helping underserved patients negotiate the health system, and developing training protocols on cultural competence. Also, it has just launched a Disparities Solutions Center dedicated to developing patient-centered care practices that will reduce ethnic and racial disparities in health care.

## How MGH Practices PCC

The leadership and staff at MGH have created an environment where PCC is a priority, which enables various departments and sites to pursue multiple PCC-related activities in a decentralized manner. The following major elements make up the PCC activities that have a particular focus on vulnerable populations (note there is some overlap across elements.)

### *Element #1: Welcoming, familiar environment*

MGH has a huge, decentralized campus that can be intimidating to anyone, let alone a recent immigrant to this country or an individual who speaks little or no English. To address this issue, MGH attempts to make the environment seem familiar and welcoming:

- Most signs are written in both English and Spanish, which is by far the most frequent non-English language spoken by MGH patients.
- MGH staff wear tags saying "May I Help You?" and are trained to go the extra mile for patients and families needing assistance.

- In some cases MGH will reach out into the community to welcome new families, such as refugees who have just come into the community, often from war-torn nations. For example, MGH developed a wallet-sized “basic medical card” that was specifically designed to help refugee and immigrant populations understand how to navigate the healthcare system. These bright yellow cards (which attract attention and are visible at night) were distributed to hundreds of foreign-born attendees at the annual New Bostonians Community Day that is sponsored by the mayor of Boston.
- Staff at MGH’s Chelsea HealthCare Center, which serves primarily low-income minority and immigrant patients, routinely make home visits to new refugee families in Chelsea. An outreach worker and/or interpreter who speaks the family’s language will go on the visit; in some cases physicians go along as well. *The goal is to welcome the families to the area and to begin to understand the environment in which they live, their cultures and traditions, their attitudes about health care, and their health care and other related needs.* The end result is the joint development of a family “plan” for their health, a plan that includes setting up appointments for them to come to the center for care. The visit and the plan help to make the family less intimidated by the health care system.
- “Navigator” programs have been developed in a number of areas to assist minorities in navigating the large MGH system (discussed further below), and thereby alleviate what could be an intimidating experience.

#### *Element #2: Patient empowerment and “activation”*

MGH makes numerous efforts to educate patients and families about their health issues and to empower them to take a more active role:

- The Maxwell and Eleanor Blum Patient and Family Learning Center provides support and education on a wide variety of topics. The center, located at MGH’s main campus, is open daily during normal working hours and is managed by a nurse and staffed by 2-4 individuals who are trained in helping patients access the information they need. The center includes a variety of materials designed to meet the needs of racial and ethnic minorities, including a booklet that is available in 18 languages that defines common hospital terms. In addition, a variety of multilingual materials are available through MGH’s Intranet system. Staff are also trained to help patients find relevant multilingual materials that are available through the Internet. The center has educational videos that can be viewed in the center or “piped” to any patient’s room, thus allowing patients and family members to watch them. The existence of the center is highlighted in materials that are given to all patients, and nurses, physicians, and other staff are trained to encourage patients and family members to take advantage of this resource.
- MGH sponsors educational workshops on health literacy in both English and Spanish. The program is geared at a sixth- to eighth-grade reading level.
- Specific sites within MGH also sponsor their own patient education and empowerment activities. For example, the Chelsea HealthCare Center holds “group visits” that bring together a number of patients with similar health conditions and provider(s) who answer questions. These group visits are highly valued by both patients and staff, and they are held in a variety

of areas such as asthma, breast cancer, nutrition (e.g., refugees are taught about food and how to use food stamps), birth control, and hygiene. In some cases seminars are held on non-health issues that can affect health status, such as financial literacy.

### *Element #3: Socio-cultural competence*

MGH makes numerous attempts to help its staff better understand and consider a patient's culture and language, and also address each individual's specific situation and expressed needs. In general, patient care is provided by clinical teams that are expected to work together to assess the patient as an individual rather than a member of a group. Yet MGH also acknowledges disparities in care provision across ethnic and racial lines, and creates opportunities for medical students, new and existing nursing and support staff, medical residents and physician faculty to learn about cultural diversity in order to better serve their minority and immigrant patients. (These are described in detail under "Workforce Recruitment and Development, below). And through recruitment practices, MGH attempts to hire a staff that reflects the population being served (also described further below). The patient care services department, for example, has made an explicit effort to increase the percentage of non-Caucasian nursing staff, raising this figure from 5.5 percent to 7.0 percent between 1997 and 2003. This figure, however, is still well below the overall representation of non-Whites in the general population, which is approximately 20 percent in both the city of Boston and the state of Massachusetts.

Staff diversity is greater at MGH's community-based health centers, which serve a much more diverse population than does the main campus. For example, almost all staff at the Chelsea HealthCare Center are bilingual or trilingual. The 25-30 staff members of the center mirror the population of the community at large, with four staff members from Somalia; two from Bosnia; and one each from Afghanistan, Sudan, and Bangladesh. Many of the remaining staff are of Latino descent. The staff not only reflect the community, but in many cases they are in fact from the local community and may have experienced many of the same kinds of challenges (e.g., being a refugee from a war-torn nation) as the residents being served.

