American Hospital Association®

INSTITUTE FOR DIVERSITY in Health Management
An affiliate of the American Hospital Association

Eliminating Disparities, Advancing Diversity to Achieve Health Equity

Prepared by:
Sharon C. Allen, MBA
Senior Executive Director of Operations
Institute for Diversity and Equity of Care
American Hospital Association

Date: August 11, 2016

SESSION OBJECTIVES

1. Learn about AHA's #123forEquity Pledge to Act to Eliminate Health Care Disparities
2. Understand the WHY for eliminating disparities and advancing diversity
3. Gain a better understanding of EOC Goals
4. Find out about the resources to help hospitals

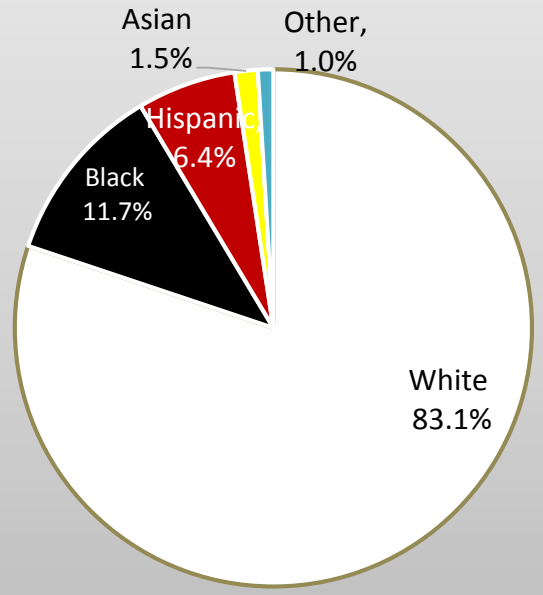
Working Definitions

- **Health disparities** can be defined as inequalities that exist when members of certain population groups do not benefit from the same health status as other groups.
- Evolving definition of **diversity** -- inclusive of race, ethnicity, language preference, disability status, gender identity, sexual orientation, veteran status, and socioeconomic factors.
- **Health equity** is the attainment of the highest level of health for all people.

Source: https://www.healthypeople.gov

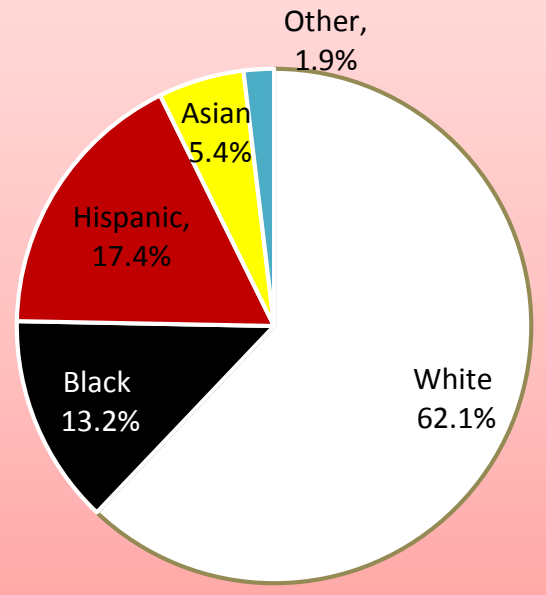
DIVERSITY IS A REALITY IN THE U.S.

1980 U.S. Population by Race/Ethnicity



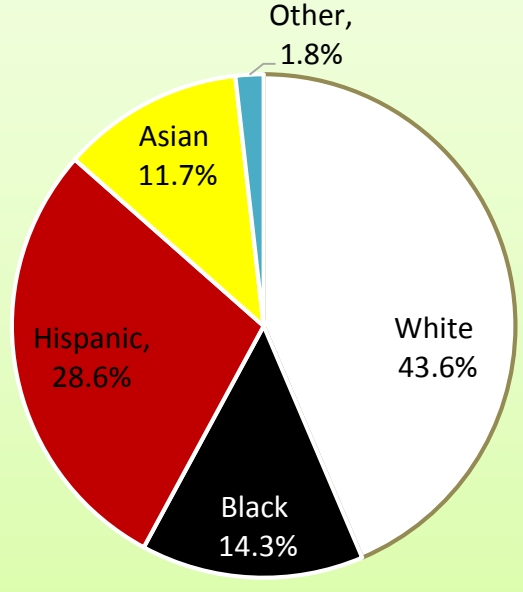
The way it used to be -- health care concentrated on homogeneous population.

2014 U.S. Population by Race/Ethnicity



Today's population much more diverse, the need for equity of care more important.

Projected 2060 U.S. Population by Race/Ethnicity



Majority of U.S. population comprised of people of color, equity of care is an essential.

The Challenge & Opportunity

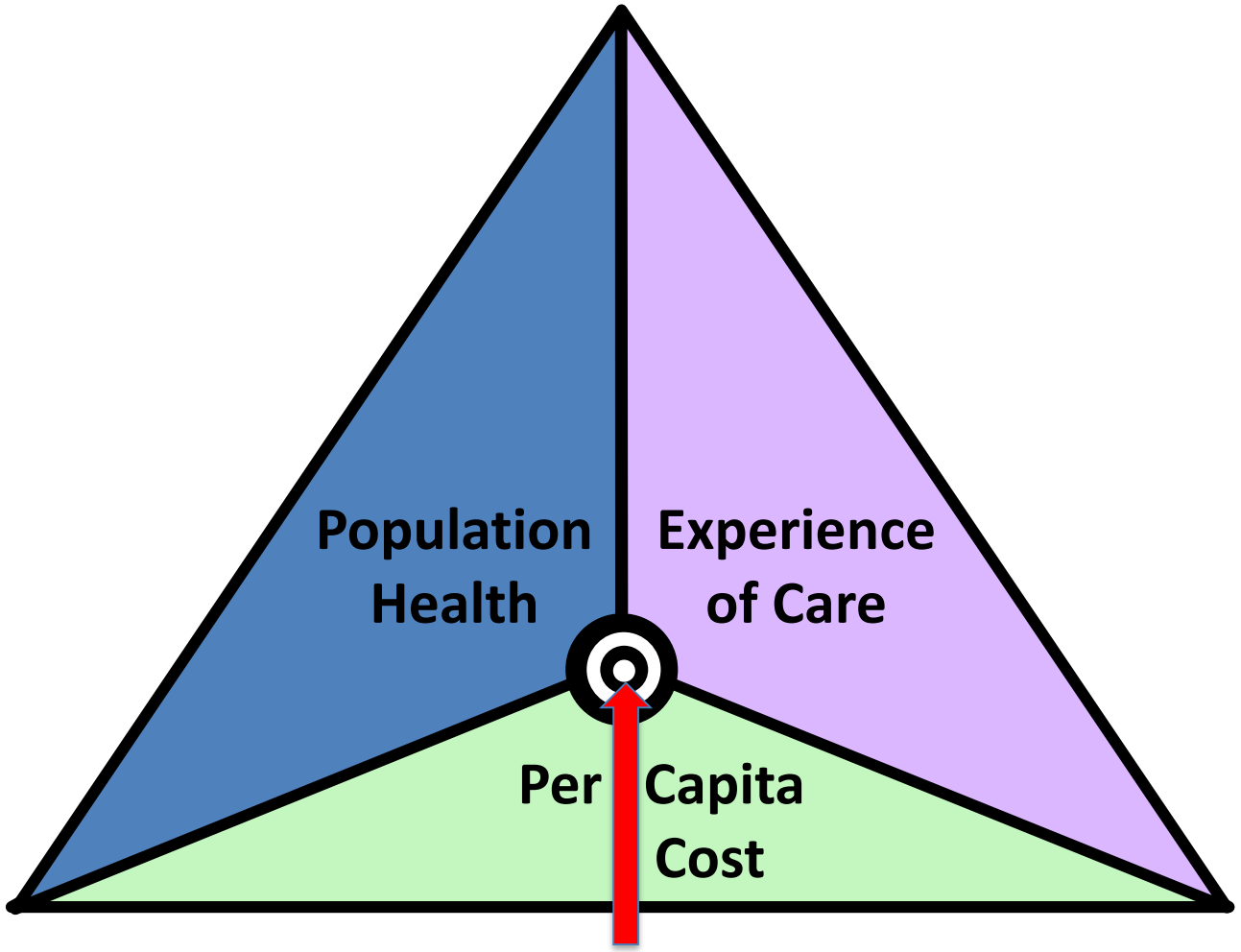
Differences in health status by racial and ethnic groups and low socioeconomic status, also known as “health disparities” or “health inequities,” remain disturbingly widespread in the United States.

