HR SOLUTIONS, INC.

THE STATE OF HEALTH CARE DIVERSITY AND DISPARITIES: A BENCHMARK STUDY OF U.S. HOSPITALS

EXECUTIVE SUMMARY

FOR

INSTITUTE FOR DIVERSITY
in Health Management
An affiliate of the American Hospital Association

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HR SOLUTIONS INTERNATIONAL, INC.
Turning Data Into Action™

State of Health Care Diversity and Disparities: Benchmark Study

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State of Health Care Diversity and Disparities: Benchmark Study

INTRODUCTION

The Institute for Diversity in Health Management (IFD) and HR Solutions, Inc. (HR Solutions) recently completed a survey of U.S. Hospitals which collected data and measured attitudes on diversity and disparities in the health care arena. The purpose of the study was fourfold: 1) to establish diversity benchmarks, 2) measure future progress, 3) educate organizations regarding diversity and disparities, and 4) recognize organizations embracing diversity and leading the way in addressing patient care disparities.

The survey was administered from October 27, 2008 through February 19, 2009. A total of 182 organizations participated in the study. This survey tool was based on research included in "Strategies for Leadership," a diversity and cultural competency assessment tool IFD created in conjunction with the American College of Healthcare Executives (ACHE), the American Hospital Association (AHA) and the National Center for Healthcare Leadership (NCHL). The survey instrument also drew from recent work in the areas of culturally competent patient care, health care disparities, and leadership conducted by The Joint Commission (in its Hospitals, Language, and Culture study) and by the National Public Health and Hospital Institute's collaboration with the Institute for Healthcare Improvement and the Disparities Solutions Center at Massachusetts General Hospital.

Finally, HR Solutions wishes to thank IFD employees who helped with the planning and execution of the survey process. Special thanks are given to *Mr. Fred Hobby, Mr. Ed Martinez, Ms. Elaine Johnson, and Mr. Zachary Benjamin*; without their commitment and hard work, smooth implementation of the survey would never have been possible. In addition, we would like to thank the ARAMARK Charitable Fund at the Vanguard Charitable Endowment Program for their support of the study with a three-year grant.

KEY FINDINGS

The study found that despite representing 72% of their respective community populations and 72% of full-time employees, 83% of Board of Trustees and 91% of Executive Groups were comprised of Caucasians.

TRENDS

Financial Allocation to Diversity

Only 37% of the 182 organizations indicated they had an annual financial allocation towards achieving diversity and cultural competency goals. For those 68 organizations with an annual financial allocation, they averaged $479,971 for the 2008 Fiscal Year (Adjusted to $424,152 for two health systems which entered identical financial data for all of their system entities). Furthermore, of those with an annual allocation, 12% allocated over $1 million. The top allocated amount was $5.7M, followed by $3M, $2.5M, $2M, $1.5M, $1.2M, $1.1M, and $1M.

In total, the 68 organizations reported spending approximately 2% (3% of adjusted for health systems) of their FY2008 operating budget on achieving diversity and cultural competency goals. The highest percentages (90th percentile and higher) of the FY2008 budget being allocated to diversity was (25%), followed by a pair of organizations at 5% and another pair at 2%. On average, the organizations at least at the 90th percentile of their FY2008 budget allocation to diversity set aside $615,250 (adjusted to $587,625 without Health System duplication).

