SHIRE

SUMMIT HEALTH INSTITUTE FOR RESEARCH AND EDUCATION, INC.

Perspectives on the HIT/Health Disparities Connection

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Introduction

With strong private sector initiative and bipartisan leadership from the executive and legislative branches of the Federal government, health information technology (HIT) is emerging as an important strategy to improve the quality and cost-effectiveness of the nation's health care system. Summit Health Institute for Research and Education, Inc. (SHIRE), a policy research, advocacy, and outreach organization with deep community roots, firmly believes that communities of color, which will probably comprise over 50 percent of the nation's residents by 2050, must not be left behind as the HIT movement gains momentum.

SHIRE recognizes the potential benefits of HIT with respect to addressing the urgent health needs of racial and ethnic minority groups, as well as other underserved populations. We support the goal, articulated by the President and reflected in Executive Order 13335, of achieving widespread adoption of electronic health records (EHRs) by 2014.[1] SHIRE also supports a related aim, as expressed by the Institute of Medicine (IOM) – to provide consumers with personal health records (PHRs) as a tool for crossing the quality chasm in the U.S. health system.[2]

SHIRE's organizational mission is to work to achieve a third goal – the elimination of racial and ethnic health disparities. There is compelling evidence that this aim must remain foremost on the nation's agenda. From the 1985 Heckler report, to the IOM's *Unequal Treatment* landmark study, to the 2006 National Healthcare Disparities Report issued by the Agency for Health Care Research and Quality[3], there is abundant documentation of health gaps in treatment and outcomes. These mortality and morbidity statistics necessitate urgent action:

- Death rates for African Americans are higher than for non-Hispanic whites for heart diseases, stroke, cancer, chronic lower respiratory diseases, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

- According to the most recent data available, Native Hawaiians are 2.5 times more likely to be diagnosed with diabetes than non-Hispanic white residents of Hawaii of similar age.

- In the Latino/Hispanic community, Puerto Ricans suffer disproportionately from asthma, HIVAIDS, and infant mortality, while Mexican-Americans suffer disproportionately from diabetes.

- Asian Americans have a high prevalence of chronic obstructive pulmonary disease, hepatitis B, HIV/AIDS, smoking, tuberculosis, and liver disease. Tuberculosis is 13 times more common among Asian subgroups, such as Cambodians, Chinese, Laotians, Koreans, Indians, Vietnamese, and Filipinos, than among the U.S. population. Compared to the U.S. average, Hepatitis B is 25 to 75 times more common among immigrants from Cambodia, Laos, Vietnam, and China.

- American Indians and Alaska Natives have an infant death rate almost double the rate for whites. AI/ANs are twice more likely to have diabetes than whites. AI/ANs also have disproportionately high death rates from unintentional injuries and suicide.[4]

HIT Benefits

Potential HIT benefits for the nation's health care system, providers, and consumers include:

- More efficient delivery of health care services – minimizing such problems as lost records, repetitive data-gathering, and duplicative procedures;

- Reduction of medical and pharmaceutical errors;

- HIT-enhanced provider/consumer communication in order to facilitate behavior change and enhance health outcomes;[5]

- Increased knowledge, health management skills, and compliance with treatment regimens among health consumers;

- Expanded capacity of health care providers to serve "hard to reach populations; and

- Cost savings.[6]

Barriers to Minority Participation in HIT

HIT adoption rates among health care providers are low throughout the nation. Studies completed to date suggest that providers in underserved communities, both rural and urban, have not kept pace.[7] Only eight percent of community health centers have adopted health information technology, compared to 18 percent of private, office-based primary physicians.[8]

Studies on the adoption of HIT among providers in racial and ethnic communities are nearly non-existent. Based on other data, research, and extensive consultation with community observers, SHIRE has identified several barriers to be overcome. They are:

- The digital divide – disparate access to the technology required for HIT use
- Lack of culturally/linguistically appropriate communications and outreach to facilitate HIT adoption by consumers and providers who serve them and to ensure effective delivery and comprehension of health messages among racial/ethnic minority populations
- Lack of capital to invest in HIT and HIT sustainability
- Trust issues and concerns about inappropriate use of HIT among providers and consumers
- Minimal participation of minority stakeholders in HIT policy development, planning, implementation, research and evaluation

The Digital Divide

Gaps among U.S. residents with regard to Internet use are narrowing, but a digital divide continues to exist. These differences occur at all educational and income levels, and are reflected among minority health providers and consumers. Available statistics on differences between whites and African Americans are illustrative:

