



Public Hospitals Focus on Reducing Health Care Disparities

Public hospitals historically have been among the foremost providers of health care for underserved populations, giving these institutions extensive experience in providing services to a racially, ethnically, culturally, and socioeconomically diverse patient base. Accordingly, studies conducted by the National Association of Public Hospitals and Health Systems (NAPH) and its research affiliate, the National Public Health and Hospital Institute (NPHHI) suggest that public hospitals are leaders in providing culturally and linguistically appropriate services.¹ In its latest research monograph, *Assuring Healthcare Equity: A Healthcare Equity Blueprint*,² NPHHI builds upon previous work by setting forth a framework that offers hospitals guidance on implementing policies that encourage high quality care to patients of all demographic backgrounds.

As part of its commitment to helping members find ways to reduce racial, ethnic, cultural, linguistic, and socioeconomic health care disparities, NAPH embarked on a study in May 2008 to identify promising, replicable

practices that are already reducing health care disparities in member institutions. NAPH surveyed its entire membership to identify hospitals and health systems with research institutes or centers focused on reducing health care disparities, and followed up with in-depth interviews of eight responding hospitals to obtain more comprehensive information about such activities and their outcomes. This

Research Brief includes findings from this study and offers specific examples of how these eight public hospitals are reducing disparities and improving the health of underserved populations. It also contains detailed information on:

- Organizational models of disparities-focused research centers and departments;
- Characteristics and common themes of disparities-reduction activities; and
- Conferences at which public hospitals can share promising practices and research findings around reducing health care disparities in safety net settings.

TABLE 1 NAPH Members Interviewed about Efforts to Reduce Disparities

Hospital	Location	Center or Department
Truman Medical Centers	Kansas City, MO	Diversity Council
Cambridge Health Alliance	Boston, MA	Department of Community Affairs
Grady Health System	Atlanta, GA	Department of Multicultural Affairs
UMass Memorial Health Care	Worcester, MA	Department of Community Affairs
Nassau University Medical Center	East Meadow, NY	Institute for Healthcare Disparities
The MetroHealth System	Cleveland, OH	Center for Reducing Health Disparities
Hennepin County Medical Center	Minneapolis, MN	Center for Urban Health
University of South Alabama	Mobile, AL	Center for Healthy Communities

Organizational Models of Disparities-Focused Research Centers and Departments

Many public hospitals and health systems organize their efforts to reduce racial, ethnic, cultural, linguistic, and socioeconomic health care disparities using one of two structural models: an affiliated research institute/center or a designated coordinating hospital department (see below).

Model 1: Disparities Institutes or Centers
A number of NAPH members organize their disparities activities by forming affiliated institutes or centers, which heavily—and sometimes exclusively—rely on outside grants or donations to fund their work. Disparities institutes tend to combine education, research, and community engagement to understand and address disparities and are usually closely affiliated with a university and/or medical school. Examples include Nassau University Medical

Center, MetroHealth Medical Center, the University of South Alabama Medical Center, and Hennepin County Medical Center.

Model 2: Departments that Focus on Disparities

Some public hospitals have internal departments that coordinate the hospital’s efforts to reduce health care disparities. These departments also focus on issues affecting internal hospital quality and cultural competency. Although mainly supported by the hospital, some disparities-focused departments receive funding from outside organizations. They also collaborate with community partners to leverage funds, maximize resources, and minimize duplication of efforts to address health disparities and the needs of the underserved. Public hospitals that follow this organizational structure include Cambridge Health Alliance, Truman Medical Centers, Grady Health System, and UMass Memorial Health Care.

Characteristics and Common Domains of Disparities Reduction Activities

Regardless of whether disparities-reducing activities occur in public hospital institutes or departments, most activities fall into six distinct domains that are closely aligned with recommendations in the literature on health care disparities (including NPHHI’s *Healthcare Equity Blueprint*, the Joint Commission’s *Exploring Cultural and Linguistic Services in the Nation’s Hospitals*,³ and the National Quality Forum’s proposed cultural competency framework⁴).

