

**The Committee on Racial and Ethnic Disparities – Strategic Planning Meeting**  
**Meeting Notes**  
**Friday, September 28, 2007**  
**12 Noon – 1:30**

**Attendees:**

Adrian Zai, Allison Rimm, Ann Richmond, Aswita Tan-McGrory, Carmen Vega-Barachowitz, Elizabeth Donahue, Elizabeth Mort, Ellen Forman, Isaac Schiff, Joan Quinlan, Joel Weissman, Joseph Betancourt, Kelly O'Rourke (for Tavinder Phull), Nakela Cook, Nhi-Ha Trinh, Olaku Agburu, Ranna Parekh, Roger Pasiniski, Suzanne Kim, Thomas Sterne, Wanda Vega

1. Review of notes from previous meeting

- The discussion at the July meeting centered around answering the question, “What would MGH look like if the Disparities Committee achieved all of its goals?” The group reviewed the notes from the previous meeting (see Appendix A). Joan observed that the theme of education and training around cultural competence was prominent. She and Joe emphasized that this does not mean our work is done in the quality realm, but rather, the group felt a high level of confidence in the course that has been charted to integrate disparities into ongoing quality work. Because Gregg Meyer and Liz Mort have embraced this work, it is being carried on within the institution, which is exactly what we want to achieve. This frees the committee to address additional issues, while continuing to monitor quality.
- The Committee was asked to consider if there is anything missing from the list generated at the last meeting.
  - Joel suggested that there is no mention of cultural competence organizational assessments. Joe suggested that MGH could utilize the CLAS standards (culturally and linguistically appropriate services) to begin to assess the level of cultural competence at MGH.
  - Tom remarked that the cultural competence and patient experience themes seem almost too similar to not be considered one large theme. He also suggested making a set of indicators to assess patient experiences.
  - Liz Mort stated that we need to add the importance of understanding disparities, identifying where they exist and developing interventions to address them.
  - Joel suggested that institutional self-assessment be added. He also noted that the diversity theme is just as important as the others. Finally, he mused if it is possible to have the focus be out in the community.
  - Joe ended this part of the discussion by reminding everyone of the progress of the committee up until this point. The quality folks have really dug in and accomplished a great deal. Therefore, it's not surprising that the 5-year themes are heavily focused on the other two areas that the committee has outlined (education and awareness and patient experience), which haven't gotten quite as much attention as the quality piece. This is not to say that nothing is being done, however, as progress is indicated by the development of the Service Matters series and the diversity committee.
  - Allison described efforts to establish a patient welcome center. The project came as a result of the diversity committee and should be accessible to all patients. The goal is to help patients with whatever they

need. In the past, non-English speaking patients with questions or concerns frequently relied on medical interpreters. While interpreters attempt to be helpful on an ad hoc basis, they do not have capacity to meet the need and play a different role within the institution. The center will be devoted to treating patients as individuals – asking what they need without presumption and then working to provide it. The project is now in its planning phase.

## 2. Small Group Brainstorming for Action

The meeting was divided into four small groups and each group was asked to use the list brainstormed at the first meeting, to brainstorm action steps. What *actions* would MGH need to take to accomplish the “wish list.” Following are the results for the four groups.

### a. Group I

- Navigators that follow people
- Re-engineer transitions/discharge
- Ongoing training – make it mandatory and include it as part of annual review; employee orientation not enough
- Focus on providers
- Create quality incentives; carrots and sticks for attending training and for exhibiting culturally competent behaviors.
- Calstat campaign should be replaced by a cultural competence campaign for FY 2009

### b. Group II

- Increasing diversity of committee membership for this committee
- Training and orientation; everyone should get training at orientation and beyond
- Suggest including implicit association testing as part of training
- Find out what the MGPO is doing to educate providers
- Dashboard - Should expand distribution so people are aware of where disparities exist in the hospital and can be held accountable for problem areas, transparency, and diseased focus

### c. Group III

- Collect and analyze anecdotes from interpreter services department to identify themes
- Communication and education re: differences in perceptions b/t patients and providers; is there an awareness when there are problems that cultural competence may be at the root?
- Engage HR in the process – move beyond employee orientation
- Increase awareness by requiring people to take the IAT and then f/u with interventions
- Design a follow-up competency assessment – this training can not be a one-time occurrence, it must be ongoing
- Do some team experience training regarding cultural competence
- Add languages spoken by employees to staff directory so people could locate resources
- Integrate languages into culture

- Implement incident reporting for issues regarding cultural competence issues
- Report experiences of minority house staff to identify themes, develop intervention strategies, and broaden to give people tools.

#### Group 4

- Joe suggested a summit that will bring together all departments that are doing any kind of training; Can learn the landscape of current training – who’s doing what; Then move forward on the same page with consistent themes for all employees
  - Joe also suggested a patient experience summit to review everything we do to collect data on patient experience and to examine how to sensitize the radar.
  - Tom and Ann stressed the importance that any changes be institutionalized and continuous in order to ensure effectiveness. Also emphasized the need to secure leadership buy-in and demonstrate to all staff the commitment by leadership.
  - Liz Mort pointed out to the group that the suggestion of replacing the Calstat campaign to a cultural competence campaign is not a joke. The campaign could include the suggestion to take the IAT. Joe remarked that he could follow-up about the possibility of providing e-learning opportunities to address issues discovered by staff after taking the test.
3. Major themes of discussion/Next Steps - summarized by Joan
- Training around cultural competence for all with incentives and with reinforcing training over time.
  - Sensitizing the radar in terms of collecting data on patient experiences and using that data effectively
  - Joe and Joan will review notes from this meeting and make suggestions for next steps.

# APPENDIX A

## Where do we want to be in 5 years?

### Diversity

- Increase diversity of patients and staff
- Change the composition of the workforce

### Patient Experience

- Any and all people can get equal access practically and functionally despite their racial/ethnic background, language and socioeconomic status
- Make hospital more welcoming
- A welcoming environment, along with public relations and community engagement, is important
- Patients perceive that MGH is operating without bias, or at least trying to in good faith. Every patient should know their PCP, main provider, and know the reason why they are coming; decrease no-show rates (ideally to <5%)
- Maintain patient focus; patients should be involved in this process
- 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
- We need to educate patients on making informed decisions

### Cultural Competence/Awareness/knowledge of Staff

- 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.
- Make sure every employee understands how they might contribute to disparities without intending to.
- Employees should know the extent of their own biases and know how to work around them.
- Hold staff and providers accountable
- 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
- 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.
- Staff should understand that biases are natural and they won't be judged; they should see this as a learning opportunity
- Competency in all of these areas should be added to performance review and merit increase.
- How do we make our radar more sensitive?
- Health literacy should be kept in mind as well. How do we ensure that providers know how to deal with health illiterate patients?
- Learn different ways to communicate with all patients to facilitate openness and initiate dialogue
- Be mindful of patient expectations
- Every provider has adopted successes and failures in ethno-racial terms

### Other Themes

- How do we collaborate across departments? How can psychiatry learn from medicine, etc.? How can we work together?
- Welcome and value communication and diversity of ideas and styles
- Different culture/ethnicity – we need to be mindful how to explain this to people
- MGH is a scholarly institution; we should set the stage for others to share what we're doing, but in a scientific manner
- Make resources on equity available to staff and patients (if need interpreter, etc.)