

# Chapter 4 – What’s being done out there?

## **In-Depth Case Studies**

Several hospitals across the country have engaged in a variety of efforts to improve quality, address disparities, and achieve equity. We had the opportunity to interview leaders from ten organizations across the country who were identified by their peers as having activities in this area. Interviews with leadership highlighted their perspectives and viewpoints on the issue of disparities, including why they think it is important to identify and address them, and what key pearls they would share with their peers in this regard. Of those ten organizations, we conducted site visits at three hospitals (Baylor Health Care System, Seattle Children’s Hospital and Duke University Hospital) to develop in-depth case studies. Information gathered during the interviews and site visits helped shape and inform this Guide. Below are the three case studies that provide in-depth information about addressing disparities from three different organizational perspectives. In addition, we’ve included a table of all ten hospitals that provides a brief overview of these organizations, highlights what they are doing, the challenges and successes they have experienced, and the key ingredients for their progress to date. This diverse group of hospitals has made great strides towards addressing the issue of racial and ethnic disparities.

## Baylor Health Care System Case Study

The Baylor Health Care System has a long history of improving the health of underserved communities, but it was in 2001, after the release of the Institute of Medicine's report, *Crossing the Quality Chasm*, that the institution began massive organizational transformation to improve quality of care and address health care disparities. Their service mission dates back to 1903, when the founder of Baylor, Baptist minister George W. Truett stated, "It is out and out time to begin erection of a great humanitarian institution, one in which men of all creeds and those of none may come with equal confidence." This philosophy has permeated Baylor's sense of institutional responsibility to provide equitable care to all who enter their doors – regardless of their background – and has been the foundation of a commitment to community health and improving the health of the people they serve.

Baylor Health Care System is a non-profit health care system. Baylor University Medical Center at Dallas serves as Baylor Health Care System's flagship hospital. The medical center is recognized as a major center for patient care, teaching and medical research throughout the Southwest. The Health Care System provides full-range, inpatient, outpatient, rehabilitation and emergency medical services through 15 owned, leased or affiliated hospitals and surgical services at six short-stay hospitals. Each year Baylor Health Care System medical centers provide community education, health screenings, and community health improvement and wellness initiatives to people throughout North Texas. For fiscal year 2007, Baylor will report \$390 million in community benefit to the Texas Department of State Health Services.

### The Catalyst

The release of the Institute of Medicine Report "Crossing the Quality Chasm" served as the impetus for Baylor to refocus its efforts on improving quality of care. Hospital leadership viewed this as an opportunity for "clinical transformation", which undoubtedly also required a cultural transformation. The six pillars of quality as delineated by the Chasm Report (trademarked as STEEEP by Baylor–Safe, Timely, Effective, Efficient, Equitable, and Patient-centered) presented the institution with a more formal framework to address equity in its delivery of services. The leadership began to develop efforts along each particular pillar of quality, and Dr. Jim Walton emerged as natural champion for the pillar of equity given his longstanding commitment to the underserved. Dr. Walton had become a fixture in the community as a physician dedicated to the care of those with limited access or ability to seek care in formal settings – particularly in the design and oversight of a home visiting program.

### Tipping Point

As Baylor began to explore the ways in which it could both identify and address issues related to equity, two factors came together to create a natural tipping point for action and leadership in this area.

#### **1. Chief Health Equity Officer and The Office of Health Equity**

To both solidify its efforts in equity, as well as create a formal organizational home for this work, Baylor named Dr. Walton their Chief Health Equity Officer, a Vice-President level position. Along with this new appointment came the directorship of a new Office of Health Equity in 2006. This office was charged to:

- Identify opportunities where Baylor could improve in the area of equity.
- Reduce variations due to sociodemographic characteristics that may be seen in the areas of health access, health care delivery, and health outcomes. These were termed the "equity dimensions" and together formed the equity triangle.

It is important to note that the Office of Health Equity did not only focus on racial and ethnic disparities, but instead looked much more broadly at issues including disparities by payor status, socioeconomic status, and gender, among others – thus following the true definition of equity as defined in the *Chasm* report.

## **2. The South Dallas Initiative**

Efforts to develop a health initiative in South Dallas received a major boost when a Board member, who grew up in the medically underserved area of South Dallas, helped secure \$15 million to target diabetes in this predominately African-American community. Although in the planning phase, these funds will allow for a major partnership between Baylor and the city of Dallas to develop a health care center with primary care services to this underserved community.

