



FROM AWARENESS TO ACTION

Stakeholders' Strategies to Eliminate Racial and Ethnic Health Disparities

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The views presented here are those of the authors and Summit Health Institute for Research and Education, Inc. (SHIRE) and should not be attributed to the funding agencies, their directors, officers, or staff.

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The full text of this report is available at www.shireinc.org. where viewers can also obtain more information about Summit Health Institute for Research and Education, Inc.

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EXECUTIVE SUMMARY

The issue of racial and ethnic disparities has moved to the center stage of public policy since the mid 80s. The task force report, which was issued in 1985 by Department of Health and Human Services Secretary Margaret Heckler, helped to set several developments in motion. A nearly immediate outcome, for example, was the establishment of federal and state minority health entities. In 2000, the Healthy People Initiative identified the elimination of health disparities as an overarching national goal to be attained by 2010.

By most accounts, the report issued by the Institute of Medicine (IOM) in 2002 – *Unequal Treatment/Confronting Racial and Ethnic Disparities in Health Care* – represents a *landmark* contribution to heightened interest and concern. The IOM's principal finding that racial and ethnic differences remained, even after adjustment for socioeconomic and access factors, reverberated among health stakeholders at every level. Another significant contribution bringing attention to the issue has been the series of *National Healthcare Disparities Reports*, published annually since 2003 by the Agency for Healthcare Research and Quality.

In addition to these initiatives, hundreds of individual scholars, supported by academia, foundations, and other institutions, have cast light on racial and ethnic health gaps. The result is a torrent of studies, which by an overwhelming majority have reinforced the conclusions reached by IOM that racial and ethnic healthcare disparities exist. The overwhelming consensus with respect to research on racial and ethnic health disparities – their existence and the need to address them – has led some stakeholders to conclude that it is time for a paradigm shift.

■ STUDY PURPOSE

In the summer and fall of 2005, the authors of this report surveyed 20 organizational representatives to determine what key stakeholders, in fact, were *doing* to address racial and ethnic health disparities. Stakeholders represented several kinds of organizations that were viewed as being involved in health-related issues; and they included associations, foundations, quality-focused organizations, government agencies, business-related entities, and advocacy/community organizations. The authors approached this investigation using a theoretical construct advanced by Bowen and Kwi, which assesses the impact of external and internal influences and factors on an organization's pathway to evidence-informed policy and actions.

■ THEORY APPLICATIONS: INTERNAL AND EXTERNAL DECISION-MAKING FACTORS AND INFLUENCES

With regard to internal factors, the authors found that, for the overwhelming majority of the organizations contacted, an *institutional commitment* provided the context for making decisions to address health gaps and most saw this focus as integral to their organizational mission. More than a third of the organizations that reported institutional commitments cited the *influence of key individuals* – top leaders and other inside advocates – as the primary decision-making factor. Others noted the critical role played in their organizations by newly appointed leaders as well as other respected key decision makers at top levels who have pressed for attention to health gaps over time. It was also apparent that internal advocates also comprised individuals functioning in other organizational capacities. The authors' interviews confirmed that several respondents were among these champions, as evidenced not only by their knowledge and activities, but also by their own commitment and passion.

External factors also surfaced as important contributors to organizational decision making about health disparities. By far, the most important catalyst was the release of IOM's *Unequal Treatment* study. Philanthropic and government agencies served as important catalysts as well. Several respondents noted that the availability of financial support helped launch activities and/or lent credibility to efforts already underway.

Finally, external realities and pressures contributed to agency decisions to address health disparities. One organizational respondent noted that “pressure from the field” to address minority health issues was a key factor. Verizon's representative noted the linkage between controlling health-related costs and closing employee health gaps. A third respondent pointed to demographics as a compelling consideration – the rising numbers of people of color in communities across the nation.

■ FROM COMMITMENT TO ACTION: ORGANIZATIONAL ACTION STRATEGIES TO CLOSE HEALTH GAPS

The authors found that there are six principal strategies employed by participating organizations to act on racial and ethnic health disparities, as shown in Table 1 on the following page. The study report provides examples from the field for each of these action strategies; it also presents the actions taken by stakeholders participating in the study.

■ ACHIEVING RESULTS

A frequently encountered success indicator encountered during this study was the shift or new emphasis in an organization's receptivity and readiness to address health disparities, as evidenced by references to health disparities in agency publications, the establishment of departments or organizational programs as a focal point for racial/ethnic organizational efforts, active pursuit of networking and partnership opportunities with minority organizations and others involved in parity and quality issues, and the like. The fundamental issue of health *outcomes*, however, was acknowledged by many as being the ultimate measure of the positive impact of organizational strategies and actions.

Table 1
Action Strategies for Addressing Racial/Ethnic Health Disparities

Capacity Dimension	Action Strategies
Institutional Leverage	<ul style="list-style-type: none"> • Incorporation of a commitment to address racial and ethnic disparities within agency vision and mission statements • Specific Board directives; leadership mandates • Creation of organizational divisions or departments dedicated to racial and ethnic health disparity issues • Issuance of performance standards reflecting agency commitments • Use of contracting/purchasing power to advance agency commitments
Policy Advocacy	<ul style="list-style-type: none"> • Conduct of policy-related research and analysis related to health disparity issues • Recommendation of federal legislative/agency policies • Promotion of (or opposition to) policies, programs, and funding proposals advanced by others
Research and Programs	<ul style="list-style-type: none"> • Survey and research, focus groups, think tank activities, pilot and demonstration efforts, etc. that contribute to the development of short- and long-term projects and agency programs
Partnership/Coalition-building	<ul style="list-style-type: none"> • Stakeholder activities aimed at the development or promotion of collaborations and networks, involving single or multiple partners • Support for coalition-building • Support and continuity with public, private, and community-based entities
Information Dissemination	<ul style="list-style-type: none"> • Generation of publications, reports, manuals, newsletters, and articles intended to inform organizational constituents and others • Creation of dedicated Web site pages or features • Forums, workshops, and conferences conducted to address racial and ethnic health disparities
Community Engagement/Empowerment	<ul style="list-style-type: none"> • Interaction of organizations with organizations of color and other community advocates and groups • Training and technical assistance • Targeted outreach, education, and information dissemination • Solicitation and engagement of community leadership in organizational activities or participation in partnerships • Community organization and mobilization

■ EXPANDING THE CIRCLE

Numerous workshops, forums, symposia, and conferences have addressed the topic of racial and ethnic health disparities. During the course of this project, Summit Health Institute for Research and Education, Inc. (SHIRE) made its own contributions by organizing both a Multicultural Leadership Working Forum/Setting a National Agenda to Address Health Disparities and a Congressional Breakfast Briefing/Ensuring Quality Health Care for All.

Responses from those participating in this study indicated that these events and others, similarly conceptualized and structured, can be beneficial despite – and even because of – their frequency. Such activities were viewed as important to maintain momentum and keep racial and ethnic health disparities on the “front burner.” They also serve to reinforce and reaffirm ongoing efforts, build awareness within organizations, and strengthen connections. Further, respondents described an expanded “comfort level” as a consequence of knowing that health disparities is not a tangential issue, but rather a “mainstream” concern that deserves and is receiving national focus.

More than 70 percent of those contacted reported that their participation in either the forum or the briefing triggered or contributed to a positive organizational response. Comments regarding presentations on the legislative process were of particular interest. Several respondents referred to a new interest and desire to work in a bipartisan and bicameral way to address minority health legislation, inspired and facilitated in part by their participation in project events.

■ ENGAGING NEW PARTNERS

During the survey, the authors asked respondents to recommend organizations and/or sectors that were not yet involved in addressing health disparities issues, but who were potential stakeholders. Mentioned most frequently were health providers and their associations, particularly those representing medical specialties and hospitals, which have considerable influence but do not mention disparities as one of their priorities. The business community was also cited as a potential stakeholder. Also to be engaged were the media, unions, community-based organizations, the faith community (e.g., the Association of Professional Chaplains), as well as government agencies and quality-focused organizations beyond those involved in this project.