Source: http://minorityhealth.hhs.gov

WHY ELIMINATE DISPARITIES, INCREASE DIVERSITY? THE AHA'S PERSPECTIVE

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

THE GOAL: THE TRIPLE AIM



Health equity is the target.

DIVERSITY AND DISPARITIES BENCHMARKING SURVEY

- Produced by Health Research and Educational Trust (HRET) and the Institute for Diversity (the Institute) – subsidiaries of the American Hospital Association (AHA)
- A national survey of hospitals to determine actions that hospitals are taking to reduce health care disparities and promote diversity in leadership and governance.
- Results offer a snapshot of some common strategies used to improve the quality of patient care regardless of race or ethnicity
- Administered in 2011, 2013 and 2015

National Call to Action Partners

American Hospital Association

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

CHA
Catholic Health Association of the United States

American College of Healthcare Executives
for leaders who care®

AMERICA'S ESSENTIAL HOSPITALS

BENCHMARKING SURVEY RESULTS AND PROJECTIONS

Milestones by Year	Collection and Use of REaL Data	Cultural Competency Training	Increasing Diversity
2011 (Baseline)	18%	81%	Governance 14% Leadership 11%
2013 (Progress Data)	19.4%	86.4%	Governance 14% Leadership 12%
2015 Goal (Progress Data)	41%	83%	Governance 14% Leadership 15%
2017 Goal	50%	95%	Governance 18% Leadership 15%
2020 Goal	75%	100%	Governance 20% Leadership 17%

AHA Goals

NATIONAL CALL TO ACTION PARTNERS – Started in 2011

As determined by the partners:

- Some progress reported from benchmarking surveys, more work needs to be done
- Partners wanted to **move the needle** to accelerate progress
- AHA created a new national strategy to accelerate progress
- The #123ForEquity Pledge Campaign was launched

