



AMERICA'S  
ESSENTIAL  
HOSPITALS

FINDINGS AND RECOMMENDATIONS OF  
THE EQUITY LEADERSHIP FORUM

*February 2016*

## INTRODUCTION

As we approach the 15th anniversary of two seminal reports from the Institute of Medicine (IOM)—*Crossing the Quality Chasm*<sup>1</sup> and *Unequal Treatment*<sup>2</sup>—we find that racial and socioeconomic inequity persists in health care quality and patient safety. In *Crossing the Quality Chasm*, the IOM stressed the importance of equity in care as one of the six pillars of quality health care, along with efficiency, effectiveness, safety, timeliness, and patient-centeredness. Indeed, *Unequal Treatment* found that even with the same insurance and socioeconomic status and when controlling for comorbidities, stage of presentation, and other confounders, minorities often receive lower-quality health care than their white counterparts.

In 2011, America's Essential Hospitals stood with its hospital association peers in a National Call to Action to eliminate health care disparities by increasing cultural competency training, diversity in governance and leadership, and collection and use of race, ethnicity and language preference data. Additional actions at the national level—by The Joint Commission and National Quality Forum (NQF), and under the Affordable Care Act—have further underscored the need for providers and facilities to more closely examine health care disparities and identify solutions that provide more equitable care—not solely as an issue of social justice, but also as essential to performance and community health improvements.

Equity issues span the work of America's Essential Hospitals, touching all pillars of its strategic plan: advocacy, policy, quality, and innovation and adaption. Specific activities in which the association's quality and research arm, Essential Hospitals Institute, focuses on equity include these:

- ongoing equity research guided by the Institute's research committee
- board-approved "Principles on Equity of Care"
- an information series on social determinants of health
- stratification of hospital-acquire infections, readmissions, and adverse drug events by age and race, ethnicity, and language (REAL) data
- educational programming, including distance learning and in-person events
- development and deployment of its Ask Every Patient: REAL training module to show hospital staff how to collect REAL data in culturally appropriate ways<sup>3</sup>

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<sup>1</sup> Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

<sup>2</sup> Institute of Medicine. DC. Smedley BD, Stith AY, and Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press; 2002. <https://iom.nationalacademies.org/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>. Accessed January 2016.

<sup>3</sup> America's Essential Hospitals. Ask Every Patient: REAL An eLearning Module for Training Staff in REAL Data Collection. Help Sheet. October 2014. <http://essentialhospitals.org/wp-content/uploads/2014/11/Help-Sheet-eLearning-Works-for-Collection-of-REAL-Data.pdf>. Accessed January 2016.

Recognizing the momentum to reduce disparities in care, the Institute sought to make equity a focus of a national patient safety standard by convening an Equity Leadership Forum (the Forum) in Washington, DC, in October 2015. The purpose of the Forum was to convene a group of thought leaders (see Appendix A) to share best practices, identify targeting approaches aimed at enforcing such practices, and ultimately draft recommendations to The Joint Commission for review and possible adoption as national standards.

In the months leading up to the Forum, a robust dialogue took place among the participants about equity and eliminating disparities as the next generation of harm reduction in this country. This dialogue took place through email and an online interest group created and hosted by America’s Essential Hospitals. The online platform allowed participants to freely exchange ideas, draft language, and provide supporting literature. On a September 2015 conference call, they developed themes for further discussion at the in-person Equity Leadership Forum in October 2015. Following the initial Forum meeting in October, two subcommittees were formed to examine more closely (1) stratification and use of data; and (2) language access. The recommendations, as drafted by the subcommittees and reviewed and approved by Forum members (excluding staff from America’s Essential Hospitals and The Joint Commission) are detailed here.