■ RECOMMENDATIONS

In addition to examining the scope of organizational activity with respect to health parity and equity issues, the authors took advantage of the opportunity to solicit views on future directions with respect to corrective efforts. The following recommendations were informed by both those perspectives and the study’s findings

- More intensive work should be directed toward making the “business case” for eliminating racial and ethnic health disparities – exploring the economic costs of continuing health gaps and inequities and documenting how saving lives is both a moral imperative and cost-effective.
- There needs to be a determination of the existence and extent of disparities in care delivered to racial and ethnic minorities by health professionals in the private sector, and ways to hold these providers accountable for equal treatment should be found.
- Efforts should continue and accelerate to collect racial, ethnic, and primary language preference data; and a racial/ethnic and primary language data collection and reporting accreditation standard should be established.
- Programs intended to strengthen cultural competency of health providers and systems, improve language access, increase workforce diversity, and foster community empowerment and leadership in addressing issues of quality and parity should be institutionalized.
- Continuity and appropriate levels of support for minority-focused programs and organizations, such as Title VII and federal/state Offices of Minority Health, must be maintained. Appropriate federal authorization and appropriation levels are essential to preserve past gains and ultimately achieve health parity and equity in the nation.
- Strategic efforts should be launched to expand the ranks of stakeholders invested and involved in addressing the elimination of racial and ethnic health disparities. Particular targets are health providers from all disciplines and specialties, as well as business/corporate entities.
- Further study is recommended regarding the relationship between health disparities and quality, with an emphasis on strategies for achieving progress in both areas concurrently.
- The potential impact of health information technology (HIT), with respect to either reducing or exacerbating health disparities, should be addressed in the context of federal and private sector HIT initiatives.
- Consideration should be given to new strategies to bring about universal health care as a prerequisite for the attainment of health parity and equity.

FROM AWARENESS TO ACTION

Stakeholders' Strategies to Eliminate Racial and Ethnic Health Disparities

INTRODUCTION

Since 1985, the issue of racial and ethnic health disparities has edged to the center stage of public policy. Secretary Margaret M. Heckler, who led the Department of Health and Human Services (DHHS) at that time, spurred this movement with the *Report of the Secretary's Task Force on Black and Minority Health*.¹ The study gave currency to the concept of “excess deaths” and documented “a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole.”²

The Heckler report also helped to set in motion a series of related developments. A nearly immediate outcome was the establishment of federal and state minority health entities, launched by the Office of Minority Health in DHHS.³ The publication by the Office of Management and Budget of *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* in 1997, which highlighted the importance of consistent race/ethnicity data categorization in data collection and reporting, contributed to increasing awareness of race and ethnicity, particularly in federal agencies. In 2000, the Healthy People Initiative, which had its origins in a 1979 *Surgeon General's Report on Health Promotion and Disease Prevention*, identified the elimination of health disparities as an overarching national goal to be attained by 2010 – a goal endorsed by thousands of organizations and individuals.⁴

By most accounts, the report issued by the Institute of Medicine (IOM) in 2002 – *Unequal Treatment/Confronting Racial and Ethnic Disparities in Health Care* – represents a *landmark* contribution to heightened interest and concern. Charged by Congress to examine the role of race and ethnicity in healthcare differences, the IOM’s principal finding reverberated among health stakeholders at every level:

*The majority of studies . . . find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors.*⁵

Another significant contribution to an increased emphasis on this issue is the *National Healthcare Disparities Report* (NRDR), published annually as of 2003 by the Agency for Healthcare Research and Quality (AHRQ). Each study, again in response to a Congressional mandate, monitors the nation’s progress toward eliminating disparities in health care, focusing on 46 core quality and 13 access measures. Each report has signaled progress made with respect to these indicators. Yet, in the latest publication AHRQ concludes: “Consistent with extensive research and findings in previous NHDRs, the 2005 report finds that disparities related to race, ethnicity and socioeconomic status still pervade the American health care system.”⁶

In addition to these initiatives, hundreds of individual scholars, supported by academia, foundations, and other institutions, have cast light on racial and ethnic health gaps. The IOM committee responsible for *Unequal*

Treatment examined more than 500 studies prior to issuing that report. Research conducted since 2002 has been nearly as abundant.

The resulting torrent of studies has reinforced the same conclusion. Only recently, in fact, have a few dissenting voices been heard that challenge the assumption that racial and ethnic disparities persist and, in some instances, are widening.⁷ Authors of a recent article appearing in the *New England Journal of Medicine* maintain, for example, that while the quality of health services everyone receives is poor, minorities fare slightly better than white males.⁸⁻⁹

Notwithstanding these outlying observations, there is substantial agreement evidenced in the literature that racial and ethnic health disparities not only exist, but should be eliminated. IOM gave three justifications. First and foremost: “Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.” Second, although IOM acknowledges the broader socioeconomic and behavioral risks to health, the study committee also concluded: “More so than the broader socioeconomic and behavioral risks to health...., racial and ethnic healthcare disparities are well within our reach to address.”

A third conclusion stated in *Unequal Treatment* addressed the need for better quality of care. The point was made that eliminating racial and ethnic disparities can lead to raising the overall quality of the nation’s healthcare, and therefore is cited as one of the six overarching goals identified in the IOM’s report, *Crossing the Quality Chasm*.¹⁰ This last rationale, which places the elimination of health disparities among people of color within the context of quality improvement generally, has been echoed by a growing number of voices, including researchers associated with The Commonwealth Fund.¹¹

Offering a final rationale for action, a team of researchers recently revisited the “excess deaths” theme given visibility in the Heckler report. Their review of U.S. Census data from 1991 to 2000 revealed that nearly 900,000 deaths were attributable to excess mortality among African Americans. They contrasted the total number of lives saved by medical advances (approximately 180,000) and concluded that addressing racial disparities (in this instance) would result in a far greater return on investment.

The US health system spends far more on the “technology” of care (e.g., drugs, devices) than on achieving equity in its delivery. ...Achieving equity may do more for health than perfecting the technology of care.¹²

This overwhelming consensus with respect to research on racial and ethnic health disparities – their existence and the need to address them – has led some stakeholders to conclude that it is time for a paradigm shift. In an editorial written for the *New England Journal of Medicine*, Dr. Nicole Lurie described the challenge:

During the past decade, hundreds of articles have been published documenting the existence of racial and ethnic disparities in health and health care - a data deluge that has led many observers to suggest that it is time to stop documenting disparities and turn our efforts to *doing* (our emphasis) something about them.¹³

■ STUDY PURPOSE

In the summer and fall of 2005, the authors of this report conducted surveys of 20 organizational representatives to determine what key stakeholders in fact were *doing* to address racial and ethnic health disparities. Stakeholders represented several kinds of organizations that were viewed as being intentionally and substantially involved in health-related issues: associations, foundations, quality-focused organizations, government agencies; business-related entities, and advocacy/community organizations.

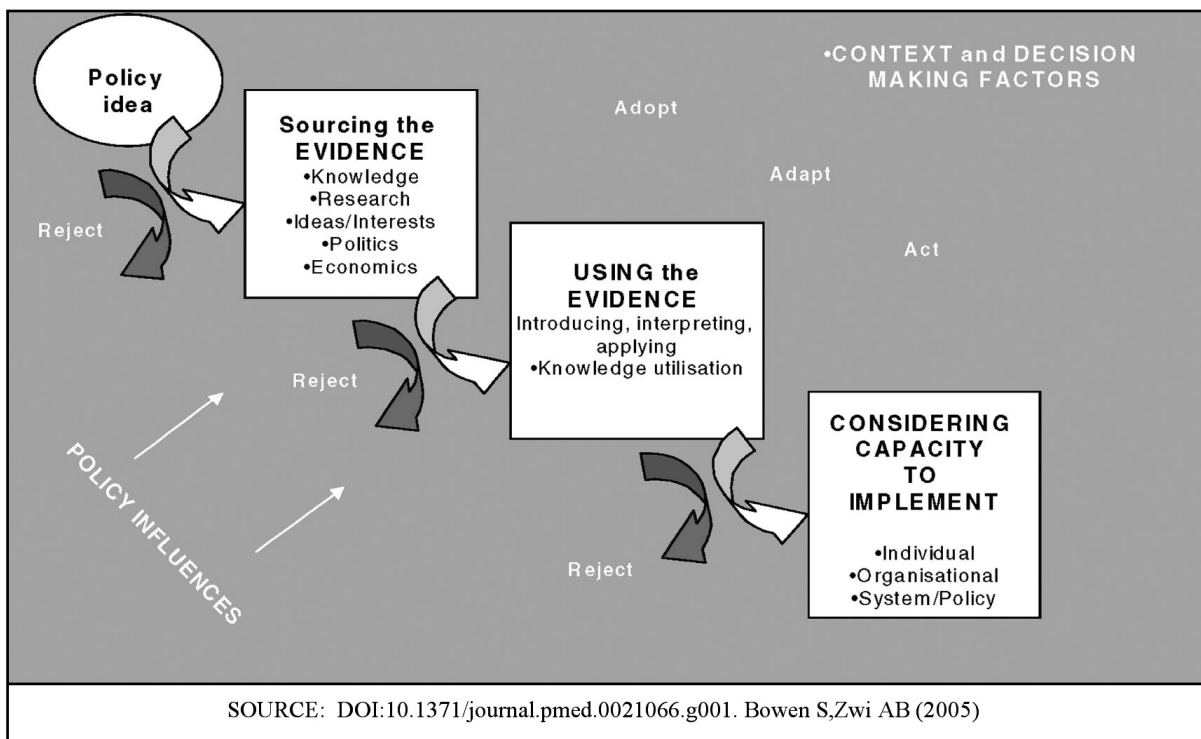
The interest of these organizations in racial and ethnic health disparities was a matter of record, confirmed in part by their active participation in disparity-focused events conducted under the auspices of this project. Unknown to the authors was the extent to which interest and concern for these health gaps had been translated into action. Further to be determined were the lessons to be learned from their involvement and activities. Finally, the authors sought to explore ways to enhance awareness of racial and ethnic disparities so that an increased commitment to action among a broader range of stakeholders might result.

