Patients, Profits, Pressures, and Professionalism

Gene Farley Lectureship

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University of Pittsburgh/UPMC
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1. Understand and prioritize patient and family-centered care in a culturally-diverse environment
2. Recognize the drivers influencing the healthcare industry today
3. Identify the impact of industry transformation on physicians and the health care team
4. Preserve integrity and professionalism in the midst of the storms
Case Study

- Ms. S is 54 years old, works as a nurse, cares for her disabled mother, two teen/ish children, and is the back-up babysitter for her 2 year old granddaughter.
- She is active in her church ladies’ group.
- Because of increased expenses and her older daughter moving back home, she has taken an extra part-time job to help with expenses.
- Ms. S has felt stressed and overwhelmed for many months now, gets most of her comfort from cooking and eating with friends, and cannot remember the last time she did any regular exercise.
Ms. S has been feeling tired lately – even when she goes to bed early, she does not feel rested when she awakens.

She finds herself urinating more frequently and even gets up to urinate at least begun having a little wine with meals to relax herself and has restarted an old smoking habit she quit more than 5 years ago.

She is having increasingly frequent episodes of mid-epigastric abdominal pain that improves somewhat when she ingests antacid tablets.

Her daughter thinks she should talk to someone about these symptoms…
Although her daughter makes her an appointment to see her physician, Ms. S becomes impatient while waiting for the physician, and just asks for a prescription medication to help her abdominal pain.

She leaves the physician’s office with a prescription for Ranitidine and goes to work her part-time job.

Her daughter calls her best friend – and asks her what she should do? She is worried that she will lose her mother just like she lost her aunt who died of a stroke at age 57 two years ago.

???????
Case Study (4)

- Ms. S calls her daughter the next afternoon saying she felt nauseous when she arrived at work, but worked with several patients, grabbed bites of MacDonald’s hamburgers a co-worker picked up. She vomited multiple times throughout the shift and is now in the emergency department of the local hospital.

- What do you think is going on?
Identifying Chronic Illness

~50% of people with chronic illness have multiple conditions

But there are many deficiencies in the management of diseases such as diabetes, heart disease, depression, asthma and others.

Those deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients untrained to manage their illnesses
Who is likely to be providing care for Ms. S?
The Millennial Generation, or simply Millennials

- Also known as Generation Y, because it comes after Generation X — those people between the early 1960s and the 1980s.
- Has also been called the Peter Pan or Boomerang Generation because of the propensity of some to move back in with their parents, perhaps due to economic constraints,
- Growing tendency to delay some of the typical adulthood rites of passage like marriage or starting a career.

Millennials

- High educational debt
- Reared under duty hours regulations
- Attended college with few first generation college students – so grew up surrounded by professionals
- Represent the smartest, healthiest, and wealthiest….caring for citizens who live at a time of increasing wage and income disparities
Millennial characteristics

- **Special** - Have always been treated as special and important
- **Sheltered** - Highly protected as children
- **Confident** - They are motivated, goal-oriented, and confident in themselves and the future.
- **Team-Oriented** - They are group oriented rather than being individualists.
- **Achieving** - Grade points are rising with this generation; focus on getting good grades, hard work, involvement in extracurricular activities, etc. is resulting in higher achievement levels
- **Pressured** - Tightly scheduled as children and used to having every hour of their day filled with structured activity.
- **Conventional** - Respectful to the point of not questioning authority.

Spirit of confidence, self-sufficiency, privilege
Figure 1. Patient-Centeredness and Cultural Competence Integral to Health Care Quality

- Patient-Centered Health Care Systems
- Culturally Competent Health Care Systems

- Patient-Centered Health Care Interactions
- Culturally Competent Health Care Interactions

- Individualized (Patient-Centered) Care
- Equitable Care

- Safety
- Effectiveness
- Efficiency
- Timeliness

Quality of Care

Improved Health Outcomes
Components of Cross-Cultural Health Care*

Culture within the served community

Culture of providers

Culture of the health care organization

Health care organizational culture has a profound effect on the capacity as well as the commitment to provide culturally competent care.

