Health Equity Report

Fiscal Year 2019

Data from Fiscal Year 2018

Anne Arundel Medical Center

LIVING HEALTHIER **TOGETHER.**

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Executive Summary

Following the Institute of Medicine's ***Unequal Treatment: Confronting Racial and Ethnic Disparities*** report in 2002, several agencies and organizations created initiatives to combat healthcare disparities. The Agency for Healthcare Research and Quality annually publishes the *National Healthcare Quality and Disparities Report*, which tracks the nation's performance on healthcare access, quality, and disparities. While some measures have improved nationally over time, others have fared worse, encouraging the American Hospital Association, with four other partner organizations, to launch a national call to action to eliminate health disparities. Anne Arundel Medical Center joined this effort and established the Board Health Equity Task Force (HETF) in fiscal year 2016 in order to analyze and address health disparities within the system. The inaugural *Health Equity Report* (Fiscal Year 2018) was a result of the work done by the HETF in fiscal years 2016-17 and a start of the HETF's efforts to address disparities within the system. After assessing 35 areas, 4 disparities were identified: (1) **C-Section Rates;** (2) **Readmission Rates;** (3) **Length of Stay;** and (4) **AAMG Patient Satisfaction[1].** Each was assigned a champion to lead work in helping to reduce disparities. Updates on progress will be reported throughout the document.

Within this second annual *Health Equity Report*, the 35 areas were again assessed, and the same four areas persisted as top priorities for the organization. In this report, we highlight the progress made during the past year. We have also learned more of the complexity involved in influencing the many socioeconomic and external factors involved in changing these results in the long-term. We anticipate that as efforts continue and are refined, results will show reductions in disparities. In the summary table, only white and black/ African American rates are provided although there are several instances throughout the document that report other racial/ethnic categories. The summary table is limited to white and black/ African American rates because of the low number of respondents in other categories. We recognize that there are disparities in these other minority groups that warrant further data collection and targeted initiatives.

Table 1: Results Comparison

	2017		2018	
	White	Black	White	Black
NTSV C-Section Rate	22.0%	34.0%	22.3%	25.4%
30-Day Readmission Rate	8.22%	10.87%	8.16%	11.28%
Length of Stay	4.09	4.80	3.84	4.33
AAMG Patient Sat.: Office Follow up with Test Results	78.6%	68.0%	79.2%	70.1%

[1] For office follow-up with test results

Introduction

In 2002, the Institute of Medicine produced the landmark report, ***Unequal Treatment: Confronting Racial and Ethnic Disparities***, which outlined the multi-faceted and complex set of issues evident in the persistent disparities of care in the United States. Since that time, the Agency for Healthcare Research and Quality has annually published the *National Healthcare Quality and Disparities Report* (QDR), which tracks the nation's performance on health care access, quality, and disparities. The report has increased awareness and visibility to the stark reality that disparities are pervasive across the health care industry. Research shows that disparities in health care can lead to increased medical errors, prolonged length of stays, avoidable hospitalizations and readmissions, and over- and under-utilization of procedures.

Specific to disparities in care, data in the QDR indicate that improvements are not closing the overall disparities gap: some measures regarding disparities have improved over time, while others have gotten worse. With this context, in 2012, the American Hospital Association (AHA), in collaboration with four partner organizations, launched a national call to action to eliminate health disparities. The goals of this seminal event were three-fold[2]:

1. Increase the collection of race, ethnicity, and language (REaL) preference data to facilitate its increased use.
2. Increase cultural competency training for clinicians and support staff.
3. Increase diversity in governance and management.

Anne Arundel Medical Center (AAMC) first committed to these efforts when, led by the Board of Trustees, the organization signed on to the AHA's #123forEquity Campaign. AAMC is one of more than 1,400 organizations who have joined this pursuit of clinical and cultural excellence by pledging to deliver equitable care and eliminate health disparities. AAMC's governing board formed the Health Equity Task Force in 2016 for the purpose of placing *even greater* emphasis on addressing disparities. The first annual report served as the next step for AAMC in highlighting several disparities and helping to prioritize them. The Health Equity Report committee identified 10 major recommendations in 5 categories: (1) Data Collection and Analysis; (2) Education and Training; (3) Communication and Awareness; (4) Engagement of Stakeholders; (5) Leadership Commitment [see Table 2]. The first recommendation, tying patient demographic data to patient outcomes, is the core of this AAHS Health Equity Report. Various quality measures were stratified by different patient demographic data to assess what disparities existed.

[2] http://www.hpoe.org/Reports-HPOE/eliminating_health_care_disparities.pdf

Table 2: AAMC Health Equity Prioritization

Priority and Actions		To-Date Actions
Data Collection and Analysis	1. Tie patient demographic data to patient outcomes	Health Equity Report and action plans
Education and Training	1. Provide training to all executives, directors, managers and supervisors on how to manage a diverse workforce, including LGBTQ 2. Develop enhanced cultural competency education for all staff and clinicians 3. Provide training to all executives, directors, managers and supervisors on "Unconscious Bias" 4. Provide training on "Workplace Bullying"; Conduct follow-up survey and focus groups targeted at RNs	Educational Classes
Communication and Awareness	1. Approach culture in a broad and inclusive basis of race, ethnicity, religion, economic status 2. ONGOING: Provide language translation/access support	Educational Classes Business Resource Groups
Engagement of Stakeholders	1. Include patient family advisors; include the patient's voice in identifying health and social issues	Patient & Family Advisors and their representation in all groups
Leadership Commitment	1. Create an ombudsman position within Human Resources 2. Implement hiring practices to support leadership diversity	True North workforce metric Diversity and Inclusion Manager

Source: *AAMG FY18 Internal Data*

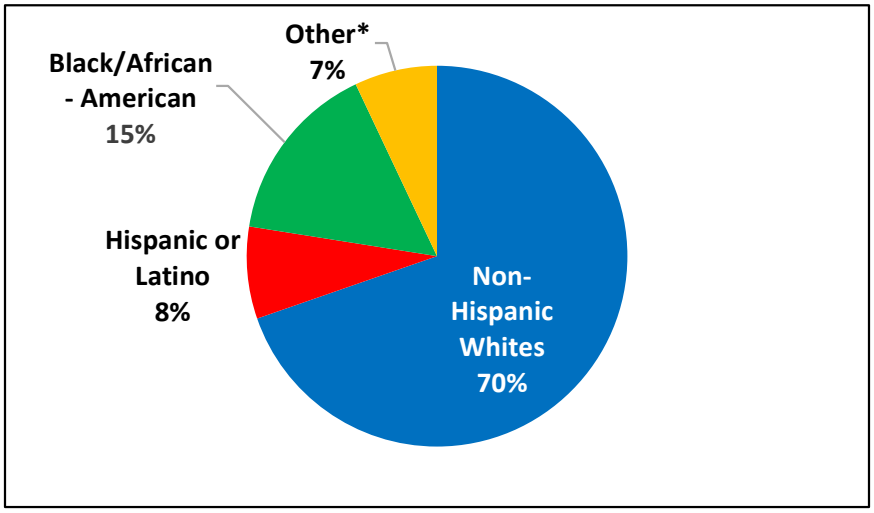
The work that followed hoped to uncover differences and determine which factors (socioeconomic and demographic factors, both patient-related and system-related) may be at play. Several follow-up and next steps were developed and mentioned in the report. These included:

1. Re-design of REaL data capture processes and re-training of staff on these processes.
2. Continued stratification of data, including the analysis of potential contributing factors.
3. Development of targeted, collaborative action plans aimed at addressing root causes.