S TAKEHOLDER ACTIONS TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES

THEORETICAL FRAMEWORK

Although not yet comparable in popularity to health disparities as a topic for study, the concept of “evidence-based” practices has received considerable research attention in recent years. An intriguing variation on this theme has been presented by Bowen and Zwi, who have incorporated the concept into a theory describing *how* organizations move to take action.¹⁴ Figure 1 describes the pathway to “evidence-informed” policy and practice. The researchers propose starting from a policy idea; then proceeding to sourcing the evidence; then considering that research within policy and decision-making contexts; and, finally, determining an organization’s capacity to act on evidence compiled. This pathway is illustrated in Figure 1.

Figure 1: The Evidence-Informed Policy and Practice Pathway



■ THEORY APPLICATIONS: INTERNAL AND EXTERNAL DECISION-MAKING FACTORS AND INFLUENCES

The authors' investigation described in this report addressed several aspects of this "pathway." Of keen interest were the significant external "policy influences" and internal "context and decision-making factors" that impacted on organizational decisions to act on racial and ethnic health disparities, the "policy idea" in this formulation.

With regard to internal factors, the authors found that, for the overwhelming majority of the organizations contacted, an *institutional commitment* provided the context for making decisions to address health gaps. Of this group, 50 percent saw this focus as integral to their organizational mission.

More than a third of the organizations that reported institutional commitments cited the *influence of key individuals* – top leaders and other inside advocates – as the primary decision-making factor. Among survey participants, for example, were four presidents or executive directors whose personal involvement in addressing racial and ethnic disparities was confirmed by their survey responses and by other documentation.¹⁵ Others noted the critical role played in their organizations by newly appointed leaders as well as other respected key decision makers at top levels who have pressed for attention to health gaps over time.

It was also apparent that internal advocates also comprised individuals functioning in other organizational capacities. The authors' interviews confirmed that several respondents were among these champions, as evidenced not only by their knowledge and activities, but also by their own commitment and passion.

External factors also surfaced as important contributors to organizational decision making about health disparities. By far, the most important catalyst was the release of IOM's *Unequal Treatment* study, as reported by half of those citing an institutional focus on the issue.

The IOM's Unequal Treatment report has driven so much. Previously, people inside did not understand the need for change – over the past three years that awareness has grown.

Philanthropic and government agencies served as important catalysts as well. Several respondents noted that the availability of financial support helped launch activities and/or lent credibility to efforts already underway.

Finally, external realities and pressures contributed to agency decisions to address health disparities. One organizational respondent noted that "pressure from the field" to address minority health issues was a key factor. Verizon's representative noted the linkage between controlling health-related costs and closing employee health gaps. A third respondent pointed to demographics as a compelling consideration – the rising numbers of people of color in communities across the nation.

■ ACTION STRATEGIES TO ATTAIN HEALTH PARITY: REPORTS FROM THE FIELD

As depicted in Figure 1, a critical step in the pathway to change, once an institutional commitment is made, is the *use* of evidence reflecting the organization's capacity to implement. As described by Bowen and Zwi:

Capacity in the health sector refers to the ability to carry out stated objectives; it is the expertise and resources at individual, organizational, and system levels for the production and application of new knowledge to health problems. At the individual and organizational levels, capacity is often visible as skills and competencies, leadership, partnerships, the development of appropriate workforce and organizational structures, and the ability to mobilize and allocate resources....Key at the system level are processes, policies, politics, and people.¹⁶

This report provides insights into several "capacity dimensions" which surfaced during the stakeholder interviews. These dimensions, which also describe ways in which organizations have acted to address racial and ethnic health disparities, are presented in Table 1.

Table 1
Action Strategies for Addressing Racial/Ethnic Health Disparities

Capacity Dimension	Action Strategies
Institutional Leverage	<ul style="list-style-type: none"> • Incorporation of a commitment to address racial and ethnic disparities within agency vision and mission statements • Specific Board directives; leadership mandates • Creation of organizational divisions or departments dedicated to racial and ethnic health disparity issues • Issuance of performance standards reflecting agency commitments • Use of contracting/purchasing power to advance agency commitments
Policy Advocacy	<ul style="list-style-type: none"> • Conduct of policy-related research and analysis related to health disparity issues • Recommendation of federal legislative/agency policies • Promotion of (or opposition to) policies, programs, and funding proposals advanced by others
Research and Programs	<ul style="list-style-type: none"> • Survey and research, focus groups, think tank activities, pilot and demonstration efforts, etc. that contribute to the development of short- and long-term projects and agency programs
Partnership/Coalition-building	<ul style="list-style-type: none"> • Stakeholder activities aimed at the development or promotion of collaborations and networks, involving single or multiple partners • Support for coalition-building • Support and continuity with public, private, and community-based entities
Information Dissemination	<ul style="list-style-type: none"> • Generation of publications, reports, manuals, newsletters, and articles intended to inform organizational constituents and others • Creation of dedicated Web site pages or features • Forums, workshops, and conferences conducted to address racial and ethnic health disparities
Community Engagement/Empowerment	<ul style="list-style-type: none"> • Interaction of organizations with organizations of color and other community advocates and groups • Training and technical assistance • Targeted outreach, education, and information dissemination • Solicitation and engagement of community leadership in organizational activities or participation in partnerships • Community organization and mobilization

GENERAL OBSERVATIONS

The overwhelming majority of stakeholders participating in this study have taken action with respect to addressing racial and ethnic health disparities – in a variety of ways. Guided by an institutional commitment, they have engaged in policy advocacy, applied research and programs, partnership/coalition-building, and information dissemination; and they have supported community engagement and empowerment. Five agencies, in fact, reported taking action in all six categories.

Table 2 summarizes these involvements. Illustrative activities for each action category are presented in the sections that follow.

Table 2
Key Organizational Strategies to Attain Parity and Improve Care Quality for Minority Populations

Organization	Institutional Commitment	Policy Advocacy	Research/ Programs	Partnership/Coalition Building	Information Dissemination	Community Engagement
AAMC	x	x	x	x	x	
APHA	x	x	x	x	x	x
AHIP	x	x	x	x	x	x
F-USA	x	x	x	x	x	x
IHI	x		x	x	x	
JACHO	x		x	x	x	
NACHC	x	x	x	x	x	x
NAHU	x		x	x	x	
NAPH	x	x	x	x	x	x
NCI/CRHD	x		x	x	x	x
NQF	x		x		x	
OMO	x	x		x	x	x
PCC	x		x	x	x	
RWJF	x		x	x	x	
TCE	x		x	x	x	x
Verizon	x		x	x	x	

LEGEND

AAMC	Association of American Medical Colleges
APHA	American Public Health Association
AHIP	America's Health Insurance Plans
F-USA	Families USA
IHI	Institute for Healthcare Improvement
JACHO	Joint Commission on Accreditation of Healthcare Organizations
NACHC	National Association of Community Health Centers
NAHU	National Association of Health Underwriters
NAPH	National Association of Public Health Hospitals and Health Systems
NCI/CRHD	National Cancer Institute/Center to Reduce Health Disparities
NQF	National Quality Forum
OMO	Out of Many, One
PCC	Primary Care Coalition of Montgomery County, Maryland
RWJF	Robert Wood Johnson Foundation
TCE	The California Endowment
Verizon	Verizon Communications

INSTITUTIONAL COMMITMENT

The authors sought information with respect to this strategy regarding evidence of a rooted commitment to address health disparities on the part of an institution and organization. This commitment can be manifested in various ways – through a statement of mission or Board policy; by actions of institutional leaders; by the creation of a department or division specifically targeted to diversity and disparity issues; and by use of an agency’s institutional leverage and power to influence large numbers of members, constituents, employees, or organizations.

