

Why Companies Are Making Health Disparities Their Business:

*The Business Case and Practical Strategies*

Prepared by:  
National Business Group on Health

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## Overview

There are numerous studies that document racial and ethnic disparities in health and health care. Two prominent publications include the following:

- ◆ January 2000, the U.S. Department of Health and Human Services published *Healthy People, 2010*. The report lists numerous statistics about racial and ethnic disparities in health and health outcomes and proposes eliminating these disparities as one of the two overarching goals that the nation should work toward over the next decade. (To view the report online, visit <http://www.healthypeople.gov/Publications/>).
- ◆ In March 2002, the Institute of Medicine released *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The report reviewed numerous studies on health disparities and found that even when racial and ethnic minorities have the same health insurance and conditions as whites, they often receive different health care treatment, receive lower quality health care and suffer worse health outcomes. (The entire report is available online at <http://www.nap.edu/catalog/10260.html>).

Many employers are disturbed by the evidence of health disparities and their repercussions on the health and well being of diverse workforces. Because few initiatives have homed in on the impact of health disparities on large employers, the business case for large employers to launch initiatives to reduce disparities in health and health care has yet to be outlined. Also absent are the practical strategies that large employers can implement as the major purchasers of health care to reduce these disparities among their diverse workforces and within the nation as well.

The National Business Group on Health (formerly known as the Washington Business Group on Health) developed **Why Companies Are Making Health Disparities Their Business: *The Business Case and Practical Strategies*** for a corporate audience. It focuses on the impact of racial and ethnic disparities in health and health care on large employers. While the disparities that exist among diverse populations without insurance are extremely disturbing and important to reduce, they are less relevant to large employers who include health insurance as a component in the compensatory packages they offer their workforces.

Chapter I – **Same Insurance, Different Treatment: *Research That Documents The Disparities*** – distinguishes between disparities in health and disparities in health care to set the framework to assess the research terrain. This chapter highlights the key findings that document differences in health outcomes and health care services between diverse populations. Additionally, Chapter I builds the context within which the business case for large employers to assume a role in reducing disparities in health and health care exists.

The second chapter – **The Business Case: *Health Disparities and the Impact on Large Employers*** – uses compelling research findings as a framework to explain the rationale and business case for employers to reduce health disparities. Chapter II explores how health disparities result in employers investing healthcare dollars in a system that does not equally administer services to diverse workforces. This chapter also explores the possible direct and indirect costs of disparities in health and health care on corporate America, and identifies incentives for large employers to engage in efforts to help reduce health disparities.

The third chapter – **How Companies Can Make Reducing Health Disparities Their Business: *Innovative Strategies*** – assesses the role that large employers can play to reduce

racial and ethnic health disparities. Additionally, this chapter introduces forward-thinking, practical strategies that large employers may consider implementing to reduce the prevalence of these disparities among their diverse workforces.

The fourth chapter – **Cultural and Linguistic Competence in Health Care: A Vehicle to Help Reduce Disparities** – explores the feasibility of ensuring cultural competence in healthcare as an effective vehicle to reduce health disparities. Chapter IV not only defines cultural competency, but also focuses on the Culturally and Linguistically Appropriate Standards (CLAS) of care -- established by the Department of Health and Human Services, Office on Minority Health – that large employers can work to ensure in the health care services their workforces receive.

## Chapter I: Same Insurance, Different Treatment: *Research That Documents The Disparities*

Health disparities research is useful to employers because it focuses on diverse employee pools and the health conditions and challenges that may affect employees at the worksite. The term “health disparities” is often used as an umbrella term used to describe the following:

- ◆ **Disparities in health**, which refer to differences in health outcomes and status.
- ◆ **Disparities in health care**, which refer to differences in the preventive, diagnostic and treatment services offered to people with similar health conditions.

(When relevant, this analysis paper will differentiate between racial and ethnic disparities in health and in health care. Otherwise, the term “health disparities” will be used.)

### Racial and Ethnic Disparities in Health

On average, racial and ethnic minorities are in poorer health, suffer worse health outcomes, and have higher morbidity and mortality rates than their white cohort.<sup>1</sup> Some of the most striking findings focus on infant mortality – considered one of the strongest and most sensitive indicators of health and well being in a population.