“If you ask a shoemaker to make a hat, it will remarkably resemble a shoe”

“To a hammer, everything looks like a nail”
Multiple Cultures

- Health care culture
- Academic culture
- Political culture
- Geographic; Ivy League; Big Ten

Case of Ms H – a Muslim woman with IUFD
Cultural Humility

- A lifelong commitment to self-evaluation and self-critique
- Redressing the power imbalances in the patient-physician dynamic
- Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations

Within - Group Diversity is often greater than Between - Group Diversity
All aspects of an individual are recognized as contributing to diversity.

**A Diverse Workforce Offers ...**

**Marketing Advantage**
Insight and cultural sensitivity, ability to tap diverse markets

**Creativity**
More alternatives and higher quality solutions.

**Cross-Cultural Skills**
Enhances global competency and the capability to function in diverse cultural environments.
## Continuum of Cultural Competence

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural destructiveness</td>
<td>Attitudes, policies and practices destructive to cultures and individuals, e.g. Native American boarding schools, Tuskegee Syphilis Study</td>
</tr>
<tr>
<td>Cultural incapacity</td>
<td>Maintain biases and lacks capacity to work with diverse communities, e.g. discriminatory hiring practices</td>
</tr>
<tr>
<td>Cultural blindness</td>
<td>Belief that “all people are the same,” ignores strengths, differences, and encourages assimilation, e.g. lack of language signs</td>
</tr>
<tr>
<td>Cultural pre-competence</td>
<td>Recognize weaknesses and initial attempts through hires, outreach, training, etc. -- some commitment and some action</td>
</tr>
<tr>
<td>Cultural competence</td>
<td>Accept and respect differences, continually assesses competence, active hiring, training. Commitment to policy and action</td>
</tr>
<tr>
<td>Cultural proficiency</td>
<td>Holds culture in high esteem, advocates for cultural competence throughout the system</td>
</tr>
</tbody>
</table>
Socioeconomic Disparities in Health

- National data of 5 child and 6 adult health indicators
- Those with lowest income and least educated were consistently least healthy
- Gradient patterns seen often among non-Hispanic Blacks and Whites and less consistently among Hispanics
- Health in the US is often, though not invariably, patterned strongly along both socioeconomic and racial/ethnic lines

Figure 2. Population rising in high- and medium-poverty tracts

Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors’ calculations.
Figure 9. Poor African Americans, Hispanics live disproportionately in high-poverty neighborhoods

Source: U.S. Census Bureau, Decennial Censuses of Population and Housing and American Communities Survey five-year estimates, based on authors’ calculations.
1. Between 2000 and 2010, residential segregation by race declined – but did not disappear – with respect to African Americans and Hispanics. Racial segregation in housing persistent pattern nationwide;

2. Segregation continued predictor of significant health disparities -- as measured by divergent rates of infant mortality – in comparisons between African Americans and whites and between Hispanics and whites;

Updates previously published findings - relationship between residential segregation and racial disparities in infant mortality rates across U.S. cities (LaVeist 1989, 1993).

3. Although residential segregation is decreasing, the relationship between segregation and infant mortality disparities has intensified; and

4. Simulations of effect of segregation on racial gaps in infant mortality rates complete black-white residential integration would result in at least two fewer black infant deaths (2.31) per 1000 live births. With full integration, Hispanics would have a lower rate of infant mortality rate than whites.

Are racial and ethnic disparities in five selected health status measures associated with the racial composition and poverty level of neighborhoods?

The primary findings from the second study:

- Place matters and it makes a significant difference for 3 out of 5 common health indicators, including:
  - (a) general health,
  - (b) mental health and
  - (c) diabetes.

The second study (Pendall, et al) tested whether the correlation between segregation and health disparities varies more in accordance with the racial composition of neighborhoods or the concentration of neighborhood poverty.

Data from the 2006 Medical Expenditure Panel Study (MEPS) along with zip code level data from the 2000 US Census (Summary File 1) were used to examine the relationships between segregation, concentrated poverty and racial and ethnic health inequalities.