But having a diverse staff is no guarantee that patients will not face language and/or cultural barriers when they seek care. To help overcome these barriers, MGH runs a large interpreter service that is available 24 hours a day, 7 days a week. MGH employs roughly 25 full-time interpreters who speak the 10 most frequently spoken languages among MGH patients, including Spanish, Portuguese, and Arabic. MGH also works with 85 independent "freelance" interpreters who cover 30 additional languages; these interpreters are on-call when needed to come to the hospital. In addition, telephone-based interpreting services are available through independent companies.

Interpreters go through an extensive evaluation before they are hired, including a two- to three-month process in which they are tested via role-playing and other assessment techniques. Candidates also "shadow" caregivers for a period of time to ensure that they want to work in the kind of environment MGH has to offer.

Registration staff at MGH are trained to ask patients about their preferred language for communication; translators are then present when these patients come in for their appointments. For walk-ins and in other cases where the need for an interpreter is not known in advance, providers can call interpreter services, which is staffed with live personnel at all times. The department's

phone number is included in materials given to all patients (a language card available in 19 languages explains how to access an interpreter) and is widely promoted among the staff as well.

The interpreter's main job is to ensure that there is two-way understanding between the provider and patient—i.e., they make sure that the doctor understands what the patient is saying and what he or she knows and does not know, and they also make sure that the patient understands the physician, particularly with respect to medical and scientific terminology that may not be easily understood.

#### *Element #4: Care coordination and “navigation” assistance*

MGH has developed a number of “navigator” programs to help underserved minorities facing specific health problems to access the care they need in a timely manner. The Chelsea HealthCare Center runs the Breast Cancer Navigation Program (see box below) and the Cervical Cancer Navigation Program; a third program in the area of colon cancer is currently under development. The goal of both existing programs is to make care more accessible for Spanish-speaking women who may be at risk for cancer.

The cervical cancer program is similar to the breast cancer program, although it is not as well funded (there is no nurse practitioner).<sup>1</sup> A special clinic offering diagnostic tests for cervical cancer to Chelsea patients is held every Tuesday afternoon at the downtown cancer center, with a Spanish-speaking navigator assisting Chelsea patients in arranging for and getting to an appointment.

Evaluations of the Avon-sponsored programs are underway, including how they are influencing patient and provider satisfaction. Anecdotal evidence suggests that the program has been successful in catching previously undetected breast cancer, as the number of diagnoses of new breast cancer has increased from roughly six to 32 per year.

#### *The Breast Cancer Navigation Program*

MGH's Chelsea Healthcare Center operates a “navigation” program for women in the local community who are at risk for breast cancer. Most of these women are Hispanic and low-income; many are immigrants. Key features of the program are the following:

On Thursday mornings, a specialized breast cancer clinic is held at the main MGH campus, *with time slots being reserved especially for Chelsea patients*. This approach allows patients to get in quickly for services, often within a few days of seeing their primary care doctor at the Chelsea Healthcare Center. The clinic serves as a “one-stop shop” for basic screening and diagnostic services, offering mammography, ultrasounds, and consults.

A bilingual navigator works with patients to arrange appointments and make sure the women get there. The navigator will often meet the patient at the Chelsea center beforehand, travel on the free shuttle with the patient to the appointment at MGH's main campus, and also help to coordinate any needed follow-up tests or treatment. The navigator also serves as an interpreter for patients. She will also aggressively reach out to any “no shows,” literally knocking on their doors if they cannot be reached by phone. Also as part of the program, a nurse practitioner runs a support group for Spanish-speaking patients with breast cancer.

The Breast Cancer Navigation Program is funded by MGH and a grant from the Avon Corporation.

#### *Element #5: Physical comfort and emotional support*

Social workers are an integral part of the patient care team; they are assigned to every inpatient unit as well as to all outpatient sites, including the five community-based health centers. The social work department runs a whole host of programs that are designed to support patients and family members both physically and emotionally. These programs include how to deal with and

<sup>1</sup> The cervical program is funded by the MGH Cancer Center and MGH Community Benefits.

adjust to illness and how to cope with death and dying. The department helps low-income families from outside the area find affordable shelter if a family member has to be at the hospital for a long period of time. Social workers also have access to a computerized community resource center that helps to link patients to needed services within their local community. The tool covers Massachusetts and some neighboring states. In cases where patients come from outside of these areas, social workers will contact appropriate state and local agencies to find out what resources may be available.