The California Endowment

The power of leadership was clearly articulated in the authors’ interview with the president and chief executive officer of The California Endowment. The Endowment, which is a private, statewide health foundation guided by a vision for a healthy California, clearly incorporates an emphasis on diversity and health disparities and speaks directly to a “multicultural approach to health.” This approach is reinforced by investments made in local communities and focuses on three program areas: access to health, culturally competent health systems, and community health and the elimination of health disparities.

The Endowment’s representative described a comprehensive, longitudinal, and multi-faceted institutional strategy to reach these aims, which is buttressed by targeted resources:

We have major strategic initiatives in both disparities in health care and disparities in health status. These initiatives include efforts to strengthen cultural competency, improve language access, and increase workforce diversity. We are also funding community-based efforts to control and reduce obesity and asthma in communities of color. All told, we are investing more than \$50 million annually to fight racial and ethnic disparities.

Joint Commission on Accreditation of Healthcare Organizations

Also illustrative of the use of institutional leverage is the decision of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) to propose a new requirement for the collection of information on race, ethnicity, and primary language. In light of the fact that the Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the United States as the nation’s predominant standards-setting and accrediting body in health care, the initiative is an important one, with potentially far-reaching impact. Through consultation with health care experts, providers, measurement experts, purchasers, and consumers, the approved portion of the proposed requirement includes language and communication needs. Specifically, the requirement is intended to “support the provision of care, treatment, and services in a manner that is conducive to the cultural, language, literacy and learning needs of individuals.”¹⁷

Leadership for this initiative has clearly flowed from the top. In the words of the Joint Commission’s Senior Vice President: “The delivery of culturally competent services is more than simply a patient’s right, but in fact a key factor in the safety and quality of patient care.” Survey respondents noted that, although the field apparently was not quite ready for the standard on race and ethnicity data collection, the issue has not been pulled indefinitely and a standard addressing this matter will be released for comment at a later time. One Joint Commission employee stated during an interview, “The Joint Commission is primed to start making movement toward pushing the field.”

Verizon Communications

Leveraging institutional resources was a theme also sounded by the representative of Verizon Communications interviewed by the authors. Reflecting a corporate commitment to diversity and quality health care, Verizon has utilized its vast purchasing power (\$3.6B spent on health care in 2005) in its rating of health plans’ actions with respect to their awareness and response to disparities. An assessment of plans’ performance in serving employees from different racial and ethnic groups is also part of the company’s renewal evaluations.

Verizon has used the IOM's *Unequal Treatment* report as the source of guidance for "best actions" for health plans, which include collecting racial/ethnic patient information, analyzing the race and ethnicity of providers, sponsoring forums and training for physicians to foster cultural competence, and sponsorship of member disease management programs tailored for employees of color who are at higher risk. Verizon continues to share information with employees to raise awareness of disparities through internal communications, partnerships with employee affinity groups and other internal organizations, and incorporation of diversity guidelines in the development of new health care initiatives with health-related vendors. Verizon also continues to partner with organizations that encourage health plans to provide services that are culturally and linguistically appropriate.

POLICY ADVOCACY

As indicated in Table 1, this action category deals with organizational activities that focus on national policies – both legislative and administrative – and encompasses efforts directed at Congressional authorization and appropriation actions; non-partisan, bipartisan, and issue-oriented advocacy; as well as support for and opposition to pending bills and proposals.

American Public Health Association (APHA)

APHA describes itself in policy and advocacy terms. The oldest and largest organization of public health professionals in the world, representing more than 50,000 members from more than 50 occupations in public health, "APHA has been influencing policies and setting priorities in public health. . . . For more than 130 years the American Public Health Association has led efforts to improve the public's health through advocating for resources to promote a healthy society."¹⁸

APHA's entry into the health disparities arena became a matter of public record in 2000. In October of that year, APHA spearheaded an initiative in which DHHS and a broadly representative group of national leaders publicly signed a "Call to the Nation: to Eliminate Racial and Ethnic Disparities in Health." APHA dedicated its 2000 Annual Meeting and its November issue of the *American Journal of Public Health* to the issue of racial and ethnic disparities, and the organization elected its first American Indian president.¹⁹ These activities contributed to the national push to incorporate eliminating health disparities as a primary goal of *Healthy People 2010*.

The organization's policy efforts encompass advocacy on the national level to produce meaningful minority health legislation. State and local chapters are also encouraged to get involved in policy issues. In 2004-2005, for example, APHA advocacy actions directed to Congress included support for bipartisan health disparities legislation. APHA looks as well at the potential impact of broader legislation on minority health.

People ask us about the workforce bill – we look at the disparities angle. We need to see more persons of color admitted into programs and establish 10 year horizons in the workforce. With regard to the environment, we focus in on the health disparities piece . . . in order to get the issue integrated.

The National Association of Public Hospitals and Health Systems (NAPH)

NAPH, which represents over 100 entities that serve a significantly disproportionate number of low-income individuals, provides an institutional "safety net" for America's most vulnerable patients. Health disparities have been identified by NAPH as one of its top issues for advocacy for this reason: "NAPH members serve a vital role in communities of diverse populations by providing culturally and linguistically appropriate services."²⁰

NAPH's representative participating in the survey described the organization as "mission driven" – a mission powered by an increasing recognition of the needs of immigrant populations. The organization is thus acutely aware of the importance of providing culturally and linguistically appropriate care. There is also concern to improve the

quality of care: “That is another part of what we do. Quality involves addressing health disparities, culture and language – all are connected with quality.”

These institutional commitments translate into policy advocacy, “weighing in,” for example, on minority health bills introduced in past and current Congressional sessions. They also are reflected in programs, research, training, and dissemination activities that are implemented by the National Public Health and Hospital Institute (NPHHI). NPHHI has also identified addressing disparities and serving diverse communities as a key program area, and has produced a report, with the support of the Office of Minority Health, DHHS, that underscores the importance of executive leadership at the institutional level in addressing these issues effectively.²¹

Out of Many, One (OMO)

OMO is a national multicultural advocacy organization established in 2000, which comprises representatives of the five racial and ethnic groups identified as minorities by the Office of Management and Budget. Over the past several years, OMO has been involved in advocacy, with respect to the Congress, and has actively supported legislation that authorizes, strengthens, and provides increased funding for minority agencies and programs. In 2005, OMO supported efforts to produce bipartisan bills that address these priorities, working in particular with Congressional caucuses representing communities of color. Another advocacy target was the issue of expanded and sustained Medicaid coverage for persons impacted by recent natural disasters, who were disproportionately from racial and ethnic minority groups.

OMO’s representative reported further that the organization has also engaged in administrative advocacy in the form of ongoing discussions with the Centers for Medicare and Medicaid Services (CMS) to promote strategies to increase staff diversity; program, research, and contracting participation by people of color; racial/ethnic and primary language data collection and reporting to ascertain the participation of minority beneficiaries in CMS programs; and other strategies to enhance CMS’ capacity to respond to the diverse individuals and communities served by the agency.

RESEARCH AND PROGRAMS

During the survey, the authors encountered a full range of activities in this action area, which included survey and applied research, focus groups, demonstration programs, short- and long-term initiatives, projects, and programs.

Center to Reduce Cancer Health Disparities (CRCHD)

A top priority of NCI is “to correct an unacceptable fact –the burden of cancer is borne unequally and unjustly in our society.”²² CRCHD was created in 2001 to provide direction for a wide-ranging research program that spans the cancer control continuum – from disease prevention to end-of-life care.

NCI is addressing unequal patterns of access to standard care through the multi-site Patient Navigation Research Program (PNRP). This research focuses on developing and testing Patient Navigation interventions. The Program encompasses four cancers with great disparity in screening and follow-up: breast, cervical, prostate, and colorectal. PNRP grantees will conduct formal qualitative and quantitative program evaluation to measure efficacy and cost-effectiveness.