National Call to Action Partners

American Hospital Association

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

CHA
Catholic Health Association of the United States

American College of Healthcare Executives
for leaders who care®

AMERICA'S ESSENTIAL HOSPITALS

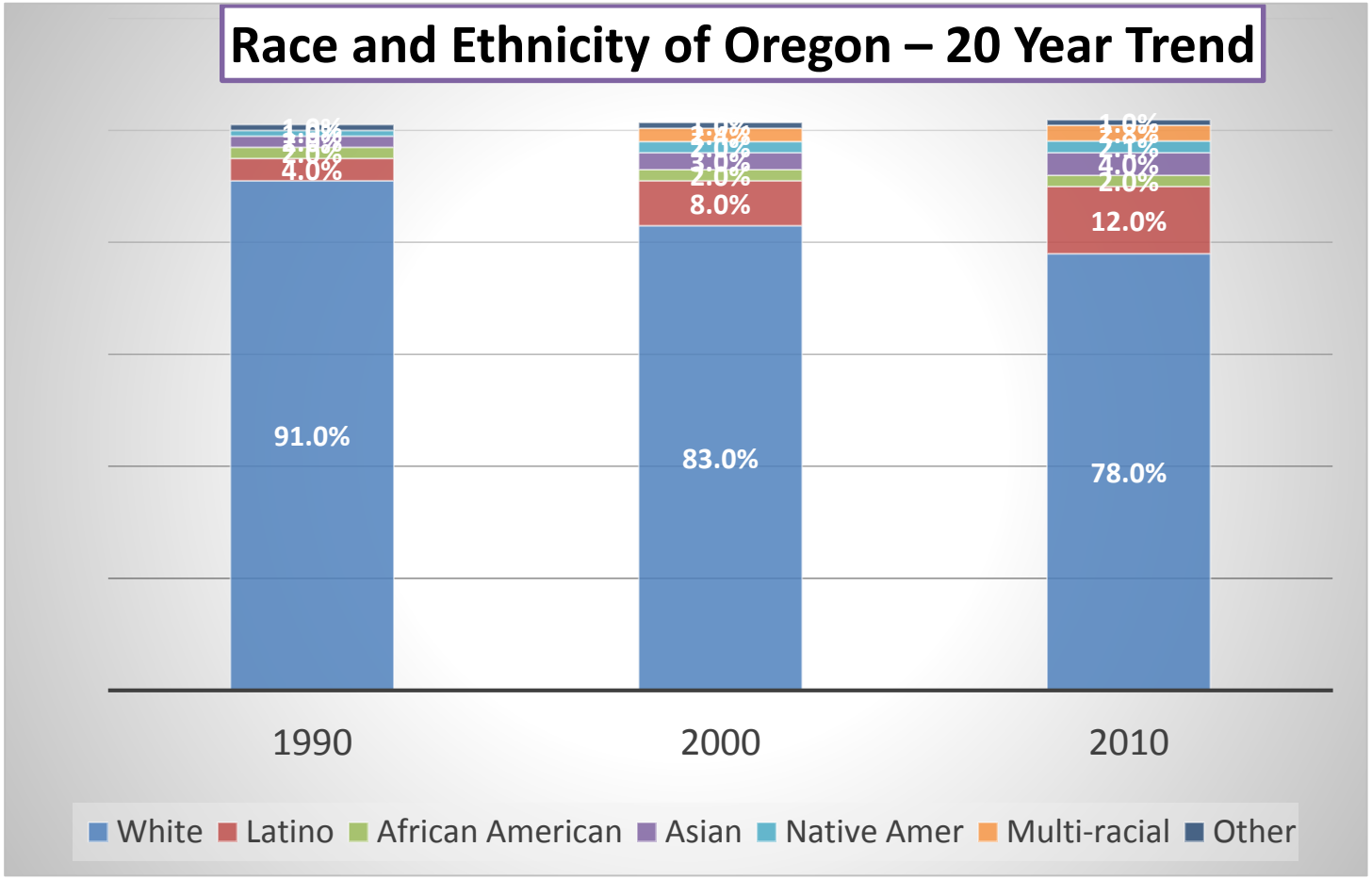
NATIONAL CALL TO ACTION - #123FOREQUITY PLEDGE

Equity of Care

EOC Pledge Goals

1. Increase collection and use of race, ethnicity and language (REaL) preference data – expanded to include other demographic measures (age, gender preference, income, religion, disabilitis, veteran status, LGBTQ, etc.)
2. Increase cultural competency training
3. Increase diversity in leadership and governance

#123forEquity – GOAL 1



Source: http://www.oregonlive.com/pacific-northwest-news/index.ssf/2011/02/census_2010_more_on_oregons_racial_and_ethnic_diversity.html

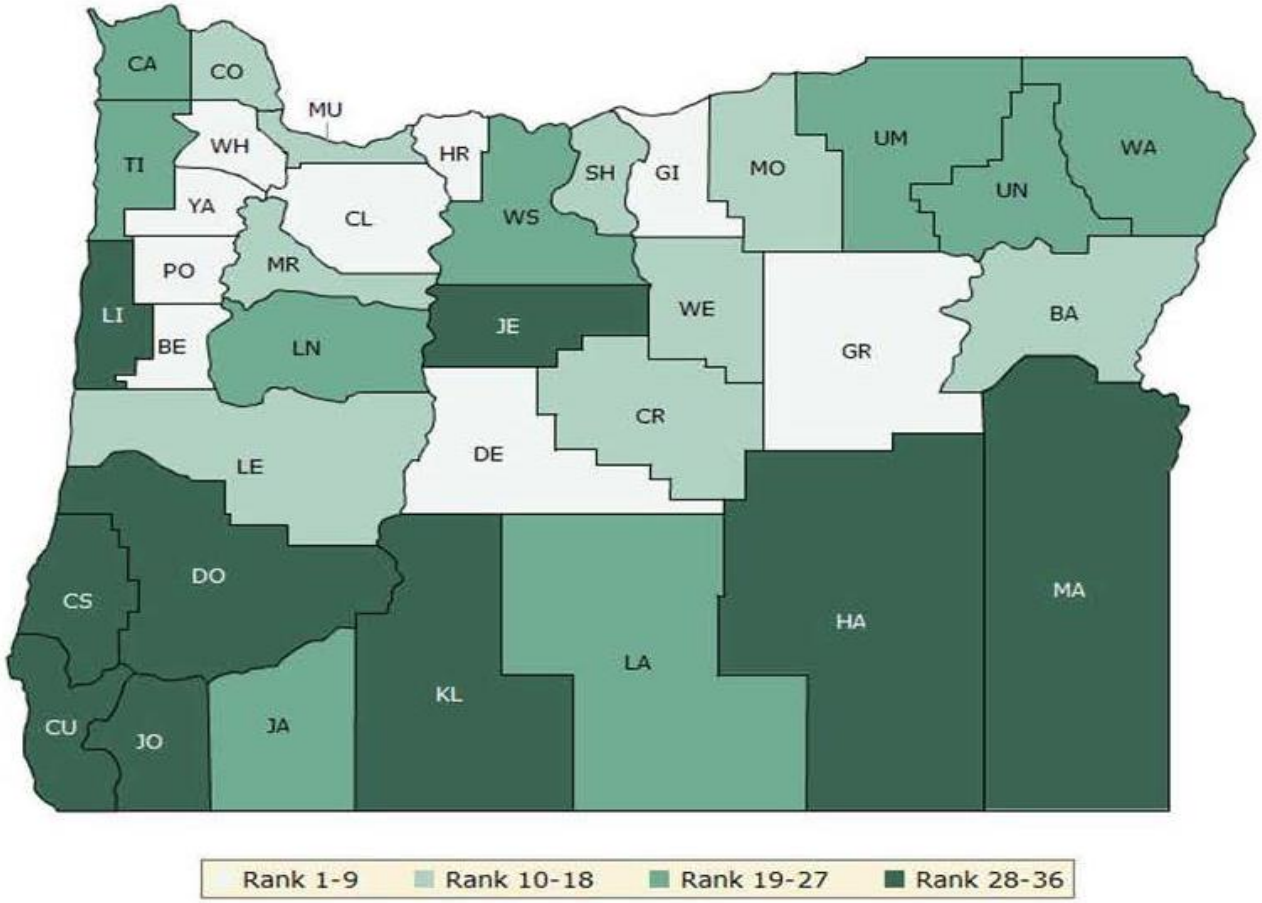
Increase collection and use of race, ethnicity and language (REaL) preference data and other demographic measures:

Socio-economic status, LGBTQ, Disability, Veteran status

- Could focus on other demographic measures…
- To start, assess population demographics and health factors
- Identify other demographic measures relative to population
- Select the measure, set the goal, work to achieve the goal

How Healthy is Oregon?