## RECOMMENDATION 1: STRATIFICATION AND USE OF DATA

### Background and Rationale

Since the release of the two aforementioned IOM reports, countless discussions, initiatives, and committees have sought to improve equity in health care delivery. While these efforts have achieved pockets of success in the United States, systemic equity in health care delivery has not yet been realized. Consider that as recently as 2013, the Centers for Disease Control and Prevention identified major disparities in the categories of mortality, morbidity, access, and behavioral risk factors.<sup>4</sup> Quite simply, the problem remains.

Thus, the time has come for performance standards—developed collaboratively with entities that accredit health care organizations—that drive meaningful and expeditious action to improve equitable health care delivery across the United States.

Such performance standards do not need to be reinvented. They already exist and have been used by many forward-thinking health care institutions across the country. The recommendations in this document contemplate several of these best practices and

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<sup>4</sup> Centers for Disease Control and Prevention. *CDC Health Disparities and Inequalities Report—U.S. 2013*. Atlanta: Centers for Disease Control, Center for Surveillance, Epidemiology, and Laboratory Services; November 2013. <http://www.cdc.gov/minorityhealth/CHDIRReport.html>. Accessed January 2016.

recommend specific standards to spur all health care organizations forward on a path to equitable care.

## **Recommendation**

It has been demonstrated—and cited by many health care leaders, including The Joint Commission—that stratification of race, ethnicity, and language (REAL) data would allow health care organizations to monitor and improve the quality of care for diverse populations. To that end, the following recommendation, succinct and actionable, mirrors language The Joint Commission published in 2007 in collaboration with The California Endowment:<sup>5</sup>

1. Hospitals should stratify clinical quality measures and patient experience by race, ethnicity, language, gender, disability status and socioeconomic status to discern potential disparities
2. Hospitals should develop action plans to address disparities found in stratified analyses of quality measures

## **Elements of Performance**

### Data Collection Element of Performance

More than 80 percent of all unique patients seen have demographics recorded as structured data for race, ethnicity, and preferred language—a meaningful use Stage 2 requirement under the federal Electronic Health Records Incentive Programs and the only available metric.

*Data collection guidance:* The preferred method for collecting race, ethnicity, and language data is self-identification.<sup>6</sup> Hospitals should solidify and support an infrastructure for REAL data collection from patients within all health care settings. Gold standard guidance from the health care community—from the IOM, NQF, and Health Research & Educational Trust—should be followed for self-reporting. Furthermore, America’s Essential Hospitals now offers a tool to standardize REAL data collection: the **Ask Every Patient: REAL** module.

Hospitals should develop a locally relevant and culturally appropriate set of categories that are standardized across the organization. Stratified quality measurement data should be used to discern potential disparities and support active improvement. An organization-wide process should be established to ensure data integrity, accuracy, and

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<sup>5</sup> The Joint Commission, The California Endowment. *Hospitals, Language, and Culture: A Snapshot of the Nation*. April 2007. [http://www.jointcommission.org/assets/1/6/hlc\\_paper.pdf](http://www.jointcommission.org/assets/1/6/hlc_paper.pdf). Accessed January 2016.

<sup>6</sup> When self-identification is not feasible, indirect estimation can serve as a complementary technique for the short term.

comprehensiveness. Hospitals should use Office of Management and Budget–recommended categories for race, ethnicity, and spoken preferred language.<sup>7</sup>

### Data Stratification Element of Performance

Stratify at least one existing and validated core clinical quality measure (e.g., hospital inpatient quality reporting (IQR) measure) and one existing and validated patient experience measure (e.g., hospital consumer assessment of healthcare providers and systems (HCAHPS) scores) by race, ethnicity, and preferred language (REAL), as well as gender, disability status and socioeconomic status (SES).

Use available population demographic data to determine the composition of the surrounding community and stratify selected quality performance data for all racial, ethnic, and preferred language groups that comprise at least 5 percent of the community served by the hospital.