- ◆ African-American infant mortality rates are 2.3 times higher than among whites.<sup>2</sup>
- ◆ Although they comprise less than 2% of the total U.S. population, the death rate among American Indian/Alaska Native babies (9.3 per 1,000 births) is higher than the national average (7.0 per 1,000 births).<sup>3</sup>

Other key findings of disparities in health include:

- ◆ At each stage of life span, American Indians and African Americans have higher mortality rates than whites.<sup>4</sup>
- ◆ African-American women are *nearly four times more likely* than White women to die during childbirth or from pregnancy complications.<sup>5</sup>
- ◆ Latino and African American adults, aged 18 years and older, are more likely than white adults to report chronic conditions such as high blood pressure, heart disease, cancer, diabetes, asthma, anxiety, depression or obesity.<sup>6</sup>
- ◆ HIV is the leading cause of death for African Americans, 25-44 years of age. Cancer is the leading cause of death in Asian/Pacific Islanders of the same age. For all other groups of the same age, the leading cause of death is accidents.<sup>7</sup>

#### **QUICK DISPARITIES FACT 1:**

**African-American women have the highest death rates from heart disease, breast and lung cancer, stroke and pregnancy among women of all racial and ethnic backgrounds.**

*Source: Health, United States, 2002. National Center for Health Statistics, United States Department of Health and Human Resources.*

- ◆ Rates of heart disease mortality have decreased the most for whites and the least for African Americans.<sup>8</sup> In fact, mortality rates for heart disease are 50% higher for African Americans than for whites.<sup>9</sup>
- ◆ American Indian/Alaska Natives have diabetes rates that are nearly 3 times (2.8) the overall rate and African Americans are two times more likely to have diabetes than whites.<sup>10</sup>

Some recent studies have found that racial and ethnic minorities receive the same care as whites for the same conditions and have the same health outcomes.

- ◆ Eleven studies of racial and ethnic disparities in health care found no differences in cardiac care among diverse populations.<sup>11</sup>

Despite these findings, the number of studies that have found evidence to the contrary is far greater.

### Racial and Ethnic Disparities in Health Care

#### *Disparities in Cardiac Care*

Last year, over 710,000 men and women in the United States died from heart disease<sup>12</sup> and more than 61 million men and women – many of whom are in their prime working years – currently are afflicted with a health condition, such as obesity or diabetes, that puts them at significantly increased risk for heart disease.<sup>13</sup> Coronary heart disease and heart disease risk factors also are among the leading cost drivers that large employers grapple with each year.

#### **QUICK DISPARITIES FACT 2:**

**Whites with congestive heart failure were more likely to be hospitalized – and thus more likely to receive appropriate cardiac care – than racial and ethnic minorities with the same condition.**

*Source: Condlario, et al. (2000).*

More than 80 studies on differences in cardiac care between whites and racial and ethnic minorities were conducted between 1984 and 2001. More than three-fourths (68) found disparities in cardiac care for at least one racial and ethnic minority group, and of those 68 studies, 46 found differences in cardiac care for *all* heart disease treatments and procedures for at least one racial and ethnic minority group.<sup>14</sup>

Racial and ethnic differences in cardiac care – such as cardiac catheterizations, coronary angiography, angioplasties and heart surgery – may contribute to disparate heart disease prevalence and mortality rates. Coronary angiography is a crucial prerequisite for angioplasty and coronary bypass surgery. These procedures and treatments are integral components in appropriate care for heart disease patients, as they can screen for, detect and treat heart disease in its earliest stages, which can be less expensive and increase life expectancy. Racial and ethnic disparities in coronary angiography may contribute to differences in subsequent cardiac care procedures and treatments, and further jeopardize the health and well-being of heart disease patients of racial and ethnic minority backgrounds.

#### **QUICK DISPARITIES FACT 3:**

**Although they have stroke rates that are as much as 35% higher than Whites, African Americans are significantly less likely to receive appropriate diagnostic and treatment interventions.**

*Source: "Unequal Treatment", The Institute of Medicine, 2002.*

- ◆ Insured African Americans are significantly less likely than Whites with health insurance to undergo angiography.<sup>15</sup> These disparities likely contribute to perpetuating the following differences in subsequent cardiac care:
- ◆ African Americans are less likely than Whites to undergo heart bypass surgery<sup>16</sup> and these disparities tend to be the most pronounced among sicker patients who would benefit the most from surgery.<sup>17</sup>
- ◆ African-American women with health insurance are 40% less likely than Whites with health insurance to be recommended for cardiac catheterization.<sup>18</sup>
- ◆ Although cardiac catheterization, angioplasty and bypass surgery are effective procedures used to diagnose and treat heart disease, Latinos and African Americans are less likely than whites to undergo these procedures despite having the same health insurance coverage and disease severity.<sup>19</sup>

### *Disparities in Cancer Screening and Treatment*

Cancer screening technologies have helped increase cancer screening rates and detection, and successful cancer treatment among adults across all racial and ethnic groups. Like coronary heart disease and other chronic conditions, cancer can be treated more successfully when detected in its earliest stages. Unfortunately, screening rates among racial and ethnic minorities are lower than that among whites, even when all populations groups are equally insured. These disparate screening rates may place racial and ethnic minorities at greater risk than whites of being diagnosed with later stages of cancer.