DOMAIN ONE: ASSESS COMMUNITY NEEDS TO IDENTIFY HEALTH CARE DISPARITIES

One of the first steps to reducing disparities is to understand the demographics and needs of all members of a community. All eight NAPH members interviewed for this study conduct community needs assessments, though their approaches vary somewhat—five create data collection mechanisms and base their analyses upon such primary data, while three rely more heavily on secondary data from local public health departments or similar entities.

Assessments generally involve surveying the community, conducting focus groups with community members, analyzing pre-existing public health and census data, and using demographic data collected from patients. Staff interviewed at the eight selected hospitals stressed the impor-

TABLE 2 Six Domains of Public Hospital Efforts to Reduce Disparities	
Domain One	Assess community needs to identify health care disparities
Domain Two	Integrate culturally competent services into patient care
Domain Three	Improve language and interpreting services
Domain Four	Provide community outreach, preventive screenings, and related services at health fairs, churches, and schools
Domain Five	Collaborate with community members and organizations on research efforts
Domain Six	Provide literacy, education, and job training programs, thereby addressing social factors that are associated with poor health
SOURCE NAPH Disparities-Reducing Activities Study, 2008	

tance of holding focus groups because the qualitative information gleaned from talking to community members is often more informative than abstract demographic statistics. For instance, without having conducted focus groups, Cambridge Health Alliance may not have discovered that newly-arrived Brazilian immigrants only visit primary care providers when ill and, therefore, forego screenings and other preventive services. Likewise, the University of South Alabama Medical Center implemented policies that better manage patient flow through the emergency department (ED) after conducting focus groups with frequent ED users.

Most hospitals reported asking for similar information in their assessments, including the composition of their community by race, ethnicity, language, socioeconomic, health status, and health insurance. Respondents use these data to better estimate needed health services, to identify specific groups (e.g., Asian diabetics) that could be targeted more directly to improve local health, and to compare the health outcomes of different subpopulations. One interviewee reported that this information helps identify workforce diversification needs. Other respondents use assessments to understand the relationship between type of health insurance and health outcomes; the impact of medical costs on patient behaviors; and the incidence of chronic diseases by race, ethnicity, and socioeconomic status.

Similarly, all eight respondents collect patient demographic data. The most common patient data points

collected are age, sex, race, ethnicity, socioeconomic status and language, which the hospitals use to:

- Plan the type and amount of clinical services;
- Determine how many interpreters to employ;
- Understand outcomes across different patient groups to help identify barriers and improve access, especially for chronic disease management;
- Monitor delivery of services and outcomes of services to different groups; and
- Stratify quality and patient satisfaction measures.

While all of the interviewed hospitals collect these data with existing data mechanisms, many are enhancing or standardizing existing information technology. Cambridge Health Alliance, for example, is focusing on improving patient language data by training registration staff to more accurately screen and collect this information. Truman Medical Centers is aligning data collection standards with guidelines published by the Health Research and Education Trust, the research institute affiliated with the American Hospital Association. Additionally, Truman is using its data to publish an internally-distributed “equity report card” to measure performance and set goals for improvement. However, although data collection mechanisms are becoming more sophisticated, respondents suggest that public hospitals are still trying to determine how best to collect and analyze the data.

Public hospitals are constantly working to improve the quality and quantity of interpretation services, translated written materials, and signs.