The creation of the of Chief Health Equity Officer position and Office of Health Equity, combined with a major financial commitment to develop a significant equity initiative in the community, formed a tipping point which allowed equity to solidify its already present roots at Baylor.

### **Mitigating Factors and Barriers**

Baylor has faced several barriers in its newly energized journey towards equity, ranging from the practical to the political.

- *Achieving Broad Acceptance:* As is the case in many institutions, although the Board and leadership are strong supporters of this effort, a critical task that remains is achieving buy-in among other leaders within the organization. This is an ongoing struggle that is strategically managed with the intent of developing supporters for this effort. Baylor has handled this by being proactive in engaging a diverse set of leaders, keeping them abreast of progress (without any surprises), and continuing to make the business case for equity.
- *Appropriate Messaging:* The measurement of equity always poses the risk of publicly disclosing areas of deficiency in the care provided by an institution. As such, this needs to be managed so as to not undercut support—both internal, as well as in the community.
- *Defining a Disparity:* A debate has emerged about what constitutes a disparity. Is it a 5% or 10% variation between groups? More? Less? This remains a challenge for measurement and reporting. Baylor continues to try to sort this out.
- *Identifying the Right Measures:* In addition to the stratification of existing measures, are there additional measures which can be sensitive markers of equity? As the portfolio of measurement expands, this question remains a barrier to progress and is currently being debated internally.

### **Sustaining Elements**

The Office of Health Equity began by focusing on two areas: (1) measurement along the equity dimension of access and (2) health equity reporting. In terms of measurement along the equity dimension, the goal was to identify opportunities to improve access to preventive and primary care services in the community, particularly for underserved patients within their catchment area—among which racial/ethnic minorities were over-represented. Beyond the moral imperative of this initiative, the significant business case began to emerge for decreasing unnecessary emergency room visits, avoidable hospitalizations, cost, and utilization by patients with multiple chronic conditions who may be either under- or uninsured. Several important initiatives were developed such as:

- Increasing the number of primary care providers in community and alternative settings (including faith-based settings),
- Community care coordination (through the use of teams of doctors, nurses, social workers, and community health workers),
- Developing medical homes, and
- Continuing home visits to patients who are either disabled or who have chronic conditions and most heavily utilize health services. Initial analyses and financial models have shown this to be a cost-effective approach—and one that both improves equity and efficiency.

Next, the Office focused its sights on equity in health care delivery. The central target here was health equity reporting, which included stratification of the National Hospital Quality Measures, ambulatory care measures (i.e. mammography screening), and other care process measures by various sociodemographic characteristics. The first among these targets was surgical infection prophylaxis. Initial analyses showed variations in surgical infection prevention measures, particularly by payor status where statistically significant differences were identified between commercially-insured and self-pay (i.e. uninsured) patients. The Office of Health Equity worked with high and low-performing hospital facilities within BHCS to identify root causes of the observed differences and best practices that could be implemented to improve equity in SIP performance across the system. Again, in addition to the importance of this measure in terms of quality of care, there was also a business case for improvement. Efforts to standardize surgical infection prophylaxis and assure equity would in turn prevent unnecessary readmission or prolonged length of stay due to preventable, post-surgical infections. Plans exist to expand the set of equity measures Baylor will be routinely reviewing as part of its standard quality monitoring and reporting portfolio. Particular interest is emerging in the area of chronic disease, especially congestive heart failure, given the impending changes regarding payment for readmissions within 30 days of discharge currently being discussed at the Centers for Medicare and Medicaid Services.

Efforts are just beginning on the equity dimension of health outcomes—to assure that there are not variations by sociodemographic characteristics. The aforementioned successes in access and service delivery have served to sustain Baylor’s efforts in equity, as well as convert skeptics among those who doubted the importance and financial viability of this work. Measurement and intervention have been the focal points of their approach to date.

## **Successes**

Board support, leadership support, and the emergence of a champion have all contributed to the successes of Baylor to date. The view that high quality, equitable care is not only good medicine but good business further fortifies these efforts. Whereas measurement has been the foundation for this work, this phase hasn’t been prolonged and interventions have been quick to follow. Equity, and disparities, have been defined broadly to not only include race/ethnicity as variables, but also socioeconomic status and payor status, to name a few. For Baylor’s catchment area, minorities are over-represented among the underserved, so efforts that focus on class disparities have essentially encompassed racial/ethnic disparities as well.