*Data stratification guidance:* Five proposed steps for stratifying REAL, gender, and SES data include these:<sup>8</sup>

1. Assemble an internal working group focused on data stratification and use.
2. Validate REAL, gender, disability status and SES data collected.
3. Identify high-priority quality measures for stratification.
4. Determine if stratification is possible for selected measures.
5. Stratify the data.

Starting with just two measures (one clinical and one patient experience) will help the hospital understand how to stratify data. From there, the hospital can add more measures for stratification to fill gaps in performance.

### Use Element of Performance

Hospital provides the results of the data stratification to the hospital board, or a board-designated committee, and develops a performance improvement plan to close gaps in equitable care.

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<sup>7</sup> Office of Management and Budget. Executive Office of the President. Provisional Guidance on the Implementation of the 1997 Standards for Federal Data on Race and Ethnicity. December 15, 2000. [http://www.whitehouse.gov/sites/default/files/omb/assets/information\\_and\\_regulatory\\_affairs/re\\_guidance\\_2000update.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_guidance_2000update.pdf). Accessed January 2016.

<sup>8</sup> Ibid.

## RECOMMENDATION 2: LANGUAGE ACCESS

### Background and Rationale

The 2011 American Community Survey found that of 291.5 million people age 5 and older, 60.6 million (21 percent) spoke a language other than English at home.<sup>9</sup> Only half of this group reported speaking English “very well.” Individuals in the remaining half are considered to have limited English proficiency (LEP). That is, they are unable to speak, read, write, or understand English at a level that permits them to interact effectively with health care providers.<sup>10</sup>

Given that more than 300 languages are commonly spoken in the United States, it is not uncommon for health care providers to encounter multiple spoken languages in their care settings and to find themselves ill-prepared to communicate effectively with their patients. Nearly half (48.6 percent) of all U.S. physicians in 2008 reported that difficulty communicating with patients because of language or cultural barriers was at least a minor problem affecting their ability to provide high quality care.<sup>11</sup> Nearly 9 percent of the U.S. population is at risk of an adverse event because of language barriers, the Agency for Healthcare Research and Quality has found.<sup>12</sup> Language barriers put the health of many LEP individuals, and that of their communities, at risk by affecting their ability to access care and communicate with their health care providers, increasing the risk of life-threatening errors, wrong procedures, preventable readmissions, and other adverse events.<sup>13</sup>

Furthermore, language barriers put health care providers at risk of costly readmission penalties and non-compliance with federal and state laws. Indeed, high-utilizing LEP patients threaten the ability of providers to meet the goals of the Triple Aim: better care, lower costs, and improved health. The challenge of language barriers will only grow more acute as the U.S. population transitions to a majority-minority by 2043.<sup>14</sup> Immigrants and refugees are increasingly settling in areas of the country that have relatively homogenous,

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<sup>9</sup> American Community Survey Reports - Census.gov. (n.d.). Retrieved from <http://www.census.gov/prod/2013pubs/acs-22.pdf>

<sup>10</sup> U.S. Department of Justice. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. 67 Fed. Reg. 41455 (June 18, 2002). [cited 2006 July 28].

<sup>11</sup> Center for Studying Health System Change. *Modest and Uneven: Physician Efforts to Reduce Racial and Ethnic Disparities*. Washington, DC: 2010. <http://www.hschange.org/CONTENT/1114/> Accessed January 2016.

<sup>12</sup> Agency for Healthcare Research and Quality. *Improving Patient Safety Systems for Patients With Limited English Proficiency A Guide for Hospitals*. Rockville, MD; September 2012. <http://www.ahrq.gov/sites/default/files/publications/files/lepguide.pdf>. Accessed January 2016.

<sup>13</sup> Karliner LS, Jacobs EA, Chen AH, Mutha S. Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature. *Health Services Research*. 2007;42(2):727-754.

<sup>14</sup> U.S. Census Bureau. U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now. December 12, 2012. <https://www.census.gov/newsroom/releases/archives/population/cb12-243.html>. Accessed January 2016.