#### *Element #6: Easy access to care*

With a large, decentralized campus, MGH faces a challenge in making care as accessible as possible. As noted earlier, MGH has tried to facilitate access in part by setting up “navigator” programs designed to help people from nearby communities (who are likely unfamiliar with the complex city campus) access needed services at the main facility. But there are other programs as well:

- For example, one pilot “navigator” program that is currently being evaluated seeks to inform cancer patients from the community about the potential to enroll in clinical trials. This is a part of a collaborative among a number of area health care institutions that is exploring how to overcome the barriers to participation in clinical trials by these primarily minority populations. They are providing, for example, information about the trials, transportation, child care during the visit, etc.
- Another innovative “navigator” model is being piloted at MGH’s Revere Community Health Center, where the largest Medicaid plan in the area – Neighborhood Health Plan – has agreed to reimburse behavioral outreach workers for “navigation” services they provide to local, at-risk youth at the local high school. These youth are being educated on how to utilize the healthcare system and are provided with ongoing support in accessing those services. The one-year pilot will commence on October 1, 2005; a formal evaluation will be conducted to see if the program is successful in increasing use of preventive and primary care services (including mental health/substance abuse services) and reducing the number of crisis situations and use of the emergency room and inpatient care.
- Along with its navigator program, MGH is also experimenting with use of an “open access” schedule in some of its community health centers (see box).
- In addition to its navigator and open access programs, the community outreach work at MGH (discussed in detail in the next section) attempts to bring basic services out into the community (e.g., to schools and homes) whenever possible.

#### *“Open Access” Scheduling at MGH community health centers*

Unlike the traditional scheduling system where most appointments are booked several months in advance, under this model only about one third of patient slots are booked well ahead of time (e.g., for elderly patients who want the peace of mind of having a scheduled appointment). Another one third to one half of patient slots are available for booking a week to 10 days in advance, with the remainder of slots being held for walk-ins.

The theory behind this approach is that it better meets the needs of the many community residents who find it difficult to plan far in advance. This system shifts the balance of power to the *patient*, who is now able to get an appointment at a desirable time with little need for a long wait or advance planning – that is, it better meets the personal, lifestyle needs and preferences of the patients at the centers.

Physicians who have experimented with the approach have found that their no-show rate has declined dramatically, in one case from 30 percent to almost zero.

### *Element #7: Community outreach and partnerships*

MGH has a large Community Benefit Program that was launched in 1995, a year after Massachusetts' attorney general released voluntary guidelines that urged hospitals to take responsibility for the health status of underserved populations. The MGH Community Benefit Program relates directly to PCC and serving the underserved; its mission is "to collaborate with community and hospital partners to build and sustain healthier communities, and to enhance the hospital's responsiveness to patients and community members from diverse cultural and socioeconomic backgrounds."

The program had a strong foundation on which to build, as MGH had been active in the community for many years prior to this time. For example, MGH began its partnership with the Health Care for the Homeless program more than 20 years ago. The Community Benefit Program has grown rapidly from its humble beginnings 10 years ago, when it had only one full-time equivalent (FTE) staff member. Today there are nearly 40 FTEs spread out across the main campus and five community health centers. Each of these centers focuses on improving the health status of underserved populations by first understanding and then addressing their needs.

Extensive community needs assessments combined with town hall-type meetings help to identify health-related needs that are high priority to the neighborhood residents – such as domestic violence and substance abuse. Numerous community-based partnerships -- with the police, department of social services, and schools—are then designed to meet those needs. Activities include the following:<sup>2</sup>

- The Chelsea center formed a partnership with the local police to provide crisis intervention to children who have witnessed trauma and/or violence. A MGH licensed social worker (LSW) is on call to the police department, and is called whenever there is a 911 call involving a child. She comes immediately to the scene to assess the child's situation, to direct the family to any community resources they may need, and to arrange for a crisis intervention if necessary. Being at "the scene" immediately helps to ensure that the family and child get the support services that they need (services they are unlikely to access on their own).
- The Chelsea center also runs programs oriented at enhancing access to care for special populations (e.g., immigrants and refugees, children with special health needs) and at improving health outcomes through better management of chronic diseases, including asthma, breast/cervical cancer, and HIV/AIDS. Similar kinds of partnerships have been put in place at the other four MGH community-based centers.
- The Revere Community Health Center has partnered with the Revere public schools to operate a health center at the local high school, a teen clinic three blocks away (because the clinic dispenses birth control pills, it cannot be located at the school), and an after-school drop-in program for teens. These programs are staffed by adolescent nurse practitioners along with family planning, mental health/substance abuse, and/or domestic violence counselors; staff are trained to identify at-risk youth and to help them get the services they need.
- The Chelsea HealthCare Center is also quite active in the local public schools. It hired two counselors/social workers – one Somalian and one Bosnian – to help serve the large number

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<sup>2</sup> For more information on MGH's Community Benefit Program, see: [http://www.massgeneral.org/about/community\\_reportattorney.htm](http://www.massgeneral.org/about/community_reportattorney.htm).

of recent refugees and immigrants from Somalia and Bosnia, many of whom had experienced the ravages of war in their native countries. These counselors spend roughly one half of their time in the local schools and the other half at the Chelsea center, providing counseling and referrals to other services available in the community. Many of the Bosnian and Somali children in the schools have gotten to know and trust these individuals. The counselors are closely supervised by a clinical psychologist. In addition, the Chelsea HealthCare Center runs a clinic at the local high school, where a nurse practitioner helps to identify students who may be the victims of domestic violence. The Chelsea center also recently sponsored a dental fair for refugees at the schools.

- Main campus-based programs include domestic violence programs for patients and employees.