To date, successes in the access dimension have included:

- *Community Health Services Corps*: Doctors and nurses staff charitable clinics in the community focusing on the uninsured and underserved. The overarching goal of this program is to increase access to primary care and in turn decrease reliance on hospital care. To date, research has shown that emergency department use among individuals who use these services (compared to a control group) have similar Emergency Department use, but the average cost of the visit is significantly less; in addition, their hospital admission rate is significantly lower and the average length of stay is almost a day less.
- *Project Access Dallas*: This project encourages private physicians to accept 4 to 5 indigent patients into their patient panel, and is accompanied by specialist access and pharmacy benefits. Analyses of this program at participating hospitals throughout Dallas County have consistently shown decreases in emergency department visits, inpatient admissions, and related hospital costs when comparing patient utilization one year pre- and one year post-enrollment in Project Access Dallas.
- *Community Care Coordination*: Several programs focused on linking patients with services that might include those related to housing, transportation, health education.

The Vulnerable Patient Network Program focuses on patients with congestive heart failure who are frequent emergency department users and provides home visits to patients who have had neurological trauma. Research has shown a decrease in emergency department visits per patient, a decrease in average admission per patient, and a slight increase in average out-patient visits per patient.

On the health care services dimension:

- Development of the BHCS Health Equity Performance Analysis: As described above Baylor's Office of Health Equity successfully developed a methodology for stratifying quality performance indicators by patients' demographic characteristics in order to identify and track the presence of significant differences between patient groups. While the quantitative definition of "disparity" continues to be a topic of debate, the Health Equity Performance Analysis methodology has gained system-wide acceptance and serves as the primary tool for direction of Baylor's equity improvement efforts.

## Seattle Children's Hospital Case Study

In 2004, Seattle Children's Hospital recognized the importance of addressing health care disparities within their institution. Faced with a rapidly changing demographic patient population, they were challenged in new ways to meet their organizational mission to "... prevent, treat, and eliminate pediatric disease ...". Seattle Children's journey to address health care disparities and improve the quality of care of all their patients led them down the "road" of patient safety. Their decision to frame addressing health care disparities as a safety issue for their patient population became the key driver of this organizational transformation.

Consistently ranked as one of the best children's hospitals in the country by *U.S. News & World Report*, Seattle Children's serves as the pediatric and adolescent academic medical referral center for the largest landmass of any children's hospital in the country (Washington, Alaska, Montana and Idaho). For more than 100 years, Seattle Children's has been delivering superior patient care and advancing new treatments through pediatric research. Seattle Children's is a 250-bed hospital and serves as the primary teaching, clinical and research site for the Department of Pediatrics at the University of Washington School of Medicine. Beginning in 2005, the hospital increased the rigor in which it collected data on race/ethnicity and language spoken. These efforts demonstrated the rich diversity of the patients and families served and disparities among them. It was this recognition that mobilized a group of internal champions to push initiatives that address the elimination of disparities.

### The Catalyst

The initial push for the hospital to address the changing patient population was spearheaded by a Diversity Committee that was led by Pat Hagan, the Chief Operating Officer, and Susan Heath, the Nurse Executive. In these early years, the justification for the need of the Diversity Committee was primarily based on the moral imperative of addressing the needs of diverse communities. The initial work of the committee was focused on gathering data from minority patients about their perceptions of the hospital with the goal of exploring whether the data on perceptions could have some impact/effect on the way that care was being provided. Hospital leadership was also particularly interested in the hospital perception by the growing immigrant population.

### Tipping Point

There were two critical events that helped to advance the disparities agenda for Seattle Children's Hospital:

- The early work of the Diversity Committee ultimately led to the formulation and adoption of a Diversity Strategic Plan by the Hospital Board of Trustees.
- The quest of the hospital leadership to better understand the perceptions of minority patients of the hospital led to the creation of a more rigorous quantitative study to address the research question of, "Does having a limited English proficiency impact the rate of errors observed in the hospital?" Led by their pediatric research fellow, Adam Cohen, the study focused on families with LEP and compared them to families that did not have LEP. The study found that for all participants, except for Spanish speakers, error rates were the same. There was, however, a clear disparity in error rates between those that spoke only Spanish and those that did not. This study was the key driver to begin the organizational shift to make health care disparities a patient safety focus, and equity integral to effective clinical care.

