

*Eliminating Racial and Ethnic
Disparities in Healthcare*

NYAPRS Cultural Competence
Committee

Disparities are Real and Unacceptable

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003)

- The majority of studies find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access related actors (for more extensive reviews of this literature, see Kressin and Petersen, 2001; Geiger, this volume; and Mayberry, Mili, and Ofili, 2000).



What Is A Health Disparity?

- A health disparity can be viewed as a chain of events signified by a difference in:
 - Environment
 - Access to, utilization of, and quality of care
 - Health status
 - Particular health outcome

*(Public Health Reports/September-October 2002,
Volume 117)*

Costs of Racial and Ethnic Health Disparities

- \$1.24 trillion between 2004 and 2006: (The Joint Center for Political and Economic Studies: September 2009)
 - \$229.4 billion for direct medical care expenditures associated with health disparities and another
 - \$1 trillion for indirect costs of disparities
- If non-Hispanic Blacks had the same adjusted rate of preventable hospitalizations as non-Hispanic Whites from 2004 to 2007, it would have resulted in about 430,000 fewer hospitalizations for non-Hispanic Blacks and \$3.4 billion in savings (*CDC Health and Disparities Inequalities Report, 2011*)

20 Indicators of Culturally Competent Health Plans/Homes

Performance Indicators	Outcomes
Cultural Competence Plan	Comparable access and outcomes to GP
Proportionally representative governance	90% representation of community
Equal access to full continuum of care	80% know benefits and how to access
Prevention, education and outreach	Evidence of involved cultural communities
Quality Improvement	Presence of QI Plan and CC Indicators
Data Collection and Decision Support	Timely, accurate; across age and ethnicity
Cross Cultural Education for Professionals	% of staff with more than 8 hrs CC training
Access and Service Authorization Tracking	Comparable access and utilization to GP
First contact, intake and assessment	100% inclusion of cultural factors and strengths
Care coordination/management	100% of care plans with natural supports

20 Indicators of Culturally Competent Health Plans/Homes

Performance Indicators	Outcomes
Discharge planning	100% transfer to most integrated settings
Cross-cultural linguistic support	100% served in preferred language
Peer Support and Self Help Resources	Comparable access and use to GP
Provider Competencies (responsive to changing community needs)	Human Resource Development Plan
Strengthen relationships with providers	1:1 match of need to racial/ethnic staffing
Rights education and empowerment	100% racial/ethnic consumer awareness of grievance process and supports
Financial incentives	Comparable clinical outcomes to GP
Community Health Workers and Peers	Comparable prevention of hospital and ER
Ombudspersons	Comparable rates of drop out, grievance
Inclusion of cultural healing practices	Improved engagement/outcomes

Major Themes of the Top 20 Indicators

Why Document Costs?

- Improve quality and contain costs
 - Documenting groups with the poorest outcomes for the expenditures allows state agencies to target resources and interventions for quality improvement and cost savings.
- Engage stakeholders in minority health initiatives
 - Framing disparities as an issue of costs offers a new way to engage key stakeholders in minority health initiatives that would otherwise be considered as special interest and dismissed during fiscal crises.
- Track progress in reducing disparities
 - States can evaluate progress of improvement initiatives or interventions for the most vulnerable constituents based on cost and impact estimates.
- Defragmentation of health financing
 - Racial and ethnic minorities are more likely than whites to be enrolled in “lower-end” health plans (Phillips et al., 2000)
 - Equalizing access to high-quality plans can limit such fragmentation
 - Eliminate or modify payment practices that fragment the care system (IOM, 2001, p.13)

Considerations

- Using data to Having performance standards and key indicators in place to monitor and guide service delivery
- Developing patient-centered and culturally competent approaches to care
- Peers as providers of service
- Collaborating with key stakeholders to reduce disparities

One of the most promising strategies to emerge
*(for reducing racial and ethnic disparities in
health care)* is the application of a quality
improvement framework to promote
measurable improvement in persistent patterns
of unequal treatment.

Disparity and Quality improvement: Federal Policies Lessons. Health Affairs.
242 (march/April 2005) 354-364

Cultural Competence Performance Standards and Measures

Cultural Competence Planning Standard:

- *A Cultural Competence Plan shall be developed and integrated within the overall organization and/or provider network plan to assure attainment of cultural competence within manageable but concrete timelines.*
- *These standards must include but not limited to:*
 - *performance measures and key indicators in place to monitor and guide service delivery*
 - *Guidelines to ensure the stability of patients' assignments to primary care providers (and these providers' accessibility), reasonable patient loads per primary care physician, and time allotments for patient visits (IOM, 2003)*
 - *increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals*

Rights Protections

- Given that many minorities are disproportionately represented among the publicly insured who receive care within managed care organizations, the same patient protections that apply to the privately insured should apply to those in publicly funded plans
- The principle of equality in a patients' bill of rights should emphasize the importance of encouraging managed care organizations to integrate their care with local and state agencies to promote public health.