### **Critical Institutional Supports & Processes behind PCC at MGH**

MGH could not deliver PCC on a consistent basis without committed leadership, departments and committees dedicated to PCC values, concerted efforts to recruit and train a diverse and culturally competent workforce, community input, careful measurement and technological supports.

#### *Factor #1: Passionate, committed leadership*

For more than a decade the leadership at MGH has exhibited a strong commitment to PCC and serving the underserved. This commitment is demonstrated not only through constant communication on the issue, but also through the allocation of significant financial resources to establish programs and structural mechanisms to support PCC, including the aforementioned Community Benefit Program (with an annual budget of more than \$3.5 million from MGH and an additional \$3.4 million from other sources), the Disparities Solutions Center (to which MGH and the Partners HealthCare System have committed \$3 million over five years), the Multicultural Affairs Office (with an annual budget of \$400,000 to \$700,000), and the patient care services Diversity Steering Committee (see next section for descriptions of these latter three programs). The heads of many of these programs report directly to the president or to the chief medical officer of MGH.

In addition, after the Institute of Medicine's *Crossing the Quality Chasm* report was released, MGH's leadership decided to retool the organization's strategic planning process to align with each of the six pillars of quality laid out in that report, one of which is patient-centeredness. Thus, MGH's strategic plan now includes PCC as a priority.

Along with providing resources and structures, the president of MGH also challenges the institution as a whole and individual departments to constantly improve their ability to provide PCC. For example, after Boston's mayor convened Boston hospital CEOs in the fall of 2002 to explore the role that hospitals could play in eliminating health disparities, the president appointed a committee (the Committee on Racial and Ethnic Disparities) to examine and act upon disparities at MGH. Upon learning that another organization won the AAMC's<sup>3</sup> Community Service Award, the president invited the dean of that institution to visit MGH, and he required all department

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<sup>3</sup> Association of Academic Medical Centers

leaders attend a session where they learned about what it takes to offer top-notch community service. The leaders were charged with conducting a detailed assessment of current operations, and then revamping them where appropriate to emulate some of the best practices of the winning organization.

### *Factor #2: Committees and Departments that support PCC*

MGH has several committees and departments that are formally charged with supporting the delivery of the key components of PCC.

#### *Disparities Solution Center*

MGH and Partners Healthcare System recently created the Disparities Solution Center (DSC), which is working to reduce and eliminate disparities in health care among racial and ethnic minorities in Massachusetts. With \$3 million committed over five years, the DSC will be involved in a variety of activities. DSC will sponsor a team of health care specialists who will study why disparities exist and how best to address the gaps in care. In addition, the funding will be used to establish an institute to train medical professionals on healthcare inequities.

DSC's goal is to build leadership in the field by training the next generation of physicians and health researchers who can forge improvements to reduce and eventually eliminate disparities. Finally, through partnerships with physicians, insurers, community health centers, schools, state and local governments, foundations, and others, DSC will attempt to move beyond research into public action by identifying and promoting the implementation of the best practices of the various stakeholders in the system. Dr. Joseph Betancourt, the director of the center and a pioneer in the area of cultural competency, expects that these best practices will be based on culturally competent, patient-centered care principles.

#### *Multicultural Affairs Office*

MGH's Multicultural Affairs Office (MAO) was created more than a decade ago to promote the diversity and to improve the cultural competency of the approximately 3,200 physicians who make up the MGH Physician Organization. MAO is a highly visible part of the organization with a budget of between \$400,000 to \$700,000 a year. The director of the MAO reports directly to the president of the hospital; the assistant director is a former corporate attorney. MAO's mission—to recruit, develop, and retain minority physicians—is a part of the hospital's overall strategic plan. For more information on MAO, see the section on staff recruitment and development.

#### *Patient Care Services Diversity Steering Committee*

Formed in 1997, the patient care services Diversity Steering Committee supports programs and events that promote the diversity of the nursing workforce, the professional development of minority employees, student outreach, the provision of culturally competent care, and the development of patient educational materials tailored to a diverse patient population. The committee is also active in working to reduce disparities in health care.

### *The Committee on Racial and Ethnic Disparities*

As noted, this committee was formed in 2002 in response to the mayor of Boston's call for hospitals to play a larger role in eliminating racial and ethnic health disparities. The charge to the committee is to: identify key areas where racial disparities in health care may exist at MGH; develop solutions to address these disparities; and coordinate with the mayor's citywide initiative. The committee includes many of the organization's top leaders, including the president and the director of the community benefits program. There are three subcommittees, each of which addresses a specific area.

- The Access and Patient Experience of Care Subcommittee is charged with assessing the experience of care for patients of color, and developing and implementing action plans to address disparities. This subcommittee conducted a random cross-sectional survey in 2004 which asked patients about access to and experiences with various services, unmet needs, and perceptions of how welcome and respected they feel (discussed further below). This subcommittee also recommended formation of the Multicultural Community Advisory Committee (described in Factor #4, below)
- The Quality Subcommittee is charged with developing methods for ongoing quality measurement of outcomes stratified by race and ethnicity, and with designing quality improvement initiatives to address identified problem areas. Thus far the subcommittee has collected and analyzed stratified data on outcomes from quality improvement initiatives in asthma and diabetes. It is also collecting stratified data on patient satisfaction.
- The Education and Awareness Subcommittee is charged with developing plans to educate and raise awareness among the entire MGH community of disparities and the factors that contribute to them. To that end, each year the subcommittee publishes at least two articles in hospital publications and makes at least four presentations at grand round and leadership meetings. In addition, the subcommittee sponsored a major forum on disparities that was attended by over 200 people. The subcommittee developed slides on disparities that are included in the orientation of all professions, along with posters that are displayed throughout the hospital. The subcommittee periodically assesses disparities-related activities throughout the hospital using an email survey, and then shares the best practices that are identified in the survey throughout the system.