English-speaking populations, continuing a pattern of expanding language diversity illustrated by the 2011 American Community Survey report.<sup>15</sup>

Adverse events among hospitalized LEP patients are common and costly; they place patients at risk for harm and contribute to the increasing cost of care.<sup>16</sup> A Joint Commission study found that 49 percent of LEP patients who reported adverse events experienced some degree of physical harm, compared with 29 percent of English-speakers.<sup>17</sup> The same report found that LEP patients suffered permanent or severe harm or death 47 percent of the time versus 24 percent of the time for English-speaking patients. Consequently, quality of communication is an important risk factor for serious adverse events, given that it holds promise as a target for actionable intervention with clear standards. A growing body of evidence demonstrates that language concordance between patients and caregivers increase patient satisfaction, patient-reported health status, and adherence with medication and follow-up visits.<sup>18</sup>

The Joint Commission already requires hospitals to provide professional, qualified interpretation services for every patient who needs them, including materials tailored to the patients' ability to understand.<sup>19</sup> This proposed language access standard is essential to guide our nation's health care organizations even further toward delivering more equitable, culturally competent health care to a rapidly diversifying LEP patient population.

## Recommendation

Eliminating health disparities in the United States has risen to the top of the national health care research agenda, and the U.S. Department of Health and Human Services (HHS) has identified it as a foundational goal of Healthy People 2020.<sup>20</sup> Further, it is well established that language barriers contribute to health disparities for LEP patients.<sup>21</sup>

Federal regulations pertaining to language access have remained mostly static since August 2003. But that is about to change. HHS has proposed a regulation to carry out

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<sup>15</sup> American Community Survey Reports - Census.gov. (n.d.). Retrieved from <http://www.census.gov/prod/2013pubs/acs-22.pdf>

<sup>16</sup> Lion KC, Rafton SA, Shafii J, et al. Association Between Language, Serious Adverse Events, and Length of Stay Among Hospitalized Children. *Hospital Pediatrics*. 2013;3(3):219-225.

<sup>17</sup> Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in U.S. hospitals: A pilot study. *International Journal for Quality in Health Care*. 2007;19(2):60-67. <http://intqhc.oxfordjournals.org/content/intqhc/19/2/60.full.pdf>. Accessed January 2016.

<sup>18</sup> Manson A. Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma. *Med Care*. 1988;26(12):1119-28.

<sup>19</sup> Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*. Oakbrook Terrace, IL. The Joint Commission. 2008. <http://www.jointcommission.org/assets/1/6/hlconesizefinal.pdf>. Accessed January 2016.

<sup>20</sup> U.S. Department of Health and Human Services. About Healthy People.

<http://www.healthypeople.gov/2020/About-Healthy-People>. Accessed January 2016.

<sup>21</sup> Jacobs EA, Agger-Gupta N, Chen AH, Piotrowski A, Hardt EJ. *Language Barriers in Health Care Settings: An Annotated Bibliography of Research Literature*. Woodland Hills, CA: The California Endowment; 2003. pp. 1-80.

Section 1557 of the Affordable Care Act (ACA),<sup>22</sup> which broadly prohibits discrimination in health care or health care coverage based on race, color, or national origin (including immigration status and English language proficiency). The proposed rule would extend the ACA provision by prohibiting discrimination based on sex, sexual orientation, or gender identity, and align the reform law with the well-established Title VI of the Civil Rights Act of 1964. Of particular interest to this discussion, HHS seeks to use the new regulation to address the problem of untrained ad hoc interpreters (bilingual staff without formal training as interpreters, adult family members and friends, and minor children).

Specifically, the department would move the legal standard for the type of interpreters a health care organization must provide from “competent” to “qualified.” This higher standard of care for and legal duty to LEP and deaf and hard of hearing patients would require health care organizations that receive federal funds to bear the cost of increasing the professionalism of their language access programs and services.<sup>23</sup> Thus, this recommendation seeks alignment with the expected change in interpreter qualifications.