Health Outcomes: Communities Ranked by County

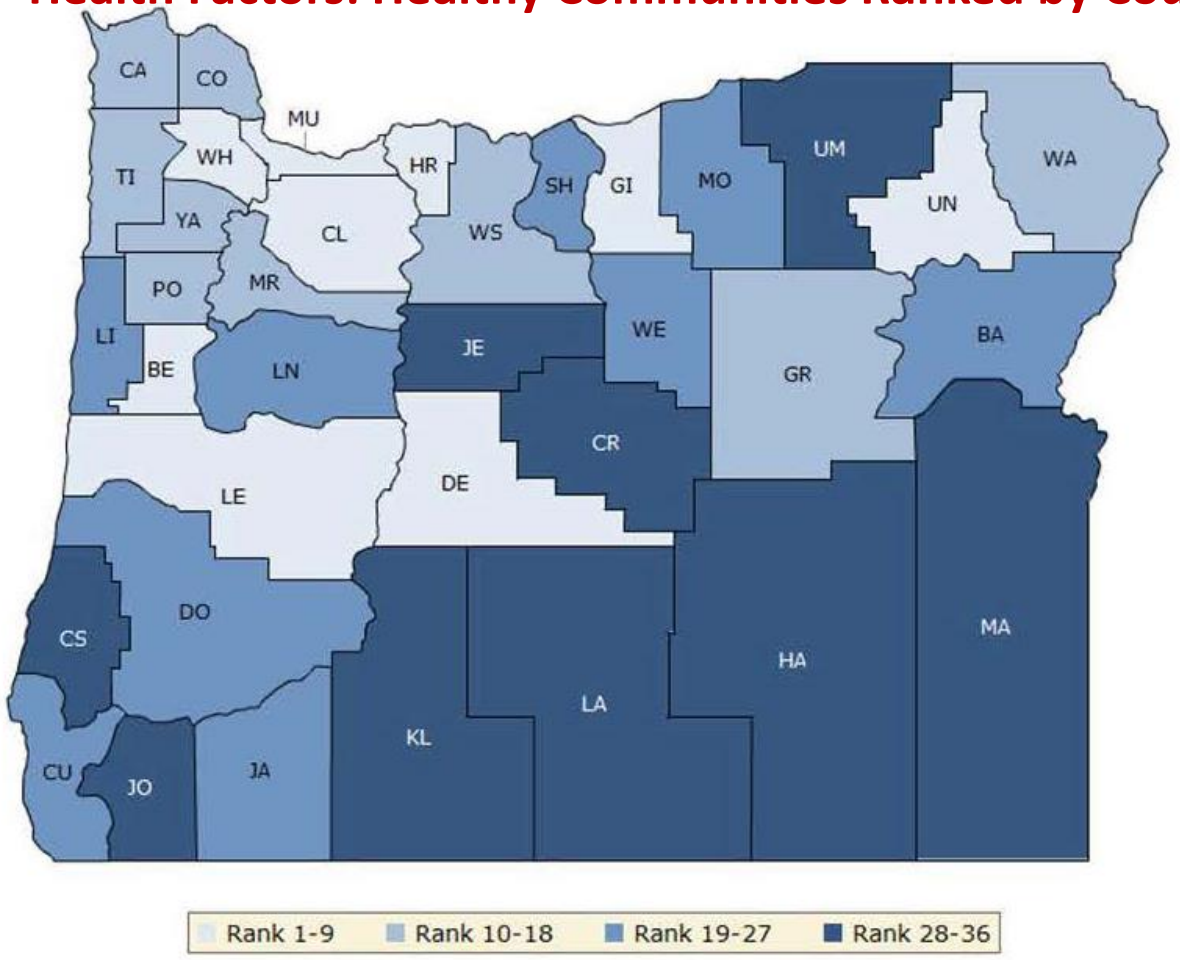


		Health Outcomes	
FIPS	County	Z-Score	Rank
41067	Washington	-1.66	1
41005	Clackamas	-1.30	2
41003	Benton	-1.02	3
41027	Hood River	-1.01	4
41017	Deschutes	-0.91	5
41053	Polk	-0.70	6
41023	Grant	-0.60	7
41071	Yamhill	-0.60	8
41021	Gilliam	-0.51	9
41009	Columbia	-0.35	10
41049	Morrow	-0.35	11
41039	Lane	-0.34	12
41047	Marion	-0.27	13
41051	Multnomah	-0.26	14
41013	Crook	-0.17	15
41069	Wheeler	-0.10	16
41055	Sherman	-0.09	17
41001	Baker	-0.03	18
41037	Lake	0.03	19
41065	Wasco	0.04	20
41029	Jackson	0.07	21
41043	Linn	0.09	22
41061	Union	0.30	23
41063	Wallowa	0.32	24
41059	Umatilla	0.33	25
41057	Tillamook	0.33	26
41007	Clatsop	0.40	27
41033	Josephine	0.44	28
41041	Lincoln	0.49	29
41045	Malheur	0.65	30
41019	Douglas	0.66	31
41015	Curry	0.77	32
41011	Coos	0.79	33
41025	Harney	1.47	34
41035	Klamath	1.52	35
41031	Jefferson	1.56	36
41000			

- *Map shows the distribution of Oregon's **health outcomes**, based on an equal weighting of length and quality of life.*
- *Lighter shades indicate better performance in the respective summary rankings.*
- *Detailed information on the underlying measures is available at www.countyhealthrankings.org*

How Healthy is Oregon?

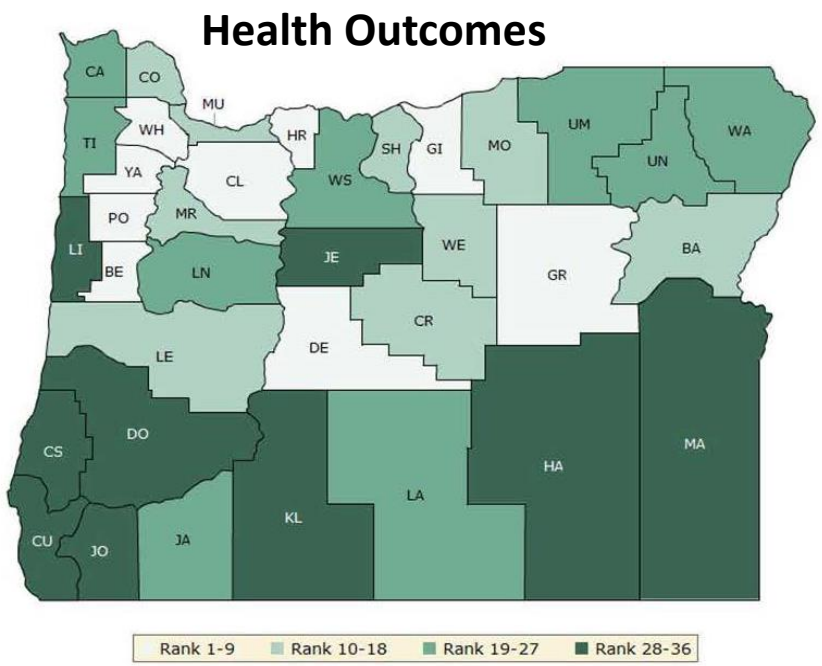
Health Factors: Healthy Communities Ranked by County