### *The John D. Stoeckle Center for Primary Care Innovation*

This Center is dedicated to improving the practice of primary care from the patients', families', and clinicians' perspectives. Directed by PCC pioneer Susan Edgman-Levitan, the Center conducts research and education to foster collaboration between providers, patients, and their families in clinical decision-making, and strives to improve the experience of care for patients and clinicians. For example, the Center has conducted surveys of MGH employees about their experiences as patients, and it has offered monthly seminars designed to explore emerging innovations within primary care, and educate providers about new methods to improve patient and clinician experiences through communication and decision-making – including how to access credible medical information to share with patients, strategies for managing difficult patient-clinician interactions, and the medical legal implications of sharing important medical decisions with patients.

### *Factor #3: Workforce recruitment and development*

#### *Recruitment*

MGH makes a concerted effort to recruit nursing, physician, and non-clinical staff that are representative of the community it serves. As noted above, the patient care services Diversity Steering Committee focuses much of its work on increasing the diversity of the nursing staff by supporting foreign-born and minority nurses through programs such as an on-site BSN and MSN program and a nursing career ladder. The committee's efforts are paying off, though there is still a long way to go—at the end of 1997 there were 98 non-Caucasian nurses at MGH (representing 5.5 percent of all nurses), but by the end of 2003 there were 216 (representing 7.0 percent of all nurses).

As noted earlier, the MAO is charged with recruiting minority physicians. The Multicultural Affairs Office (MAO) initially concentrated its efforts on those minority groups that were identified by the American Association of Medical Colleges (AAMC) as being underrepresented, including African Americans, Mexican Americans, Puerto Rican Americans, and Native Americans. In 2004, MGH conducted its own analysis comparing the MGH physician pool to the population being served; this analysis highlighted the need to recruit Brazilian physicians to serve MGH's large, growing Portuguese patient population. To date, MAO's work has focused on building a physician pipeline by targeting college students, medical students, and residents. Programs include the following:

- For the past 12 years, MGH has invited college juniors and seniors and first- and second-year medical school students who are underrepresented minorities to come to MGH for an eight-week internship. This highly competitive, nationwide program is open to any underrepresented minority student who has an interest in medicine. Roughly 10 to 12 students win the award each year (usually one-half come from college and the other half from medical school). The program has been very successful in terms of generating and/or confirming interest in medicine, as 98 percent of the college students in the program have gone on to medical school. But only six of the program's 100+ graduates have come back to MGH.
- For the past five years Harvard Medical School (HMS) has invited non-HMS fourth-year medical students who are underrepresented minorities to apply to participate in a month-long visiting clerkship program. Under this program MGH hosts approximately 10 students per month (up from 1-2 students per month a few years ago). It has been a highly successful recruiting tool, as in the last two years roughly 60 percent of MGH's underrepresented minority residents have come from this program.
- The MAO's primary focus is on recruiting physician residents from underrepresented minority populations. The effort was initially launched in internal medicine, but is now being expanded to each of MGH's 21 residency programs. It has been fairly successful, with 20 out of 55 "matched" residents (i.e., residents that MGH wanted to recruit) accepting a residency at MGH, roughly the same percentage as for non-minority applicants. Given the intense competition for minority residents, this is a fairly high success rate. Key elements of the program include the following:
  - MAO hired an underrepresented minority who is a recent MGH residency program graduate on a part-time basis to assist with the recruiting of underrepresented minorities.

- Applicants are invited to registration dinners where they have an opportunity to meet with minority residents who are already in the program. In 2004, 70 percent of those who were invited attended the dinners (even though they had to pay for their own travel); MGH also hosts a handful of underrepresented minority residents who want to come back for a second visit, with MGH picking up the tab for that trip.
- MGH recently began to include underrepresented minority residents as a part of the team who interviews applicants. Anecdotal data would suggest the practice is successful, as the emergency medicine department successfully recruited two of three applicants using this approach; prior to this, the department had not recruited a minority applicant for many years.
- The MAO has also made a concerted effort over the past few years to encourage residents to remain at MGH after finishing their residency program. Minority residents now meet periodically with the chiefs and program directors of various service lines. In addition, a systematic effort is underway to keep tabs on minority residents, including having MAO's leadership meet with them periodically for an hour to discuss and address any issues or concerns they may have. This program has been successful, with more than a third (35 to 37 percent) of residents staying at MGH over the past few years, up from 16 percent three years ago.