The PNRP’s goal is to develop and test interventions to reduce time to delivery of quality, standard cancer care (non-cancer resolution or cancer diagnosis and treatment) after identification of an abnormal finding. Although anyone may benefit from Patient Navigator services, the primary participants for this research program are populations experiencing cancer health disparities. These encompass racial/ethnic minorities, individuals with lower socioeconomic status, and residents of rural areas.²³

The National Association of Community Health Centers, Inc. (NACHC)

NACHC is the national voice for the nation's network of more than 1,000 Federally Qualified Health Centers that serve an estimated 15 million people through 5,000 sites. As reported by the NACHC representative who participated in the survey, the organization has addressed health disparities in multiple ways. Backed by a statutory mandate and a 40-year history, NACHC provides training and engages in legislative advocacy in support of policies that would eliminate health disparities as well as expand and strengthen health centers.

Perhaps less well known, as reported by the NACHC representative participating in the survey, is the organization's support of research, which has yielded firm evidence that the elimination of disparities is an achievable goal. Pursuant to the findings of *Unequal Treatment*, NACHC sought to examine the role of health centers in improving health outcomes for all patients, especially minorities, and commissioned two studies conducted for that purpose.

These research studies have provided substantive documentation for the conclusion that health centers have eliminated disparities among patients, even after controlling for socio-demographic factors other than race and ethnicity, in such areas as: low birth weight, prevention services, and chronic care.²⁴ Also significant are findings that health centers are associated with reducing health disparities on a statewide level. As the proportion of a state's population served by health centers grows, racial gaps narrow with respect to infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates.²⁵

The Robert Wood Johnson Foundation (RWJF)

RWJF is the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans. Health care disparities represent one of the Foundation's many interest areas, which also include vulnerable populations and quality health care. RWJF's focus in this area is to eliminate the gaps in care experienced by racial and ethnic minorities by improving the understanding of what causes these disparities and by working with health care systems to improve health care for all. Thus, RWJF's response to the IOM's *Unequal Treatment*, as reported by SHIRE's survey respondent, is to view reducing health gaps as a quality of care issue. An assumption underlying this approach is that if "best care" protocols are implemented on a "color-blind" basis, particularly in settings where disparate care has been provided previously, minorities will benefit disproportionately and gaps will close.

Recent interventions initiated by the Foundation reflect this theme:

- **Expecting Success: Excellence in Cardiac Care** is a national initiative that will lead 10 selected hospitals through a collaborative effort to develop and document processes to improve the quality of cardiac care provided to minority populations in the United States.
- **Finding Answers: Disparities Research for Change** will engage organizations in the implementation and evaluation of interventions aimed at reducing disparities by encouraging health providers to focus on racial and ethnic disparities as a priority in their quality improvement agenda.

PARTNERSHIP/COALITION-BUILDING

Use of this action strategy entails the engagement of single or multiple partners, as well as the development of, or participation in, collaborations, networks, and coalitions. Work with coalitions may involve creation; sponsorship; participation and/or support; and other joint efforts with private, public, and community-based entities to address health disparities collectively.

Association of American Medical Colleges

AAMC's activities in support of health parity and diversity in the health professions are illustrative of five of the six action strategies addressed by this report. For example, the organization's Tool for Assessing Cultural Competence Training, which received impetus from a project supported by The Commonwealth Fund, provides important information to health professions on issues of culture. In the fall of 2005, AAMC convened a national summit to address medical education debt – a major obstacle to efforts to increase racial diversity among health providers. AAMC's publications also contribute to health parity. *Minorities in Medical Education: Facts & Figures 2005* is an example, as are articles in the AAMC's *Reporter*, which is a vehicle for addressing current policy issues.²⁶

In 2004, AAMC re-established the Health Professionals for Diversity (HPD) Coalition, which was originally created in 1996 to respond to state anti-affirmative challenges. This move was inspired by the findings of two major reports on this topic,²⁷ as well as a growing backlash against the 2003 Supreme Court decision in *Grutter v. Bollinger*. AAMC's senior leadership convened more than 20 health-professions-related organizations and academic institutions. HPD now exists in its own right with the mission of promoting diversity in the health professions. Its Web site offers a *Member Toolkit*, a fact sheet on the need for diversity in the health professions, and additional resources.²⁸

The Institute for Healthcare Improvement (IHI)

IHI's survey participant identified the Health Disparities Collaborative as an important partnership initiative with the Health Resources and Services Administration, Bureau of Primary Health Care. Working through more than 500 health centers, IHI is building agency capacity to implement a chronic care model that seeks to transform clinical practice through models of care for 300,000 patients presently, with the goal of eventually reaching all 16 million. Because a substantial majority of health center users are from communities of color, IHI has operated on the assumption that this quality emphasis helps to close gaps. Although IHI has not conducted targeted racial/ethnic analyses, that assumption appears to be substantiated by health center data published by NACHC, as well as by IHI's "Improvement Stories" on the agency's Web site.²⁹

Out of Many, One

As reported by its representative, OMO has taken a unique approach to coalition building as a strategy to eliminating health disparities. With funding from DHHS, OMO served as a partner with SHIRE in creating a guide with broad applicability in federal, state, and community settings. *Building Coalitions among Communities of Color/A Multicultural Approach* was published by the Office of Minority Health in 2005. The guide, which was developed through consultation with more than 100 representatives of racial/ethnic minority groups and state Offices of Minority Health throughout the nation, offers a variety of practical strategies and steps for effective coalition-building.³⁰

INFORMATION DISSEMINATION

As implemented by responding organizations, this strategy involves the development and distribution of information through a variety of means. These measures include print media (i.e., publications, reports, manuals, newsletters, articles) and Web site features, as well as forums, workshops, and other types of meetings.

America's Health Insurance Plans (AHIP)

AHIP is a national association representing nearly 1,300 member companies that provide health benefits to more than 200 million individuals. The association's goals include providing a unified voice for the health care financing industry and for expanding access to high quality, cost-effective health care for all Americans.

Citing findings from recent reports, including *Unequal Treatment*, AHIP has moved vigorously to address several key issues associated with closing the health gap. As further evidence of this emphasis, AHIP has identified “Diversity and Cultural Competency” as one of the key health and medicine issues highlighted on its Web site. Accordingly, AHIP’s representatives participating in the survey reported the implementation of several strategies to bring about greater equity in health services; however, the organization’s commitment to information dissemination is predominant.

In 2005, AHIP published a data collection toolkit, *Data as Building Blocks for Change*, as part of its four-part series of *Tools to Address Disparities in Health*. The toolkit was used and distributed at regional workshops around the country for health care organizations interested in taking the first steps to using data as the foundation for quality improvement.³¹ The purpose of the toolkit is to increase awareness of the importance of collecting data on race, ethnicity, and primary language of their enrollees. It also serves as a first step to identify and measure disparities in care for overall quality improvement.

The second resource promoting “culturally sensitive health care” includes a one-hour online continuing medical education course that offers physicians tools and skills to communicate more effectively with patients from diverse backgrounds and improve overall quality of care. An abbreviated 20-minute introductory course is also available to stimulate interest in the area of cultural competency to better serve America’s racial and ethnically diverse populations.

AHIP’s newly published resource, *Communicating Effectively to Close the Gap*, was developed with input from a multi-cultural advisory panel and highlights tools, Web sites, and steps to incorporate culturally and linguistically appropriate messages into everyday communications with consumers. AHIP is also launching “*Models that Work*,” an on-line clearinghouse of information on approaches to reducing disparities that have proved successful. The health insurance community has a tradition of sharing information on effective models so that these programs, or elements of them, can be adapted for more widespread use and to benefit more individuals.

Additionally, as in 2003, AHIP collaborated with RWJF in 2006 to conduct a follow-up survey with its member health insurance plans. The purpose of the 2006 follow-up survey was to assess any differences or trends in health insurance plans ability to collect and use data on race, ethnicity, and primary language of their enrollees. The results will serve as an opportunity for AHIP, its member companies, and RWJF to expand on the issues identified in the initial survey and continue to learn from the experiences and practices of health insurance plans.

National Quality Forum (NQF)

NQF is a private, not-for-profit membership organization that was created to develop and implement a national strategy for health care quality measurement and reporting. Its mission is to improve health care in America through endorsement of consensus-based national standards and through public reporting of performance data. Launched in 1999, NQF is structured around four Member Councils, representing key stakeholders, and has more than 350 organizational members.³²

Two basic concepts underlie NQF’s work in the area of health disparities and cultural competence:

- Quality health care is equitable health care – inequality and quality cannot co-exist. Disparities must be addressed across all domains of quality – these are *not* separate issues.
- In order to improve care for ethnically, racially, linguistically, and culturally diverse groups, we must have the capacity to measure and report the quality of *their* care.³³

These concepts reflect the interests of the organization’s leadership that, since 2000, has taken action to address health parity and equity issues.