The most recent census estimates that the county is increasing in its diversity. Since 2000, the Hispanic population has grown over 205%, up to 8% in 2016 from about 2.5% in 2000. At the same time, the non-Hispanic white population has seen a decrease from about 80% in 2000 to 70.3% in 2016. The black/ African American population and Other[3] population has also seen an increase in population size, though substantially smaller growth than the Hispanic population. Figure 1 displays the most recent demographic data from the U.S. Census Bureau.

[3] Other includes: American Indian and Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, some other race, two or more races

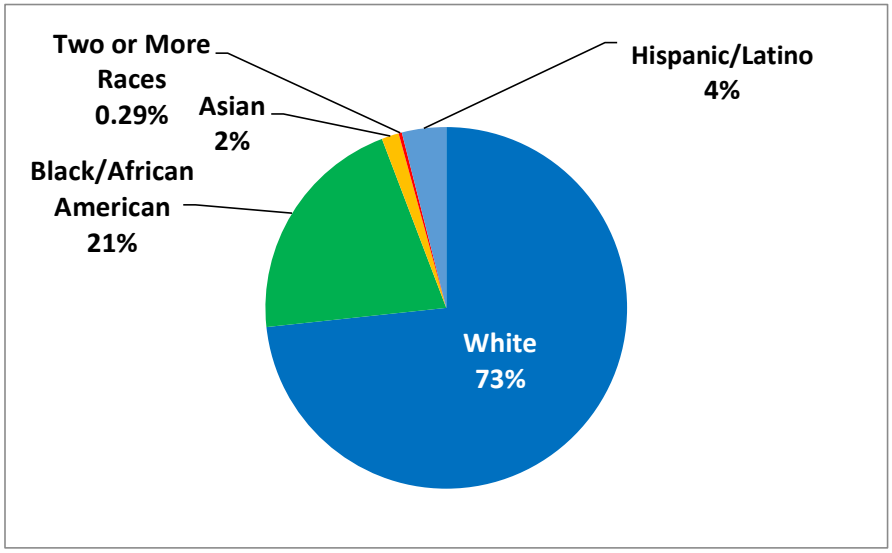
Figure 1: Anne Arundel County Demographics, 2016



Source: *U.S. Census Bureau, American Community Survey 2016*

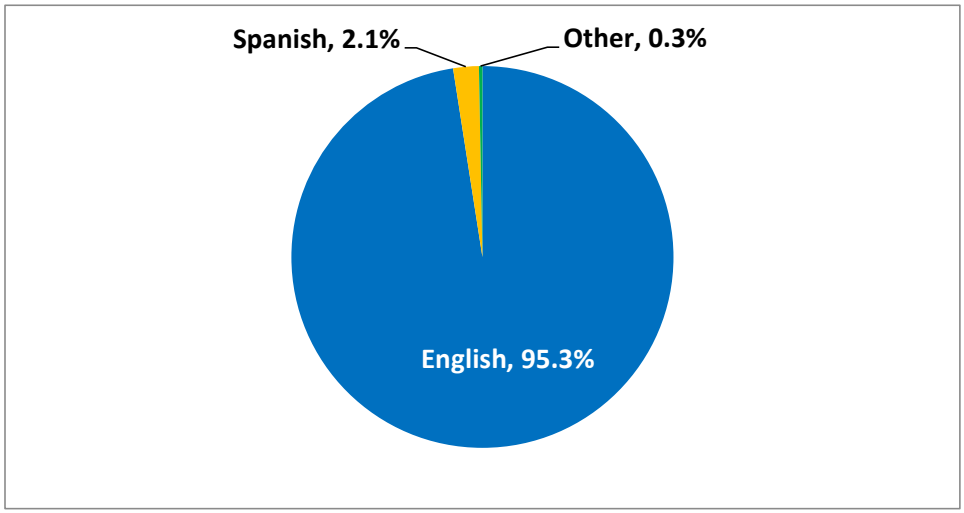
Of patients serviced at Anne Arundel Medical Center in fiscal year 2018, 94% had race, ethnicity, and/or language preferences documented within their Electronic Health Record. Training a wide range of staff responsible for the registration of patient information to include REaL data demographics has resulted in an increase of demographic documentation. AAMC recently began collecting sexual orientation gender identity (SOGI) data, with over 2000 patients SOGI documented three months after implementation. Continued efforts will focus on SOGI data collection in addition to REaL data collection. Inpatient demographics and language preference are displayed in the following figures (2-3).

Figure 2: FY18 AAMC Inpatient Demographic Data, Race/Ethnicity, July 2017-June 2018



Source: *AAMC FY18 Internal Data*

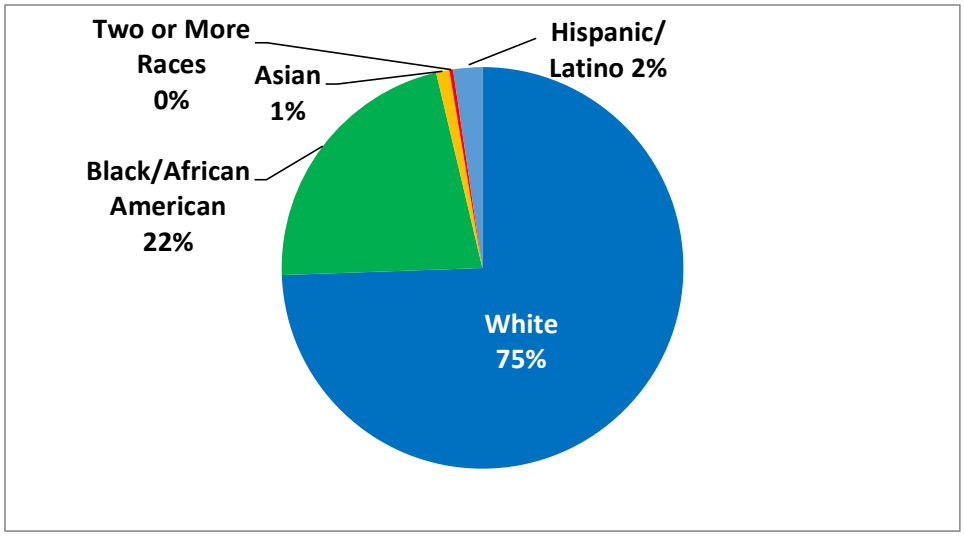
Figure 3: FY18 AAMC Inpatient Demographic Data: Patient Language, July 2017-June 2018