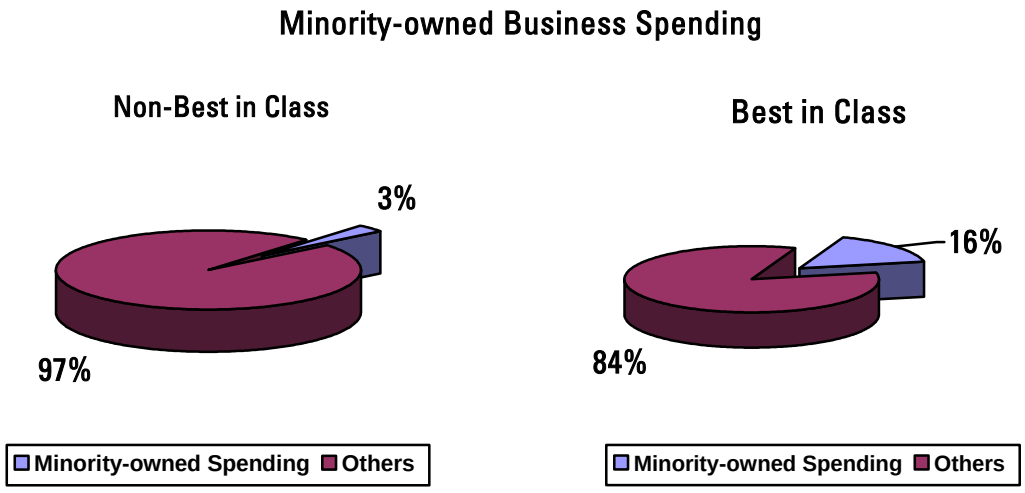
Minority/Female-owned Business Patronage

Fully, 127 of the 182 organizations participating in the study answered questions investigating their patronage of minority-owned or female-owned businesses. In all, these 127

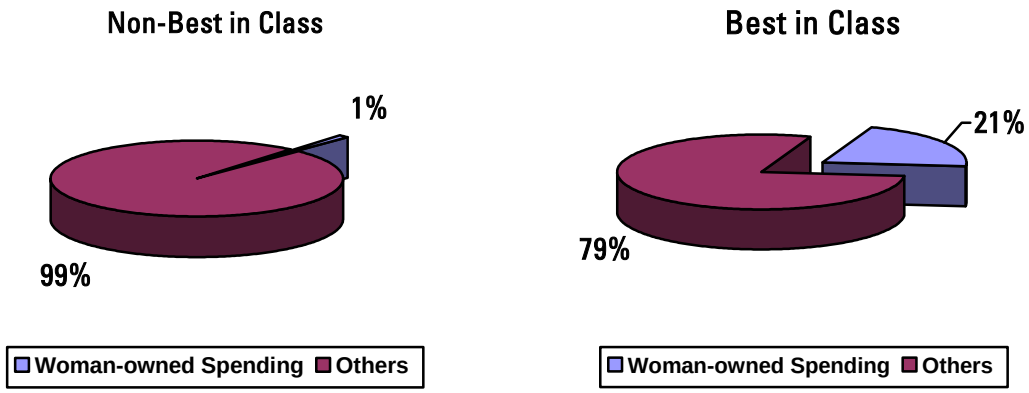
organizations purchased 4.3% of goods/services from minority-owned businesses and 4.1% from female-owned businesses.

The Best in Class organizations (≥ 90th percentile for percentage of spending) typically spent five to two times more with minority and or woman-owned business when purchasing goods and services.

Chart 1: Percentage of Spending with Minority and Women-owned Businesses by Best in Class vs. Others



Women-owned Business Spending



Hiring Practices

On average the organizations had 4.7 executive-level vacancies in the 12 months prior to their participation and indicated they had hired or promoted a minority or female for 2.7 positions. With over 90% of organizations responding, the majority indicated they had hired or promoted a female or minority for 55% of executive-level vacancies in the past 12 months.

Promotions

With 97% of organizations responding, the average organization in the study had placed 205 minorities, 354 women, and 7 disabled individuals over a three-year period (if adjusted for the eight duplicate entries by one health system the figures would be 135 minorities, 231 women, and 7 disabled individuals respectively).

QUALITATIVE ANALYSIS

The following section examines the open-ended questions from the study which allowed organizations to elaborate on their responses. During our qualitative data analysis, there were responses within the questionnaire that gave insights to organizational work in narrowing the disparities gap.