### **Proposed Elements of Performance**

Without access to language competent individuals and qualified medical interpreters, the rapidly growing LEP population will continue to suffer disparities in health and access to safe, high-quality health care. The following are proposed metrics health care organizations can routinely demonstrate through policies and standardized practices and plans:

- *Identification of participants’ need for language services* – application of data collection methods and measures to identify participants’ proficiency in the majority language and need for language services
- *Use of most appropriate individuals* – use of qualified medical interpreters throughout the care continuum, and consideration of policies which address the use of minors and family members when qualified interpreters are not immediately available. Establishment of measurable thresholds for use of qualified interpreters—i.e., what percent of encounters qualified interpreters should be used rather than less ideal alternatives—across inpatient and outpatient settings.

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<sup>22</sup> U.S. Department of Health and Human Services. Fact Sheet: Nondiscrimination in Health Programs and Activities Proposed Rule. <http://www.hhs.gov/civil-rights/for-individuals/section-1557/summary/index.html>. Accessed January 2016.

<sup>23</sup> Under the proposed rule on Section 1557 of the Affordable Care Act (ACA), the term “qualified interpreter” is defined as an individual who has the characteristics and skills necessary to interpret for an individual with a disability, for an individual with limited English proficiency, or for both. The proposed rule specifies that an individual with above-average familiarity with speaking or understanding a language other than English *does not* suffice to make that individual a qualified interpreter. Further, the criteria for a “qualified interpreter” also would include adherence to generally accepted interpreter ethics principles, including client confidentiality. Thus, under the proposed rule, a competent bilingual health care professional might not be a “qualified interpreter” if serving as an interpreter would pose a conflict of interest with their treatment of the patient.

- *Patient engagement* – evidence of input by and engagement of patients in the design, implementation, and evaluation of the language access services and written translated documents
- *Stratification of performance data by language* – stratification of patient experience, clinical performance, and safety data by language to detect and address health care disparities
- *Leadership competency* – provision of cultural competence training and/or orientation programs for all administrative and clinical leaders, as well as the hospital's governance

## APPENDIX A

### Equity Leadership Forum – List of Members

**Anthony Armada, MHA, MBA,** CEO, Swedish Health Services

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**David Baker, MD, MPH,** Executive Vice President for Health Care Quality Evaluation, The Joint Commission

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**Marshall Chin, MD, MPH,** Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine, University of Chicago

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**David Engler, PhD,** Senior Vice President for Leadership and Innovation, America's Essential Hospitals

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**Don Goldman, MD,** Chief Medical and Scientific Officer, Institute for Healthcare Improvement

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**Maryellen Guinan, JD,** Policy Analyst, America's Essential Hospitals

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**Romana Hasnain-Wynia, MS, PhD,** Director, Addressing Disparities, Patient-Centered Outcomes Research Institute

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**Tomas Leon, MBA,** President and CEO, Institute for Diversity in Health Management, American Hospital Association

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**Ana Pujols-McKee, MD,** Executive Vice President and Chief Medical Officer, The Joint Commission

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**Anna Roth, RN, MS, MPH,** CEO, Contra Costa Regional Medical Center & Health Centers

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**Bruce Siegel, MD, MPH,** President and CEO, America's Essential Hospitals

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**Nicholas Tejada,** CEO, The Hospitals of Providence – East Campus

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**Kimberlydawn Wisdom, MD, MS,** Senior Vice President, Community Health & Equity, Chief Wellness & Diversity Officer, Henry Ford Health System

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**Eugene Woods, MHA, MBA,** President and Chief Operating Officer, Christus Health

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**Ron Wyatt, MD, MHA,** Medical Director, Health Improvement, Office of the Chief Medical Officer, The Joint Commission

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**Clyde Yancy, MD,** Vice Dean for Diversity and Inclusion, Chief, Division of Medicine-Cardiology, Northwestern University