Source: *AAMC FY18 Internal Data*

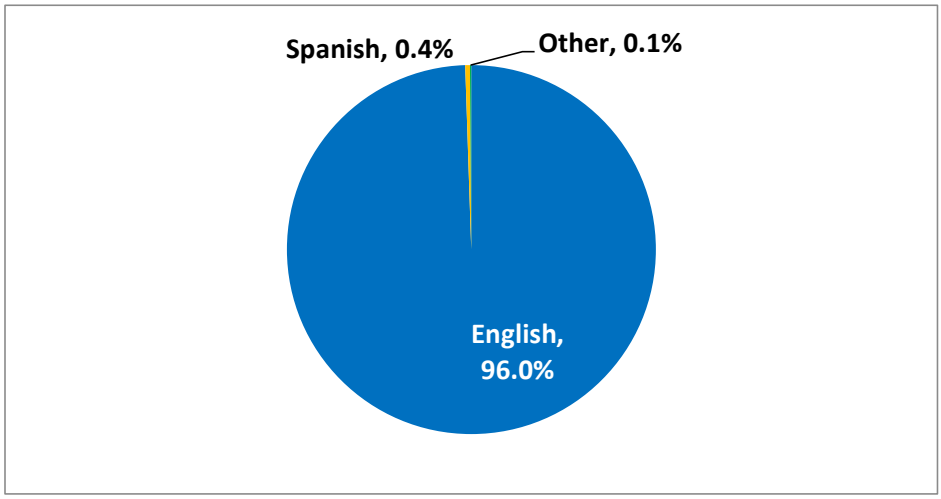
For patients that were serviced at our outpatient settings in fiscal year 2018, 93.0% of respondents completed REaL demographic data. There was little difference from the inpatient data collection, though Spanish speaking patients self-reported or attended outpatient settings less than the inpatient setting. The demographic and language data can be found in Figures 4-5.

Figure 4: FY18 AAMC Outpatient Demographic Data: Patient Race / Ethnicity, July 2017-June 2018



Source: *AAMG FY18 Internal Data*

Figure 5: FY18 AAMC Outpatient Demographic Data: Patient Language, July 2017-June 2018



Source: *AAMG FY18 Internal Data*

In reviewing the latest data, the patient population has changed only slightly from the inaugural *Health Equity Report*. The identified leaders of the four areas with identified disparities continue to develop action plans for improvement. In addition to this work, AAMC remains committed to fostering honest dialogue and open conversation about our patients, our care practices, and our disparities. The previously mentioned initiatives help set the tone for the development of a culture of equity throughout the organization. Support from leadership remains a crucial aspect to our commitment to this valuable work and helps us define our future plans. The awareness of disparities and commitment to resolving them will drive improvements inside our organization and has the potential to lead to positive cultural impact both within the hospital and the community at large.

Results Overview

As identified in the first annual report, differences by patient demographics that required further investigation were recognized in four major areas. These areas had a leader identified who was tasked with action plan development. These include:

1. **C-Section Rates**
2. **Readmission Rates**
3. **Length of Stay**
4. **AAMG Patient Satisfaction** with office follow-up with test results

Based upon initial analysis, follow-up work was conducted with a broad group of stakeholders to further understand the differences, the causes and subsequent improvement efforts to eliminate the disparities. Clinical and administrative responsibility involved creating systems and processes allowing everyone to maximize their skills, expertise, and effort. This report provides an update in each of the identified areas.

C-SECTION RATES

Initial C-section results revealed a disparity between white patients and black / African American patients. Fiscal year comparison from 2017 to 2018 is listed below.

Table 2: NTSV Births and C-Section Rates

NTSV* C-Sections ***Mother's Race***	FY17 NTSV Births	FY17 Total C-Sections	FY17 Total C-Section Rate	FY17 NTSV C-Section Rate	FY18 NTSV Births	FY18 Total C-Sections	FY18 Total C-Section Rate	FY18 NTSV C-Section Rate
White	1,261	**1,075**	32.2%	22.4%	1,182	1,060	31.3%	23.4%
Black or African American	401	**498**	41.8%	34.7%	364	418	39.5%	33.0%
Hispanic	158	**145**	26.7%	22.2%	141	149	28.9%	19.1%
Asian	72	**67**	36.8%	33.3%	74	60	32.6%	20.3%

Source: *AAMG FY18 Internal Data*

***NTSV** refers to nulliparous (first-time mothers) and term (greater or equal to 37 weeks) women carrying a singleton and vertex-presenting (head down) fetus. NTSV births are often referred to as "low risk". Also it is important to note that the information excludes races of other, Native American, as well as those who declined to answer; the sum of the NTSV columns will not total our NTSV total

Following the initial analysis referenced above, AAMC determined to take a closer look at provider-specific performance as well as patient-specific diagnoses' such as uterine fibroids/leiomyomata, a personal history of prior myomectomy (uterine surgery for fibroids) and hypertension, to determine the contribution of these factors in NTSV c-section rate disparities. NTSV C-Sections carry higher risks of negative outcomes for both mothers and babies, and nationally, non-Hispanic black women have disproportionately higher rates of NTSV C-Sections and much higher complications and maternal death rates. Reducing NTSV C-sections (and unnecessary C-Sections) can help reduce complications, costs, and improve care.

The Women's & Children's leadership team established several initiatives to reduce the disparities among minority women. A number of efforts were focused on improving patient education. After recognizing there was a higher number of C-Sections occurring in populations from Bowie, Maryland, prenatal courses were launched. The emphasis in the education was to give a better understanding of prenatal risks and pregnancy "to-do's". In addition, the Birth Class curriculum was updated with extensive clinical recommendations for promotion of vaginal deliveries, including management of early labor at home. We anticipate a slow and steady transition from higher rates of NTSV C-Sections to a culture that encourages NTSV vaginal deliveries. As AAMC continues to move several aspects of education to a technological platform, an educational "Benefits of Vaginal Birth" video was created in fiscal year 2018 and is being added to the Anne Arundel Medical Center's Birth and Baby Website, and the Spanish version is in the final stages of production. Both are set to be ready for viewing by mid fiscal year 2019.

A major advance in patient education and engagement is the partnering with Babyscripts (an online/app platform that is incorporated with MyChart). The patient will be able to access the application through AAMC's MyChart as soon as their pregnancy is determined. Babyscripts will provide mothers information pertinent to their stage of pregnancy and will allow staff to push reminders and notifications. In addition, it allows the mother to participate in the tracking of important information, like weight gain, throughout the pregnancy. In the future, the application may be paired with Bluetooth blood pressure monitors that can be used during the pregnancy, allowing for real-time information to be sent to the providers.

