

SPECIAL ISSUE

Healthcare Disparities and Models for Change

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With *Healthy People 2010* making the goal of eliminating health disparities a national priority, policymakers, researchers, medical centers, managed care organizations (MCOs), and advocacy organizations have been called on to move beyond the historic documentation of health disparities and proceed with an agenda to translate policy recommendations into practice. Working models that have successfully reduced health disparities in managed care settings were presented at the National Managed Health Care Congress Inaugural Forum on Reducing Racial and Ethnic Disparities in Health Care on March 10-11, 2003, in Washington, DC. These models are being used by federal, state, and municipal governments, as well as private, commercial, and Medicaid MCOs. Successful models and programs at all levels reduce health disparities by forming partnerships based on common goals to provide care, to educate, and to rebuild healthcare systems. Municipal models work in collaboration with state and federal agencies to integrate patient care with technology. Several basic elements of MCOs help to reduce disparities through emphasis on preventive care, community and member health education, case management and disease management tracking, centralized data collection, and use of sophisticated technology to analyze data and coordinate services. At the community level, there are leveraged funds from the Health Resources and Services Administration's Bureau of Primary Health Care. Well-designed models provide seamless monitoring of patient care and outcomes by integrating human and information system resources.

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With the launch of *Healthy People 2010*, the goal of eliminating health disparities has been placed on the national disease prevention and health promotion agenda.¹ Although there is no consensus regarding what a health disparity is,² healthcare and policy leaders agree that the healthcare sector plays an important role in the elimination of these disparities. Racial and ethnic minorities experience multiple barriers to accessing healthcare, including not having health insurance, not having a usual source of care, location of providers, lack of transportation, lack of child care, and other factors. A growing body of evidence shows that racial and ethnic disparities in health outcomes, healthcare access, and quality of care exist even when insurance, income, and other access-related factors are controlled.³⁻⁷ In 2002, the Institute of Medicine concluded that the sources of these disparities are complex and that a comprehensive multilevel strategy is needed to eliminate these disparities. In its 2003 *National Healthcare Disparities Report*, the Agency for Healthcare Research and Quality concluded that inequality in healthcare persists, disparities have a personal and a societal price, dif-

ferential access may lead to disparities in quality, opportunities to provide preventive care frequently are missed, little is known about why disparities exist, and improvement is possible, although data limitations hinder targeted improvement efforts.⁸ Policymakers, researchers, medical centers, managed care organizations (MCOs), and advocacy organizations have been called on to move beyond the historic documentation of health disparities and proceed with an agenda to translate policy recommendations into practice and to disseminate and replicate successful models more broadly.⁹

An active participant identified in this agenda is managed care. To highlight and disseminate information about effective local, regional, and national models to reduce health disparities and to bring together experts to compare experiences, the National Managed Health Care Congress convened the Inaugural Forum on Reducing Racial and Ethnic Disparities in Health Care on March 10-11, 2003, in Washington, DC. The invited audience included managed care physicians, nurses and nurse practitioners, pharmacy directors, social workers, case managers, disease management program managers, and compliance staff. Representatives from health plans, MCOs, research organizations, private foundations, and federal and state government shared models, case studies, best practices, and guidelines they have developed.

In this article, we describe working models presented at the conference that have successfully reduced health disparities in managed care. Included are examples from federal, state, and municipal governments, as well as from private, commercial, and Medicaid MCOs.

GOVERNMENT LEGISLATION, REGULATIONS, AND GUIDELINES

In addition to being the largest purchasers of healthcare in the United States, federal and state governments

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have laws, regulations, and guidelines that govern how healthcare is provided. For example, under Title VI of the 1964 Civil Rights Act, all institutions receiving federal assistance from the US Department of Health and Human Services are prohibited from conducting any of their programs, activities, and services in a manner that subjects any person or class of persons to discrimination on the grounds of race, color, or national origin.¹⁰ The federal government also has issued regulations and guidelines to ensure that necessary data are available to monitor and enforce existing civil rights legislation. Examples of federal regulations that require the collection and/or reporting of racial/ethnic data include those for Medicaid managed care and the State Children's Health Insurance Program (SCHIP).^{11,12} The Health Resources and Services Administration provides oversight to "ensure that all federally qualified community and migrant health care centers collect race, ethnicity, and primary language data."⁷

Congress also encourages private-sector HMOs and health plans to develop quality assurance standards. The Agency for Healthcare Research and Quality and the National Committee for Quality Assurance promote the development of quality assurance tracking systems.⁷