Neighborhood Poverty

- Community-level poverty - more important to health status than neighborhood racial composition.
- After controlling for concentrated poverty - health status advantages for whites decreased in comparison with blacks and Hispanics.
- Policy makers should address the problems associated with concentrated poverty.

Case Study (5)

Ms. S’s Physical Exam in the ED

- BP 170/98, HR 88, T 37, R 16, Weight 80 kg, BMI 32
- Skin is damp and she is sitting up on bed, anxious, and uncomfortable
- Neck supple without distended neck veins; Carotid pulses strong without bruits
- Lungs clear to auscultation and percussion
- Tachycardic, no murmurs or ectopy
- Abdomen obese, soft, generalized tenderness to palpation without organomegaly or rebound
- Extremities without deformities or edema
Ms. S

- Glucose = 315
- Urinalysis – unremarkable
- Hemoglobin = 14
- Total cholesterol = 250
- CXR – No evidence or cardiomegaly, pulmonary infiltrates
- Electrocardiogram – No acute changes or ventricular enlargement
- Abdominal ultrasound – Gall stones
What factors affect caring for Ms. S?
What factors influenced the care of the Muslim patient (Ms H)?
Factors affecting care of Ms. S
- Patient resistance to care
- Multiple clinical issues
- Work schedule between 2 jobs
- Need for acute and chronic care
- Need for patient education
- Need to engage her family
- Need for health care system support
Factors affecting care of Ms. H
- Patient non-traditional religious mores
- Discomfort (cultural incompetence) with this minority group
- Urgency of situation and care by multiple providers
- Documentation of important info lost in a voluminous EMR
- Impact of state regulations
- Need for health care system support
Problems with Current Disease Management Efforts

- Emphasis on physician, not system, not individual behavior
- Lack of integration across care settings hindering quality care –
  - Use of urgent care centers and emergency departments rather than one primary care clinician
- Available interventions not being used successfully
- Commonalities across chronic conditions unappreciated
  - Multiple conditions respond to diet and exercise
Family Medicine for America’s Health:

Four year plan to transform our health care system and ensure the health of all Americans. Specifically, we aim to:

1. Increase **patient accessibility** to their primary care team, including remote access to patient records, electronic communication with their care team and availability after hours.

2. Encourage every practice to have a **patient advisory council** or similar mechanism to facilitate meaningful and ongoing patient engagement.

3. Increase **transparency in pricing of health care services** and educate patients to better understand cost of care.

4. Integrate **public and mental health into the Patient-Centered Medical Home (PCMH)** and add care managers, health coaches and population health professionals to the primary care team. Incorporate training to practice in a team-based setting into graduate medical education.

5. Support policies that drive **at least 40 percent of medical students toward primary care specialties** with the goal of increasing the number of primary care physicians by a minimum of 52,000 by 2025.

6. **Sunset fee-for-service payment in primary care.** Work with public and private payers to adopt a uniform and simplified model of comprehensive payment that encourages front-end investment in expanded practice infrastructure and technology, rewards Triple Aim goals (better care, better health and lower costs) and supports broad, team-based care. Support efforts to drive HHS goal of having 85 percent of Medicare payments tied to quality or value by 2016 and 90 percent by 2018.
Number of Americans who lack health insurance took big dip in 2014

The proportion of Americans who lack health insurance took a big dip last year, with nearly 9 million people gaining coverage since 2013, according to federal figures announced Wednesday. The figures from an annual Census survey found that the share of people across the country who were uninsured fell from 13.1 percent in 2013 to 10.4 percent last year.

Spreading health insurance to more Americans was a main purpose of the 2010 Affordable Care Act. But from the outset, it was clear that it would take years for firm evidence to materialize of whether the law was succeeding at that goal.