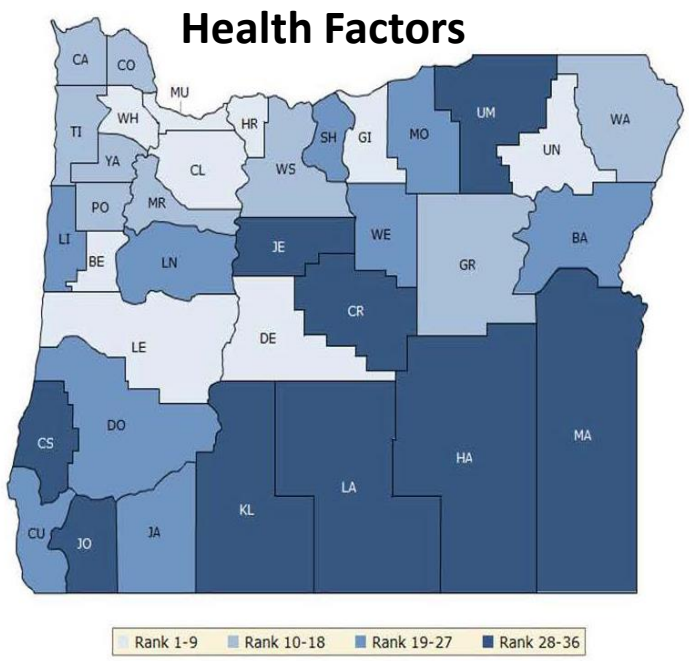


		Health Factors	
FIPS	County	Z-Score	Rank
41003	Benton	-1.04	1
41067	Washington	-0.96	2
41005	Clackamas	-0.85	3
41027	Hood River	-0.82	4
41017	Deschutes	-0.50	5
41021	Gilliam	-0.34	6
41039	Lane	-0.28	7
41051	Multnomah	-0.26	8
41061	Union	-0.14	9
41023	Grant	-0.11	10
41053	Polk	-0.08	11
41071	Yamhill	-0.08	12
41009	Columbia	-0.06	13
41063	Wallowa	-0.05	14
41007	Clatsop	-0.04	15
41057	Tillamook	0.01	16
41047	Marion	0.02	17
41065	Wasco	0.05	18
41001	Baker	0.05	19
41055	Sherman	0.08	20
41069	Wheeler	0.09	21
41049	Morrow	0.10	22
41015	Curry	0.15	23
41041	Lincoln	0.18	24
41019	Douglas	0.20	25
41043	Linn	0.24	26
41029	Jackson	0.27	27
41013	Crook	0.31	28
41033	Josephine	0.34	29
41011	Coos	0.34	30
41059	Umatilla	0.38	31
41025	Harney	0.41	32
41037	Lake	0.41	33
41035	Klamath	0.57	34
41031	Jefferson	0.68	35
41045	Malheur	0.71	36
41000			

- *Map displays Oregon's summary ranks for **health factors**, based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment.*
- *Lighter shades indicate better performance in the respective summary rankings.*
- *Detailed information on the underlying measures is available at www.countyhealthrankings.org*

RANKING MEASUREMENTS – PUTTING PLANS INTO ACTION





- Rankings measure current overall health of nearly every county in all 50 states
- They also look at a variety of measures that affect the future health of communities such as:
  - School graduation rates
  - Access to healthy foods
  - Rates of smoking
  - Obesity
  - Teen births

Rankings can be used by hospitals to help identify issues and opportunities for local health improvement and, most importantly, as a basis for signing the pledge and achieving the goal(s).

2016 *COUNTY HEALTH RANKINGS*: MEASURES AND NATIONAL/STATE RESULTS

Measure	Description	US Median	State Overall	State Minimum	State Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	7,700	6,000	4,300	9,800
Poor or fair health	% of adults reporting fair or poor health	16%	15%	11%	21%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	4.2	3.3	4.7
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.7	4.1	3.3	4.4
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	6%	5%	8%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	18%	17%	12%	19%
Adult obesity	% of adults that report a BMI ≥ 30	31%	26%	20%	34%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.2	7.3	3.1	8.8
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	28%	16%	13%	23%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	62%	88%	7%	99%
Excessive drinking	% of adults reporting binge or heavy drinking	17%	19%	17%	24%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	31%	30%	0%	67%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	287.7	363.7	117.3	518.0
Teen births	# of births per 1,000 female population ages 15-19	40	29	9	65
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	17%	17%	13%	24%
Primary care physicians	Ratio of population to primary care physicians	1,990:1	1,070:1	1,950:0	470:1
Dentists	Ratio of population to dentists	2,590:1	1,330:1	1,930:0	690:1
Mental health providers	Ratio of population to mental health providers	1,060:1	270:1	970:1	160:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	60	35	24	51
Diabetic monitoring	% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	85%	86%	74%	91%
Mammography screening	% of female Medicare enrollees ages 67-69 that receive mammography screening	61%	61%	46%	70%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	86%	70%	38%	82%
Some college	% of adults ages 25-44 with some post-secondary education	56%	67%	36%	82%
Unemployment	% of population aged 16 and older unemployed but seeking work	6.0%	6.9%	5.3%	10.8%
Children in poverty	% of children under age 18 in poverty	23%	21%	13%	40%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.4	4.6	3.6	6.5
Children in single-parent households	% of children that live in a household headed by a single parent	32%	31%	13%	48%
Social associations	# of membership associations per 10,000 population	13.0	10.4	7.2	23.1
Violent crime	# of reported violent crime offenses per 100,000 population	199	249	13	487
Injury deaths	# of deaths due to injury per 100,000 population	74	66	43	134
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	11.9	8.9	7.7	10.0
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	NA	NA	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	14%	20%	12%	26%
Driving alone to work	% of workforce that drives alone to work	80%	71%	61%	82%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	29%	27%	8%	54%

List of Health Factors & Outcomes in Oregon

The extension of REaL data:

