The story begins – as so many do – with the birth of a child. Every 70 seconds, a child is born uninsured; and nearly one in ten of the 47 million nonelderly uninsured Americans is a child. In many cases, these children are born into circumstances of socioeconomic, developmental, racial, ethnic, gender, religious, geographic or cultural disenfranchisement that further separates them from, among other critical resources, the healthcare system. Stemming the tide of this cumulative disadvantage was a key driver of the Patient Protection and Affordable Care Act (ACA), which aims to greatly reduce the lack of access to healthcare coverage.2

The unrelenting debate over the ACA emphasizes the tension between the demand for increased accountability for metrics-driven results – and clearly defined outcomes – and the need to improve access to quality healthcare for increasingly diverse patient groups. Myriad research speaks to a direct correlation between greater workforce diversity and improved public health, leading to both greater access to healthcare services for underserved populations and better interactions between patients and health professionals.3 Ultimately, improving care disparities is critical to an organization’s financial health.

Healthcare organizations struggle to ensure that staff members have the skills and resources necessary to deliver culturally competent care to increasingly diverse patient populations, within the context of heightened competition for limited resources. Creative thought leaders in this space are leveraging culture to recalibrate healthcare inequalities and, through their applied efforts, increasing both access and adherence to treatment, engendering higher levels of trust in the healthcare system and providing more responsive and inclusive research and advocacy.

Start with Outcomes in Mind
According to George Miller, the CEO of the largest Federally Qualified Health Center (FQHC)5 in Texas, CommUnityCare, the genesis of healthcare disparities – and health status disparities – begins in the womb. "Investing time and money in prevention and education, including prenatal care, would save the system a tremendous amount of money in the long term and lead to significantly greater outcomes. This calls for an investment in the beginning of life, creating a medical home so that those who are poor, those who are vulnerable, those in populations that don’t have a voice can receive quality healthcare, understand wellness, gain education and training and participate actively in the process that can improve their lives and well-being. We must start with these outcomes in mind and reeducate participants in the process."

To that end, CommUnityCare providers typically speak several languages (and utilize a telephone medical translation service for less common languages) to provide outpatient primary healthcare, specialty care, behavioral health services, HIV/AIDS treatment, and care for the homeless to those whose incomes and lack of private health insurance qualify them for enrollment. While Miller lauds the emphasis on comprehensive, coordinated care, he acknowledges persistent challenges nationwide as socioeconomically and otherwise disadvantaged patients often find it more difficult to access specialty care due to insurance status, inefficient referral systems, or long wait times.
Workforce Diversity: Driver for Equality of Access to Healthcare

One way to reduce this barrier for health centers,” says Miller, is to “forge public-private partnerships and find ways to advance collaboration efforts with provider networks.” The ACA has positioned FQHCs like CommUnityCare to play a crucial role in the future healthcare environment, as newly insured and uninsured populations will likely depend on FQHCs and FQHC look-alikes for primary care.7

Meet Patients Where They Are
In seeking racial, ethnic, socio-economic and language concordance amidst an often deep shortage of resources, diversity and inclusion consultant Kim Sharp asserts that providers must understand the community they serve and develop a strategy specific to that community. The information and resource deficit in rural and developing communities can complicate that strategy, but providers should keep an eye towards, as Sharp puts it, “meeting the patients where they are” by working with community leaders to gain patients’ trust.

Capella Healthcare, which operates general and acute-care community hospitals, has earned a reputation for identifying creative partnerships tailored to specific communities, guided by the philosophy that “all healthcare is local.” Beverly Craig works as Vice President of Regulatory Compliance and Clinical Risk Management of Capella and also serves as a member of the Health Systems Corporate Liaison Advisory Group of The Joint Commission.8 In Craig’s view, there is a correlation between The Joint Commission’s performance standards (and Capella’s achievement of them) and advanced efforts to reduce disparities and improve health and health outcomes for vulnerable populations. And as Carolyn Schneider, Vice President of Human Resources for Capella, asserts, reaching the members of the communities Capella serves through a diverse workforce and culturally and linguistically appropriate services may require both traditional diversity strategies and disruptive innovation.