The two big strategies built into the law to widen access to health coverage — insurance exchanges selling private health plans to people who cannot get insurance through a job, and an expansion of Medicaid for people with lower incomes — took effect at the start of 2014.
Strategies for Achieving a Culturally Competent Organization

- Environmental assessment
- Institutional team to monitor the environment
- Case-by-case counseling
- Public health assessment of the community
- Team building activities
Perform Cultural Self-Assessment

- Organization assesses and understands its own culture
  - The shared values, beliefs, language that are used, images and themes explored in conversation and the various rituals of daily work
- Examine how the organization’s culture interfaces with that of the staff and community
  - Is this an institution that honors and demands intolerance to acts of racism, sexism or some other “isms” or has it systematically actively or passively allowed or even promoted these “isms”
Institutionalize Cultural Knowledge

- Educate staff on the cultural groups that the organization serves
  - History, traditions, language, values, family systems
- Incorporate cultural knowledge into service delivery
- Training in and development of systems to manage medical and social issues
  - Female interpreters for Muslim women
- Provide language appropriate resources, referrals
Barriers to Achieving a Culturally-Competent Organization

- People
- External forces (e.g., regulations)
- Internal pressures (e.g., bias, historical insults, stress, ignorance)
- Limited resources
- Lack of willpower
- Unfocused leadership
Importance of Community

- Recognition of who they are – cultural mix
- Addressing historical hurts
- Enlisting their support
- Valuing and using their input
What do these environmental changes mean for those in academic medicine?
Adherence to recommended care is low for chronic conditions

- Breast Cancer: 75.7%
- Prenatal Care: 73%
- Coronary Artery Disease: 68%
- Hypertension: 64.7%
- COPD: 58%
- Hyperlipidemia: 48.6%
- Diabetes Mellitus: 45.4%
- Alcohol Dependence: 10.5%

Source: McGlynn et al. NEJM 2003
# The toll on patients is high: US Data

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>SHORTFALL IN CARE</th>
<th>AVOIDABLE TOLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Average blood sugar not measured for 24%</td>
<td>29,000 kidney failures 2,600 blind</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>62% not screened</td>
<td>9,600 deaths</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>36% of elderly didn't receive vaccine</td>
<td>10,000 deaths</td>
</tr>
<tr>
<td>Heart attack</td>
<td>39% to 55% didn't receive needed medications</td>
<td>37,000 deaths</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Less than 65% received indicated care</td>
<td>68,000 deaths</td>
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</tbody>
</table>

Insurance Cost Growth Quadruple the Rate of Wages and Inflation

Cumulative Changes in Health Insurance Premiums, Inflation, and Workers’ Earnings, 1999-2010

### Daily System Charge Report

**Date:** September 15, 2015

#### Month to Date Gross Charges

<table>
<thead>
<tr>
<th>Metric</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UPP</strong></td>
<td>$88,502,099</td>
<td>$94,551,343</td>
<td>$(6,049,244)</td>
<td>-6.40%</td>
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<tr>
<td><strong>CMI</strong></td>
<td>$17,885,124</td>
<td>$19,516,381</td>
<td>$(1,631,257)</td>
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<tr>
<td><strong>RFP</strong></td>
<td>$1,046,904</td>
<td>$1,061,087</td>
<td>$(14,183)</td>
<td>-1.34%</td>
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<tr>
<td><strong>ERMI</strong></td>
<td>$6,123,887</td>
<td>$6,781,973</td>
<td>$(658,086)</td>
<td>-9.70%</td>
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<tr>
<td><strong>EPN</strong></td>
<td>$636,561</td>
<td>$712,510</td>
<td>$(75,949)</td>
<td>-10.66%</td>
</tr>
<tr>
<td><strong>TRISTATE</strong></td>
<td>$1,167,310</td>
<td>$1,272,187</td>
<td>$(104,877)</td>
<td>-8.24%</td>
</tr>
<tr>
<td><strong>DONOHUE</strong></td>
<td>$339,840</td>
<td>$423,361</td>
<td>$(83,521)</td>
<td>-19.73%</td>
</tr>
<tr>
<td><strong>COMPLETE CARE</strong></td>
<td>$127,792</td>
<td>$119,438</td>
<td>$8,354</td>
<td>6.99%</td>
</tr>
<tr>
<td><strong>TRI RIVERS SURGICAL</strong></td>
<td>$2,833,919</td>
<td>$2,549,876</td>
<td>$284,043</td>
<td>11.14%</td>
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<tr>
<td><strong>Total PSD</strong></td>
<td>$118,663,436</td>
<td>$126,988,155</td>
<td>$(8,324,719)</td>
<td>-6.56%</td>
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</tbody>
</table>