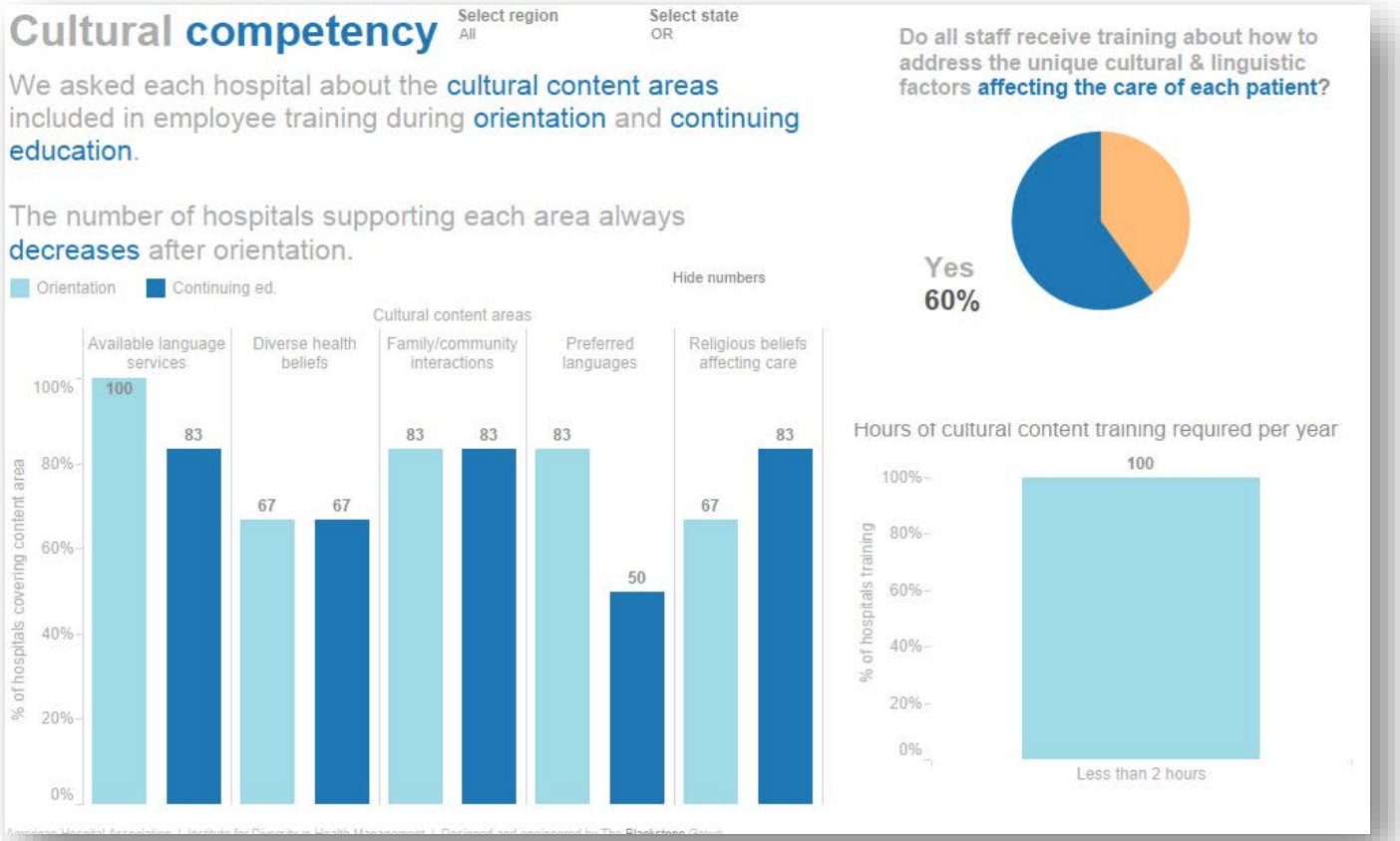
- Identify diverse patient population served
- Collect data on the diverse population
- Consider stratifying data by health factors
  - Health behaviors
  - Clinical Care
  - Social and Economic Factors
  - Physical Environment
- Select a factor or two to make improvements to achieve the goal

#123forEquity – GOAL 2

Increase cultural competency training

Strategies that can be executed:

- Train all clinical staff on cultural competence topics during orientation.
- Establish guidelines for incorporating cultural and linguistic competencies
- Include cultural competency metrics in strategic plans.
- Offer continuing education opportunities on cultural competency



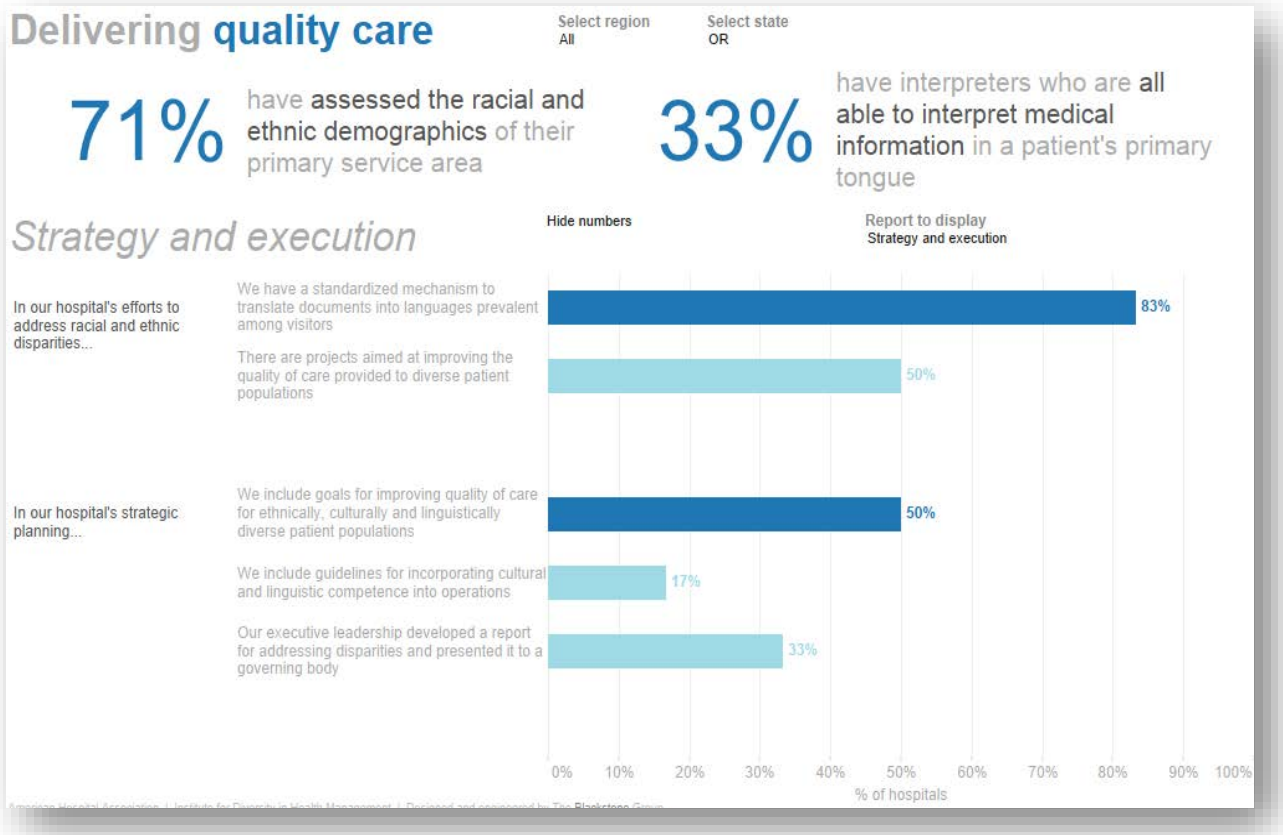
Data as reported by the participating Oregon hospitals from the 2015 Diversity and Disparities Survey.