DOMAIN TWO: INTEGRATE CULTURALLY COMPETENT SERVICES INTO PATIENT CARE

There are currently no specific cultural competency requirements for hospitals, but that is soon to change. In October 2008, the National Quality Forum released a proposed framework for measuring and reporting cultural competency in health care settings.⁵ The Joint Commission is also developing hospital standards for culturally competent patient-centered care, which build upon the Joint Commission's two recent reports, *Exploring Cultural and Linguistic Services in the Nation's Hospitals*⁶ and *One Size Does not Fit All: Meeting the Health Care Needs of Diverse Populations*.⁷ Incorporating cultural competency into health care is widely viewed as a key step toward reducing disparities and improving quality of care.⁸

All eight of the responding hospitals train and educate hospital staff on cultural competency and diversity issues. Some identify topics for such educational programs by surveying providers about their needs. Specific NAPH member training activities include:

- Creating programs to teach clinical researchers to be more culturally competent with study participants;
- Conducting pilot research studies that examine the impact of enhanced cultural competency education for clinic providers on patient satisfaction;
- Providing educational sessions for staff led by representatives from minority cultures;
- Requiring cultural competency training during orientation for new hires; and
- Partnering with the affiliated university to include cultural competency courses in the medical school's curriculum.

All responding hospitals are heavily involved in promoting culturally competent services throughout the hospital. For example, Grady Health System has begun a campaign to empower patients to take part in their health care decisions by encouraging them to question their providers if they do not agree with or understand the recommended course of treatment. Many patients are also given a checklist of what to bring to their visit and what questions to ask to make the visit more productive. And like other members, Grady also has a patient navigation system in which volunteers help non-English speaking patients understand the physical layout of the building, as well as how to communicate with staff and how to understand and apply for programs that offer care to low-income populations.

Truman has recently started a pilot project that will examine the relationship between cultural competency education for providers and increased patient satisfaction. Specifically, patients from Truman's three affiliated clinics are being surveyed after medical visits to assess patient satisfaction. To test the intervention, providers from only one of the hospital's three affiliated clinics will receive an intensive series

of cultural competency education modules. That clinic’s patient satisfaction results will later be compared with those at the other two clinics that did not receive this education. The results could be extremely helpful in making the case for increased cultural competency education for health care providers, particularly because all hospitals are now required to publicly report patient satisfaction data to the federal Centers for Medicare and Medicaid Services (CMS).

In coordination with its pilot project to assess patient satisfaction, the Diversity Council at Truman recently conducted a self-assessment on cultural competency. The self-assessment was based on a tool published by the Joint Commission in 2007 that identified practices hospitals must develop to meet basic standards around cultural and linguistic services. The self-assessment led Truman to restructure its approach to collecting race and ethnicity data and also resulted in the development of its “equity report card,” which tracks specific performance on diversity indicators. The report card stratifies patient and employee profiles, patient payor source, and even CMS core measure scores by race and ethnicity.

Compounding the challenge of providing culturally competent care in most urban safety net hospitals is the influx of new immigrants, who can present at hospitals with diseases that are uncommon in the United States and, as such, are less familiar to local clinicians. To bridge the gap,

Hennepin County Medical Center established an Infectious Diseases and International Medicine Department that specializes in treating malaria, tuberculosis, and other diseases prevalent in immigrant populations. While providing training on conditions that are common among immigrants new to the Minneapolis region, Hennepin is also providing its clinicians with the tools they need to provide effective care and to build trust with local immigrant communities.

DOMAIN THREE: IMPROVE LANGUAGE AND INTERPRETING SERVICES

Language and interpretation services for limited English proficient (LEP) patients are critical in reducing health care disparities. Cambridge Health Alliance has taken great strides in improving the way it collects data on patients’ preferred language. As a participant in *Speaking Together*,⁹ a Robert Wood Johnson Foundation (RWJF)-sponsored project, Cambridge improved

its process of language screening by working with information technology department to add new fields to the existing patient registration system—such as the patient’s primary language at home, preferred language for care, and preferred language for written materials. The hospital then trained registration staff and provided employees with a standard script to follow when registering patients. Cambridge also strategically placed posters listing the 30-plus languages that LEP patients can select from when requesting an interpreter.