- ◆ All racial and ethnic minority women, aged 40 years and older, are less likely than white women the same age to have been screened for breast cancer with mammography.<sup>20</sup>
- ◆ Latino and African-American men are less likely than white men to be screened for prostate cancer and are at greater risk of being at more advanced stages of prostate cancer at the point of diagnosis.<sup>21</sup>
- ◆ Less than one-quarter (24%) of American Indian/Alaska Natives were screened for colorectal cancer in the last two years.<sup>22</sup>
- ◆ Latina, Asian/Pacific Islander and American Indian/Alaska Native women, aged 18 years and older, are less likely than white women of the same age to receive cervical cancer screening with Pap smears.<sup>23 24</sup>
- ◆ African-American men are less likely than White men to undergo colonoscopy – a technically advanced diagnostic procedure – African-American men received 28% fewer sigmoidoscopic examinations than White men.<sup>25</sup>
- ◆ Latina women who were newly diagnosed with lung and/or breast cancer were diagnosed in later stages and had lower survival rates than white women.

There are serious cost challenges associated with inadequate cancer screening and diagnostic services. When many forms of cancer are detected in early stages, the treatment options are more cost-effective because they not only help contain future health care costs by reducing excessive tests and exorbitant follow-up care services, they also offer increased survival odds.

Racial and ethnic differences in cancer *treatment* include the following:

- ◆ African-American women with breast cancer are significantly less likely than White women with breast cancer to receive progesterone receptor assays – an important prognostic test – as well as radiation therapy in combination with mastectomy.<sup>26</sup>
- ◆ African-American men with colorectal cancer are 41% less likely than white men to receive the major diagnostic and treatment procedures for colorectal cancer. African-American men are nearly 13% less likely than white men to undergo resection and one study estimates that if the surgery rates were equivalent for both population groups, 308 more African-American men with colorectal cancer would have been alive at five years.<sup>27</sup>

The total amount of direct costs of cancer is higher than diabetes, cardiovascular disease and depression.<sup>28</sup> While many erroneously believe that cancer is a chronic condition of the elderly, roughly 40% of cancer cases occur in people between the ages of 18 and 64 – in their prime working years.<sup>29</sup>

### *Disparities in Care for Other Chronic Conditions*

Health care disparities exist across a range of other chronic conditions.

- ◆ Hospitalization for asthma is an avoidable admission if the condition is adequately managed. Yet, insured African Americans with asthma are more likely than insured whites with asthma to be hospitalized for asthma-related health conditions and less likely to be treated by an asthma specialist.<sup>30</sup>
- ◆ The morbidity and mortality rates of diabetes among American Indian/Alaska Natives, African Americans and Latinos is 50% to 100% higher than among whites. However, insured racial and ethnic minorities are significantly less likely than White to receive diabetes education as well as the recommended standards of preventive and treatment care for diabetes.<sup>31</sup>

### *Disparities in Pain Management*

Racial and ethnic differences in pain management services given to patients with similar injury conditions also exist. For example:

- ◆ More than four in every 10 (43%) African-American patients with extremity fractures, compared to 26% of white patients with the same condition, did not receive treatment for pain.<sup>32</sup>
- ◆ African American cancer patients were 63% more likely than Whites to receive no medication for pain relief.<sup>33</sup>
- ◆ Latino patients with broken bones were 64% less likely than White patients to receive adequate pain treatment.<sup>34</sup>

Appropriate use of analgesics can increase patient recovery,<sup>35</sup> reduce unnecessary suffering among some minority patients and may increase direct and indirect costs by increasing hospital stays, doctor visits, and the number of missed or low-productivity work days.<sup>36</sup>

### Disparities in the Over-utilization of Health Care Procedures and Services

Health disparities exist not only in the under-utilization of preventive and diagnostic services, but also in the over-utilization of some health care services and treatments that are sometimes inappropriate and even harmful. For example, racial and ethnic minorities often are more likely to receive invasive health care procedures and treatments than their white cohort with the same symptoms and conditions.

- ◆ African-American diabetics were nearly 3.5 (3.47) times more likely than white diabetics to have had a lower limb amputation procedure performed.<sup>37</sup>
- ◆ African-American and Latina women with health insurance were more likely than insured White women to undergo cesarean deliveries.<sup>38</sup>

Such over-utilizations can jeopardize the health of patients by exposing them to unnecessary testing, treatments and procedures – many of which require recovery time – and poorer health outcomes. Additionally, it is a costly waste of expensive health care dollars and resources.

Latinos and African Americans, compared to Whites, over-utilize hospitals to gain access to a health care provider, which is an extremely costly way to access the health care system. For example:

- ◆ African-American children with asthma are three to four times more likely than White children with asthma to be hospitalized.<sup>39</sup> These differences in hospitalization suggest that the chronic condition is not appropriately monitored, treated or managed in many African-American children.

