<u>The Committee on Racial and Ethnic Disparities</u>
Meeting Minutes
Friday, July 27, 2007
12 noon – 1:30 pm

Attendees: Joseph Betancourt, Joan Quinlan, James Beck, Nakela Cook, Ann Daniels, Ellen Forman, Cy Hopkins, Suzanne Kim, Elizabeth Mort, Kelly O'Rourke, Ranna Parekh, Carlyene Prince Erickson, Allison Rimm, Isaac Schiff, Thomas Sterne, Nhi-Ha Trinh, Carmen Vega-Barachowitz, Joel Weissman, Albert Yeung, Adrian Zai, Elizabeth Donahue, Maria-Pamela Janairo, Jessie Kimbrough-Sugick, Wanda Vega

I. Committee updates
  a. DSC Disparities Leadership Program
    i. The DSC kicked off its inaugural Disparities Leadership Program in May. Its members consist of hospitals, health plans, and community-focused organizations spanning the entire country.
  b. Quality Update:
    i. CRC Screening:
      1. 300 patients have been called, 60 colonoscopies have been scheduled and 63 have been performed.
    ii. Diabetes
      1. Qualitative Interviews are being done by a bilingual summer student
      2. Coaching intervention and other components have brought down average HbA1c by 1.5 points.
    iii. Dashboard
      1. The Dashboard is undergoing reconstruction and overhaul with stratification with a new computerized format. With this new program, reports can be created targeting a particular interest. We should thank Gregg and Liz for all their hard work in mainstreaming this.
    iv. Chief's Review
      1. Drs. Slavin and Torchiana conduct an annual review with every clinical chief using a one page check sheet of key priorities. A new question has been added to this check sheet, "Do you stratify your quality measures by race and ethnicity?"
    v. Trustees Quality Subcommittee
      1. Gregg has asked Joe to sit on the Trustee Committee on Quality and Patient Safety
  c. New Orleans
    i. Don Irwin, head of the St. Thomas Community Health Center in New Orleans, has reached out to Massachusetts General Hospital to for help in addressing three key issues post-Katrina, which include culturally competent health care systems (medical home programs), research and evaluation, and mental health work. Joe, Joan and Greg Fricchione from psychiatry made a trip to New Orleans in June. A Commonwealth Fund Planning Grant is being written.

d. JGIM article
    i. Alex Green's article on medical residents from MGH, BWH, BIDMC, and Emory was featured in the Boston Globe
        1. James Beck encouraged everyone to learn more about Implicit Association Tests (IATs) and to take a sample test
        2. Joe explained that all incoming first year medical students are required to take IATs, which measure unconscious bias on race/ethnicity, gender, physical size, sexuality, etc. and how that might might impact clinical decision making. After the exam is taken, you are shown your results and ways in which to help interpret them
        3. Carlyene Prince Erickson asked how we can translate these results into a way to create change
e. Other Updates
    i. The MGH Disparities Committee website is being updated
    ii. Joe welcomed Adrian Zai who was helpful in stratifying the MGH registry on race/ethnicity.

II. The MGH Disparities Committee – the next phase
a. Joan proceeded to introduce the next session. Key question to answer: "What does success look like?"
b. Joe then reviewed our Progress to Date <handout>
c. Allison Rimm then began the strategic planning discussion, highlighting key steps to be mindful of. <Powerpoint slide>
    i. How do we define success? No detectable disparities?
    ii. Ten years ago, gender disparities in care was the main issue being addressed. Now, there is hardly any mention of it.
    iii. How do we define ourselves? How do you meet the needs of an increasingly diverse population?
    iv. Other issues come up as well, such as medical literacy problems and disabilities.
d. Where do we want to be in 5 years?
    i. Joan: The MGH Disparities Committee Mission Statement is to identify and address racial and ethnic disparities in care anywhere at MGH.
    ii. Increase diversity of patients and staff
    iii. Any and all people can get equal access pratically and functionally despite their racial/ethnic background, language and socioeconomic status
    iv. It should be a continuous effort
    v. Our workforce will one day have deep knowledge of issues related to variation in care based on racial/ethnic; There will be an appetite for tools to deal with. People will have competency, knowledge and know how to take action.
    vi. Make hospital more welcoming. Change the composition of the workforce.
    vii. Make sure every employee understands how they might contribute to disparities without intending to.
    viii. A welcoming environment, along with public relations and community engagement, is important

ix. Employees should know the extent of their own biases and know how to work around them.
x. MGH is a scholarly institution; we should set the stage for others to share what we're doing, but in a scientific manner
xi. Make resources on equity available to staff and patients (if need interpreter, etc.)
xii. Hold staff and providers accountable
xiii. If all HMS students take Implicit Association Test, then all employees should take it. Everyone in this room should take it, let's begin with us
xiv. All staff members should be trained, mentored and supported in understanding differences and importance of seeing the world in another's shoes. This should be included in their performance evaluation. In real time, converse and share information in the patients' languages in which they are most comfortable speaking.
xv. Patients perceive that MGH is operating without bias, or at least trying to in good faith.
xvi. Every patient should know their PCP, main provider, and know the reason why they are coming; decrease no-show rates (ideally to <5%)
xvii. Staff should understand that biases are natural and they won't be judged; they should see this as a learning opportunity
xviii. Competency in all of these areas should be added to performance review and merit increase.
xix. Maintain patient focus; patients should be involved in this process
xx. How do we make our radar more sensitive?
xxi. Health literacy should be kept in mind as well. How do we ensure that providers know how to deal with health illiterate patients?
xxii. Our goal should be that the patient has a good experience overall and their needs are met in a compassionate way; we need to make sure that all patients have a good outcome as you can get
xxiii. How do we collaborate across departments? How can psychiatry learn from medicine, etc.? How can we work together?
xxiv. Welcome and value communication and diversity of ideas and styles
xxv. Different culture/ethnicity – we need to be mindful how to explain this to people
xxvi. We need to educate patients on making informed decisions
xxvii. Learn different ways to communicate with all patients to facilitate openness and initiate dialogue
xxviii. Be mindful of patient expectations
xxix. Every provider has adopted successes and failures in ethno-racial terms

III. Next Disparities Committee Meeting will be held on September 28th from 12noon – 1:30pm in the Trustees Room