The New Jersey legislature is addressing the standardization of cultural competency. New Jersey Senate Bill S-144 will require cultural competency training as a condition of physician licensure.¹³

The Office of Minority Health in the US Department of Health and Human Services has issued national standards for culturally and linguistically appropriate services (CLAS) in healthcare.¹⁴ Four CLAS standards based on Title VI of the Civil Rights Act of 1964 apply to services for individuals with limited English proficiency (LEP). These are provision of timely language assistance services at no cost to each patient/consumer with LEP; providing written and verbal notices to patients/consumers in their preferred language; assurance of competent language assistance; access to easily understood patient-related materials; and signage. The remaining standards recommend that patients/consumers receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language; that efforts are in place to recruit, retain, and promote a diverse staff; that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery and that there are measures to hold the healthcare organization accountable for neglect in this area, so that CLAS-related activities are regularly monitored; and that data are collected on patient/consumer race, ethnicity, and spoken and written language to maintain a current demographic, cultural, and epidemiologic pro-

file of the community so collaborative partnerships can be developed. Healthcare organizations also are encouraged to resolve cross-cultural conflicts or complaints by patients/consumers. The Office of Minority Health suggests that healthcare organizations make their progress and successful innovations known to the public.

REDUCING BARRIERS TO CARE

To accomplish the *Healthy People 2010* goal of eliminating health disparities, the current healthcare system, which is fragmented and difficult to navigate, must be changed from "top heavy . . . tertiary care to one that is based in primary and preventive care."¹⁵ Vulnerable community members in both rural and urban settings face barriers to healthcare due to financial and geographic constraints that lead to reduced levels of care. These individuals endure administrative barriers such as limits on network choices, long waits for appointments with few minority physicians, and limited culturally appropriate educational and communication services.¹⁵

Community Models

Over the past few years, community providers and other organizations have taken on the challenge of reducing these barriers. Noteworthy among these are the initiatives funded by the Federal Health Resources and Services Administration's Bureau of Primary Health Care (BPHC). Community providers have partnered with BPHC to establish collaborative models that address 1 or more chronic diseases known to affect minorities disproportionately, such as diabetes, asthma, cardiovascular disease, and cancer.¹⁵

Most BPHC models start with 1 disease and expand to several over a few years, with effective results.^{15,16} These community based programs have significantly improved statistics for targeted diseases even when other barriers to care remain, such as poverty, lack of education, lack of insurance or employment.¹⁵ This approach supports the conclusion of Donald Berwick, MD, MPP, president, Institute of Healthcare Improvement, that if a community-based chronic disease management program can significantly change the data around 1 chronic disease, it can effectively address other diseases through the same model.¹⁵

Bureau of Primary Health Care uses the chronic care model developed by Ed Wagner, MD, MPH, director, and associates at the McColl Institute for Healthcare Innovation, Group Health Cooperative in Seattle, Washington. The model has 3 elements: care, improvement, and learning. The care element has 6 components: support of patient self-management; support for collabor-

rative decision making; upgrade of clinical information systems; redesign of delivery systems; reorganization of healthcare systems to include senior leaders and clinic champions on teams; and development of partnerships that take into consideration community resources and policies. The second element, improvement, supports rapid system change under the guidance of senior leadership partnered with the BPHC. The improvement model requires that teams plan, implement, review, and then integrate the change into the healthcare system (ie, plan, do, study, act). The third element, learning, brings teams together to test specific elements of the improvement model during 12 months of intensive learning sessions.¹⁶

State and Municipal Models

To reduce health costs, the Washington State legislature mandated a disease management program for Medicaid fee-for-service disabled, blind, and aged clients who receive supplemental security income and are high users of health services. Clients with asthma, diabetes, and congestive heart failure are targeted. Key components of the model include establishment of a telephone call center; use of field staff nurses to manage high-risk clients through home visits; payments for interpreter and translation services; and a strong information system that links staff in the field with central experts and makes appropriate referrals.¹⁷

Some public hospital systems have taken the lead in reducing barriers to access. According to Karen Scott Collins, MD, MPH, Senior Assistant Vice President, New York City Health & Hospitals Corporation (HHC), its hospitals are seeing results from several major efforts to improve access by minorities, who constitute the overwhelming majority of patients served.¹⁸ First, HHC has enhanced its efforts to certify eligible uninsured clients for Medicaid and other third-party reimbursement. Enrollment staff are now located within ambulatory care clinics to assist clients in filling out applications and securing coverage.