- Seventy-three percent (73%) of white adults use the Internet compared with 61% of African Americans.[9]
- Forty-two percent (42%) of white adults have Broadband connectivity at home compared with 31% of African Americans.[10]
- Sixty-eight percent (68%) of whites and 50% of Blacks have a home computer.[11]
- In households with annual incomes less than $30,000, 21% have broadband connectivity, compared with 68% with annual incomes greater than $75,000.[12]
- The poverty rate for African Americans is three times that of non-Hispanic whites, 24.7% versus 8.6%.[13]

Potential Negative Impact of HIT in Communities of Color

As the HIT revolution has progressed, potential negative consequences for racial and ethnic minority groups have received little attention.[14] Concerns are surfacing that, *if barriers prevent minority providers and consumers from participating fully in HIT are not addressed, health disparities could increase significantly*. For example:

- If reimbursement policies are linked to EHR requirements, undercapitalized providers in communities of color, who are unable to make the requisite investments in HIT, will leave the health field, thus exacerbating access gaps.
- Among minority providers remaining in the field, many are not able to make the needed HIT investments. Their patients will not be able to benefit from HIT, and as a result, the gap between them and non-minority consumers with HIT access could increase.
- Communities without access to broadband technology cannot benefit from HIT.
- HIT applications will not be effective in promoting behavior change if they do not meet the cultural, language, or literacy needs of diverse users.
- Information about HIT and its benefits has not reached trusted stakeholders in communities of color.
- Issues of trust and trustworthiness, which are of particular concern among African Americans, could generate a backlash effect that blocks adoption.

Recommended HIT Principles

1. The Federal government has an essential leadership role to play in ensuring that communities of color and other underserved populations participate fully in HIT initiatives.

2. We believe there is a need to affirm, as a key principle, that *consumers* own personal health data and that privacy/confidentiality safeguards are essential. Accordingly, the Federal government must increase its efforts to ensure privacy and security of personal health information, in consultation with consumer representatives from diverse populations in the nation.[15]

3. The goal of ensuring that most Americans have access to EHRs by 2014 cannot be reached unless there is a commitment by all stakeholders – government leaders, the HIT industry, foundations, providers, and consumers – to achieve universal access to the technology required to realize that aim. SHIRE believes further that universal availability will be instrumental in attaining health parity, and anything less can only contribute to the perpetuation of health inequities.

4. Community partnerships are essential to attain HIT adoption – true partnerships where representatives from communities of color and other vulnerable groups have a seat at every table – from the development of policies and the conduct of HIT demonstrations to full-scale program implementation, research, and evaluation.

HIT Policy Recommendations (Partial List)

1. Fully fund current Federal initiatives to provide critical resources to complete the goal of the President's Health Information Technology Executive Order, that most Americans will have an electronic health record by 2014, and ensure the inclusion of racial/ethnic and other underserved communities in such initiatives, which should also include informing clinical practice, interconnecting providers, personalizing care, and improving population health.[16]

2. Establish public/private partnerships through which incentives, as well as technical and financial resources, can be directed to providers and consumers in minority and other underserved communities to help close the "digital divide."

3. Enact comprehensive legislation that will address the impact of HIT on health disparities, to include:
    - Grants and other incentives to establish Health Information Technology Empowerment Zones that demonstrate effective practices for promoting the adoption of HIT by consumers from vulnerable populations, as well as by providers who care for patients who are medically underserved and are impacted by health and/or digital disparities.

- Grants and contracts to assess the potential impact of non-adoption of HIT among providers serving racial/ethnic, low-income, and other vulnerable, medically underserved populations with respect to the possible exacerbation of health gaps in health care quality, treatment, and outcomes. Special efforts should be made to engage minority institutions and organizations in these efforts.
- Resources to support outreach efforts to promote HIT adoption by informing racial/ethnic and other underserved communities regarding HIT utilization options, benefits, and privacy safeguards. These initiatives should utilize activities and strategies that are culturally and linguistically appropriate and that engage community stakeholders in the development, execution, and evaluation of such efforts.
- Policies to promote use of HIT in Federally-funded programs, with the provision that targeted resources will be made available to health care providers in racial/ethnic and other underserved communities so that they will not be disadvantaged by such policies.

About SHIRE

Summit Health Institute for Research and Education, Inc. (SHIRE) is a policy research, advocacy, and outreach organization with deep community roots. Established in 1997, SHIRE is guided by a vision in which health care is a human right, fully implemented, and where individuals, families, and communities are empowered to achieve and sustain optimal health and well-being. SHIRE promotes effective strategies to eliminate health disparities and also helps communities galvanize to improve health care access, quality, and outcomes. SHIRE engages with communities, government agencies, corporations, foundations, and other institutions by: a) convening diverse individuals to take collective action, b) informing public policy decision makers on strategies to eliminate health disparities, c) raising awareness of policy implications for communities of color, d) serving as a trusted source of information, and e) providing technical assistance and consulting to allied organizations.

For more information, please contact:

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