### Mitigating Factors and Barriers

Systems typically are resistant to change and Seattle Children's faced several challenges in trying to advance the disparities agenda. There were several factors that played a critical role in making the case to address disparities and advancing the importance of improving quality of care as a patient safety issue. The key factors were:

- *Achieving Broad Acceptance*: There was a degree of cynicism from hospital staff (clinical and non-clinical) about the commitment of leadership to address issues of diversity and disparities. Many hospital employees saw these efforts as just the "flavor of the day".

- *Appropriate Messaging:* By making the link between patient safety and health disparities – driven by data – it made the issue of disparities apparent and its impact on patient safety very real.
- *Leadership:* There were key individuals to drive issues (champions): Pat Hagan, Susan Heath, Ben Danielson, Deb Gumbardo, Beth Ebel, and Sarah Rafton. However, once the hospital leadership committed to fully addressing health disparities, the challenge was finding the suitable individual(s) to formally lead this work. It took over 1.5 years for hospital leadership to fill a key diversity leadership position to drive this work.
- *Commitment:* A solid commitment from the Board of Directors (BOD): The BOD has become data driven, particularly the Board Chair.
- *Diversity:* There was an ongoing push to increase the diversity of clinical staff as a way to continue to build momentum for their disparity efforts, however, the institution has had difficulty attracting diverse residents, fellows and faculty staff to the hospital.
- *Research:* Although their research clearly delineated the association of language barriers and error rates for specific patient population, there still needed to be further exploration of root causes why other disparities existed. Many other unanswered questions existed about other population’s perceptions of the hospital.

### **Sustaining Elements**

For organizational change to be institutionalized the change needs to be sustainable. For Seattle Children’s Hospital, there are three critical elements that continue to drive this work:

- Leadership – Key leadership roles are now major advocates:
  - Hospital President and COO, Pat Hagan is a big supporter
  - CMO – David Fisher, was recruited because of his passion and interest in this area
- Institutionalization of the work – Hospital leadership created a “Center for Diversity and Health Equity” and committed staff and financial resources
- Health Services Redesign:
  - Improved structure and delivery for interpreter services, and protocols instituted
- Strong and committed decision support department (Knowledge Management Dept) with direct access to an analyst with public health training /background (with a population health focus)

### **Successes**

Board support, leadership support, and the emergence of a champion have all contributed to the successes of Seattle Children’s Hospital. The driving force for change to address health care disparities in their health system was the universal understanding that high quality, equitable care is critical for patient safety.

To date, successes have included:

- Diversity Committee ultimately led to the formulation and adoption of a Diversity Strategic Plan by the Hospital Board of Trustees.
- Creation of the “Center for Diversity and Health Equity” and recently appointed Douglass L. Jackson as Chief of the Center for Diversity and Health Equity. Prior to joining Children’s, Jackson was the Associate Dean of the Office of Educational Partnerships and Diversity at the University of Washington (UW) School of Dentistry. Jackson is also director of the Robert Wood Johnson Foundation funded grant “Pipeline Profession and Practice,” and is co-director of the Robert Wood Johnson Foundation funded grant “Summer Medical/Dental Education Program” in partnership with the UW School of Medicine.
- State-of-the-art translational services that have been fully integrated into inpatient as well as outpatient care for the health care system.

## Duke University Hospital Case Study

In 2003, Duke University Health System embarked on a process of organizational transformation to address the issue of diversity and disparities based on the critical business case that equitable quality of care improved the financial viability of their institutions. As the only major source of inpatient care and the majority of outpatient care in the county, Duke University Health System, which includes a large, previously public community hospital, Durham Regional Hospital, provides healthcare for a large minority population. Providing equal access and health care by identifying and eliminating disparity in treatment and outcomes for this population became a priority for the leadership from an ethical perspective as well as a business perspective.

Duke University Hospital (DUH) is a 946-bed not-for-profit hospital and the flagship hospital for the Duke University Health System, an academic medical center serving Durham, North Carolina. DUH is one of the primary providers of care for Durham County where almost half of the residents are either African American (40%) or Latino (8%).