Hashimoto, 2001



Data and Outcomes

- Development and implementation of Health Information Technology (HIT)
- Standardize data collection and analysis on race and more finely grained ethnicity across systems and providers
- Collect data on language needs
- Collect data on social determinants – housing, employment, lack of access to fresh food, etc.
- Create awareness of and educate intake staff on the importance of collecting and use of data on clients served
- Link client data to quality, performance, outcomes
- Use data to identify and stratify health care disparities



Funding & Contracting

- Blend and braid funds across systems
- Implement a performance-based contracting
- Incentivize providers whose programs and processes reduce disparities
- Redeploy funds from higher costs services
- Pay for the use of interpretation and translation services
- Use data to Inform program development, planning, and priority setting
- Have CC and disparities requirements in contracts



Services and Research

- Evaluate and measure the effectiveness of evidence-based practices (EBPs) interventions for cultural groups
- Identify community disparity indicators and monitor progress towards the elimination of healthcare disparities
- Identify for replication community defined evidence that have produced positive outcomes for cultural groups
 - Pilot test evidence informed care tailored to the individual according to age, gender, race, ethnicity and culture
 - Develop, implement and monitor targeted interventions aimed at identified disparity gaps.



Access to health care services

- Healthcare coverage must be affordable, comprehensive, equally accessible to all.
- Coverage must be portable
- Behavioral health care must be integrated with primary health
- Financing must be flexible (case rate) to ensure health homes emphasize prevention, primary care, chronic care management, care coordination, and providing person centered, culturally relevant and appropriate services
- community-based interventions and programs must be responsive to the needs of cultural groups within the service area
- Support the use of community health workers – health navigators, cultural brokers, peer coaches, etc.

Education and Empowerment

- Inform people of their right to receive interpretation and translation services
- Implement patient education programs to increase patient's knowledge on how to best access care and participate in treatment (IOM, 2001)
- People must be encouraged and taught how to be active participants in their care
- Increase providers, community and stakeholders awareness of healthcare disparities

Creating Financial Incentives

- Structure payment systems to ensure an adequate supply of services to minority patients and limit provider incentives that may promote disparities
- Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice such as:
 - Reward time spent engaging people and their families to overcome barriers of culture, communication, and empathy
 - Encourage adherence to evidence-based protocols for frugal practice and to engage in age and gender appropriate disease screening to promote efficient, quality care
 - Penalize deviations from protocol, regardless of race or ethnicity
 - Link financing to favorable clinical outcomes, where reasonably measurable (e.g. control of diabetes, asthma, and high blood pressure) can also promote equity of care (Bloche, 2001).



Workforce Development

- Development of a workforce that is representative and reflective of community being served
- Engage with and incentivize colleges and universities to develop curricula to ensure the availability of providers to deliver person-centered, culturally, linguistically , relevant and appropriate care
- Accrediting and licensing agencies must include strong requirements and oversight for the provision of culturally and linguistically competent care
- Development of diverse executive leadership and governance bodies of the system of care is essential for implementing effective healthcare that meet the needs of the diverse minority population

Community Health Workers (Peers!)

- ...lay health advisors, neighborhood workers, indigenous health workers, health aides, *consejera*, or *promotora*—fulfill multiple functions in helping to improve access to healthcare.
- ...serve as liaisons between patients and providers, educate providers about community needs and the culture of the community, provide patient education, contribute to continuity and coordination of care, assist in appointment attendance and adherence to medication regimens, and help to increase the use of preventive and primary care services (Brownstein et al., 1992; Earp and Flax, 1999; Jackson and Parks, 1997).
- ...evidence suggests that lay health workers...help improve the quality of care and reduce costs (Witmer et al., 1995), and improve general wellness by facilitating community access to and negotiation for services (Rodney et al., 1998).

Interpreter Services

- Language barriers...affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision making, or ethical compromises (e.g., difficulty obtaining informed consent; (Woloshin et al., 1995).
- Linguistic difficulties...also result in decreased adherence with medication regimes, poor appointment attendance (Manson, 1988), and decreased satisfaction with services (Carrasquillo et al., 1999; David and Rhee, 1998; Derosé and Baker, 2000).

Strengthening Relationships with Key Stakeholders

Doctors:

- Minority patients...are less likely to enjoy a consistent relationship with a provider, even when insured at the same levels as white patients (Lillie-Blanton, Martinez, and Salganicoff, 2001).
- Health systems should attempt to ensure that every [person]...has a sustained relationship with an attending physician....(IOM, 2003).

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Go to www.NYAPRS.org for more information or to join the Cultural Competence Committee.

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