Two major HHC quality-improvement goals have also shown results: the first is to accommodate any outpatient for a visit within 3 days of the initial call, and the second is to streamline the visit and waiting time so that a client can complete a visit in 45 minutes. Several hospitals are now close to these goals, and the no-show rate of clients has dropped from 40% to 20% for hospitals furthest along in improving access.¹⁸ Additional HHC initiatives include reducing language barriers and hiring patient navigators to help move patients within a healthcare center.

Managed Care Organization Models

Commercial and Medicaid MCOs have been active in developing programs to reflect cultural and ethnic

needs of members in various ways. As noted by Jacqueline Simmons, MD, MPH, CPE, chief medical officer at Passport Health Plan in Louisville, Ky, to have a health plan staff “that is going to be sensitive to the needs of the population they serve, the [staff] need to look like the people they serve.”¹⁹

Passport Health Plan, an HMO serving Medicaid and SCHIP clients, responded to an influx of Hispanic and African American populations with several activities. It began publishing a Spanish language version of its member newsletter; it modified its SCHIP videos and materials; it implemented cultural diversity training for its home visit nurses; translated member benefits into 5 languages; and hired a trainer in cultural proficiency to work with providers, staff, and members.

Several basic elements of MCOs help to reduce disparities through emphasis on preventive care, community and member health education, case management and disease management tracking, centralized data collection, and use of sophisticated technology to analyze data and coordinate services.

In addition, many MCOs have begun efforts to increase access and improve treatment for minorities. Among these, Aetna, one of the largest for-profit providers of managed care benefits in the country, announced in early 2003 that eliminating health disparities was a corporate priority.²⁰ Since then, they have collected racial and ethnic data on a voluntary, self-identification basis from HMO-based members in 24 states and the District of Columbia and from traditional plan/PPO-based members in 46 states and the District of Columbia. The data are being used to implement programs to improve outcomes for members at high risk for specific diseases prevalent among minorities. Aetna is also collecting data on race, ethnicity, and languages spoken by network physicians. During 2003, about 80% of Aetna’s clinical staff completed a training course on disparities awareness and targeted health programs such as the maternity management program for African-American women and a cervical cancer prevention program for Vietnamese women continued.

Keystone Mercy Health Plan, a Pennsylvania Medicaid managed care program, has developed broad health education collaborative programs with the community. Keystone works with about 50 churches on its faith-based Health Ministry Program for Women, providing staff, transportation and childcare. The program helps underserved African-American women gain awareness of health issues and change behavior so they can reduce stress and decrease risks for chronic diseases such as hypertension and asthma. Keystone also provides an influenza immunization program for its members; regular mammography van screenings; and screenings for

diabetes, breast cancer, and perinatal care. In early 2003 Keystone's Healthy Hoops program brought nearly 700 children with asthma and their families to meet college basketball celebrities and learn about how to manage their asthma.^{19,22}

PARTNERSHIPS

Developing partnerships to reduce health disparities is an essential element of all models. At one end of the spectrum, partnerships are forged between patients who receive and providers who administer culturally competent care. To achieve this partnership, "Healthcare professionals need to be immersed in a patient-based, cross-cultural curriculum that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors."²³ Partnerships between patients and providers are enhanced with the utilization of culturally competent care and access to language services. These elements create the potential for better patient adherence and satisfaction with healthcare. Providers may deliver higher quality and more cost-effective service by reducing unnecessary care or inappropriate treatment that can lead to medication errors.

If MCOs are to remain financially competitive, they must consider the societal and business expenditures associated with health disparities. According to Barrie Baker, MD, regional medical director, Keystone Mercy Health Plan, health disparities can be calculated as social and business expenditures. The societal impact of disparities in healthcare can lead to increased disability, poverty, family stress, premature death, and mortality.²¹ The business costs related to health disparities can be measured, for example, as the number of inpatient and outpatient days, the amount of medication utilization, and the number of requests for specialty care. Healthcare disparities become evident in a community when the percentage of healthcare utilization, stratified by race and related to chronic diseases, differs from the actual racial percentage breakdown in the community.²¹