#### Year to Date Gross Charges

<table>
<thead>
<tr>
<th>Metric</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
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<td><strong>UPP</strong></td>
<td>$470,443,459</td>
<td>$482,344,185</td>
<td>$(11,900,726)</td>
<td>-2.47%</td>
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<tr>
<td><strong>CMI</strong></td>
<td>$97,155,747</td>
<td>$97,775,372</td>
<td>$(619,625)</td>
<td>-0.63%</td>
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<tr>
<td><strong>RFP</strong></td>
<td>$5,429,330</td>
<td>$5,424,181</td>
<td>$5,149</td>
<td>0.09%</td>
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<td><strong>ERMI</strong></td>
<td>$35,362,134</td>
<td>$37,011,650</td>
<td>$(1,649,516)</td>
<td>-4.46%</td>
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<td><strong>EPN</strong></td>
<td>$3,562,904</td>
<td>$3,523,345</td>
<td>$39,559</td>
<td>1.12%</td>
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<td><strong>TRISTATE</strong></td>
<td>$6,481,452</td>
<td>$6,742,591</td>
<td>$(261,139)</td>
<td>-3.87%</td>
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<td><strong>DONOHUE</strong></td>
<td>$1,722,158</td>
<td>$1,967,661</td>
<td>$(245,503)</td>
<td>-12.48%</td>
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<tr>
<td><strong>COMPLETE CARE</strong></td>
<td>$617,339</td>
<td>$609,992</td>
<td>$7,347</td>
<td>1.20%</td>
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<tr>
<td><strong>TRI RIVERS SURGICAL</strong></td>
<td>$12,688,508</td>
<td>$12,668,506</td>
<td>$20,002</td>
<td>0.16%</td>
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<td><strong>Total PSD</strong></td>
<td>$648,087,484</td>
<td>$648,087,484</td>
<td>$(14,050,782)</td>
<td>-2.17%</td>
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<tr>
<td>Business Unit</td>
<td>MTD Actual (Net of Delays)</td>
<td>MTD Budget</td>
<td>Variance Over / (Under) Budget</td>
<td>Percentage Over / (Under) Budget</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>13,492,609</td>
<td>14,653,761</td>
<td>(1,161,152)</td>
<td>-7.92%</td>
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<tr>
<td>Cardiothoracic Surgery</td>
<td>884,220</td>
<td>1,012,356</td>
<td>(128,136)</td>
<td>-12.66%</td>
</tr>
<tr>
<td>Critical Care Medicine</td>
<td>2,883,228</td>
<td>3,058,555</td>
<td>(175,327)</td>
<td>-5.73%</td>
</tr>
<tr>
<td>HVI - Cardiology</td>
<td>4,425,910</td>
<td>4,794,590</td>
<td>(368,680)</td>
<td>-7.69%</td>
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<tr>
<td>Dermatology</td>
<td>1,399,041</td>
<td>1,195,297</td>
<td>203,744</td>
<td>17.05%</td>
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<td>Emergency Medicine</td>
<td>2,733,317</td>
<td>3,092,381</td>
<td>(359,064)</td>
<td>-11.61%</td>
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<tr>
<td>Family Medicine</td>
<td>161,113</td>
<td>137,971</td>
<td>23,142</td>
<td>16.77%</td>
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<tr>
<td>HVI - Cardiac Surgery</td>
<td>1,784,367</td>
<td>1,804,747</td>
<td>(20,380)</td>
<td>-1.13%</td>
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<tr>
<td>Internal Medicine</td>
<td>7,070,149</td>
<td>7,670,319</td>
<td>(600,170)</td>
<td>-7.82%</td>
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<tr>
<td>Neurology</td>
<td>1,665,238</td>
<td>1,882,676</td>
<td>(217,438)</td>
<td>-11.55%</td>
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<tr>
<td>Neurosurgery</td>
<td>3,773,168</td>
<td>4,579,461</td>
<td>(806,293)</td>
<td>-17.61%</td>
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<tr>
<td>Ophthalmology</td>
<td>2,010,687</td>
<td>2,084,941</td>
<td>(74,254)</td>
<td>-3.56%</td>
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<tr>
<td>Orthopedics</td>
<td>4,691,691</td>
<td>5,348,806</td>
<td>(657,115)</td>
<td>-12.29%</td>
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<td>Otolaryngology</td>
<td>2,574,018</td>
<td>2,575,947</td>
<td>(1,929)</td>
<td>-0.07%</td>
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<tr>
<td>Pathology</td>
<td>3,301,583</td>
<td>3,373,372</td>
<td>(72,789)</td>
<td>-2.13%</td>
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<tr>
<td>Pediatrics</td>
<td>6,729,578</td>
<td>6,559,897</td>
<td>169,681</td>
<td>2.99%</td>
</tr>
<tr>
<td>PM&amp;R</td>
<td>696,053</td>
<td>992,286</td>
<td>(296,233)</td>
<td>-29.85%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>843,844</td>
<td>790,887</td>
<td>52,957</td>
<td>6.70%</td>
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<tr>
<td>Radiology</td>
<td>9,468,493</td>
<td>9,751,374</td>
<td>(282,881)</td>
<td>-2.90%</td>
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<tr>
<td>Radiotherapy</td>
<td>424,360</td>
<td>276,992</td>
<td>147,368</td>
<td>53.20%</td>
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<tr>
<td>Surgery</td>
<td>6,176,024</td>
<td>6,474,753</td>
<td>(298,729)</td>
<td>-4.61%</td>
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<tr>
<td>UPP Plastic Surgery</td>
<td>1,211,191</td>
<td>996,278</td>
<td>214,913</td>
<td>21.57%</td>
</tr>
<tr>
<td>UPP Urgent Care Centers</td>
<td>1,377,907</td>
<td>1,399,478</td>
<td>(21,571)</td>
<td>-1.47%</td>
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<td>UPP Urology</td>
<td>1,969,681</td>
<td>2,194,907</td>
<td>(225,211)</td>
<td>-10.26%</td>
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<tr>
<td>Total UPP</td>
<td>$ 88,502,099</td>
<td>$ 95,541,853</td>
<td>($ 6,049,754)</td>
<td>-6.40%</td>
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Current Health Care Environment