Relationships with Community Entities

The question 1.11 (b) had a total of 140 of the 182 organizations that have formed collaborative relationships with community service providers and social services agencies to facilitate appropriate and efficient referral processes. Of these 140 listed other entities, most of whom (109) have had these collaborative relationships active for more then 3 years. There were ten respondents that have formed these relationships 1-3 years ago and three have begun this active relationship in less then one year.

- Of the organizations 109 also listed over three years active collaboration with homeless shelters while 55 were not active within shelters.
- Of the organizations 133 also listed over three years active collaboration with faith-based organizations while 24 are not active within faith-based organizations.
- 138 organizations also listed over three years active collaboration with schools and universities while 20 were not active within schools and universities.
- The trends noticed within the qualitative responses included clusters around: American Heart Association, Assisted Living facilities, community health centers/clinics, Federal Qualified Healthcare Centers, hospice, Kids Homes, Mental health centers/facilities, nursing homes and Planned Parenthood, Salvation Army, United Way, women's shelter/abuse shelters.
- The overall impression is that hospitals and health clinics which are actively using the collaborative relationship in the community find benefit in doing so and will subsequently utilize more then one method.

The question 1.11 (c) related to the above, had also formed collaborative relationships to promote the provision of quality health care. Of the 182 responding organizations, 142 worked with other community entities for more than 3 active years. Similarly, 96 (52%) have relationships with homeless shelters for more than 3 years while 3% do not have active relationships with this group. There were 125 (69%) with relationships formed for more than 3 years with faith-based organizations while 16% do not. Lastly, there were 140 (77%) organizations with relationships formed for more than 3 years with schools/universities while 11% do not.

Opportunities Provided to Underrepresented Professionals

The question 2.1 asked for organizations to comment on the opportunities provided to underrepresented racial and ethnic minority professionals.

- Of the 182 respondents, 108 organizations do not have a documented action plan for providing opportunities for underrepresented racial and ethnic minority professionals to serve on boards and in executive positions.
- 17 organizations have a documented plan for increasing minority representation in the executive positions of the organization.
- 43 have a documented plan for increasing minority representation on both governing body and in executive positions.
- 12 respondents have a documented plan for increasing minority representation specifically for service on governing body.
- Six organizations use recruitment as a method for increasing minority representation in the executive positions of the organization and the same amount have specific seats for diverse members on their boards and committees.
- There were a handful of organizations attempt to increase minority representation in the executive positions via retention and use Affirmative Action plans as guidelines for increasing minority representation. Both of these organizations also use recruitment as a tool.

- Few organizations develop relationships in the community with minority professional organizations, career fairs, and networking as a method to increase minority representation in executive positions of the organization.

- The 43 organizations that have a documented plan for increasing minority representation on both governing body and in executive positions engaged a variety of methods to do so, including recruitment, retention/succession planning efforts, Affirmative Action guidelines, connections with local and professional organizations, reserving board, committee and executive seats for minorities, and special leadership programs.

    1. Recruitment (utilizing special executive recruitment agencies, requiring the percentage of minority candidates to match the community percentage, etc.) – 14 organizations
    2. Retention/Succession Planning (mentoring, employee development, etc.) – 16 organizations
    3. Affirmative Action (following these specific guidelines) – 1 organization
    4. Professional Organizations/Local Relationships – 3 organizations
    5. Reserving Board/Committee/executive seats for minorities – 14 organizations
    6. Offering leadership development programs – 10 organizations

Identification of Qualified Individuals for Governing Bodies

The question 2.3 also asked organizations to comment on the other ways to identify qualified individuals for serving on governing bodies from diverse groups. There were over 80% of responding organizations identify qualified individuals for serving on governing bodies and for executive positions from diverse racial and ethnic communities through networking/proactive outreach attempts to professional associations.

- From this majority another 37% who identified use of the Chambers of Commerce to identify qualified individuals for serving on governing bodies and for executive positions from diverse racial and ethnic communities.

- Approximately 70% of the organizations identify qualified individuals for serving on governing bodies and for executive positions from diverse racial and ethnic communities through corporations and community leaders.