### The Catalyst

***“We are the only emergency rooms in town. So, patients that are underserved that wind up in emergency rooms with threatening illnesses are our responsibility ... If we’re not out there, identifying and treating hypertension in the uninsured Latino patient, we’re going to be taking care of him after he has a stroke”***

– William Fulkerson, MD, CEO of Duke University Hospital and Vice President for acute care division of Duke University Health System

In 2003, it was determined that racially and culturally based rifts between some staff members were compromising productivity and increasing turnover. DUH embarked on a process of organizational transformation, prompting a system-wide diversity training initiative, including self assessment, cultural competency training, and eventually, disparities initiatives. Addressing issues of diversity and culturally competent care delivery also played a significant role in Duke’s success in achieving Magnet status by the American Nurses Credentialing Center.

### Tipping Point

In 2003, William Fulkerson asked Kerry Watson to take the lead on strengthening the diversity initiative at Duke Health System.

In October, 2005, Duke received funding from the Robert Wood Johnson Foundation to participate as one of 10 centers around the country in the *Expecting Success: Excellence in Cardiac Care* program to address racial/ethnic disparities in the management of cardiovascular disease. *Expecting Success* helped Duke develop a platform internally for identifying, understanding and addressing disparities. This initiative extended Duke’s ongoing diversity and cultural competency efforts into directly measuring and addressing racial/ethnic disparities in care. For DUH that meant improving the collecting and tracking of patient data by race, ethnicity and spoken language, and using accurate patient demographic data to identify possible areas of disparities in care.

### Mitigating Factors and Barriers

Achieving Broad Acceptance – Achieving buy-in from physicians was critically important to developing an organizational-wide transformation process. Feedback from a group of physician leaders indicated the need for published research data to make the case.

***“From my perspective, ... the biggest challenge is to get this in front of our physicians and to get them interested and engaged, not only in the health system’s diversity issues, but also into the disparity issues.”***

– William Fulkerson, MD, CEO of Duke University Hospital and Vice President for acute care division of Duke University Health System

### **Sustaining Elements**

Early on Duke brought together a diverse group of leaders from different parts of the health care team to brainstorm and develop strategies for addressing diversity, cultural competency and disparities. This group has provided ongoing direction and has helped to sustain the effort.

### **Leadership**

William Fulkerson, MD, MBA, is the CEO and the executive sponsor of Duke’s participation in the *Expecting Success* program. In 2003, William Fulkerson asked Kerry Watson to lead the diversity initiative at Duke Health System.

Eric Velazquez, MD, is a cardiologist and Program Director of Duke’s *Expecting Success* program. He has led the charge for Duke to systematically collect patient-reported race/ethnicity data and use this to stratify quality measures for cardiovascular disease and identify disparities in readmission rates for African Americans and Latinos. Presenting real data on disparities has helped to achieve buy-in for cultural competency initiatives among physicians.

Kerry Watson is the CEO of Durham Regional Hospital and was previously the Senior Associate Operating Officer for Duke Hospital. He has led the effort to implement diversity training for managers, including a mandatory eight hour module for all leadership and a four hour module for all staff.

### **Successes**

By developing and monitoring balanced score cards for Duke Heart Center’s Center for Excellence and DUH, they were able to identify that African Americans and Latinos were more likely to be readmitted after treatment and discharge for heart failure. DUH developed several strategies to ensure proper discharge process, including:

- Improving technology to schedule follow-up appointments.
- Implementing culturally sensitive patient education materials.
- Evaluating heart failure patients for appropriateness for patient disease management.
- Ensure discharge medications are appropriately available at locations where patients access their pharmacy.
- Improving patients’ access to follow-up cardiac care by providing advanced consultative services in the community.

