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Addressing Racial and Ethnic Disparities in Healthcare

Senior management has an ethical responsibility to take a leadership role.

Racial and ethnic disparities in healthcare status and access have been extensively documented.

Black women in Washington, D.C., suffer from obesity, diabetes, heart disease and generally poor health in alarmingly high numbers, and white women do not, according to a study released by the Kaiser Family Foundation. The study reveals there is a large disparity in the incidence of certain chronic diseases between black and white women. Kaiser's analysis was based on data compiled by the Centers for Disease Control and Prevention and the federal Current Population Survey from 2004 to 2006.

A study by researchers at Johns Hopkins School of Public Health and the University of Maryland found that eliminating health disparities for Asians, blacks and Latinos would have saved an estimated \$229 billion in U.S. medical care expenditures between 2002 and 2006.

The racial gap in colon cancer death rates is widening. Colon and rectal cancer death rates are now nearly 50 percent higher in blacks than in whites, according to American Cancer Society research. In its 2008 report, experts partly attributed the

gap to blacks' lower screening rates and poor access to quality care.

Not surprisingly, research has found that minority populations have a higher level of mistrust of healthcare providers due to these inequities. Fortunately, more hospitals and other institutional providers are now becoming increasingly aware that activism, not passive behavior, is essential to achieve significant improvements.

Historically, healthcare executives have rationalized their too modest efforts in this area. Typically, disparity issues were not viewed as critical to the organization's mission; higher priorities demanded attention; and public hospitals and faith-based institutions were expected to assume principal responsibility for the provision of services to the underserved, a disproportionate number of whom are minorities. Furthermore, even in so-called progressive communities, physicians of color were not recruited or welcomed a few decades ago, and most governing boards remain predominantly white.

Three Exemplary Programs

Beginning last year, Detroit's Henry Ford Health System initiated a

three-year Healthcare Equity Campaign to address potential sources of inequality in healthcare. The campaign defined healthcare equity as: "Providing care that does not vary in quality by personal characteristics such as ethnicity, gender, geographic location and socioeconomic status."

Last year, the campaign's focus was on raising awareness within the organization about health disparities. A toolkit provided to managers highlighted five examples:

1. Black babies are three times more likely to die in the first year of life than white babies.
2. Across the nation, American Indians/Alaska Natives have the highest death rates for diabetes and chronic lower respiratory disease of any group.
3. Blacks are referred less often than whites for cardiac catheterization and bypass grafting.
4. Latinos and blacks receive less pain medication than whites for long bone fractures in the emergency department and for cancer pain on the floors.
5. Blacks with end-stage renal disease are referred less often to the transplant list than whites.

This year the campaign has emphasized the implementation of tools to improve cross-cultural communication and competency. The third year will concentrate on integrating these principles throughout the system to make them sustainable and ensure

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accountability. By collecting more information from patients, the system will be positioned to determine if differences continue to exist in the preventive, diagnostic and treatment services offered to people with similar health conditions.

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For more than two decades, New York's Queens Hospital Center has had an exceptionally active, assertive and influential community advisory board. The board helps ensure community health needs are identified, programs are developed and effectiveness is measured. The area's population is remarkably diverse (43 percent black, 23 percent other, 16 percent Latino, 13 percent Asian and 5 percent white), and 120 different languages are spoken by people in the service area.

Queens Hospital Center's four centers of excellence were specifically established to address the community's most significant needs: diabetes, cancer, women's health and behavioral health. Its Barbershop and Beautician Initiative is an innovative collabora-

tion that enlists barbers and hair stylists to encourage men to receive prostate screenings and women to obtain mammograms. In addition to conducting community health fairs, the organization operates asthma and mammogram vans for those who cannot come to the hospital.

Based on data from the Office of Vital Statistics, NYC Department of Health and Mental Hygiene, the people served by Queens have had a major reduction in the years of potential life lost between 2001 and 2007, the last year for which information is available. (Years of potential life lost measures the difference between the age at death and a standard life expectancy target, typically 75 years.)

Trinity Health, based in Novi, Mich., with 47 hospitals and a variety of other services in nine states, has approximately 47,000 employees and more than 8,000 physicians. President and CEO Joseph R. Swedish, FACHE, emphasizes that a culturally competent work force is essential to eradicating disparities and inequities in care delivery and outcomes. He believes leadership must move beyond mere rhetoric and demonstrate a moral and business commitment to a formal diversity strategy.

Trinity's strategy has seven parts: commitment and accountability, training and education, recruitment,

communication, retention and development, community partners, and supplier diversity. In 2006, Trinity Health added a balanced scorecard standard titled "Circuit Breaker." At each of Trinity's sites, the CEO is required to create action plans to achieve specific diversity objectives over a period of two years. If even one of its 47 hospitals fails to meet its diversity and inclusion audit requirement, all 200 participating leaders do not receive their incentive compensation payments.

Minimal Steps

A growing number of publications containing descriptions of innovative programs to reduce racial and ethnic disparities are now available. The adoption of best management practices in this area is overdue. At a minimum, two preliminary steps are a prerequisite to understanding where resources should be allocated.

1. Perform a comprehensive community health assessment on a regular basis, and devote particular attention to the needs of the underserved and racial and ethnic minorities. Such an assessment is an essential component for measuring meaningful progress. With reliable baseline measures and metrics, definitive annual goals and objectives can be established and monitored.
2. Examine your organizational complexion. Equity is one of the six criteria used in evaluating applicants for the AHA-McKesson Quest for Quality Prize. For several years, the Quest for Quality Prize Committee has asked candidates to provide patient diversity demographics,

Don't miss the special ethics program, **"Ethical Wisdom: Doing the Right Thing Every Day, Everywhere in the Organization,"** to be held Oct. 6 in conjunction with ACHE's San Francisco Cluster. The program, led by Jack A. Gilbert, EdD, FACHE, is funded in part by ACHE's Fund for Innovation in Healthcare Leadership. For more information, visit ache.org/Ethics.

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specifically the percentage of Asian, black, Latino, white and other major groups. Applicants for the 2011 award are being asked to provide the same racial/ethnic background information for the governing board, medical staff, senior management, all employees and volunteers. Based on past experience, committee members have determined hospitals are more likely to demonstrate success in meeting the equity criterion when their organizational complexion mirrors that of the communities they serve.

The Agency for Healthcare Research and Quality has reported that 32 million Americans spoke a language other than English at home in 1990.

By 2000, the number had risen to 52 million, which is almost 20 percent of the population. Next year, The Joint Commission will implement a new standard stipulating that hospitals effectively communicate with patients when providing care, treatment and services, and surveyors will be checking to confirm the patient's race, ethnicity and preferred language for discussing healthcare have been documented in the medical record.

Demands for increased public reporting, accountability and transparency in all spheres of our economy will not diminish. Healthcare reform will continue to be subject to intensive debate; however, successfully addressing well-documented racial and ethnic disparities should be a high priority for senior

management, not because of external pressures but because we have a moral obligation to do no less. ▲

Paul B. Hofmann, DrPH, FACHE, is president of the Hofmann Healthcare Group and a Senior Fellow of the Health Research & Educational Trust. Dr. Hofmann coordinates the annual ACHE ethics seminar at the Congress on Healthcare Leadership; programs also can be arranged on-site. For more information, please contact ACHE's Customer Service Center at (312) 424-9400 or visit ache.org.

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