- While 30% of the organizations identify qualified individuals for serving on governing bodies and for executive positions from diverse racial and ethnic communities through advocacy groups.

- From the total group of respondents, 15% listed the use of another method such as advertisements, personal relationship and internal recruiting to identify qualified individuals for serving on governing bodies and for executive positions from diverse racial and ethnic communities.

Measures for Improving Quality of Care

Within the survey questionnaire, 2.7 asked the organizations to identify yes or no if they have developed reliable measures designed to improve customer service and quality of care for diverse patient populations.

- The majority (53%) of the organizations responded "yes" to this item. A strong recurring theme found among 43 of these organizations included the development and implementation of patient satisfaction surveys.

- Upon review of the data, it appears that a quarter (26%) were categorized as "Other not-for-profit (including NFP Corporation)" organizations.

- Of the 97 organizations that responded "yes" to this item, 63% of the organizations were located in urban areas with the focus of their service being "general medical and surgical" for the majority of their admissions.

- The most important inference to be made from the data is that over half of the organizations surveyed have developed measures to gauge customer satisfaction and in turn, the quality of care for diverse patient populations. By systematically measuring customer satisfaction and quality of care, healthcare organizations can understand the bigger "picture" and eventually improve both areas. In turn, there will be better healthcare, targeted at a diverse population.

Interpreter Training

Item 4.49 of the survey asked if there a difference between standards for training and competency of hospital interpreters and outsource service interpreters.

- The vast majority (95%) of the organizations responded to this item. Most (68%) suggest that there is no difference among the standards for training and competency of hospital interpreters and outsource service interpreters.

- Of the approximately 30% of organizations that did respond "yes"; the common theme among their written explanations suggest that outsource service interpreters typically provide patients medically-based translations (including explanations of procedures and consent), while internal interpreters provide non-medical, identification-based translations (including demographic and patient information/history).

APPENDICES

DESCRIPTIVE STATISTICS SECTION

The following section of the summary examines the statistical data collected during the study.

Regional Composition of Study

There were 182 participating organizations; of the 182 surveys completed, 60 organizations (33%) were located in the **Midwest region**, followed by 47 organizations (26%) in the **South region**, 32 organizations (18%) in the **Middle Atlantic region**, 18 organizations (10%) in the **Southwest region**, 13 organizations (7%) in the **West region**, and 12 organizations (7%) in the **New England region**.

Table 1: Survey Participation by U.S. Region

U.S. REGION	STATES	Percentage of Organizations	Number of Participating Organizations
MIDWEST	IL, IN, IA, KS, MI, MN, NE, ND, OH, SD, WI	33%	60
SOUTH	AL, AR, FL, GA, KY, LA, MS, MO, NC, SC, TN, VA, WV	26%	47
MID-ATLANTIC	DE, MD, NJ, NY, PA, DC	18%	32
SOUTHWEST	AZ, NM, OK, TX	10%	18
WEST	AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY	7%	13
NEW ENGLAND	CT, ME, MA, NH, RI, VT	7%	12

Ownership/Control

Of the 182 surveys submitted, the majority of the respondents (138 organizations or 76%) indicated they were **Non-government, Not-for-profit (NFP),** followed by 27 organizations (15%) categorized as **Government, Non-federa**l, 12 organizations (7%) were Investor-owned, for profit and only 5 organizations (3%) responded as **Government, Federal**.

Of the 182 respondents in the organizations' ownership/control category, 119 organizations (65%) identified themselves as **Other not-for-profit (including NFP Corporation)**, followed by 19 (10%) **Church-operated** establishments, 12 **Corporations** (7%), 10 (5%) **State-operated** organizations, 8 organizations (4%) categorized as **Hospital District or Authority**, 7 (4%) **County-operated**, 3 organizations (1.6%) classified as **Veterans' Affairs**, 2 (1%) **City-operated**, one (.5%) **Public Health Service** and one (0.5%) categorized as **Federal other than 41-45 or 47-48**.

