BUILDING QUALITY & EQUITABLE HEALTH CARE SYSTEMS

JUNE 7-9, 2010
Wilshire Grand Hotel
930 Wilshire Boulevard, Los Angeles
On the heels of the passage of historic national health care reform legislation, 245 researchers, clinicians, educators, administrators, policymakers, advocates, and community members from throughout California came together to develop strategies for building quality and equity in the rapidly changing health care landscape. Experts who have led recent activities on language access, cultural competency, data collection, and workforce diversity from across the country joined the California participants. This conference was intended to seize this current juncture in health policy as an unprecedented opportunity to address disparities in health care and promote improved access and quality for all communities. Materials from the conference can be found on CPEHN’s website at www.cpehn.org.

*Dr. Robert Ross*, President and CEO of The California Endowment, opened the conference by noting: “in the year 2015, we’re going to look back and describe one of two scenarios. In scenario A, we’ll look back and reflect that a group of people took strategic advantage of this confluence of opportunities and came out with a health care system that is advancing health equity and reducing disparities. In scenario B, we’ll reflect back on wasted opportunity. As John Wooden said ‘never mistake activity for achievement’….Thank you for what you’ve done so far. But that was just the preamble. Now comes the real work, making sure we don’t miss this golden, strategic opportunity to have a quality, equitable health care system for everyone.”
Building the Foundation for Equity

Before turning to discussions of national health care reform and its implications for communities of color and other underserved populations, conference speakers and participants shared some of the many advances toward health care equity that have been made in the past decade.

In an opening plenary session, representatives of three leading national quality organizations described their activities to integrate issues of language access, cultural competence, and health care disparities into their work. Robyn Nishimi, Senior Advisor to the National Quality Forum (NQF), described NQF’s work on minority health and health disparities issues, culminating in a national framework for cultural competency for health care organizations, published in April 2009. NQF has a unique role and influence as a consensus-setting organization for the quality improvement field.

Sarah Scholle, Assistant Vice President for Research at the National Committee for Quality Assurance (NCQA), discussed the development of NCQA’s distinction program for multicultural health care, which became available in July 2010. After working with health plans that demonstrated innovation and leadership on culturally and linguistically appropriate services and health care disparities, physicians, community health centers, and other health care organizations can now participate in the distinction program.

Finally, Amy Wilson-Stronks, Project Director from The Joint Commission, described The Joint Commission’s activities on promoting patient-centered-ness, language access, and cultural competence among its accredited health care organizations. The Joint Commission accredits more than 17,000 health care organizations and programs in the United States, including almost 90 percent of all U.S. hospitals. They have recognized the many potential dimensions of cultural competency that impact on health care quality, patient safety, and equity.

Accordingly, new Joint Commission accreditation standards, effective January 2010, require more effective communication with patients, more demographic data collection and utilization, explicit non-discrimination policies, and more patient and family involvement in care that includes respect for cultural, religious, and spiritual needs and beliefs.

Factors That Influence Health Equity

- Race
- Education
- Health Literacy
- Economic Status
- Age
- Ethnicity
- Gender
- Religion
- Physical or mental disability
- Language
- Gender identity
- Income
- Access to care

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These three national quality organizations have all acted within the last year to integrate issues of language access, cultural competency, data collection, and workforce diversity as essential components of health care quality improvement. While health plans, hospitals, and physicians have become more aware of and begun to act on these issues, they have not been integrated as a standard of practice in the health care system. The speakers noted that there is a vital role for community advocates to continue to push the expectations of consumers and purchasers that addressing health care disparities is integral to providing quality health care for all. We need support from all stakeholders to advance these issues forward.

Accomplishments to Celebrate

Throughout the conference participants shared their own work advancing health equity within the health care system. Experts were asked to provide resource materials, which can be found at CPEHN’s website at www.cpehn.org. Some of the accomplishments highlighted in the workshops included:

**Data Collection**
- Many health plans and hospitals have begun to collect race, ethnicity, and language data.
- California Senate Bill 853, co-sponsored by CPEHN, is a model for requiring all health plans to collect demographic data.
- Race, ethnicity, and language data will be collected as part of the requirements for incentive payments for health information technology.

**Language Access**
- Many health systems, hospitals, and health plans have made significant efforts to establish language access policies and train interpreter staff.
- Matching federal funding for language assistance services under the Children’s Health Insurance Program and Medicaid has been increased.
- A national certification for health care interpreters is being developed.
- Valid and reliable tools to assess physician language capabilities are being implemented.