America needs to improve healthcare quality overall by implementing systematic and coordinated methods of measuring and reporting quality, but in doing so special attention needs to be directed to addressing the disparities that exist for racial and ethnic minorities. Healthcare quality in the United States must rise to both a higher and more equitable level than currently exists.³⁴

NQF's participant in the survey cited several projects that are illustrative of the importance of communication and information dissemination as strategies to close the health gap. For example, a grant provided by The Commonwealth Fund in 2000 made possible a workshop to look at health care measurement and reporting for minority populations, which culminated in the publication two years later of proceedings entitled, *Improving Healthcare Quality for Minority Patients*.³⁵ A second initiative, which addresses ways to advance appropriate language and cultural assistance, culminated in a "user's guide" on informed consent, which is available on the NQF Web site for consumers and health care professionals/providers.

Verizon Communications

The dissemination-related activities of the survey respondent from Verizon Communications clearly reflect a commitment to spread the word far and wide, both within the corporate community and beyond. Backed by Verizon's corporate leaders, this "Paulette Revere" has conveyed the "business case" – the message that the private sector has been and is playing a leadership role in tackling and eliminating racial and ethnic disparities in health care, and it is in its economic interest to do so. This individual reported making frequent presentations, such as a Congressional briefing conducted pursuant to SHIRE's study effort, which, in turn, has generated many new requests. In addition, this person has served on disparities advisory boards and panels to represent the business case from the employer purchaser's perspective.

The respondent also chaired the Health Disparities Initiative Employer Council of the National Business Group on Health (NBGH), a role in which she has provided impetus for a number of informational activities. These include the award-winning *Employer Toolkit: Reducing Racial and Ethnic Health Disparities*.³⁶ The respondent continues to work with NBGH to keep the disparities concern in front of corporate employers in an effort to leverage their combined influence to include disparities initiatives in all quality health care objectives.³⁷

COMMUNITY ENGAGEMENT

Engaging racial/ethnic and other stakeholders at the community, state, and national levels in the battle to eliminate health disparities is seen in many quarters as an essential strategy to close health gaps. Associated activities include training and technical assistance, outreach, education and information dissemination, and community environmental scans. Of particular importance are activities to assure meaningful community leadership, participation or partnerships in program development, research and evaluation, as well as the mobilization of communities around issues through advocacy efforts.

The California Endowment

Embodied in The California Endowment's vision for a healthy California is the concept of "grassroots-to-treetops" advocacy and mobilization. The Endowment visualizes a state where community members and policy makers work together to improve health and health care, "and there is a respect for the experience and knowledge of the people who are the most directly affected by health disparities." The foundation sees itself as a change agent in bringing this vision into reality.

We actively promote and support an array of local grassroots coalitions, which are deeply rooted in communities and know best the conditions that need to change, as well as statewide and, in some cases, national organizations. Together, these individuals, organizations and coalitions act to influence health decision-makers and shape policies and systems at all levels so that they reflect ideas that emerge from the grassroots and work for everyone.³⁸

The Endowment's community investments take several forms, such as:

- Conducting a community needs assessment to determine opportunities for physical activity
- Community organizing and education among farm workers to seek redress for the effects of pesticide over-spraying
- Developing youth "champions" to educate and advocate for healthy eating and exercise
- Providing financial, training, and educational resources to community-based organizations and the groups that support them in building their public policy and advocacy capacity and skills

Families USA

Families USA's involvement in community advocacy is well-known. As the "Voice for Health Care Consumers," the organization has managed for more than 20 years a grassroots advocates' network of organizations and individuals. Families USA has provided training and technical assistance to state and community-based organizations, working collaboratively as they address critical health issues in their own locales.

With the creation of its Minority Health Initiatives program has come a new opportunity, funded by the W.K. Kellogg Foundation, to build "the capacity of communities of color to address health disparities through policy and advocacy," particularly at the state and local levels. Initiative staff members work in partnership with the National Medical Association, the National Association of Latino Elected and Appointed Officials Education Fund, and the Joint Center Health Policy Institute. Targeting faith leaders and other community leaders, as well as the media, who may not have been engaged previously in addressing health disparities, the Initiative has held trainings and has published an action kit on policy advocacy.

National Cancer Institute's Center to Reduce Cancer Health Disparities

The Community Networks Program (CNP) of the National Cancer Institute's Center to Reduce Cancer Health Disparities, was initiated in May 2005 through grants to 25 institutions to support community-based participatory education, training, and research. The intent was to maintain the momentum generated by earlier initiatives, such as Special Populations Networks (SPN), in order to reduce the "unequal burden" borne by communities of color with respect to cancer morbidity and mortality. Hence, grantees are expected to strive to significantly improve access and utilization of beneficial cancer interventions in those communities.³⁹

There were major successes associated with the SPN program, which should be amplified through CNP. One of the most impressive is the emergence of representatives of coalitions organized through these grants who have become national figures. An agency contact cited several instances where American Indian, Latino, and Asian community representatives have become "major players" as spokespersons at the national level and as members of the NCI Advisory Board.

ACHIEVING RESULTS

An organization's decision to take action – or the actions actually taken – is not the culmination of the pathway to change. The true destination is the change itself; in the health arena, the change will be the attainment of health parity and access to health services that meet the highest achievable quality standards.

After receiving information about action strategies, the authors queried respondents about positive outcomes that have resulted from their work thus far. Respondents gave insights into outcomes experienced, as well as their definitions of success. As might be expected, given the relatively brief duration of efforts to date, most responses focused on processes rather than outcomes. Yet, a number of efforts held the promise of significant results in the

future and, hence, were seen as worthy of mention.

A frequently encountered success indicator was the shift or new emphasis in an organization's receptivity and readiness to address health disparities, evidenced by presidential messages, editorials, and other references in agency publications; the establishment of departments or organizational programs as a focal point for racial/ethnic organizational efforts; dedicated Web portals and pages; active pursuit of networking and partnership opportunities with minority organizations and others involved in parity and quality issues; support of projects, workshop attendance, and other expressions of member support; and a higher volume of inquiries from both the field and internally about health disparities and related topics.

The following other criteria were seen as significant as well, whether or not they had been achieved:

- Attaining parity among racial and ethnic groups with respect to disease prevention and management measures (e.g., mammograms and diabetes testing) in the public and private sector (NACHC's research documenting the virtual elimination of health disparities in health centers with respect to several of these interventions provided the most definitive evidence of success in this area.)
- The rise of new leaders, engaged and/or trained through organizational initiatives, identified (Families USA) and evidenced (CRCHD and OMO)
- Collection of racial/ethnic and primary language data by health plans
- A greater number of hospitals and health systems engaged in strengthening language access policies
- Workforce improvements in terms of diversity and more physicians who are knowledgeable, educated, and engaged with respect to cultural/linguistic competency
- New and expanded funding for health disparity initiatives
- Expanded pool of research investigators from communities of color
- Patient satisfaction and increasing use of patient-centered communication
- Knowing what patients are served, what they bring in terms of culture and language
- More people of color in various health sectors (e.g., health underwriters)
- Greater participation of organizational employees in personal health improvement efforts
- Imbedding the elimination of health disparities in health care systems so that addressing them becomes "part of the culture"
- Staving off reversals that may occur when effective policies, programs, and funding have been limited, reversed (e.g., affirmative action policies), or terminated

These measures of success, albeit significant, do not yet address the "gold standard" for assessing work with respect to racial and ethnic health disparities. That is, as the result of these initiatives, are health consumers or patients from communities of color as healthy and do they live as long as those from non-minority communities, or will actions implemented contribute to that end? This question deals with the fundamental issue of health *outcomes*,

which many acknowledged as being the ultimate measure of the positive impact of organizational strategies and actions. For some, the issue could be even more broadly stated. Are people of color living in conditions (e.g., housing and environment) and do they have access to resources (e.g., employment, education, health insurance, and care facilities) that are essential for equitable individual and community health and well-being? Although there was widespread recognition that it is “too early to tell,” several participants acknowledged the criticality of these questions and the need to answer them in the affirmative if health parity and quality for all are ever to be achieved.