Type of Service

When asked to select one category that best describes their organization or the type of service it provides, the majority of participants (149 organizations or 82%) identified themselves as **General Medical and Surgical**, followed by 12 organizations (7%) that selected **Other**, 5 (3%) **Oncology** organizations, 4 (2%) **Pediatric** organizations, 3 (1.6%) **Rehabilitation** organizations, 3 **Acute long-term care hospitals** (1.6%), 2 (1%) **Hospital units of an institution**, another 2 **Psychiatric** organizations, and finally one (0.5%) **Orthopedic** organization and one (0.5%) organization categorized as **Obstetrics and Gynecology**.

Council of Teaching Hospitals

The majority of participants (121 organizations or 67%) indicated that they are not a member of the Council of Teaching Hospitals and Health Systems (**COTH**), with the remaining 60 establishments (33%) confirming their membership in COTH.

University HealthSystem Consortium

Of the 181 organizations that responded to the question regarding being a part of the University HealthSystem Consortium **(UHC)**, only 33 organizations (18%) responded positively, with the majority of 148 organizations (82%) indicating that they were not affiliated with UHC.

Urban vs. Rural Classification

Of the 182 participants, 128 organizations (70%) were classified as **urban**, with remaining 54 organizations (30%) classified as **rural**.

Bed Size

Of the 182 organizations in the bed size category, 51 organizations (28%) reported to be in the **301 to 600 Beds** range, followed by 46 organizations (25%) that fell into the **101–300 Beds** category, 28 organizations (15%) in the **Less than 50 Beds** category, 21 organizations (12%) in the **601–1,000 Beds** category, 20 organizations (11%) in the **50–100 Beds** category, and 16 organizations (9%) in the **1,001+ Beds** category.

Workforce Size

The median workforce size of the 182 participating organizations was 1,422 **full-time employees**. Of the 182 respondents, 46 organizations (25%) were in the **1000 to less than 2500** full-time employees range, followed by 31 organizations (17%) in the **2500 to less than 5000** full-time employees category, 27 organizations (15%) in the **200 to less than 500** full-time employees category, 23 organization (13%) in the **Less than 200**, another 23 organizations (13%) in the **500 to less than 1000** full-time employees. There were 18 organizations (10%) with **5000 to less than 10,000** and 14 organizations (8%) with **Over 10,000** full-time employees.

Composition of Sample versus AHA Organizations

The 182 participating organizations were compared to the American Hospital Association's 4,900 registered organizations and found to be fairly similar in composition with the exceptions of Region, Bed Size, and Ownership/Control data. The IFD sample this year was 70% urban whereas the AHA hospitals were 59% urban. The IFD sample also tended to be larger than the average AHA hospital with 49% of IFD sample organizations having over 300 beds whereas the

AHA database had only 16% in this category. Furthermore, 15% of the IFD sample had fewer than 50 beds, whereas this group comprised 29% of the AHA population. Finally, the IFD sample had a higher percentage of **Other** (not for profit) organizations (65%) when compared to the AHA (49%). The following tables illustrate how the study participants compared to the AHA Hospitals database.

Table 2: Ownership/Control Composition of Participating Organizations vs. AHA

Ownership/Control	IFD Study	AHA Organizations
Other (not for profit including NFP Corporation)	65%	49%
Church Operated	10%	11%
Hospital District or Authority	4%	11%
Corporations	7%	15%
State Operated	5%	2%
County Operated	4%	8%
City Operated	1%	2%
All Others	4%	2%

Table 3: Type of Service Composition of Participating Organizations vs. AHA

Type of Service	IFD Study	AHA Organizations
General Medical & Surgical	82%	91%
Rehabilitation	2%	4%
Pediatric	2%	2%
Acute Long-term Care Hospitals	2%	2%
All Others	12%	1%