The statistics are sobering: minority doctors account for only one-quarter of the U.S. physician workforce, according to a report from the Association of American Medical Colleges. African-Americans make up just 6.3% of physicians, and Hispanics just 5.5%.9 According to the latest census estimates, 61 million people (almost 21% of the population over five years of age) speak a language other than English at home.10 Is it any wonder that a shortage of physicians practicing in communities where disadvantaged patients live is a major contributor to disparities in access to care? Increasing the racial and ethnic diversity of the healthcare workforce may be key to eliminating health disparities, but concern remains about the supply of diverse physicians and nurses to care for these populations.

To bridge the gap, many healthcare providers are producing and using “cultural snapshots” for each culture represented by their patient base. These facts-at-a-glance sheets provide vital information for providing culturally competent patient care, such as religious customs, dietary practices, gender roles, nonverbal communications and social mores. For example, Sentara Healthcare, a ten-hospital healthcare system headquartered in Virginia, created culture sheets for more rapid response to health needs of diverse patients, streamlining the formatting and maintaining a library of the sheets and diversity-related articles for employee reference on the intranet.11

Lead the Charge
While Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) individuals are a diverse and multidimensional group with unique variations by race, ethnicity, socioeconomic status and other characteristics, they often share the common experience of stigmatization due to sexual orientation, gender identity or gender expression. A provider’s lack of cultural competence for LGBTI individuals negatively affects not only provider-patient interaction and care giving, but also a patient’s care-seeking behavior. Other factors leading to adverse health outcomes for LGBTI patients include low rates of health insurance coverage and high rates of stress due to systematic harassment and discrimination. Quite simply, the stakes could not be higher: LGBTI individuals experience worse health outcomes, and are at higher risk for certain cancers, mental illnesses, and other diseases, than their heterosexual counterparts.12

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A complicating factor for addressing the healthcare needs of LGBTI patients is the fact that no national government surveys include questions related to gender identity or expression, and only a few states ask respondents questions regarding sexual orientation or gender identity, severely limiting researchers’ ability to understand specific needs and policymakers’ ability to develop programs to improve their health and well-being. And so it is altogether more significant that, in spite of this vacuum of research data on the subject (or perhaps because of it?), Vanderbilt University Medical Center established its Program for LGBTI Health in 2012.

As only the second LGBTI program established in an academic medical center in the country, Vanderbilt’s program was born when medical students who saw room for improvement in the quantity and teaching of LGBTI health in the curriculum developed a report on these issues for the faculty and administration. In a model approach for collaborative solutions, the Vanderbilt administration worked with students to evaluate institutional barriers and opportunities, identify faculty engaged in and supportive of education reform, and support student-faculty synergies in revising courses to be LGBTI inclusive. The targeted work of an interdisciplinary team then led to Vanderbilt’s leadership status on the Human Rights Commission’s Healthcare Equality Index and the Program for LGBTI Health as it is known today, which was recognized in 2013 with the Nashville GLBT Chamber of Commerce Corporate Diversity Award.

Dr. Jesse Ehrenfeld, Co-Director of the Program for LGBTI Health (along with Kristen Eckstrand) and Associate Professor, says the program embodies the Vanderbilt credo, “It’s who we are.” According to Ehrenfeld, the program’s vision is novel: to promote national leadership in providing excellent patient care, education, research and advocacy for the LGBTI community. In so doing, it is leading the charge toward LGBTI health being viewed as an integral part of patient care and has shaped the discourse on heretofore opaque data on unequal treatment of, and disparate health outcomes for, LGBTI patients.

Vanderbilt was the first institution in the country to publish a peer-reviewed standard patient case with an LGBTI patient and has created teaching tools that have been adapted nationally. After relevant training under Vanderbilt’s modules, 82% of students have reported feeling more prepared to care for the LGBTI population and more likely to understand the LGBTI community. Vanderbilt’s Program for LGBTI Health continues to occupy the leading edge in the space by: creating sustainable training materials to support ongoing student and faculty education related to LGBTI health needs; supporting patient care through connecting patients with expert providers and training faculty on emerging LGBTI health needs; working with local community organizations to ensure effective connection to comprehensive healthcare and patient education around their health needs; and engaging in research to further understand the needs of the LGBTI community.