Public hospitals are constantly working to improve the quality and quantity of interpretation services, translated written materials, and signs. For example, Truman conducts intensive ongoing training for its team of 24 staff interpreters, including a technique called “peer shadowing,” which involves having the primary interpreter, accompanied by one of his or her other team members, into a

TABLE 3	Public Hospital Methods of Providing Cultural Competency Training to Staff
— Creating a program to teach clinical researchers to be more culturally competent with study participants — Conducting a study examining the impact of enhanced cultural competency education for clinic providers on patient satisfaction — Providing educational programs for staff led by culturally diverse trainers — Requiring cultural competency training during orientation for new hires — Partnering with affiliated university to include cultural competency courses in the medical school's curriculum — Designing and implementing a survey for hospital providers to determine cultural issues on which to concentrate additional trainings — Hiring a workforce that is representative of the patients and community	
SOURCE NAPH Disparities-Reducing Activities Study, 2008	

Public hospitals are also modifying hospital signs and pharmaceutical labels to include universally-recognizable symbols, rather than words, to ensure greater understanding across languages.

medical encounter to help encourage consistency in the translation process. Truman recently added two other quality components: hand hygiene and verification of the patient's identity, which relate to Joint Commission's patient safety goals. To improve LEP patients' understanding of prescription drug instructions, Hennepin County Medical Center trained its pharmacists to use the "teach-back"¹⁰ method, in which the pharmacist provides instructions with the help of interpreters, asking the patients to repeat the instructions in their own words, and evaluating the patient's understanding. This process is repeated until the pharmacist is satisfied that the patient clearly comprehends the instructions. Hennepin County is currently evaluating the results of the teach-back method to determine if it improves patient compliance with medication. Grady Health System's Language Interpretive Services (LIS) has a call center staffed by a team of trained interpreters to address interpreting needs. LIS interpreters take bi-weekly classes on medical terminology and note-taking and are also required to attend continued education activities.

Public hospitals are also modifying hospital signs and pharmaceutical labels to include universally-recognizable symbols, rather than words, to ensure greater understanding across languages. For example, Grady Health System participated as one of the pilot sites for another RWJF-funded project called

Hablamos Juntos,¹¹ which tested hospital signage that relies on symbols and colors rather than words. The testing was done in several areas of the building and found that patients were able to find their destination faster and easier using the new signage. Full findings from this pilot project are presented in "*Universal Symbols in Health Care Workbook: Best Practices for Sign Systems*" on the *Hablamos Juntos* website.¹² Using the guide of best practices that Grady staff helped to formulate, Grady plans to post new signs with symbols in all its facilities within five years.

DOMAIN FOUR: PROVIDE COMMUNITY OUTREACH, PREVENTIVE SCREENINGS, AND RELATED SERVICES AT HEALTH FAIRS, CHURCHES, AND SCHOOLS

Public hospitals provide a wide array of community education, preventive screenings and services, and outreach outside of the hospital. Many of them participate in local health fairs to provide preventive screenings for diabetes, HIV, and hypertension—vital services that some community members would not have access to otherwise. Three hospitals (Cambridge Health Alliance, Grady Health System and the University of South Alabama) have extensive community health programs in which volunteers from the community ("health advocates") are trained on public health issues and diseases. The health advocates promote healthy behaviors to acquaintances from their churches, schools, and other social groups.

**DOMAIN FIVE: COLLABORATE
WITH COMMUNITY MEMBERS AND
ORGANIZATIONS ON RESEARCH EFFORTS**

Public hospitals are partnering with their communities to collaborate on the hospital's research agenda in an effort to ensure that studies are beneficial to local populations. Community-based participatory research (CBPR) is a "collaborative process of research involving researchers and community representatives that engages community members, employs local knowledge in the understanding of health problems and the design of interventions, and invests community members in the processes and products of research."¹³ For example, researchers at the University of South Alabama's Center for Healthy Communities invite community members to help design and implement studies in order to capture local perspectives on the cultural issues that researchers may inadvertently overlook. Another activity at the University of South Alabama is a recently-completed research study that sought to understand the link between poor health and limited employer-provided benefits in the Mobile, Alabama area. The study found that individuals whose employers do not provide health insurance are more likely to be in poor health. The University is sharing these results with the local business community to help make the business case for providing employer-provided benefits and to show how it affects their bottom line. In this way, the Center for Healthy Communities is working collaboratively with Mobile's business sector

to reform policies and establish local solutions for the uninsured in the area.