Table 4: Urban and Rural Classification of Participating Organizations vs. AHA

REGION	IFD Study	AHA Organizations
Urban	70%	59%
Rural	30%	41%

Table 5: Bed Size Composition of Participating Organizations vs. AHA

Bed Size	IFD Study	AHA Organizations
Less than 50	15%	29%
50-100	11%	20%
101-300	25%	35%
300 or more	49%	16%

Gender Composition

The vast majority of employees at these organizations were female (77.4% **Female** and 22.6% **Male**). With regard to the female-male ratio of the full time employee workforce, the majority of respondents fell into the **3:1 to less than 4:1** female to male ratio (46 organizations or 25%), with the second largest concentration of 41 organizations (23%) in the **4:1 to less than 5:1** Female-male ratio range. The remaining organizations fell into the following ranges included in Table 6 on the following page.

Table 6: Female-to-Male Ratio of Participating Organizations

Female-to-Male ratio	# of Organizations	Percentage of Organizations
Less than 1:1	4	2%
1:1 to less than 2:1	13	7%
2:1 to less than 3:1	31	17%
3:1 to less than 4:1	46	25%
4:1 to less than 5:1	41	23%
5:1 to less than 6:1	18	10%
6:1 to less than 10:1	21	12%
10:1 or greater	7	4%

Race/Ethnicity Composition

Organizations also provided by racial/ethnic demographic group the composition of their patient population/community, full-time employee workforce, executive group and Board of Trustees members. In moving from the Patient population to Full-time Employees, Executives, and Board of Trustees there was a predictable decrease in the percentages of the minority race/ethnicity demographic groups. The percentages only increased at the higher levels for the White/Caucasian group which comprised nearly 90% of both the Executive and the Board of Trustees levels; no other minority group comprised more than 10% of these groups. See Table 7 below for a summary of reported percentages for the race/ethnicity demographics by level.

Table 7: Reported Demographic Group Sizes by Level

Demographic Group	Level	# of orgs responding	% of Group Mean	Std. Deviation
White or Caucasian (not Hispanic)	Board of Trustees	182	88.6	12.2
	Executive	180	91.3	12.1
	Full-time employees	182	72.3	20.4
	Patient/Community	178	72.2	20.4
Black or African American (not Hispanic)	Board of Trustees	131	9.4	7.7
	Executive	121	6.0	7.0
	Full-time employees	170	14.5	12.6
	Patient/Community	166	14.4	14.2
Hispanic or Latino	Board of Trustees	109	5.6	9.3
	Executive	120	5.4	14.4
	Full-time employees	177	7.1	9.1
	Patient/Community	170	9.3	11.5
Two or More Races (not Hispanic)	Board of Trustees	78	0.8	3.2
	Executive	99	0.8	2.9
	Full-time employees	148	1.1	2.3
	Patient/Community	132	3.9	10.6
Asian (not Hispanic)	Board of Trustees	88	1.7	3.2
	Executive	111	2.3	3.7
	Full-time employees	171	5.3	6.5
	Patient/Community	152	2.4	3.4
American Indian or Alaska Native (not Hispanic)	Board of Trustees	77	0.2	1.3
	Executive	97	0.2	0.7
	Full-time employees	159	0.8	1.1
	Patient/Community	135	1.7	8.8
Native Hawaiian or Other Pacific Islander (not Hispanic)	Board of Trustees	77	0.2	1.0
	Executive	98	0.3	1.6
	Full-time employees	147	0.8	3.2
	Patient/Community	123	0.6	2.9

Race/Ethnic Distribution across Levels

Caucasians were the racial/ethnic group which was most evenly distributed across the four groups (Patient, Full-time Employee, Executive, and Board of Trustees). Please see Appendices for figures illustrating the demographic distribution across levels.

Linguistic Diversity

When asked if their organizations used benchmarks such as the National Standards for Culturally and Linguistically Appropriate Services (CLAS), 74 of the 182 organizations (41%) responded affirmatively. The overwhelming majority (71%) cited their use of CLAS with the next largest percentage (18%) indicating their organization's use of Census Data for benchmarking.