| ORGANIZATION  | WHO THEY ARE   | HOW ARE THEY ADDRESSING DISPARITIES?   | CHALLENGES   | SUCCESSSES  | KEY INGREDIENTS   |
|---|--|--|--|---|---|
| <p><b>1.</b><br/>Baylor Health Care System<br/><br/>Dallas, TX</p>      | <p>A non-profit, faith-based health care system providing health care, educational, research, and community services throughout North Texas</p>    | <p>Stratify data by race/ethnicity, payer proxy, and gender</p> <p>Create the Office of Health Equity to address disparities in health access, health care delivery, and health outcomes</p> <p>Business case: address disparities by identifying inefficiencies and waste</p>                       | <p>Embed disparity issues in the quality and patient-centered frameworks</p> <p>Ensure accurate data collection</p> <p>Measure and report data: identify disparities within the data and develop appropriate quality improvement programs</p>  | <p>Within Office of Health Equity improved access (charitable clinics, link high risk patients to community health worker), delivery (reporting and monitoring disparities), and outcomes (diabetes coaching program)</p> <p>Restructure registration system for collecting patient information</p>   | <p>Following the IOM's <i>Crossing the Quality Chasm</i>, a system-wide cultural transformation to adopt the six pillars</p> <p>Getting senior level buy-in and proactive leadership that understands how inequity impacts overall quality</p> <p>Develop the business case to address disparities</p>  |
| <p><b>2.</b><br/>Contra Costa Health Services<br/><br/>Martinez, CA</p> | <p>A comprehensive and integrated county health system that provides health care services, community improvement, and environmental protection</p> | <p>Developing a system-wide goal to reduce health disparities via the Reducing Health Disparities (RHD) Framework: Key components include: enhancement and development of organizational supports, linguistic access, staff education and development, and community engagement and partnerships</p> | <p>Creating change across the entire organization to address disparities</p> <p>Establishing understanding of RHD framework, and how core principles are critical to providing culturally and linguistically appropriate services</p> <p>Influencing key CCHS decision makers to integrate RHD principles into their existing efforts</p> <p>Providing resources to assist in RHD efforts</p> <p>Establishing benchmarks to measure the success of RHD efforts</p> | <p>Creating the Reducing Health Disparities 5-year plan</p> <p>Creating the Reducing Health Disparities Unit</p> <p>Partnering in a multi-county live Health Care Interpreter Network</p> <p>Equipping Contra Costa Regional Medical Center and 8 Health Centers with interpretation equipment &amp; training for staff</p> <p>Launch of training for all CCHS managers and supervisors to promote Service Excellence standards</p> <p>Creation and distribution of Community Health Indicators highlighting population health and disparities</p> <p>Promulgation of formal policies for Linguistic Access, Service Excellence and Reducing Health Disparities</p> <p>Monthly highlights of RHD efforts in employee newsletter</p> | <p>Identifying key senior-level champions</p> <p>Marrying RHD efforts with division interests/needs</p> <p>Committing resources</p> <p>Identifying disparities through accurate data</p> <p>Developing RHD measures of success and benchmarks</p> <p>Developing organizational supports for data collection, linguistic access, end user and staff feedback mechanisms</p> <p>End user engagement</p> <p>Developing local partnerships</p> <p>Implementing cultural competency and communication training for staff</p> <p>Developing a shared vocabulary and understanding</p> |

| ORGANIZATION   | WHO THEY ARE  | HOW ARE THEY ADDRESSING DISPARITIES?  | CHALLENGES  | SUCCESES   |   |
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| <p><b>3.</b><br/>Cooper Green Mercy Hospital<br/><br/>Birmingham, AL</p>           | <p>Only county hospital in metro area providing inpatient and outpatient services, without regard for a patient's ability to pay</p>  | <p>Diversifying leadership<br/>Developing and implementing community-based disparities initiatives (e.g. African-American Health Initiative)<br/>Implementing programs to train their own community health workers<br/>Monitor outcomes through their IT systems</p>                          | <p>Addressing and embedding disparities in a quality framework<br/>Addressing disparities in communities where there are no primary care providers<br/>Securing funding for interpreter services<br/>Addressing social factors that influence health (e.g. transportation, education)</p> | <p>Development of partnerships:<br/>Interpreter services via collaboration with university and a mechanism to train community health workers via Minority Health Program at University of Alabama (UAB)<br/>Developing IT system to measure and report disparities<br/>Having specialty care facilities in communities lacking services<br/>Creation of Wellness Centers (online health and prevention resources for patients)</p> | <p>Developing partnerships with UAB, other hospitals, and local faith-based groups<br/>Educating leadership about patients' diverse backgrounds and experiences<br/>Identifying key senior-level champion<br/>Getting staff buy-in<br/>Explanation of business case to leadership and staff (e.g. makes daily jobs of staff easier)</p> |
| <p><b>4.</b><br/>Duke University Health System<br/><br/>Durham, North Carolina</p> | <p>An academic health care system comprising of three main hospitals including the Duke University Medical Center, and several primary and specialty care clinics throughout North Carolina</p> | <p>Participating as one of the hospitals in RWJF's Expecting Success: Excellence in Cardiac Care Program<br/>Stratifying performance scorecards by race and ethnicity<br/>Implementing extensive organization-wide training on culturally competent care delivery and workplace diversity</p> | <p>Getting physician buy-in<br/>Collecting of reliable and accurate patient information<br/>Addressing disparities in a large complex comprehensive healthcare delivery system with multiple locations</p>  | <p>Re-structuring registration system for collecting patient information:<br/>shift to patient self-identification<br/>Comprehensive education and training program for all staff addressing workplace diversity and conflict<br/>Interactive Grand Rounds professional development /cultural competence care delivery for clinical staff and faculty</p>  | <p>Identifying senior- and clinician-level champions<br/>Identifying disparities through strong and accurate data<br/>Integrate disparities efforts with existing performance improvement infrastructure</p>  |