LANGUAGES SPOKEN IN OREGON

Opportunity for Goal 2: Increase Cultural Competency Training

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

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



Data as reported by the participating Oregon hospitals from the 2015 Diversity and Disparities Survey.

Top 5 languages spoken in Oregon

1. English | 2. Spanish | 3. Russian | 4. Vietnamese | 5. Chinese

#123forEquity – GOAL 3

Increase diversity in leadership and governance

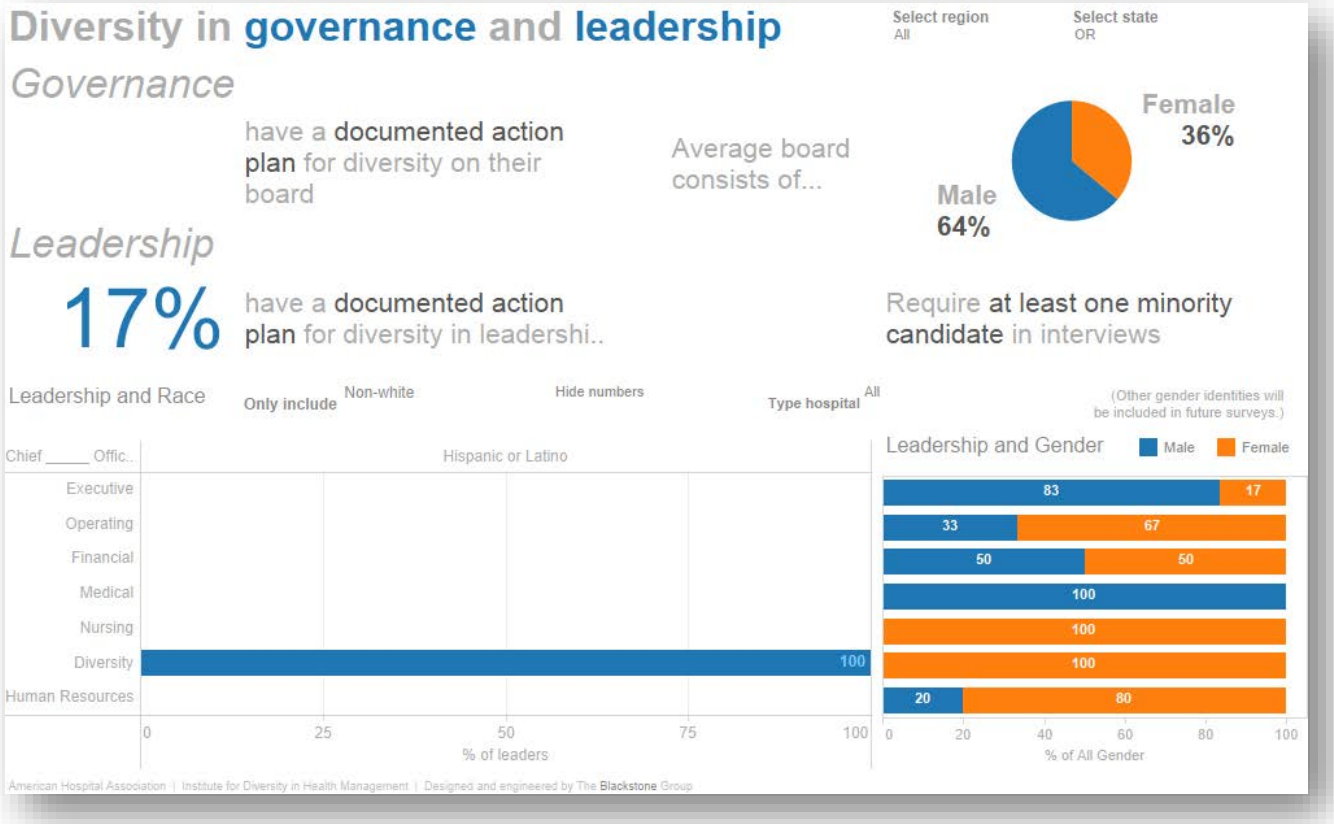
1. Hospital boards and C-Suite should reflect patient population served

   Diversity comes is varies forms:

   Education, Religion, LGBTQ, Income, Disability, etc.

2. Good business decision
   - Can Improve patient satisfaction scores
   - Control costs
   - Builds trust of patient and provider for improved behavioral health

3. Resources:



Data as reported by the participating Oregon hospitals from the 2015 Diversity and Disparities Survey.

http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf

#123forEquity Pledge to Act – Steps to Participate

1. SIGN THE PLEDGE

Pledge to achieve the three areas of the National Call to Action.

2. TAKE ACTION

Implement strategies that are reflected in your strategic plan and supported by your board and leadership. Provide updates on progress to the AHA and your board in order to track progress nationally.

3. TELL OTHERS

Achieve the goals and be recognized.
Tell your story and share your learnings with others in conference calls and other educational venues, including social media to accelerate progress collectively.

OUR PLEDGE TO ACT REQUEST

Address the following areas in the next 12 months. Below is a suggested timeline for addressing each area, but it can be modified based on your needs:

By End of Month 1

(from the date of your start)

Choose a quality measure to stratify by race, ethnicity, language preference, or other socio-demographic variables (such as income, disability status, veteran status, sexual orientation, gender, or other) that are important to your community's health

Quality measures to stratify could include readmissions or other core measures

By the end of Month 3

Determine if a health care disparity exists in this quality measure. If yes, design a plan to address this gap