EXPANDING THE CIRCLE: LESSONS AND OPPORTUNITIES

Accompanying the “data deluge” documenting the existence of racial and ethnic health disparities has been a stream of events – workshops, forums, symposia, and conferences – that also have addressed the topic. During the course of this project, SHIRE made its own contributions by organizing both a *Multicultural Leadership Working Forum/Setting a National Agenda to Address Health Disparities* and a *Congressional Breakfast Briefing/Ensuring Quality Health Care for All*. As reported by survey respondents, these activities served not only to inform, but to strengthen commitments to take or expand actions to address racial and ethnic health disparities.

■ DIALOGUE WITH A DIFFERENCE

Aware of the abundance of similar activities, SHIRE set out to maximize the impact of these events in several ways. First, the one-day forum was constructed to facilitate the creation of a product – a national agenda that reflected a broad consensus among national stakeholders.⁴⁰ Strategies to accomplish this goal included:

- Assuring representation from key sectors, including national associations, quality-focused agencies, foundations, community organizations, corporations, advocacy groups from communities of color, and the legislative and executive branches of government
- Circulating discussion drafts in advance of the session
- Engaging a skilled facilitator
- Delivering presentations on current national health disparity reports and legislative proposals from a bipartisan perspective
- Infusing health consumer perspectives via media presentations
- Consensus-building around guiding principles, policies, key messages, and target audiences

The Congressional briefing, which was co-sponsored by the Congressional Black Caucus Health Braintrust and The Commonwealth Fund, reflected an effort to broaden the discussion of racial and ethnic health disparities. Presenters addressed the relationship between equity and quality in health care, as well as the role of the private sector in addressing the issue. Speakers also focused on the implications of proposed policies with regard to malpractice reforms, medical debt, and Medicaid for closing or widening health gaps.

Responses from those participating in this study indicated that these events and others, similarly conceptualized and structured, continue to be beneficial, despite – and even because of – their frequency. Such activities were viewed as important to maintain momentum and keep racial and ethnic health disparities on the “front burner.” They also serve to reinforce and reaffirm ongoing efforts, build awareness within organizations, and strengthen connections. Further, respondents described an expanded “comfort level” as a consequence of knowing that health disparities is not a tangential issue, but rather a “mainstream” concern that deserves and is receiving national focus.

The issue goes away when people are not bombarded. These meetings “keep the drumbeat going.” Health disparities would fall off the radar screen without these efforts.

More than 70 percent of those contacted reported that their participation in either the forum or the briefing triggered or contributed to a positive organizational response. Although some of these impacts were inferred, there appeared to be a direct “cause and effect” relationship in other instances, as illustrated by the following observation.

I used this experience in talking with my Board of Directors, to let them know what is going on and what other people are doing. People don’t want to invest their resources alone.

Comments regarding presentations on the legislative process were of particular interest. Several respondents referred to a new interest and desire to work in a bipartisan and bicameral way to address minority health legislation, inspired and facilitated in part by their participation in project events.

The focus on bipartisanship has paid off. Congressional staff are working in a bipartisan way as well. That would have happened but the Forum gave a jump start to that – the bipartisan approach would have happened but maybe not as fast.

■ ENGAGING NEW PARTNERS

During the survey, the authors asked respondents to recommend organizations and/or sectors that were not yet fully involved in addressing health disparities issues, but who were potential stakeholders. Mentioned most frequently were health providers and their associations, particularly those representing medical specialties and hospitals, which have considerable influence but do not mention disparities as one of their priorities. Also cited was the business community.

The business community is not sufficiently aware of the importance of multiculturalism and addressing disparities...why the failure to address these issues will undercut the economy; conversely, the more we can do, the more vibrant our economy.

Also to be engaged were the media, unions, community-based organizations, the faith community (e.g., the Association of Professional Chaplains), as well as government agencies and quality-focused organizations beyond those involved in this project.

FINDINGS

Consultations with study participants yielded valuable information and insights with respect to individual and organizational perspectives and practices. Applying the study's purpose as a template, the authors focused attention on the following findings, which address evidence-informed *actions* implemented to eliminate racial and ethnic health disparities:

- A broad cross-section of national stakeholders has taken steps to actualize commitments to address racial and ethnic health disparities through institutional leverage, advocacy efforts, research and programs, partnership/coalition building, information dissemination, and community engagement/empowerment strategies.
- Organizations that have aligned their core vision, mission, and/or stated values with a commitment to address racial and ethnic health disparities are more likely to have taken a variety of actions to eliminate minority health gaps.
- Another key requirement for stakeholder action is the availability of organizational leaders, who provide an institutional rationale, passion, support, or resources for a focus on health disparities. Further, other individuals within the organization can play important roles in securing institutional commitments. They may not occupy top leadership positions, but may serve as internal advocates for maintaining an institutional focus on racial/ethnic health disparities.
- The IOM's *Unequal Treatment* report is viewed widely as an important external catalyst for generating stakeholder interest in minority health gaps and action commitments to address them. Foundations and other funding sources have also played key roles in moving this agenda within organizations by providing "catalytic" financial support.
- Most organizations taking action reported achieving some level of success with respect to addressing health disparities. A common indicator encountered was the shift or new emphasis in an organization's receptivity and readiness to address health disparities, evidenced by an array of institutional changes.
- Informational/educational events that address this topic have value and can contribute to stakeholder decisions to take action if the events are structured effectively, involve new partners, offer new perspectives, and provide concrete suggestions for implementation.
- It is important to expand the circle of organizations participating in awareness-building/educational events about racial and ethnic health disparities; their engagement and commitment to take action to eliminate health gaps may result.

RECOMMENDATIONS

As stated, this study provided the authors an unusual learning opportunity to understand the scope of organizational activity with respect to health parity and equity issues. At the same time, the researchers took advantage of the opportunity to solicit views on future directions with respect to corrective efforts. The following recommendations were informed by those perspectives.

- More intensive work should be directed toward making the “business case” for eliminating racial and ethnic health disparities – exploring the economic costs of continuing health gaps and inequities and documenting how saving lives is both a moral imperative and cost-effective.
- Efforts should continue and accelerate to collect racial, ethnic, and primary language preference data; and a racial/ethnic and primary language data collection and reporting accreditation standard should be established.
- Continuity and appropriate levels of support for minority-focused programs and organizations, such as Title VII and federal/state Offices of Minority Health, must be maintained. Appropriate federal authorization and appropriation levels are essential to preserve past gains and ultimately achieve health parity and equity in the nation.
- Further study is recommended regarding the relationship between health disparities and quality, with an emphasis on strategies for achieving progress in both areas concurrently. Questions of importance include:
 - When more rigorous quality protocols are introduced, does the health status improve equally for everyone involved in these initiatives, or do minorities improve at a faster rate?
 - Will new approaches, such as the implementation of tracer activities in accreditation surveys, result in reduced disparities for people of color?
 - What is the impact on disparities of paying physicians to meet quality protocols for target populations?
 - Is it possible to “imbed” corrective measures in a delivery system so that addressing disparities becomes systemic?
- There needs to be a determination of the existence and extent of disparities in care delivered to racial and ethnic minorities by health professionals in the private sector, and ways to hold these providers accountable for equal treatment should be found.
- Programs intended to strengthen cultural competency of health providers and systems, improve language access, increase workforce diversity, and foster community empowerment and leadership in addressing issues of quality and parity should be institutionalized.
- Strategic efforts should be launched to expand the ranks of stakeholders invested and involved in addressing the elimination of racial and ethnic health disparities. Particular targets are health providers from all disciplines and specialties, as well as business/corporate entities. One strategy in this regard is to convene town meetings and other forums in communities across the nation, with structured briefings tailored to culturally and educationally diverse audiences and current issues that impact on health gaps.
- The potential impact of health information technology (HIT), with respect to either reducing or exacerbating health disparities, should be addressed in the context of federal and private sector HIT initiatives
- Consideration should be given to new strategies to bring about universal health care as a prerequisite for the attainment of health parity and equity.

What is needed is a Brown v. Board of Education-type decision for health if health care is to be considered a right rather than a commodity. The difference between European health systems and our own rests on that assumption.

CONCLUSION

The most important standard for success of actions undertaken to address minority health disparities – parity of life expectancy and health status among all racial and ethnic groups – has not yet been attained. For most of the individuals participating in this study, however, equity remains a quintessential goal. There is some evidence that the goal is not beyond our reach. As important, the authors found abundant evidence of actions taken to reach that goal – actions reflecting institutional and personal commitments of time, talents, and treasure. That discovery was both unexpected and heartening.