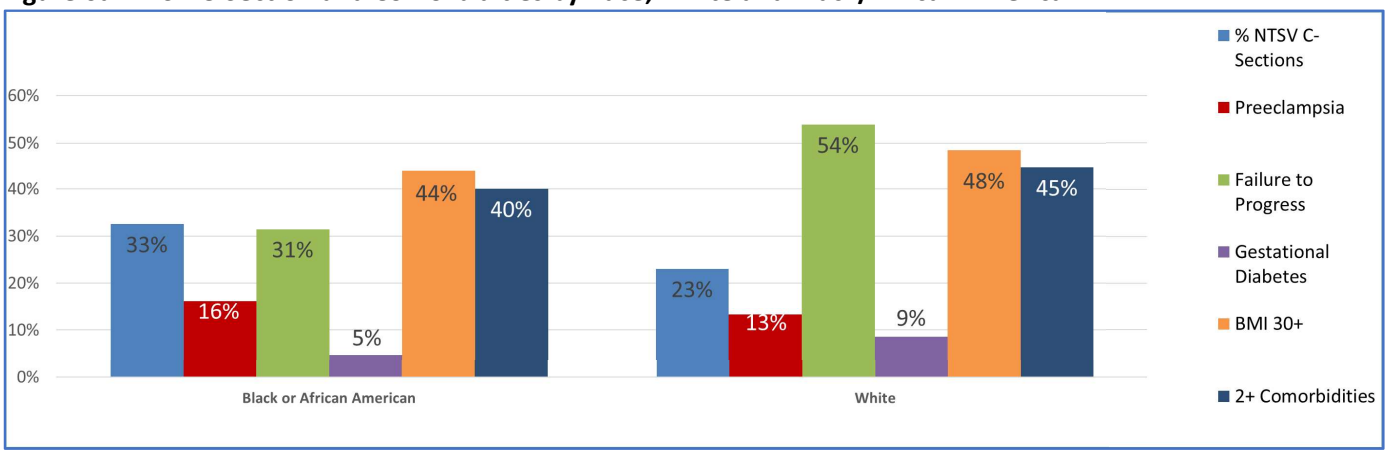
"Movement in Labor" was a concept emphasized in fiscal year 2018. All clinical staff were educated to the benefits of birthing mothers using peanut balls[4] when laboring. Appropriate use of peanut balls has been associated with an increase in the rate of vaginal birth. Peanut balls are now considered a standard part of care during the birthing process at AAMC, with an average of 40% of mothers now using peanut balls. This is a 13% increase from the beginning of fiscal year 2019. From our internal research, we also found that peanut ball use in NTSV patients correlated to lower rates of C-Section. The use of peanut

[4] Peanut balls are a specific birthing ball shaped so that they can be placed between the legs of a woman in labor. Several randomized, controlled studies found that peanut balls reduced length of labor while increasing rate for vaginal birth

balls is now considered a standard of practice, and rates are expected to continue increasing across all physician practices.

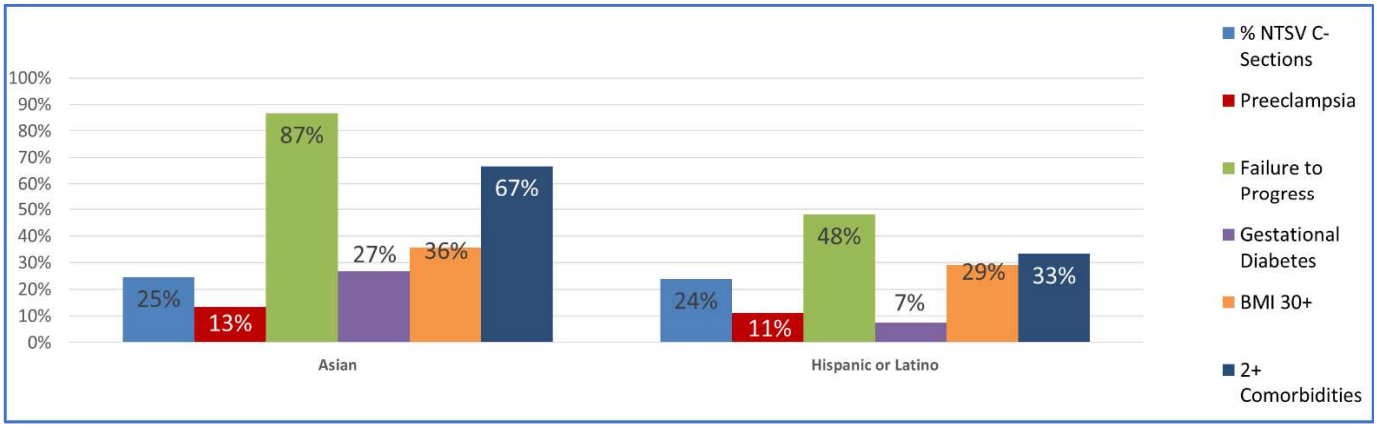
Within fiscal year 2018, many other initiatives were undertaken by the Women's & Children's Service Line to help reduce not only the disparity in NTSV C-Sections but the general C-Section rate. Several practices agreed to eliminate elective inductions. Data collection throughout Women's & Children's has allowed for a thorough analysis of the comorbidities in the patient population being served. With thorough understanding of patients' comorbidities, upcoming interventions and educational materials can be better prepared (figure 6 a,b).

Figure 6a: NTSV C-Section and Comorbidities by Race, White and Black/African American



Source: *AAMG FY18 Internal Data*

Figure 6b: NTSV C-Section and Comorbidities by Race, Asian and Hispanic or Latino



Source: *AAMG FY18 Internal Data*

There will be a continuation of this work into the fiscal year 2019. Specifically, these will include several provider education sessions around overcoming implicit bias, meetings to address team development, "cup of coffee" campaign to help foster peer coaching, and a labor management protocol that will begin in March of 2019. Next year's report will hope to show additional improvements in reducing the disparity.

READMISSION RATES

AAMC examined the 30-Day Readmission Rate and Length of Stay metrics (mentioned later) as measures of efficiency. Both revealed a disparity between white and black or African American patients. Despite volume decreases for white and black patients, readmission rates stayed relatively constant for whites and increased slightly for blacks. Asian patients, conversely, saw an increase in total visits but had a significant decrease in their readmission rates.