#### *Training and Development*

MGH trains all staff, physicians, residents, and medical students in the area of cultural competency and PCC. Training for students and residents is in part designed to create a "feeder system" for MGH whereby new physicians would already be trained in PCC and cultural competency. Brief descriptions of the major training activities are provided below:

- **Staff:** In 1999 MGH's Patient Care Services Department began formal training in culturally competent care. The curriculum<sup>4</sup> was revised and expanded several years ago. A full-day program, entitled "Introduction to Culturally Competent Care: Understanding Ourselves, Our Patients, and Each Other," brings employees—new and old—from throughout the hospital together to share and discuss personal experiences working in a multicultural environment. *Participants engage in didactic exercises that focus on understanding and assessing the individual patient rather than making assumptions based on stereotypes about a particular racial or ethnic group.* The curriculum has recently been revised to bring in the topic of health disparities, including background statistics that demonstrate the problem and training on how to work with minority populations. The program is voluntary, although staff are strongly encouraged to attend.
- The department also periodically sponsors other, focused programs on a voluntary basis; they range from a few hours to a full day, and address discrete topics such as diversity in children and caring for Muslim, Haitian, and gay/lesbian patients.
- The department is working with Human Resources to integrate training on health care disparities into the general orientation for new employees (which is mandatory). Individual departments and clinic sites also engage in training. For example, the cancer center is currently engaged in an effort to train front-line staff in cultural competency. The Chelsea HealthCare

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<sup>4</sup> Based on curricula developed at the Seattle-based Cross Cultural Health Care Program (<http://www.xculture.org/index.cfm>).

Center also sponsors several training sessions for all staff in which they discuss the cultures, customs, dietary habits, and other characteristics of the populations being served.

- **Faculty physicians:** The Culturally Competent Care Education Committee (CCCEC) is led by Harvard faculty who teach didactic sessions to MGH faculty on culturally competent care. This committee has identified 20 other faculty members who want to become experts in culturally competent care. These faculty, who go through eight hours of evening training sessions, have committed to leading teaching sessions, small group discussions and seminars for members of the MGH physician organization. MGH faculty have also developed the “ESFT Model for Communication and Compliance,” an individual, patient-based set of questions that doctors can ask to help gauge whether patients are adhering to their prescribed regimens, identify barriers to compliance, and offer intervention strategies to improve outcomes.<sup>5</sup>
- **Medical Residents:** MGH has been a pioneer in developing a cultural competency education curriculum for residents, something that is slowly growing in residency programs around the country.<sup>6</sup> For the past four years, residents have been required to complete six to eight hours of case-based work each year that highlights issues related to PCC and cultural competency, including how to screen for literacy issues, what questions to ask in order to understand the patient’s attitudes and perspectives about health and his or her condition/illness, and how to gain a patient’s trust. The curriculum, which includes a four-part video series entitled *World’s Apart*, emphasizes the need to see people as individuals and to elicit individual preferences and concerns, rather than making generalized assumptions about attitudes based on a patient’s race or ethnic background. This past year an e-learning module was added to the curriculum; this interactive session includes three cases. Residents are evaluated based on a pre- and post-test that measures cultural competence, understanding of disparities in health care, and other relevant issues.
- **Medical students:** MGH has several programs in place that are designed to orient medical students to PCC and culturally competent care. The most comprehensive of these is a systematic effort by the CCEEC to review the curriculum of all Harvard Medical School courses in order to find ways to integrate PCC and cultural competency into the curriculum. The reform effort is also focusing on finding ways for students to engage in longitudinal, independent experiences in community-based care. To that end, a new concentration called “Medicine in Society” is being added; students who choose this concentration will be required to engage in a four-month in-depth experience that can include a community-based project. In addition, several other smaller programs are underway that are designed to provide students with exposure to PCC. For example, all students are required to view the *World’s Apart* video series.
- In 2002 the Harvard Medical School allocated \$25,000 to launch the Division of Service Learning, which was charged with integrating student’s community experiences into the formal curriculum. Any student who applies for funds to support a community experience is required to attend sessions in the spring in which they learn about cross-cultural care and also

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<sup>5</sup> For more information see: Betancourt, JR, JE Carrillo, and AR Green. Hypertension in multicultural and minority populations: linking communication to compliance. *Current Hypertension Report* 1999, Dec:1(6): 482-8. ([http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list\\_uids=10981110&dopt=Abstract](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10981110&dopt=Abstract))

<sup>6</sup> The number of medical residency programs in the U.S. that provide opportunities in cultural competence awareness has increased from 36% in 2000-2001 to 51% in 2003-2004. (Sarah E. Brotherton, PhD; Paul H. Rockey, MD, MPH; Sylvia I. Etzel. US Graduate Medical Education, 2003-2004, *JAMA*. 2004;292:1032-1037).

receive assistance in planning for their community-based experience. The experience itself takes place in the summer, and in the fall the student is required to reflect on the experience and to analyze the lessons they learned about advocating on behalf of patients.

- Another pilot program, launched in 2004 with the financial support of Blue Cross and Blue Shield of Massachusetts, provides third-year students who are going through their primary care clerkship (where they spend one afternoon a week in a primary care setting) to think about ways to develop and evaluate community-based programs within those settings, including teen clinics, substance abuse coalitions, and outreach to assisted living communities.