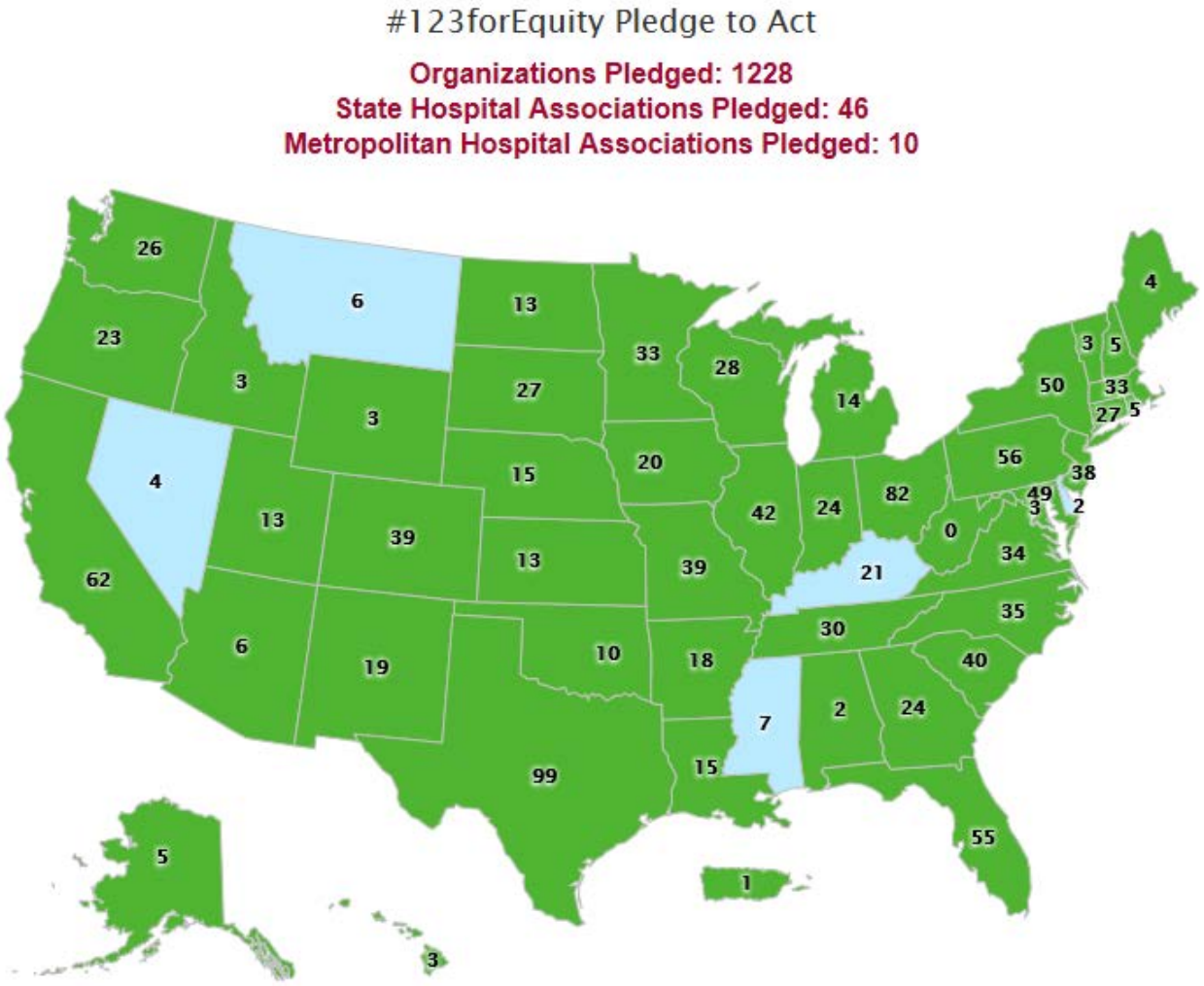
By the end of Month 6

Provide cultural competency training for all staff or develop a plan to ensure your staff receives cultural competency training

By the end of Month 9

Have a dialogue with your board and leadership team on how they reflect the community served and what actions can be taken to address any gaps

#123FOREQUITY PLEDGE TO ACT PROGRESS



2016 Goals:

- 1,000 by Mar. 31
- 2,000 by Dec. 31
- 100% of SHAs pledged
- 500 pledged hospitals reporting progress

Oregon Hospitals Pledged

- Catholic Health Initiatives
  - CHI St. Anthony Hospital
  - Mercy Medical Center
- Kaiser Permanente Sunnyside Medical Center
- Kaiser Foundation Hospital Westside Medical Center
- Legacy Health
  - Legacy Emanuel Hospital and Health Center
  - Legacy Good Samaritan Hospital and Medical Center
  - Legacy Meridian Park Medical Center
  - Legacy Mount Hood Medical Center
- Providence Health & Services
  - Providence Hood River Memorial Hospital
  - Providence Medford Medical Center
  - Providence Milwaukie Medical Center
  - Providence Newberg Medical Center
  - Providence Portland Medical Center
  - Providence Seaside Hospital
  - Providence St. Vincent Medical Center
  - Providence Willamette Falls Medical Center
- Salem Health
  - Salem Hospital
  - Salem West Valley Hospital
- St. Charles Health System, Inc.
  - Pioneer Memorial Hospital
  - St. Charles Madras
  - St. Charles Medical Center - Bend
  - St. Charles Medical Center -Redmond
- Tillamook Regional Medical Center

EQUITY OF CARE RESOURCES

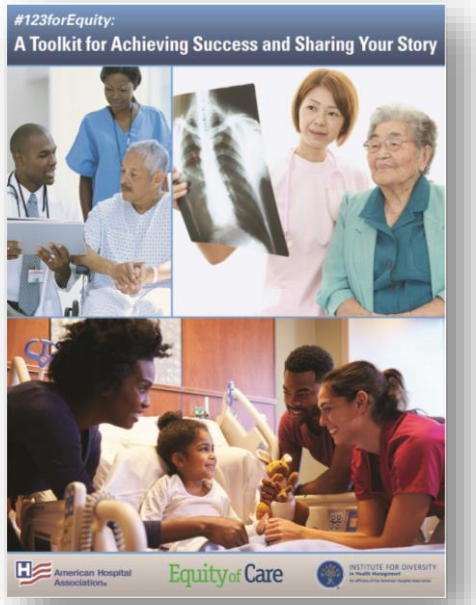
Equity of Care FAQs

Key questions with answers that provide more insight and understanding of the #123forEquity campaign.

Equity of Care Webinar Series – *Coming Soon*

1. The Value of Taking the Pledge
2. Next Steps After Signing the Pledge
3. Once Goals Have Been Achieved – What's Next

Videos from CEOs encouraging hospitals and systems to pledge and the ROI of doing so.



- A user-friendly "how-to" guide to help accelerate the elimination of health care disparities
- It contains resources that can assist all hospitals in their work to achieve the EOC goals

INSTITUTE FOR DIVERSITY
in Health Management
An affiliate of the American Hospital Association

Access to resources from the Institute for diversity

- Subject matter experts on D&I issues
- Career Center to recruit diverse talent
- Industry research and data for decision making

EQUITY OF CARE TEAM

Tomás León, MBA
President and CEO, Institute for Diversity in Health Management
tleon@aha.org | 312-422-2697

Sharon C. Allen, MBA
Senior Executive Director of Operations
Institute for Diversity and Equity of Care
sallen@aha.org | 312-422-3722

Gregg Valentine
Executive Assistant
Institute for Diversity in Health Management
gvalentine@aha.org | 312-422-2630