Table 2: Readmission Rate, Inpatient*

30-Day Readmission Rate	FY17	FY18
Race		
White		
# of Eligible Discharges	18,664	17,412
# of Readmissions	1,435	1,324
Readmission Rate	8.22%	8.15%
Black or African American		
# of Eligible Discharges	5,366	4,977
# of Readmissions	548	524
Readmission Rate	10.89%	11.28%
Hispanic		
# of Eligible Discharges	1,037	948
# of Readmissions	56	46
Readmission Rate	5.58%	5.01%
Asian		
# of Eligible Discharges	347	356
# of Readmissions	23	16
Readmission Rate	6.95%	4.71%

Source: *AAMC FY17,18 Internal Data*

* excludes pediatric patients

Understanding the disparity in readmissions requires further analysis of the inpatient population: socioeconomic status, insured status, disease type and burden, gender, access to transportation, and other factors. Though the Anne Arundel County Community Health Needs Assessment addressed that transportation remains an issue for our county, further analysis is needed for hospital-specific transportation issues.

In fiscal year 2018, black/ African American patients continue to be referred to post-discharge case management resources through The Coordinating Center, Queen Anne's County Mobile Integrated Community Health, and Prince George's County Mobile Integrated Healthcare. Participation in The Coordinating Center has demonstrated reduced readmission rates in all populations; in the seven

months of data collection, the black/ African American acceptance rate[5] was 36% compared to 30% rate for whites. But in addition, there were almost three times as many whites referred as black/ African Americans. We continue to encourage partnerships that will increase access and acceptance into these post-discharge case management resources.

[5] Here, acceptance rate refers to accepting services provided by the Coordinating Center. Additional analysis is needed to understand the combined referral network and efforts underway for fiscal year 2019 hope to better address this program.

LENGTH OF STAY

A disparity in the length of stay amongst white and black patients both in the medical inpatient adult population and in Clatanoff Pavilion (NICU, Mother Baby, Women's Surgical, and Labor & Delivery) was recognized during fiscal year 2017. In fiscal year 2018, various efforts to decrease the length of stay led to a decrease by almost equal rates among populations however, a disparity persists amongst white and black/ African American patients. English speakers saw a reduction in length of stay but Spanish patients did not. The number of Spanish speaking patients is much smaller than the other populations that it could be negatively affected by patient outliers. We continue to support Spanish speaking patients with 24-hour language interpretation. Spanish speakers saw a 15% increase in their length of stay from fiscal years 2017 to 2018.

Table 3: AAMC Length of Stay

Length of Stay* (in days)	**Inpatient Units**			
Race	**Total Patient Encounters**		**Average L.O.S.**	
	2017	**2018**	**2017**	**2018**
White	14,116	13,499	4.09	3.84
Black or African American	3,895	3,783	4.80	4.33
Language				
English	18,762	17,989	4.24	3.97
Spanish	223	192	3.80	4.35
Length of Stay^ (in days)				
Race	**Clatanoff Pavilion**			
White	4,171	4,005	2.26	2.25
Black or African American	1,404	1,215	2.64	2.69
Language				
English	5,551	5,340	2.38	2.37
Spanish	356	315	2.25	2.38

Source: *AAMG FY18 Internal Data*

*Excludes: Clatanoff Pavilion

^Only: Clatanoff Pavilion

The model of care on the medical inpatient units have been changed to include a new partnering with physicians, care managers, and the primary nurse during rounding. In addition, positions and processes were redesigned and extensive provider and staff training was provided. Reporting and accountability for outcomes was increased through additional tracking measures. Following an initial reduction in length of stay, we began to notice variance from the trend, indicating that there were additional factors that could be contributing to length of stay. Work is currently focusing on identifying gaps in care and solving for them; updates and more focused initiatives and approaches are expected through the year.

As done in the medical floors, the ICU was remodeled to a different standard of work. The ICU did notice improvement after adapting the process. Following exercises to understand current state, a

multidisciplinary rounding workflow was established to incorporate all patient care stakeholders, patients, and families in goal-oriented standard process for care treatment and planning. The multidisciplinary team changed workflow so that patient care rounds are completed three times a day, enabling increased collaboration between physicians, nurses, and patients. In this new workflow, all patient care stakeholders were required to attend the first rounds of each day, followed by having identified stakeholders in the remaining daily round times. First (morning) rounds focused on standard work set by the ICU team incorporating daily goals for care and plan management, as well as reporting structure for the team. Additional rounds focused on follow-up for daily goal completion and patient care planning. This has led to a decrease in average length of stay from 173.2 hours to 93.3 hours in 6 months' time.

We have achieved a lower length of stay in the ICU but note that the disparity persists. The next-stage of work will include expanding these efforts to identify specific differences in populations by specifically reviewing the social determinants of health. We are in development of the concept of a continuity clinic which will be run by the GME residents and fellows. This will help provide access and ensure continuity of care post discharge for some patients. Appropriate patients will benefit from easier access to services.

AAMG PATIENT SATISFACTION

The Institute for Healthcare Improvement (IHI) concisely describes what it means to be patient-centered: "Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles." AAMC's patient satisfaction scores provide excellent insight into how patients perceive the organization as well as the areas needing improvement. The scores listed in the table below indicate the percent of patients rating the questions asked by Press Ganey as a 9 or 10 on a scale of 1-10. The percentile ranks compare our system's results with all those scored by Press Ganey.

Patient satisfaction scores for the ambulatory settings were analyzed. Overall patient satisfaction scores showed variance in percentile ranks between white and black/ African American patients, though scores and changes between fiscal year 2017 and 2018 were similar. As observed in both fiscal year 2017 and 2018, one metric regarding the physician office following up with test results shows a significant difference in both percentage and percentile rank: Office Follow-Up with Test Results. Action items developed to address this disparity are discussed below.

Table 4: FY18 Patient Satisfaction*

Patient Satisfaction: Overall ***Race***	N 17 (Responses)	Score 17	Percentile Rank 17	N 18 (Responses)	Score 18	Percentile Rank 18
White	10,967	88.8%	78th	26,994	89.8%	63rd
Black/African American	1,805	85.6%	43rd	4,721	86.9%	46th

Source: Press Ganey

*AAMG Practices, not including the Community Clinics

Table 5: FY18 Individual Survey Questions from Patient Satisfaction*

Provider Spent Enough Time with You ***Race***	N 17 (Responses)	Score 17	Percentile Rank 17	N 18 (Responses)	Score 18	Percentile Rank 18
White	11,178	94.2%	63rd	26,942	94.7%	53rd
Black/African American	1,838	92.4%	43rd	4,713	92.6%	35th
Office Follow-Up with Test Results ***Race***	**N 17 (Responses)**	**Score 17**	**Percentile Rank 17**	**N 18 (Responses)**	**Score 18**	**Percentile Rank 18**
White	5,762	78.6%	71st	12,730	79.2%	64th
Black/African American	939	68.0%	23rd	2,161	70.1%	35th

Source: Press Ganey

*AAMG Practices, not including the Community Clinics

The Patient Satisfaction group developed action plans to address this data. Several initiatives were launched at the end of fiscal year 2018, and some others followed at the very beginning of fiscal year 2019. The patient satisfaction team found that the most significant disparities in office follow-up were in primary care offices or in orthopedics. As a result of this, there were some communication action plans developed for the Health Care Enterprises (HCE) team. HCE individual practices and management teams received diversity and inclusion training that included cultural competency training and orthopedics staff received customer service training from the Performance and Career development team. These initial efforts were to encourage a proactive conversation about opportunities for improvement and increasing diversity understanding, awareness, and acknowledgement throughout HCE.