#### *Factor #4: Patient/family/community input into program design, implementation*

MGH routinely solicits input from patients, families, and/or the community at large before embarking on any major initiative oriented at better serving ethnic and racial minorities and other underserved populations. MGH's recently formed Multicultural Community Advisory Committee consists of community leaders, patients, and families from various racial and ethnic minorities. This committee, modeled after MGH Cancer Center's Patient and Family Advisory Council<sup>7</sup>, is charged with advising MGH on minority patients' experiences with care at the hospital; educating MGH on various minority communities' perceptions of the hospital (both as a provider and as a member of the community); and developing recommendations to address any issues that are identified. The committee held its first meeting in October 2004.

As noted above, MGH held public meetings in each of its health center communities to get input as to the most important issues facing the community. This input was central in MGH's determination of where to invest resources in these communities. For example, in Chelsea these meetings made it abundantly clear that domestic violence was the most important issue facing the community, and a variety of programs that were described previously were set up in response. In Revere meetings with residents helped to uncover substance abuse as the major area of concern (in spite of the fact that several physicians came armed with data showing cardiac disease to be a leading health problem).

While initially there was some hesitation among the hospital's clinical leadership to get involved in substance abuse (which seemed to some to be outside of the hospital's main focus of treating acute health problems), this hesitation quickly subsided and MGH put in place two new programs to help address substance abuse in the community. The first was the establishment of a new position—the substance abuse specialist—at two health centers and the main campus. These specialists provide an assessment and immediate referrals to needed services for those individuals identified as having a problem. The second program related to assessing the risk of alcohol withdrawal among inpatients; an interdisciplinary team developed a new alcohol recovery pathway for those who screened positive for alcohol problems at admission.

MGH also periodically holds formal focus groups with community members to help understand how their needs can better be met. For example, the Chelsea HealthCare Center held focus groups with Arabic-speaking patients to understand what more the health center could do to

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<sup>7</sup> The Council's volunteers provide feedback in many areas, and serve as a crucial link between patients and administrators; they circle through waiting rooms of all clinical areas serving snacks, speaking to patients about concerns with building, environment, resources, educational materials, etc. The concerns from these informal but frequent surveys are channeled back to staff and management.

serve them. Focus groups were also conducted with women patients to try to understand why many of them were not coming in for routine cervical cancer screening.

#### *Factor #5: Measurement and feedback*

MGH is making concerted efforts to measure its ability to provide underserved minorities with patient-centered care, and to act on that information:

- In 2004, MGH put in place a system for tracking patient satisfaction rates by ethnic or racial group. The patient satisfaction survey was translated into Spanish, and is being translated into other languages, including Portuguese and Haitian-Creole. I
- At the direction of the Diversity Steering Committee, two MGH researchers designed a telephone survey that was used to gauge patient satisfaction with MGH services; minority patients (including African Americans and Hispanic/Latinos) were oversampled in order to allow for a comparison of scores between minority and white patients. Survey questions focused on whether patients feel they got “fair and equal” treatment at MGH; whether patients feel that they were treated with respect; how satisfied patients are with the care received; and how accessible needed services are at MGH. The survey of 400 patients garnered a 70-percent response rate and cost only \$18,000 to conduct. The results of this survey led to the formation of the Multicultural Advisory Committee.
- A separate phone survey of 404 patients was designed to gauge perspectives on whether the care that minorities receive (both at MGH and in society at large) is of the same quality as that received by White patients.<sup>8</sup>
- In addition to beefing up its survey capabilities, MGH also evaluates patient complaints as a means of feedback. One recurring theme in both the 2004 survey and in patient complaints is a general feeling that front-line staff at MGH were not as polite and helpful as they could be to minority patients, many of whom indicated that they did not feel welcomed when they entered the facility. In response to these complaints, MGH’s cancer center held structured focus groups with front-line support staff to get a better understanding of their views and concerns. These focus groups revealed that the staff valued their interactions with patients, but that they felt underappreciated and unsupported by both nurses and physicians. MGH’s cancer center is working to resolve these issues by providing training to front-line staff on cultural competency issues and by putting in place programs (e.g., support groups, educational sessions, lunches where support staff meet with clinician leaders) designed to improve the relationship between front-line and clinical staff.

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<sup>8</sup> The survey found that 44 percent of African American patients felt that they get lower quality care than do Whites in general, but only 21 percent of African Americans felt that they get lower quality care at MGH. There was a similarly large gap among Asian respondents. Latinos, however, seemed to feel that MGH did no better than the rest of the country in providing them with comparable care. The same survey showed that Asian Americans and Latinos were somewhat less likely than African Americans and the overall patient population to feel welcomed by nurses and physicians. Nine percent of African Americans felt that they had been treated unfairly or with disrespect based on their race/ethnicity, compared to three percent among all other survey respondents.