In a speech at the inaugural White House LGBT Health Conference, Health and Human Services Secretary Kathleen Sebelius noted, “The Affordable Care Act may represent the strongest foundation we have ever created to begin closing LGBT health disparities.” Under the ACA, exchanges and insurance companies with Marketplace products may not discriminate on the basis of sexual orientation or gender identity; no preexisting condition exclusions may apply to coverages; and preventive care must be provided without cost sharing. According to Ehrenfeld, “more LGBTI patients will gain access to affordable care through the ACA, and that will, in turn, be a huge benefit to LGBTI people who are disproportionately poor.”

Ultimately, Ehrenfeld sees Vanderbilt’s Program for LGBTI Health as a hub for connecting providers to discuss best practices for LGBTI patients, critical for both short-term gains in access to care and the long game in improved health outcomes and cultural competence. “We understand the value of LGBTI inclusiveness and education across our medical center throughout all levels, from senior leadership to the frontlines of patient care delivery. By supporting LGBTI inclusion, both in our medical center and the larger community, we know that our patients will enjoy better outcomes and our employees will enjoy better lives.”
1. See http://www.childrensdefense.org/policy-priorities/childrens-health/
http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-
population/.

2. According to current Congressional Budget Office estimates, the ACA will
extend insurance coverage to an additional 25 million people by 2016. See
CBO, “Effects of the Affordable Care Act on health insurance coverage—
publication/43900.

3. See, e.g., “Health Services Research Information Central, National
Information Center on Health Services Research and Health Care

4. See, e.g., The Advisory Board Company, “Equipping Staff to Care for
~media/Advisory-Com/Research/HRIC/Research-Study/2013/Equipping-
Staff-to-Care-for-Diverse-Patient-Populations/27346_HRIC.pdf.

5. FQHCs provide access to primary care for medically underserved
populations including those that are uninsured or covered by Medicaid.

researchfindings/hsptr/hsptr12/chap2.html.

7. The ACA is also creating cultural and linguistic standards for healthcare
professionals working in federally funded centers to maintain and meet the
needs of the diverse population that is vulnerable to unequal access. See
U.S. Department of Health and Human Services, “HHS Action Plan to
Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in
Health and Health Care,” (Apr. 2011).

8. An independent, not-for-profit organization, The Joint Commission
accredits and certifies more than 20,000 health care organizations and
programs in the United States for achieving certain performance standards
in providing quality care.

9. See Association of American Medical Colleges, “Diversity in the Physician
Workforce” (2010), available at: https://members.aamc.org/ebweb/upload/
Diversity%20in%20the%20Physician%20Workforce%20Facts%20and%20Figures%202010.pdf.

10. In some states, like California, the percentage of people speaking a
language other than English at home is as high as 44%. Of those who
speak a language other than English at home, over 25 million, or about 9%
of the U.S. population, are classified as Limited English Proficient
individuals. See http://factfinder2.census.gov/faces/tableservices/jsf/
pages/productview.xhtml?id=ACS_11_TYR_B1601&prodType=table.

11. See The Advisory Board Company, “Equipping Staff to Care for Diverse
Patient Populations,” available at: http://www.advisory.com/~media/Advisory-
Advisory-Com/Research/HRIC/Research-Study/2013/Equipping-Staff-to-
Care-for-Diverse-Patient-Populations/27346_HRIC.pdf.

Access to Care and Coverage for Lesbian, Gay, Bisexual, and
disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for
lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/.

2009) (identifying Massachusetts as the only state that includes a question
on gender identity in a government health survey), available at: http://
lgbt_health_disparities.pdf.

Standardized Patient Case, MedEdPORTAL (2012), available at:
www.mededportal.org/publication/9218. According to Ehrenfeld,
subsequent work demonstrated that targeted training in LGBTI health
needs improved students’ performance on this standardized patient case,
and that this information was retained long term. See Sullivan W., et.al,
“An Intervention for Clinical Medical Students on LGBTI Health,”
pubication/9349.


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