Following primary initiatives, additional efforts were implemented throughout HCE. A retraining plan for HCE staff in REaL data collection (via HealthStream) was launched in addition with a seminar for face-to-face training in REaL data collection. Diversity and inclusion training continued in the HCE individual practices and an external customer service assessment of orthopedics was produced to assess improvements. More recently, an Orthopedics Diversity and Inclusion workgroup was created to encourage continued improvement. Physician and provider plans are being developed for diversity and inclusion training within HCE as well as a plan for SOGI training.

One can see that there is improvement in the percent of all patients scoring answers to these questions with a 9 or 10. However, a disparity still exists and work to continue to educate staff and providers persists.

Additional Quality Measures

Additional quality measures were analyzed and stratified according to the IOM's aims for quality: safe, timely, effective, efficient, and patient-centered. Several other measures from last year were identified for review and analyzed for possible variance from previous scores. There were no disparities in these data sets. The data below were specific points we highlight in this report, and were based on their overlap with IOM aims for quality. It should be noted that several categories (e.g. OP18-b & ED1-b) show disparities between racial groups. As is the case in previous categories, the number of distinct patients within these racial groups (Asian, Hispanic) is too small to make definitive conclusions about the disparities noted and should not be taken at face value. Data presentations to the Board Quality and Safety Committee and among other hospital boards, reflect the attention to differences and care taken around action plans prepared to target different racial groups, even if not identifying them as a disparity.

Timeliness

In establishing workflows and process improvement plans, it is important that timeliness is no more of a barrier for one population than another. Two specific timeliness measures AAMC evaluates are Emergency Department wait times and AAMG Days to Appointment.

Emergency Department

When compared to the previous year, volumes of all emergency department visits decreased but maintained similar rates for percentage of visits. Both OP-18b and ED-1b values for adult emergency department visits increased significantly, while pediatric ED wait times stayed relative similar.
When considering patient adherence to recommendations, access to care and access to transportation can often pose challenges when trying to schedule and attend follow-up appointments.

Table 6a: AAMC ED Wait Times, FY18 Adult

Wait Times (in minutes)	FY17 Emergency Department				FY18 Emergency Department			
	N (distinct patients, 79,873)	% of Visits	OP-18b	ED-1b	N (distinct patients, 80,088)	% of Visits	OP-18b	ED-1b
Race								
White	57,010	71%	194	412	56,297	70%	194	412
Black/African American	17,414	22%	183	416	17,494	22%	183	417
Hispanic	3,991	5%	206	487	3,987	5%	187	416
Asian	1,136	1.4%	210	441	1,148	1.4%	187	382
Language								
English	75,375	94%	190	413	77,850	97%	190	413
Spanish	2,024	3%	190	423	2,026	3%	191	418
Ethnicity								
Not Hispanic or Latino	69,105	87%	202	460	69,701	87%	190	412
Hispanic or Latino	3,991	5%	206	487	3,988	5%	187	416

Source: AAMC FY18 Internal Data

OP-18b: *ED Arrival to ED Departure*

ED-1b: *ED Arrival to Inpatient Bed*

Table 6b: AAMC ED Wait Times, FY18 Pediatric

Wait Times (in minutes)	FY17 Emergency Department				FY18 Emergency Department			
	N (Visits, 19,535)	% of Visits	OP-18b	ED-1b	N (Visits, 19,144)	% of Visits	OP-18b	ED-1b
Race								
White	13,498	69%	166	245	13,002	68%	166	239
Black/African American	5,130	26%	158	275	4,950	26%	157	233
Asian	379	2%	156	224	407	2%	158	196
Language								
English	18,303	94%	163	239	17,447	91%	163	239
Spanish	1,867	10%	163	259	1,772	9%	162	240
Ethnicity								
Not Hispanic or Latino	68,158	94%	187	418	15,823	83%	163	237
Hispanic or Latino	4,117	6%	190	412	2,969	16%	163	239

Source: *AAMG FY18 Internal Data*

AAMG Office Times

AAMG Days to Appointment were compared from fiscal year 2017 to fiscal year 2018, which indicated that Spanish-speaking patients had shorter average days from scheduling to appointment.

Further efforts to better understand this disparity we should track the average number of days from when the order is placed within the system (normally at a patient appointment) to the day the order/encounter happens. This can be difficult as certain recurring appointments (6-month or 12-month follow-up) at certain providers can possibly skew data based on demographics per practice per time interval to follow-up appointment. Additionally, any appointments scheduled in fiscal year 2018 that have not yet occurred at time of writing will not be reflected in these numbers. Quickly identifying factors that prevent earlier appointments (such as transportation issues) can lead to additional initiatives to better address various patient groups in our region.

Table 7: AAMG Days to Appointment, FY17 & FY18

AAMG Days to Appointment Race	N (Patient Encounters) 2017	 2018	% of Patient Visits 2017	 2018	Average Days from Schedule to Appointment* 2017	 2018
White	420,737	439,008	63.8%	59.9%	24.9	24.3
Black/African American	93,385	101,188	14.2%	13.8%	22.9	22.2
Language						
English	523,972	563,167	79.4%	76.8%	21.7	23.9
Spanish	9,296	9,819	1.4%	1.3%	18.3	17.8
Ethnicity						
Not Hispanic or Latino	468,968	508,476	71.1%	69.4%	21.8	24.0
Hispanic or Latino	20,446	20,961	3.1%	2.9%	20.5	19.9

Source: *AAMG FY18 Internal Data*

**measured from the amount of time it took between scheduling the appointment to being seen in office*

Patient-Centered Care

Patient-Centric care is typically measured using satisfaction rates. In considering ED disparities (particularly in wait times as seen above), demographics were also used to compare patient satisfaction rates between groups. On average, black/ African American responders had lower scores than white counterparts in a Press Ganey patient satisfaction survey. When further broken down, overall trending was favorable in the first few months of fiscal year 2019. This indicates that throughput initiatives and other efforts were able to positively influence patient satisfaction in the emergency department. Physician champions and leaders have stated their willingness to discuss patient satisfaction in their teams, address patients with honesty towards the wait-times, and show compassion and caring as they help them through any other questions.