- Psychosocially and medically complex patients
- Culturally-diverse patients – with special needs – often unfunded and unmeasured (as opposed to core measures and meaningful use criteria)
- Socioeconomically challenges – health insurance industry transferring more cost to increasingly financially vulnerable patients
- Changing provider workforce – Millennials, Duty Hours regulatory environment
Decision making by non-clinicians
SUCCESS REQUIRES - Multipronged, interdisciplinary approach requiring collaboration and support
Respond and Adapt to Diversity

- Monitor changing demographics and community needs of the community
- Involve community representatives in planning quality improvement efforts
- Make changes in the system to address the specific needs of the organization and the community
- Be willing to negotiate and compromise to achieve improved and realistic outcomes
- Be clear about what is not flexible and why
Handling Generational Issues

- Improving mentoring
- Redefine the ideal worker
- Provide focused career development
- Encourage discussion with leaders and teams to understand differences in thinking and problem-solving

Implement Patient-Centered Medical Homes

- Comprehensive care
- Patient-centered
- Coordinated care
- Accessible services
- Quality and safety

https://pcmh.ahrq.gov/page/defining-pcmh
Compassionate Collaborators
“Effective participation by members of all racial and ethnic groups in the civic life of our nation is essential if the dream of one nation, indivisible, is to be realized.”

Justice O’Connor, in Grutter v. Bollinger
“Knowing is not enough; we must apply. Willing is not enough; we must do.”

Goethe
Competence

Health Benefits

Quality

Diversity

Care

QUESTIONS???????