Other kinds of community collaborations bring public hospitals and community organizations together to capitalize on each other's expertise with local populations, as well as to leverage funds and resources. For example, MetroHealth collaborated with the AIDS Taskforce of Greater Cleveland to improve the delivery of health services to Hispanics throughout the city. Other hospitals facilitate research via "community outreach partnership grants" (offered by Nassau University Medical Center) or offer funding to hospital researchers and investigators from community organizations (available through Hennepin County's Center for Urban Health). Additionally, public hospitals partner with affiliated medical schools to conduct research. Grady's Department of Multicultural Affairs runs a primary care center called the International Medical Center (IMC), where patients receive care in their preferred language by staff and doctors from different backgrounds who can respond to the cultural needs of patients. In the waiting area of the clinic, patients receive education about cardiovascular disease, diabetes, cancer, nutrition, etc. through partnerships with other organizations such as the Office of Health Improvement, American Cancer Society, and the Georgia Latino Diabetes Program. The IMC is also a site for medical schools to do research and recruit study participants. In exchange, Grady clinic providers act as consultants to help

inform researchers about the cultural and social issues of target populations.

DOMAIN SIX: PROVIDE LITERACY, EDUCATION, AND JOB TRAINING PROGRAMS, THEREBY ADDRESSING SOCIAL FACTORS THAT ARE ASSOCIATED WITH POOR HEALTH

Several respondents noted that, because their hospitals' missions focus not only on physical and mental health but also on the social and economic well-being of their communities, they strive to provide services that more broadly improve their patients' lives. The literature is filled with studies indicating that minimizing socioeconomic inequalities can lead to disparity reduction.^{14, 15, 16} Therefore, by offering social services to patients, public hospitals are helping to reduce the social and economic factors that contribute to health care disparities. Literacy programs are an excellent example of this phenomenon. Grady Health System, for instance, maintains a library of children's books in its International Medical Center and in several of its neighborhood health centers; this encourages parents and hospital volunteers to read to pediatric patients waiting for appointments. Likewise, Hennepin Medical Center runs a comprehensive children's literacy program. Among its most innovative initiatives is "Books for Babies," in which every baby born at Hennepin County Medical Center is offered a book to take home. Although the books arrive at the hospital in English and Spanish, Hennepin sought and received permission from the publisher to insert trans-

lations in Somali, Hmong, Oromo, and French to create bilingual editions, ensuring that almost every child born is given a book in their own language.

Providing education and training for students is another way that hospitals are investing in their communities. The University of South Alabama boasts summer learning programs for inner-city school children in grades 6, 11, and 12 to enhance students' science and math skills and expose them to possible future health care careers. Similarly, Grady provides a volunteer internship program for bilingual college students who mainly work to help patients navigate the system and to assist Spanish-speaking patients with interpretation in non-clinical situations. This volunteer program exposes students to real-world experience in multicultural health care, who in turn rate their volunteering experience very positively.

Public hospitals are also helping community members with job training skills. UMass Memorial, while conducting a needs assessment among inner city youth, found that the single most important issue was the need for employment opportunities. As a result, UMass Memorial led a coalition of more than 20 local non-profit organizations, businesses, and community leaders to increase job opportunities for 14-to-22-year-olds. In addition, UMass Memorial, in collaboration with community stakeholders, instituted a "career expo" to teach local youth about careers in health care. This past summer, UMass Memorial offered hospital-based jobs

to more than 70 youth. These activities are both fostering interest among high-risk youth in completing school and serving as an investment in a future "home-grown" health care workforce. Indeed, according to program evaluations, teens completing these workforce opportunities have found their hospital job "interesting," and many have indicated they will return to pursue a future job after graduation. The program has grown tremendously since its inception four years ago. More than 1,800 jobs were filled by city teenagers in the summer of 2008 through this collaborative effort.