| ORGANIZATION   | WHO THEY ARE   | HOW ARE THEY ADDRESSING DISPARITIES?  | CHALLENGES   | SUCCESSES   | KEY INGREDIENTS   |
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| <p><b>5.</b><br/>Henry Ford Health System<br/><br/>Detroit, MI</p>   | <p>Nonprofit integrated health system which includes six hospitals, medical centers, health plan, community services, and community partnerships</p>                       | <p>Developing and implementing wellness efforts in minority communities<br/><br/>Support from senior leadership to do research that identifies disparities and gaps in care</p>   | <p>Integrating disparity efforts into the entire system<br/><br/>Proving to leadership that disparities exist</p>  | <p>Establishing the Institute on Multicultural Health: focus on clinical guidance and community outreach<br/><br/>Establishing the Health Disparities Research Collaborative to identify opportunities for research and collaboration</p> | <p>Getting key senior-level buy-in and champions<br/><br/>Having a critical mass of influential investigators interested in disparities<br/><br/>Identifying disparities through strong and accurate data<br/><br/>Developing partnerships with other organizations</p> |
| <p><b>6.</b><br/>Los Angeles County and U of Southern California Healthcare Network<br/><br/>Los Angeles, CA</p> | <p>Partnered with the Keck School of Medicine of USC<br/><br/>One of the largest teaching and acute care hospitals in the country servicing central Los Angeles County</p> | <p>Focusing on improving communication with emphasis on cultural and linguistic issues<br/><br/>Collecting data on race and ethnicity, country of origin, and language<br/><br/>Training bilingual staff and develop collaborations</p> | <p>Embedding disparities issues in the quality and patient safety frameworks<br/><br/>Securing leadership buy-in<br/><br/>Educating leadership about patients' diverse backgrounds and experiences<br/><br/>Demonstrating that disparities issues are addressable and solvable</p> | <p>Developing and implementing rigorous data collection methods</p>   | <p>Identifying disparities through rigorous data collection methods<br/><br/>Getting senior-level buy-in<br/><br/>Developing Collaborations</p>   |