Partnerships between state, county, and local task force initiators have proven successful in reducing health disparities. Contra Costa Health Services in Contra Costa, California, had documented significant disparity between white women and minorities in terms of the percentage of early-stage breast cancer diagnosis. Seventy-two percent of white women were diagnosed at an early stage, in contrast to 58% of Hispanic women and 44% of African American women. Partnerships were established in 2002 when Contra Costa Health Services provided technical assistance during the creation of a statewide California Breast Cancer Treatment Program

for uninsured and undocumented women. The county formed the Contra Costa Breast Cancer Partnership to collaborate with medical providers, agencies, health advocates, and breast cancer survivors. The county also established African American, Latina, and Asian/Pacific Islander task groups that performed outreach to churches and door-to-door outreach with residents and local businesses. The Contra Costa Breast Cancer Partnership performed outreach to the lesbian community through softball teams and an annual picnic. By 1997, the rate of early-stage diagnosis for African American women was the same as that for white women: 72%. (Improvement for Latinas did not reach statistical significance.) By 2002, additional advocacy efforts led to a state-funded Breast and Cervical Cancer Treatment Program to treat all uninsured and undocumented women in California. A Latina Task Group of the Contra Costa Breast Cancer Partnership was formed to create and implement a patient navigator program for low-income non-English-speaking women to help get screening.¹⁵

A partnership between the BPHC and CareSouth Carolina, a nonprofit community health center, led to the center receiving accreditation from Joint Commission on Accreditation of Healthcare Organizations. The health center was able to develop reports integrating systems of primary care and mental health services. According to Ann Lewis, executive director, when the health center initially partnered with the BPHC collaborative, the center was faced with noncompliant diabetic patients that led to provider frustration. Therefore, the initial collaborative program focused on diabetes, as the mortality and morbidity rates of this center's clients were the highest in the nation. To receive assistance from the BPHC, Ms. Lewis was required to attend the model training sessions. The training provided the health center with background, knowledge, and guidance in developing the care model, the improvement model, and the learning model. In order to sustain these models, all departments received information on the management of chronic disease at board and management meetings.²⁴

CULTURAL COMPETENCY

Title VI of the 1964 Civil Rights Act mandates that all institutions receiving federal funds must provide adequate means of communication between an English-speaking provider and a non-English-speaking patient.¹⁰ This mandate is underscored in the 1989 landmark report from researchers at Georgetown University, who describe cultural competence as "a set

of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable them to work effectively in cross-cultural situations.”²⁵ Aracely Rosales, principal, Rosales Communications, contends that culturally competent care has 3 elements: “Language, culture and health literacy [that] cannot be disassociated to reduce cultural disparities.”²⁶ She contends that translation problems include inaccurate translations, omitting or changing content, producing literal translations that do not reflect culture and diversity, and hiring translators who are not well trained in the “easy to read” technique.²⁶ According to Rosales, the most effective interpreters are the healthcare providers themselves. When working with an interpreter, healthcare providers need to speak directly to the person as if the interpreter wasn’t there, insist that everything is interpreted, and use descriptive language whenever possible. Patients and doctors both are afraid that they are not being understood.²⁶

According to Barry Lachman, MD, medical director, Parkland Community Health Plan, when cultural competency is not enforced, or if cultural interpreters are not well trained, “error rates are double those of when you use trained folks.”²⁷ Use of physicians who speak the patient’s language is the best way to achieve cultural competence. For example, Dr. Lachman relates, “Puerto Ricans and Mexicans have different words for mumps and so unless you are prepared to communicate in a way that actually reaches people, you may communicate the wrong message and ask the wrong question.”²⁷ Patients are better able to self-manage their healthcare when they receive training from culturally competent providers and when they are encouraged to take an active role in their care plan.¹⁶ The use of an interpreter leads to improved client education, which leads to motivation and acceptance of disease management programs.¹⁵ A report issued by the Agency for Healthcare Research and Quality, *Providing Oral Linguistic Services: A Guide for Managed Care Plans*,²⁸ has identified 6 specific steps to follow to ensure cultural competency:

- Identify oral and linguistic needs of membership.
- Assess the capabilities of the managed care plan.
- Identify points of contact for members of managed care plans.
- Consider different oral linguistic strategies.
- Assemble an oral linguistics services plan.
- Monitor oral linguistic services strategies.