Safety

Total Joint Arthroplasty (TJA) is a highly successful and common procedure at AAMC, however, disparities in utilization between black/ African American and white patients are known to exist within the system. In a recently posted article within *The Journal of Arthroplasty*, Dr. Paul King of the AAMC Center for Joint Replacement and others retrospectively analyzed data from TJA surgeries in order to evaluate the disparity at a single high-volume institution and try to add to national understanding. Additionally, with black/ African American patients known to have higher rates of diabetes and obesity within our service area; not only are these known risk factors for TJA but then also make our black/ African American patients higher risk candidates for TJA procedures. Data analysis, as we mention throughout this report, is only one component of the battle to reduce disparities. Creating action plans and implementing them in the system is a required part of this broader strategy. After analyzing more than 7,300 AAMC Joint replacements from 2013-17, we found a racial distribution comparable to the county demographics (84% white, 14% black/ African American). In looking at some differences in patient populations, it was noticed that white patients were more likely to have CAD or A-fib but that African American / black patients had higher rates of obesity, diabetes, and hypertension. Additionally, black/ African American patients' average income was lower per household (~$90K vs $96K).

Results indicated that black/ African American patients had a longer length of stay (2.27 vs 2.08) and were more likely to experience complications requiring an additional operation. There were several socioeconomic factors that could contribute to higher incidence rates for reoperation (access, transportation, housing). Additionally, a multiple logistic regression showed that black/ African American patients were 2.6 times more likely to discharge to a skilled nursing facility (SNF). This could indicate less support in the home environment by exposing patients to possible complications like infections. As a result of the review of this data, multidisciplinary team meetings in the Center for Joint Replacement have begun. In addition, partnerships with primary care providers through the collaborative care network have been developed. By better educating all parts of the care continuum to the complications possible to higher risk patients, we hope that primary care physicians will help better prepare and help select patients appropriate for surgery. Lastly, work is occurring so that all higher risk patients will go through our pre-anesthesia testing center where recommendations might be made to reduce a patient's risk factor for surgery.

Additional Updates

While collecting patient REaL data and developing the *Health Equity Report* is the first and most important step in knowing our patient population (Figure 1, first row), AAMC is also actively involved in other critical areas focused on furthering diversity and inclusion, cultural competency, and disparities elimination. This report is intended to connect patient demographic data to patient outcomes and was not intended to discuss the additional education and training, communication, or leadership commitments taking place in the organization. Though not part of the *Health Equity Report*, these areas are an important part in trying to achieve a more diverse and equitable workforce and population. Below is a summation of these initiatives, placed here in an effort to inform readers about how the data aids the other priorities.

Table 2: AAMC Health Equity Prioritization

Priority and Actions		To-Date Actions
Data Collection and Analysis	2. Tie patient demographic data to patient outcomes	Health Equity Report and action plans
Education and Training	5. Provide training to all executives, directors, managers and supervisors on how to manage a diverse workforce, including LGBTQ 6. Develop enhanced cultural competency education for all staff and clinicians 7. Provide training to all executives, directors, managers and supervisors on "Unconscious Bias" 8. Provide training on "Workplace Bullying"; Conduct follow-up survey and focus groups targeted at RNs	Educational Classes
Communication and Awareness	3. Approach culture in a broad and inclusive basis of race, ethnicity, religion, economic status 4. ONGOING: Provide language translation/access support	Educational Classes Business Resource Groups
Engagement of Stakeholders	2. Include patient family advisors; include the patient's voice in identifying health and social issues	Patient & Family Advisors and their representation in all groups
Leadership Commitment	3. Create an ombudsman position within Human Resources 4. Implement hiring practices to support leadership diversity	True North workforce metric Diversity and Inclusion Manager

Leadership engagement in this work is demonstrated in additional ways as noted below. Please note that several initiatives began in the planning phase during fiscal year 2018 but were not officially launched until fiscal year 2019. For those that we can discuss at time of writing, we have included them for a better understanding of current and future state initiatives for the system.

LEADERSHIP COMMITMENT

1. **True North Metric on Diversity in Leadership**: In fiscal year 2019 we introduced the Diversity Equity and Inclusion Scorecard that has revealed an 8% increase in workforce diversity and 10%

increase in new hire diversity. The True North Metric definition of leadership has been expanded to include the positions Supervisor and above and is currently above goal for candidates interviewed for leadership positions.

2. **DEIL Scorecard**: In October of 2017 we implemented the DEIL Scorecard as a metric-tool to demonstrate workforce diversity efforts. Goals are set by the DEIL Council and address our applicants, candidates, and existing workforce. In the 18 months since implementation, substantial progress has been made within these various pools. Leadership diversity has increased from 14% to 21%, and full-time new hires are currently 57% diverse, with a 37% system-wide diversity. For individuals submitting applications for careers at Anne Arundel Medical Center, we are industry leaders in that diverse individual applications outweigh non-diverse individuals. Diverse applicants make up 61% of the applicant pool, and selected candidates are about 56% diverse. The DEIL Council tracks these methods with a scorecard to observe for continuous improvement in targets and goals.

3. **Community Health Needs Assessment (CHNA)**: Triennially, AAMC develops a CHNA and implementation plan, identifying our community's most important health needs and our plan to meet them. The most recent CHNA was completed jointly with the other hospital in our county and various community organizations. The work is supported by leadership and the results from the CHNA are used to shape strategic goals and initiatives.

EMPLOYEE ENGAGEMENT

1. **Business Resource Groups**: AAMC hosts 3 major business resource groups designed to support our diversity and inclusion goals. Business Resource Groups aim to create diverse inclusive environments that reflect a changing workforce and evolving communities. The groups are designed to create a welcoming environment for underrepresented new employees and are aimed at identifying synergy for business priorities and helping to remove barriers that impact the success of underrepresented populations.

    - The LGBTQIA Business Resource Group serves AAMC by positively influencing the environment, ensuring professional development for all LGBTQIA, and by assisting the organization in achieving its diversity and inclusion plan. In 2018, AAMC participated in the Health Equity Index Survey, administered by the Human Rights Campaign, and was named a "Top Performer."

        - In fiscal year 2019 the group coordinated our participation in the Health Equity Index Survey where our score increased 50 points earning AAMC an overall score of 80 making us a Role Model in the space of LGBTQIA diversity. The group also launched gender identity training for clinical staff responsible for

data collection and hosted a special information lunch n' learn during AAMC's Diversity and Inclusion Festival Week.

- The African American Business Resource Group was launched in fiscal year 2019 after unanimous approval from the DEIL Council. The group has designed a strategy to address workforce disparities by implementing programs and initiatives that include minority mentoring, professional development workshops, and life skills supports and educational opportunities for diverse applicants, candidates, and employees. The group will submit a full plan with program and target date deadlines for fiscal year 2020.