**Cultural Competency**
- Medical, nursing, and dental schools have all worked to integrate cultural competency into their respective curricula.
- In California, with Assembly Bill 1195, cultural and linguistic competency is now required as part of all continuing medical education programs.
Health Care Disparities

- Reducing disparities is increasingly recognized as essential to quality improvement.
- Multi-stakeholder and multi-payer approaches are being used to address disparities at a community level.
- Challenges faced by small group and solo physician practices are being recognized as a part of the safety net serving patients most impacted by disparities (“high volume, high opportunity, high value”).
- There continues to be a greater understanding of social determinants of health and the broader issues of health disparities beyond health care.

Workforce Diversity

- There has been increased collaboration across the health career pipeline and other programs, supporting multiple pathways to careers in health for underrepresented students and those already in the health care workforce.
- Local and regional partnerships have engaged both educational and training institutions, as well as industry employers, and have effectively leveraged government and foundation funding.

“This conference has demonstrated that we have come a long way but still have a long way to go. We have the power and passion inside and outside this room to make a difference.”

Dr. Joseph R. Betancourt
Director of the Disparities Solution Center at Massachusetts General Hospital

Workshop C: Cultural Competency
Moderated by Desiree Lie, MD, MSED, University of California, Irvine
Paul Glassman, DDS, MA, MBA, University of the Pacific
Sheryl Horowitz, PhD
Institute for Medical Quality
Pam Malloy, RN, MN, OCN®, FPCN
American Association of Colleges of Nursing

Workshop D: Health Disparities Reduction
Moderated by Robin M. Weinick, PhD, RAND
Karen Anderson, PhD
Institute of Medicine
Dianne Hasselman, MPH
Center for Health Care Strategies
Sarah Hudson Scholle, MPH, DrPH
National Committee for Quality Assurance

Workshop E: Workforce Diversity
Moderated by Jeff Oxendine, MPH, MBA
University of California, Berkeley
Tarecq Amer, MA
Insight/NCCED
Theodore D. Lucas, DMA, The California State University
José Millan, JD, California Community Colleges
Angela L. Minniefield, MP Office of Statewide Health Planning and Development
Cathryn L. Nation, MD
University of California Office of the President
The Opportunities

While acknowledging and celebrating the many achievements on these issues, the conference also highlighted the new contexts for advancing quality and equity in health care for communities of color and other underserved populations. The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, focuses on expanding access, controlling costs, and improving quality. The Health Information Technology for Clinical and Economic Health (HITECH) provisions of the American Recovery and Reinvestment Act (ARRA), the economic stimulus legislation enacted a year earlier in February 2009, provides billions of dollars in federal investments in health information technology which is a critical platform for transforming our health care system. Conference consultant Ignatius Bau underscored that for the health policy field, “the universe has changed” and highlighted many of the new frameworks as well as federal, state, and external structures, created by both pieces of legislation. These two developments combined create unprecedented opportunities for advancing quality and equity in health care.

In addition to expanding access to coverage to 32 million who are currently uninsured, the health care reform law funds demonstration projects that would improve quality and control costs. For example, new types of incentives would reward outcomes-based, patient-centered care, as well as encourage the use of medical home models and experiment with new risk-sharing structures called accountable care organizations. There is also significant funding for prevention activities, which marks a shift from payments for acute and chronic care to a focus of promoting health and wellness. In all of these efforts, issues of equity need to be incorporated.

Conference keynote speaker Dr. Thomas Tsang, Medical Director from the U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology (ONCHIT), described how the unprecedented federal investments in health information technology will be used to build a foundation for improvements in the delivery system through electronic health records and health information exchanges. The ultimate goal is to achieve sustainable improvements in health care quality and in population health.
Dr. Tsang summarized the requirements that will be in place to qualify for federal funding and emphasized the concept of “meaningful use” of health information technology. Hospitals, physicians, and community health centers will have to demonstrate more than just the purchase and adoption of electronic health record systems – they will need to show how they are meaningfully using the technology to improve health care quality, and ultimately, the health status of their patients.

“There is a whole new ‘alphabet soup’ of language and acronyms to learn. We need to become proficient at our messaging – our ‘elevator speeches’ should become about quality, safety, and cost. However, as we learn and use the new language and frameworks, we should not forget the old language. It is essential that we stay true to the roots and values of what brought us here.”