### *Factor #6: Supportive information technology (IT)*

MGH's longitudinal electronic medical record helps to facilitate the provision of PCC by providing ready access to test results, medical records, and patient education materials at all MGH sites, including the community health centers. In addition, MGH is actively investigating how technology may be able to assist in the provision of PCC. As noted earlier, an e-learning module was recently added to the cross-cultural competency curriculum for residents.

As part of MGH's "Ambulatory Practice of the Future" project (which focuses on the use of technology and other tools to make outpatient care more patient-centered), researchers are investigating the possibility of using video or web-camera-based interpretation that would allow patients and providers to see the interpreter without requiring him or her to be there in person. This approach could help to speed up the availability of interpreter services while still allowing for all-important visual contact (which allows the interpreter to read body language and facial expressions that might signal whether a patient is confused or has concerns that are not being articulated).

MGH was also recently awarded a \$100,000 grant from Gillette to create a Multilingual digital online and CD ROM resource guide for women with cancer. MGH will create materials in 10 languages and distribute them online and via CD ROM to health centers and community organizations in Greater Boston. It will draw together translation, women's health, patient education and clinical and social services to bring this resource not only to MGH patients but to the greater community.

MGH submitted a proposal to a corporation to request funding for development of a multilingual patient guide available online and/or through a CD-ROM. This guide, which would be written in the 10 most popular languages spoken by MGH patients, would provide important information on self-care and available community resources. It would be distributed through community centers and provider locations, and also made available in all health centers, schools, and libraries.

Finally, MGH's Information Technology group is in the process of developing a collaborative decision-making tool for patients with diabetes. This interactive tool will be integrated into the EMR and will allow patients and providers to sit down to discuss the patient's condition (including the risks that he or she faces) and to set and evaluate progress toward mutually agreed upon goals. The tool is being designed to facilitate comprehension by patients with limited health and general literacy.

### **Challenges**

MGH faces a number of significant challenges in providing PCC, particularly in retaining minority clinicians, recruiting and drawing appropriate boundaries for outreach workers, gauging and rewarding PCC-related performance, and obtaining adequate resources.

### *Retaining underrepresented minority physicians*

Despite all of the efforts put into recruiting, only three percent of the medical faculty (all physicians at MGH are on the faculty) are underrepresented minorities, which is roughly in line with the national average for teaching hospitals. This figure, moreover, has not changed over time.

The problem is primarily in retention rather than recruiting. Not only are minority physicians in high demand, but MGH is also a place that emphasizes independence. Minority physicians often lack structured mentorship and because of their small presence on campus, they have few peers with whom to interact. In addition, salaries at MGH are fairly low, and Boston is an expensive place to live.

#### *Drawing the line with respect to the role of outreach staff*

The outreach staff at MGH's community health centers face a challenge in drawing the line with respect to what they will do for patients. Because the staff are often of the same racial/ethnic background as the patients, and because they are so active and visibly present in the community, patients often come to them for assistance with things that are far afield from health care, such as how to pay bills. While MGH's community benefits program tends to define health very broadly, there are limits to their resources and thus some areas must be considered "out of bounds."

#### *Recruiting and retaining outreach and community center staff*

While MGH's main campus tends to recruit individuals with college degrees for interpreters and certain other roles, it is often a challenge for the community-based centers to find people with a lot of education and/or experience, particularly if the centers want to meet the goal of hiring a staff that is as culturally diverse as the community at large. As a result, these centers often relax the standards for new hires with respect to education; for example, they may accept high-school graduates who are smart and ready to learn, rather than college graduates. They also use creative methods for finding new staff, relying heavily on networking with current staff and even patients.

Finally, because many staff have had difficult lives—i.e., the Chelsea center has hired several recent refugees and immigrants from war-torn and/or impoverished nations—it can be difficult to prevent them from becoming burned out given the emotional demands of the job.

#### *Developing tools to better gauge (and then reward) performance*

MGH researchers admit that current satisfaction surveys are not optimal in measuring the degree to which MGH performs PCC. Although they are just beginning to make inroads, new tools and survey questions are needed to allow for the systematic collection of data to measure performance, identify problem areas, and promote improvement.

In addition, current reimbursement systems do not reward the practice of PCC. Indeed, with an significant demands on MGH practitioners, there are few incentives and little opportunity to put in "extra" time to participate in PCC committees, educational sessions, and activities. The emerging movement toward pay-for-performance reimbursement may help to address this issue if a meaningful amount of money can be tied to indicators that relate to PCC.

### *Finding resources to support training and education*

Much of the training in PCC and culturally competent care for faculty, residents, and medical students is provided on a volunteer or grant basis. Thus it is a challenge to sustain such initiatives. While MGH has been able to secure some grant funding to support these efforts, it is a constant struggle to find available funds to support systematic training in PCC and culturally competent care.

### **Conclusion**

MGH is trying to promote patient-centered care for underserved populations through major initiatives aimed at measuring and reducing health disparities, improving cultural competence, recruiting a more diverse workforce, reaching out to underserved local communities, and helping patients navigate the health system. Importantly, its leadership is willing to devote resources and create structures (committees, programs) that support these efforts. Though decentralized across multiple departments and sites, MGH's activities in PCC result in numerous "best practices" that should be expanded internally, and replicated in other organizations.