Cultural differences need to be addressed in medical centers, as people have different values and expectations about the type of care they will receive when they enter a healthcare facility. Rosales reminds us that in

the United States, culture is built on written communications such as pamphlets, handbooks, or doctor’s written instructions, whereas in other cultures, one-on-one conversations are the norm.²⁶ In some cultures, the entire family makes medical decisions; however, in other cultures, the husband is the main voice of the family. Healthcare providers may need to have permission from the husband before any conversation is initiated between his wife or his child and the provider. The ability to have a private face-to-face conversation in these situations may be limited. It has been suggested that physicians and patients must first develop a trust relationship before health issues are discussed.²⁶

Health literacy also is an important component of cultural competency. Health literacy is being able to read, understand, and act on health information.²⁹ Patients who lack literacy skills are more likely to be hospitalized, to make medication treatment errors, to die prematurely, to be unable to negotiate reminder letters, or to understand the policies of their healthcare benefits provider.³⁰ Rosenbaum and Shin suggest that Medicaid contract language should be standardized for nonnative speakers of English.³¹

To sustain culturally appropriate models, 2 mnemonic tools can be used during a medical appointment to assist in determining whether a patient is adherent to treatment, suggests Robert C. Like, MD, MS, associate professor and director, Center for Healthy Families and Cultural Diversity, Department of Family Medicine, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick, New Jersey. The first is ETHNIC (e_xplanation of illness; t_reatment tried or expected by patient; h_ealers seen, including nonphysicians; n_egotiate options that are mutually acceptable; i_nterventions that may include medications, alternative treatments, and/or psychosocial support; and c_ollaboration with the patient, family members, and other healers).³² The second is BATHE (b_ackground—patient’s history or current life circumstances; a_ffect—the feeling state; t_rouble—the most troubling aspect of the illness or situation; h_andling—assessment of patient’s functioning or coping skills; and e_mpathy—providing psychological support).³³

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INFRASTRUCTURE

Through implementation of evidence-based protocols and supported by electronic evaluation and care systems, healthcare providers can monitor whole populations for adherence to care plans. Patient-level information can be fed into a patient registry that is linked to medical records and finance. In doing so, the entire care process

is connected.¹⁶ Therefore, use of patient electronic care systems provides more than a means to track administrative procedures; these systems have become integral to disease prevention efforts. The patient electronic care system connects the office appointments to the medical records and sends reminders to patients and feedback and assessment follow-ups to healthcare providers. It can be used to identify subgroups of patients whose care may need to be more closely monitored. The system generates monthly progress reports that can be shared by all departments and can assist with the development of collaborative learning.¹⁶

Technology helps provide linkages among healthcare departments to cut down on red tape and facilitate prompt access to care. Technology can also improve communications so that field clinicians can get input from experts at the time of patient service. A telephone nurse triage service coupled with translators on a 24/7 basis can help health plans to improve care and contain costs by redirecting patients to the most appropriate level of care before they arrive at emergency rooms for non-urgent care. Tom Culhane, MD, medical director, Columbia United Providers in Vancouver, Washington, estimates that this MCO has saved more than \$1 million a year with its telephone nurse triaging service.³⁴ He notes a decline in avoidable hospital admissions, improved quality of care for patients, and other cost savings. Patients can be redirected from using emergency rooms to more appropriate and less costly forms of treatment. Calls can be triaged to a lower level of care or to a higher level of care. Dr Culhane found that over the first 2 years, when the nurse triage was utilized, the percentage of MCO patients who visited the emergency room declined from 37% to about 14% to 15%, with an added reduction in the percentage of no-shows at clinic appointments, and redirections to self-care increased.

According to Dr. Culhane, if patients have good access to expert advice, and if they receive the appropriate level of care, problems should not advance to the point where a hospitalization is needed, and the overall cost of care will be reduced with a possible reduction in error rates.³⁴ There is some evidence from the Columbia United Providers that nurse triage also works well in family practice and community health clinics, and may reduce the after-hours calls, which may further reduce the cost of clinic care. In addition, the anonymity of the caller may lead to higher satisfaction with the provider.³⁴

CONCLUSIONS

When developing models, stakeholders must consider what linkages exist to improve the health of commu-

nity members. Well-designed models provide a seamless monitoring of patient care by integrating human and information system resources. If additional staff, community-based resources, or updates to clinical protocols are necessary, models can be enhanced to meet the changing needs of the community, which can increase the cost effectiveness of care. Modeling allows stakeholders to obtain a snapshot of the current health of the population, as well as to track members' progress toward treatment goals. Model implementation requires strong leadership to create collaborative public-private partnerships, risk taking to develop new patient care services that include cultural-competency training, and vision to support new information system technologies. The overarching goal of reducing health disparities requires synergy among these elements. As expressed by Ira SenGupta, Cultural Training manager at the Cross Cultural Health Care Program in Seattle, Washington, "You can't approach health from only one aspect."³⁵

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