A Comprehensive Approach to Reducing Disparities: Combining Themes One through Six

Addressing the issues raised in the six themes above can propel public hospitals toward a strategy to reducing health care disparities. However, to make the greatest impact, public hospitals are actively implementing programs addressing all six areas. Contra Costa Medical Center in Martinez, CA, although not interviewed in this study, is an excellent example of how a safety net facility can combine these elements into a comprehensive plan to reduce health care disparities. In 2007, Contra Costa developed a five-year strategic plan aimed at reducing disparities that involved input from hospital staff at all levels. Its goals include: improving the experience of patients/customers, increasing engagement and partnership with community and public entities, improving staff

responsiveness and cultural sensitivity, and developing systems that support and promote access and respectful delivery of services. Contra Costa's hospital leadership also built evaluation components into the strategic plan to ensure that they consistently monitor their progress over the five years it is being implemented.

Sharing Promising Practices and Research Findings: Disparities-Focused Conferences Specifically for Public Hospitals

Going forward, it is critical that public hospitals and health systems collaborate and share successful practices to reduce racial, ethnic, cultural, linguistic, and socioeconomic health care disparities. One important venue for sharing promising activities is through sponsorship or attendance at conferences focused on disparities elimination. The New York City Health and Hospitals Corporation (NYCHHC), the largest public health system in the country, has held an annual "Urban Health Conference" for the past seven years. The conference goal is to share among health care professionals and other stakeholders innovative strategies to reduce disparities in health outcomes. The most recent conference, held in

June 2008, highlighted successful practices in the areas of obesity, palliative care, depression, substance abuse, and patient safety. The New York City conference invites public health and hospital professionals from across the nation to learn how a large public health system can address the complexities of health care disparities.

Conclusion: The Outlook for Reducing Disparities in Public Hospitals

Racial, ethnic, cultural, linguistic, and socioeconomic disparities in health care delivery pose daunting challenges to public health. Though this Research Brief is only a sampling of activities identified in NAPH's recent study, it provides concrete examples of how public hospitals are dismantling these disparities. NAPH will continue to seek additional opportunities to inform members about promising and innovative practices. As the nation's hospitals increasingly are held accountable to cultural competency and language standards, sharing best practices is becoming ever more critical and provides an important opportunity for public hospitals to serve as models to the entire hospital industry. ■

**UPCOMING EVENT:
1ST ANNUAL HEALTH CARE
DISPARITIES CONFERENCE**

In conjunction with NAPH, Nassau University Medical Center's Institute for Healthcare Disparities is holding its first annual conference on addressing and reducing health care disparities in April 2009. The focus is to share promising, innovative practices to reduce disparities and to create sustainable community change. The conference is specifically targeting the 15 NAPH members that, in NAPH's 2008 survey, expressed an interest in forming a national collaborative of safety net hospitals to reduce racial and ethnic health care disparities. NAPH encourages public hospital leaders and representatives to attend this conference. For more information, contact Lindsey Marshall, NPHHI Research Associate, at lmarshall@naph.org.

Notes

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9. NAPH members involved with the Robert Wood Johnson Foundation's *Speaking Together* project include Cambridge Health Alliance, Bellevue Hospital Center, Hennepin County Medical Center, UMass Memorial Health Care, and the UC Davis Health System.
10. The teach-back method is recommended by the Joint Commission in the 2009 National Patient Safety Goals. For more information, please see: Schillinger D, Piette J, Grumbach K, et al. "Closing the loop: physician communication with diabetic patients who have low health literacy." *Arch Intern Med*. 2003;163:83-90.
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