- The GenerationNOW Younger Professional and Emerging Leaders Business Resource Group were also launched in fiscal year 2019 after unanimous approval from the DEIL Council. The group has identified key priorities to be a voice for emerging demographics to enhance the patient and employee experience at AAMC. The group plans to focus on professional development, new employee onboarding, and recruitment efforts for members of emerging generations. The group will submit a full plan with program and target date deadlines for fiscal year 2020.

2. **Champions of Inclusion Network of Ambassadors Committee**: was formally launched in fiscal year 2019. With a top down, bottom up, middle out approach, to diversity and inclusion at AAMC, COIN is aimed at supporting bottom-up effort and empowering staff employees to champion awareness programs and architect programs to foster inclusion within their work teams. Designed to assist in developing action-oriented steps for each department and COiN supports our goals to introduce and integrate accountability measures around supporting diversity and inclusion throughout the system.

3. **Coming to the Table**: AAMC has a first-in-the-nation hospital-sponsored chapter of Coming to the Table that meets monthly. This program supports open, honest dialogue to heal wounds of discrimination due to race, ethnicity, sexuality and other cultural identifiers. In fiscal year 2019 the program trained additional CTTT facilitators so that we are able to host various sessions simultaneously in different locations and at different shifts throughout the system. In fiscal year 2020 the program aims to have 5 new facilitators and introduce 2 additional series.

STAFF EDUCATION

1. **Education and Training:** Education recently completed includes training on unconscious bias, workplace bullying, and enhanced cultural competency. Education recently completed includes training on unconscious bias, workplace bullying and incivility, grand round trainings on the varying dimensions of diversity, gender identity, disability employment awareness lunch n' learns, and enhanced cultural competency. Additional training efforts include the introduction

of DIVERSITY MATTERS Virtual Resource Center and incorporating Harvard University's Project Implicit IAT.

2. **New Employee Onboarding:** Introduce new employees to AAMC's philosophy and expectations regarding diversity equity and inclusion.

3. **Physician Onboarding**: Provide education about our diversity and inclusion strategy and increase cultural competency and knowledge of diversity as a service provider.

4. **Leadership Essentials**: Provide organizational leaders with the tools to lead without disrupting inclusion with key learning objectives to; provide staff and team members with the opportunity to foster inclusion, recognize their own bias, and be equipped with tools and techniques to lead and make leadership decisions not rooted in bias, be prepared to intentionally implement efforts to support diversity and inclusion at AAMC.

5. **Inclusion Series**: A nontraditional approach towards diversity and cultural competence training. The program uses interactive diversity theater to engage leaders and staff into open dialog about varying cultures and mitigating the impact of unconscious bias. The program theatrically acts out scenes from employee and patient experiences and demonstrates varying cultural perspective. By allowing reflection moments and self-assessment opportunities the key learning objectives are to bring awareness to unconscious bias and provide tools and techniques for mitigating unconscious bias. This helps develop greater cultural competency.

6. **Inclusion Groups:** The development and aims of our various inclusion groups are to support our diversity and inclusion goal to foster a workplace environment of inclusion. All the groups with their individual priorities and goals collectively work towards achieving this overarching goal.

7. **Inclusion Includes Y.O.U**.: as the umbrella for our diversity equity and inclusion strategy the initiative plays host and brand identifier to an abundance of projects and efforts aimed at increasing diversity, fostering inclusion, eliminating barriers to culturally customized care, ensuring equity in opportunity, and increasing supplier diversity. The initiative sponsors a monthly awareness campaign designed to bring attention and education around the diversity focus of certain months.
    a. In fiscal year 2019 we hosted 9 diversity campaigns with both awareness and educational programming including; February- Black History Month with an opportunity to remember, recognize, and learn about the medical breakthroughs in minority health and the African American pioneers in healthcare; March- Women's HERstory Month; May- Asian Pacific Islander Campaign; September- Hispanic Heritage recognition and training, October- Disability Employment Awareness recognition and training sessions.

8. **Cultural Workplace Diversity Initiative**: The aim of the Cultural Diversity Initiative and Workplace Advocacy Committee is to promote acceptance of peoples' differences while identifying and embracing their similarities. This work provides education and activities designed to enhance awareness and acceptance of the diverse cultures within AAMC and surrounding communities. The initiative creates collaboration with departments regarding clinical staff education and professional development as well as community outreach and engagement.
    a. In fiscal year 2019 the group supported initiatives to recognize the Rev. Dr. Martin Luther King holiday with a partnership with local area elementary, middle, and high schools to encourage students to enter AAMC's MLK Essay contest. The partnership engaged more than 60 youth and honored 7 children and young adults and their families. The committee hosts a weeklong festival during the month of June to help raise awareness and provide information and education about the cultures of the different communities and countries represented by the AAMC workforce.

PATIENT AND FAMILY ADVISORY COUNCIL (PFAC)

1. **Health Equity Patient-Family Advisory Sub-Committee**: This group of patient-family advisors evaluates programs at AAMC through a health equity lens. They are encouraged to be present at workgroups and task forces throughout the system.

SUPPLIER DIVERSITY

1. **Supplier Diversity**: Supplier diversity reflects purchasing products and services from diverse suppliers, such as those that are from minority-owned, female-owned, and veteran-owned businesses. In fiscal year 2018, AAMC collected baseline information on the current breakdown of supplier diversity and created an action plan to implement in fiscal year 2019. In efforts to expand supplier diversity, AAMC has incorporated several key components in promoting supplier diversity within the purchasing policies, thereby enforcing the goals of the action plans. Fiscal year 2018 spend on qualified, diverse, certified vendors was $3,349,401, equating to 1.07% of total supply spend. Targets were set to increase the percentage of spend in fiscal year 2019 to 1.25% or $3,930,459. This target remians fluid, and we will expect that, as we progress, we will adjust to reflect our business.

Conclusion

As we consider the future initiatives of our health system and better understand how we can help our patients, this report becomes an outline and guideline for continued discussion among leaders in developing system-wide initiatives. We will continue to evaluate progress on our identified disparities and monitor data to ensure we identify any new disparities that may appear.

Many socioeconomic and demographic factors, both patient-related and system-related, may be at play, and we hope that our efforts identify, address, and attempt to mitigate disparities as a result of these factors.

Follow-up and next steps include:

1. Continuation of REaL data capture and increased efforts of SOGI data capture.
2. Implementation of action plans aimed at root causes with periodic updates to boards and executive leaders, as necessary.

During all stages of these action plans, AAMC is committed to fostering honest dialogue and open conversation about our patients, our care practices, and our disparities. Data and analytics will continue to play a vital role in meeting the goals by tracking goals to identify areas of opportunity in our existing plans as well as supporting next-level analysis.

The ongoing initiatives help set the tone for the culture of equity taking shape throughout the organization. Support from leadership remains crucial to ensuring this valuable work carries momentum into the future and our awareness of disparities and commitment to solving them will drive improvements inside our organization and the community we serve.