The actions reported are eminently replicable by stakeholders in both the public and private sectors. There is a widespread recognition of the need for multiple strategies to achieve the desired ends. It is also clear that the active engagement by corporations, providers, and people of color – acting collectively and individually – must be significantly heightened in order to see an end to health disparities and inequities in the United States.

Finally, it is apparent that the philanthropic community has made a substantial investment in organizations and individuals committed to close racial and ethnic health gaps and to improve the quality of health for these and all Americans. In this era of competitive demands and shrinking resources, that commitment represents lifeblood for these efforts. At the same time, it is appropriate and necessary to expect that the nation's governmental agencies – at federal, state, and local levels – must carry their share of the responsibility to ensure that health inequities, unequal treatment, and disparate care for people of color end by a definitive date, in keeping with the aims of *Healthy People 2010*. “Lives are at stake.”⁴¹

APPENDIX A METHODOLOGY

SHIRE's charge with respect to the survey was to interview selected organizational representatives, by means of telephone or in-person interviews, in order to document stakeholder decisions and action strategies pursued to eliminate health disparities and advance health care quality for communities of color. Survey respondents had participated in earlier project activities – either the Multicultural Leadership Forum (2004) or the Congressional Breakfast Briefing (2005).

Respondent selection was purposive rather than random, and emphasis was given to obtaining information and viewpoints across a broad spectrum of stakeholder groups. Twenty individuals participated in the survey, which was conducted in the summer and fall of 2005. Survey respondents represented 16 organizations and one Congressional office. The authors supplemented data collected during interviews with printed materials and other information obtained either directly from respondents or from Internet research and other means.

APPENDIX B SURVEY PARTICIPANTS

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National Quality Forum

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NOTES

1. U.S. Department of Health and Human Services, *Report of the Secretary's Task Force on Black & Minority Health, Report of the Secretary's Task Force on Black and Minority Health* (August 1985).
2. Secretary's forward and charge to the task force, *ibid.* page 21.
3. The Office of Minority Health of the U.S. Department of Health and Human Services was established in 1986. Today, there are several offices in HHS components and approximately 40 state minority health entities that focus on issues affecting American Indians and Alaska Natives, African Americans, Asian Americans, Hispanics/Latinos, Native Hawaiians and other Pacific Islanders.
4. The Healthy People (HP) initiative is a strategic management tool for the achievement of the nation's prevention agenda. It had its origins in a 1979 publication prepared during the tenure of U.S. Surgeon General Julius B. Richmond. For a detailed discussion of HP 2010, see: Summit Health Institute for Research and Education, Inc., *Racial, Ethnic and Primary Language Health Data Collection and Reporting: An Assessment of Federal Policies, Practices and Perceptions* (October 2001).
5. Institute of Medicine, *Unequal Treatment/Confronting Racial and Ethnic Disparities in Health Care*. National Academy Press (March 2002), page 4.
6. Agency for Healthcare Research and Quality, *2005 National Healthcare Disparities Report*, U.S. Department of Health and Human Services (December 2005), page 2.
7. The referenced report notes that, with respect to core report measures, access disparities for African Americans, American Indians and Alaska Natives and Asian Americans had improved since the last reporting period, but had worsened for Hispanics/Latinos. *Ibid.*, page 6.
8. Authors of a recent article maintained that while the quality of health services everyone receives is poor, minorities fare better than white males. S. Asch *et al.*, Who is at greatest risk for receiving poor-quality health care? 344:1147-56.
9. J. Klick and S. Satel, *The Health Disparities Myth: Diagnosing the Treatment Gap*. American Enterprise Institute Press (2006).
10. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academies Press (2001).
11. A. Beal, Policies to reduce racial and ethnic disparities in child health and health care, *Health Affairs* (September/October 2004.) See also *Health Disparities and Quality: Framing the Issue for National Policies*. The Commonwealth Fund (Power point presentation), The Commonwealth Fund (February 2005).
12. S.H. Woolf *et al.*, The health impact of resolving racial disparities: an analysis of US mortality data. *American Journal of Public Health* (December 2004), Vol. 94, No.12, p. 2078.
13. N. Lurie, Health disparities – less talk, more action, *New England Journal of Medicine* (August 18, 2005), p. 727.

14. S. Bowen, AB Zwi, Pathways to “evidence-informed” policy and practice: A framework for action. *PLoS Medicine* (July 2005), Volume 2, Issue 7, e166. www.plosmedicine.org
15. These individuals were: Georges Benjamin, M.D, executive director, American Public Health Association; Jordan Cohen, M.D., president of the Association of American Medical Colleges; Steve Galen, executive director, Primary Care Coalition of Montgomery County; and Robert Ross, M.D., president and chief executive officer, The California Endowment.
16. Bowen and Zwi, *op. cit.*, p. 0604.
17. Joint Commission on Accreditation of Healthcare Organizations, *Joint Commission 2005 Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care* (May 12, 2005), p. 1.
18. See <http://www.apha.org/about/> and also <http://www.apha.org/legislative/>
19. Michael E. Bird was elected president-elect of the American Public Health Association in 2000 and assumed its presidency in 2001. He is a Santo Domingo-San Juan Pueblo Indian from New Mexico and the first American Indian ever to lead APHA.
20. See http://www.naph.org/template.cfm?Section=Issues_Advocacy.
21. National Public Health and Hospital Institute, *Serving Diverse Communities in Hospitals and Health Systems* (November 2003).
22. Center to Reduce Cancer Health Disparities, Introduction to the center, <http://crchd.nci.nih.gov/introduction/>
23. Freeman, H.P., Wingrove, B.K., *Excess Cervical Cancer Mortality: A Marker for Low Access to Health Care in Poor Communities*. National Cancer Institute, Center to Reduce Cancer Health Disparities (May 2005). NIH Pub. NO. -5-5282.
24. S. Rosenbaum *et al.* *Reducing Racial and Ethnic Health Disparities: A Summary of State Disparities and Statistical Results*. George Washington University (September 2003).
25. Fact Sheet/Health Centers’ Role in Reducing Racial and Ethnic Health Disparities. National Association of Community Health Centers, Inc. (October 2004) Fact sheet #0405.
26. The *AAMC Reporter* has served as a vehicle for communicating messages from the organization’s president. For example, see “What Can We Do About Disparities” in the June 2005 issue. http://www.aamc.org/newsroom/reporter/june_05/word.htm
27. Institute of Medicine, *In the Nation’s Compelling Interest: Ensuring a Diverse Health-Care Workforce* (2004). See also Sullivan Commission on Diversity in the Healthcare Workforce, *Missing Persons: Minorities in the Health Professions*
28. See <http://www.hpd-coalition.org/about.htm>

29. [http://www.ihl.org/IHI/Topics/ChronicConditions/Diabetes/Improvement Stories/Reducing...](http://www.ihl.org/IHI/Topics/ChronicConditions/Diabetes/Improvement%20Stories/Reducing...)
30. Summit Health Institute for Research and Education, Inc. and Out of Many, One, *Building Coalitions among Communities of Color/A Multicultural Approach*. Office of Minority Health, Department of Health and Human Services (July 2005) See www.shireinc.org
31. America's Health Insurance Plans, *Tools to Address Disparities in Health: Data as Building Blocks for Change*. (May 2005) See www.ahip.org
32. See <http://www.qualityforum.org/about/home.htm>
33. H. Wu, *Cultural Competence and Disparities: The National Quality Forum's Role*. (Power point presentation at) National Quality Forum (April 2005).
34. K. Kizer, *Improving Healthcare Quality for Minority Patients Workshop Proceedings*, National Quality Forum (2002).
35. *Ibid.*
36. See http://www.wbgh.org/prevention/et_reducingdisparities.cfm
37. A. Izlar, *Perspective: Verizon works to eliminate disparities in health care for its diverse workforce*. *Health Affairs*. (March/April 2005) Vol.24, No. 2, p.421ff.
38. See <http://www.calendow.org/foundation/index.stm>
39. Details are available at <http://crchd.nci.nih.gov/initiatives/>
40. The Commonwealth Fund, Summit Health Institute for Research and Education, Inc. *National Policy Agenda/Eliminating Health Disparities in Communities of Color*. (April 2004) www.shireinc.org
41. *Ibid.*

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SHIRE's logo has three elements. The pyramid connotes our respect for the wisdom and accomplishments of ancient cultures and our focus on persons of African descent. The flame of life is a fitting symbol of spirituality and health. The rising sun indicates renewal and hope as each day offers a new beginning.

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