Dr. Joseph R. Betancourt
Director of the Disparities Solution Center at Massachusetts General Hospital
Ways to Move Forward

Leaders from California health organizations highlighted both challenges and opportunities as their health systems prepare for these massive changes. **Dr. Alice Chen**, Medical Director of the Adult Medical Center at San Francisco General Hospital, described our existing health system as one that is provider-centric rather than patient-centered. Dr. Chen emphasized that national health care reform offers the opportunities to add more value to primary care and to move more resources into the community.

**Traci Van**, Director of Community Benefits for Sutter Health, described the challenges of understanding and implementing this very complex law, even within a large health system. She observed that having more and better data about patients will help identify how to improve the quality of care and to focus community benefits upstream.

**Dr. Bill Walker**, Director of Contra Costa County Health Services, observed “buried within the health reform bill are some huge investments in community health – if we look at these investments to address the highest needs of people in our communities that suffer health disparities, we can go a long way.” Dr. Walker also highlighted the parts of the national health care reform legislation that will support workforce development, including community health workers, patient navigators, and others working at the grassroots community level.

Finally, **Cherie Kunold**, Team Lead for Transformational Care at Catholic Healthcare West, noted that “we are seeing the beginning of a just and compassionate health care system that many of us have worked for – being a leader in health care at this time is one of the most dynamic things in history.”

All of the speakers emphasized that it will be important to remain involved and keep up with the details of implementation of both the national health care reform and health information technology legislation.
Key Issues for the Future

Throughout the conference, participants discussed both current achievements and the new, emerging contexts for advancing quality and equity for all communities. The event culminated with break-out sessions to identify key issues that are critical to moving our work forward:

1. Engage Patients, Consumers, and Communities
   • How do we educate consumers and communities so that they can understand and navigate the changes in the health care system?
   • With the move towards more technology, we need to bridge the “digital divide” for communities that do not have access to technology, including linguistically isolated populations, communities of color, and seniors.
   • We need to have some specific definitions about what it means to engage diverse patients and families.
   • What is the role of organizing and movement-building in communities to transform a provider-centric, profit-centered system?

2. Engage All Providers
   • How did leading organizations get ahead of the curve? What are common themes and threads within organizations that have pushed them ahead of the curve?
   • How can we engage physicians in private practice so that communities that are most impacted are better served?
   • How will we build the workforce capacity to serve the 32 million people who will become insured?
   • We need to ensure that underserved populations have access to basic education and skills in science, technology, engineering, and mathematics to pursue health careers.
   • What will be the long-term impact for our physicians of changing the health care model so often?

3. Ensure Access and Preserve the Safety Net
   • Under health care reform, a number of patients currently uninsured and seen by safety net providers will have coverage – we need to pay attention to preserving those systems of care and ensuring access for those who will remain uninsured.

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Dr. Winston Wong
Medical Director for Community Benefit and Director of Disparities and Quality Initiatives at Kaiser Permanente
• We need to make sure that the safety net can keep up with the pace of health information technology and health care reform implementation.

• There is a need to address California state budget issues that are impacting the safety net.

• Small group physician practices often care for disproportionate numbers of vulnerable patients – these providers and their staff need training and support on population management.

• How do you provide care to the rural, marginalized communities (e.g., far northern California) who need physicians?

• Providing services to immigrants who are excluded from many of the national health reform programs is key to avoiding further marginalization of underserved populations and impacts on their service providers.

• Risk adjustment in pay for performance will be critical for sustaining providers traditionally serving communities of color.

4. Improve Data Collection and Analyses

• We need to improve and standardize collection of sexual orientation and gender identity/expression data so that it is included in the data conversation.

• Health information technology will help us collect more data but we need good baseline data to know if things are improving.

• Creating a patient-centered health care system begins with collecting and using quality data.

• There are still challenges in categorizing individuals and getting data with sufficient granularity to identify disparities in subpopulations.
• Extensive planning, education of staff and patients, reorganization of workflow and adaptation of technology is needed for a good system of data collection and reporting.

• We must ensure a connection between data collection and meaningful use of the information; for example, using data on patient language to schedule an interpreter.

5. Explicitly Identify and Reduce Health Disparities

• We need to expand beyond health systems’ current focus and reach to address the social determinants of health.

• We should incorporate a “health and equity in all policies” approach by collaborating across sectors and areas of expertise.

• There are still areas of disparities that are under-addressed including disparities among lesbian, gay, bisexual, and transgender (LGBT) people, particularly LGBT people of color.

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The agendas, speaker biographies, presentations, and resource handouts from the conference are available on CPEHN’s events page: [www.cpehn.org/register.php](http://www.cpehn.org/register.php)

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