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|---|---|---|--|--|--|
| <p><b>7.</b><br/>Massachusetts General Hospital</p> <p>Boston, MA</p> | <p>A private, non-profit, academic health center providing health care, education, research, and community services throughout the greater Boston area</p>  | <p>Collecting patient race/ethnicity data</p> <p>Stratifying quality measures by race/ethnicity</p> <p>Monitoring for disparities through routine release of a Disparities Dashboard for hospital leadership</p> <p>Developing interventions to address disparities in diabetes management and colon cancer screening</p> <p>Creating several efforts to raise awareness and educate hospital faculty and staff about disparities</p> | <p>Developing additional measures to identify disparities</p> <p>Better monitoring of patient experience by race/ethnicity</p> | <p>Developing Disparities Committee</p> <p>Developing Disparities Dashboard</p> <p>Reporting equity measures publicly available on web</p> <p>Developing and implementing Chelsea Diabetes Management Program</p> <p>Developing and implementing Colorectal Cancer Screening Navigator Program</p> | <p>Following the IOM's <i>Crossing the Quality Chasm</i></p> <p>Having senior level buy-in and proactive leadership that understands how disparities impacts overall quality</p> <p>Using an action-oriented approach</p> <p>Seeding money for interventions</p> <p>Identifying and having champions, expertise, and cross-institutional support</p> |
| <p><b>8.</b><br/>Montefiore Medical Center</p> <p>Bronx, NY</p>       | <p>An integrated healthcare delivery system of hospitals, primary care sites, home health, post-acute, and community programs throughout the Bronx</p> <p>The university hospital for the Albert Einstein College of Medicine</p> | <p>Participating as one of the hospitals in RWJF's Expecting Success: Excellence in Cardiac Care Program</p> <p>Implementing standardized training and IT mechanisms for collecting patient demographics</p> <p>Developing and implementing community-based programs in an ethnically and culturally diverse community</p> <p>Focusing on conditions prevalent in the community, such as diabetes and cardiovascular disease</p>      | <p>Extending and integrating quality improvement efforts into post-acute and community settings</p>                            | <p>Implementing extensive changes to registration systems to collect patient race, ethnicity, and language information</p> <p>Improving cardiovascular care</p> <p>Physician leadership and engagement</p> <p>Interdisciplinary teamwork</p>   | <p>Senior Executive stewardship</p> <p>Collecting input from "front-line" staff at an early stage</p> <p>Involving a broad number of disciplines in the implementation design process</p> <p>Embedding a cognizance of disparities into quality and service improvement efforts</p>  |

| ORGANIZATION  | WHO THEY ARE  | HOW ARE THEY ADDRESSING DISPARITIES?  | CHALLENGES  | SUCCESSSES   | KEY INGREDIENTS   |
|---|---|---|---|--|---|
| <p><b>9.</b><br/>Seattle Children's Hospital</p> <p>Seattle, WA</p>               | <p>A leading children's academic hospital that offers advanced in-patient, surgical, emergency, and, specialty care and child advocacy programs</p>                     | <p>Evaluate hospital goals, family satisfaction, and clinical outcomes by race/ethnicity and language</p> <p>Creation of The Center for Diversity and Health Equity</p> <p>Creation of Patient and Family Relations Program</p> <p>Participant in RWJF's Speaking Together: National Language Services Network</p>  | <p>Getting physician- and staff-level buy-in: shifting provider behavior to engage in active communication with patients and family</p> <p>Identify key leaders in disparities to spearhead efforts at the hospital</p> <p>Diversify leadership, faculty, and staff</p> | <p>Center for Diversity and Health Equity has increased diversity, improved linguistic services, and mandated cultural competency training</p> <p>Extensive interpreter services</p> <p>Strategic Plan for Diversity approved by board and institutionalized a long-term commitment to diversity</p>   | <p>Getting buy-in from key leadership champions</p> <p>Having the commitment from the Board of Directors</p> <p>Institutionalized Initiatives</p> <p>Identifying disparities through rigorous data collection methods</p> <p>Developing partnerships between data analysts and clinical champions</p> |
| <p><b>10.</b><br/>University of Mississippi Medical Center</p> <p>Jackson, MS</p> | <p>As the health sciences campus of the University of Mississippi, the Medical Center focuses on teaching, research, service, and leadership in the health sciences</p> | <p>Participating as one of the hospitals in RWJF's Expecting Success: Excellence in Cardiac Care program</p> <p>Participating in the AMA's Patient-Centered Communication Program</p> <p>Participating in Jackson Heart Study in collaboration with Jackson State Univ., Tougaloo College, and NIH</p> <p>Participating in the Delta Health Alliance: partnerships with universities to improve access and availability of care</p> | <p>Creating a continuity between educational and hospital-centered disparities initiatives</p>  | <p>Enhancing research resources at minority institutions, and increased opportunities for minority students in health sciences through the Jackson Heart Study, which is the largest investigation of cardiovascular disease (CVD) in African-Americans</p> <p>Continuation of the Patient-Centered Communication Program at the hospital</p> <p>Organization-wide priority and goal to increase underrepresented minorities at the medical school</p> | <p>Getting key senior-level buy-in and support</p> <p>Developing partnerships and collaborations such as the Mississippi Institute for the Improvement of Geographic Minority Health and Delta Health Alliance</p>  |