### Racial and Ethnic Disparities in Perceptions About Health Status and Health Care

Racial and ethnic minorities are more likely than whites to rate their health as fair or poor and report negative experiences interacting with health care providers as well as increased difficulty getting needed, appropriate health care services. For example:

- ◆ More than one in ten Latinos (12.9%), American Indian/Alaska Natives (17.2%) and African Americans (14.6%), compared to 7.9% of whites, rated their health as fair or poor.<sup>40</sup>
- ◆ More than one in every three African Americans (35%) and Latinos (36%) reported that they, a family member, friend or someone they know was treated unfairly because of race/ethnic background when getting medical care. Only 15% percent of surveyed Whites reported the same experiences.<sup>41</sup>
- ◆ Compared to Whites – 75% of whom reported that their doctor involved them in decision-making as much as they wanted –just over half (56%) of Asian Americans and 65% of Latinos reported similar experiences.<sup>42</sup>
- ◆ While more than three in every four Whites (79%) reported that they *did not* think they had difficulty getting care because of their racial or ethnic background, more than half (52%) of African Americans and nearly half (45%) Latinos reported that they had difficulty getting care because of their racial or ethnic backgrounds.<sup>43</sup>

Coincidentally, just over one-half (51%) of Asian Americans, roughly one-third (34%) of Latinos and 40% of African-American adults who had a health care visit in the past two years admitted they did *not* adhere to the doctor's recommendations.<sup>44</sup> This finding suggests a

possible correlation between a patient's health care experiences and the likelihood that they will adhere to a doctor's advice.

### Conclusion

This chapter provided a review of the robust body of evidence of racial and ethnic disparities in health outcomes, and differences in morbidity and mortality rates, as well as in preventive, diagnostic and treatment services for various conditions. While this review of the literature was not exhaustive, the statistics and analysis presented – particularly those that focused on similarly insured populations – help establish the framework for the development of the business case for large employers to launch initiatives to help reduce health disparities.

## Chapter II: The Business Case: *Health Disparities and the Impact on Large Employers*

### Why Companies Are Making It Their Business: *The Rationale*

Employers believe that they are getting the same health care for all of their employees. In some instances, they are paying for care that is inappropriate or inadequate for their employees. They believe they are treating all employees appropriately according to medical need, but their employees and dependents may be overserved or underserved in the health care system. These disparities may exacerbate large employers' already daunting task of ensuring quality health care while moderating increasing health care costs. Employers would not tolerate these inequities if they knew about them and how to improve the system.



Large employers provide health benefits to two out of three Americans with health insurance. Because of this, they drive the health care marketplace and are well poised to leverage their collective resources to bring necessary changes in the way health care services are delivered.

Many corporate executives are disturbed by the evidence of health disparities and their impact on the health and well being of a diverse workforce. However, few initiatives have addressed the impact of health disparities on large businesses and the business case for large employers to assess and reduce health disparities has yet to be outlined. Also absent are solutions that employers can implement on their own, given how hard it is to change anything in the complex health system.

### Why Companies Are Making It Their Business: *The Business Case*

There are multiple incentives for large employers to launch initiatives to reduce racial and ethnic health disparities. The two major financial incentives are the following:

#### *The Possibility of Decreased Direct Costs*

Preventive-, diagnostic- and treatment-related services for coronary heart disease, cancer and other expensive chronic health conditions may be effective preventing, serious, costly health problems *before* they develop or treating them more appropriately once manifested. Early detection of some chronic conditions may reduce the amount of care needed, improve quality of life and increase the chances for survival.<sup>45</sup>

In 2002, for example, large employers assumed over \$325 billion – nearly \$200 billion of which were for direct costs – in health expenditures for coronary heart disease among their workforces. Reducing disparities in preventive, diagnostic and treatment for cardiac care may

help reduce the prevalence and severity of coronary heart disease among racial and ethnic minority members of the workforce and reduce the total expenditures large employers assume for coronary heart disease. <sup>46</sup>

### *Possibility of Decreased Indirect Costs*

When employees receive inadequate health care services, a number of indirect costs result including increased rates of absenteeism and presenteeism, as well as decreased rates of productivity. Employees with chronic health conditions have an increased likelihood of leaving the workforce, for a short term, an extended period of time or permanently. Medical costs result along with costs associated with disability benefits, stress on other employees, hiring and training new employees, and quality costs.

Working to reduce health disparities, particularly in preventive-, diagnostic- and treatment-related services, could reduce the prevalence and severity of chronic disease conditions among employees, improve the quality of employee health care and play a role in reducing employers' annual health care expenditures. .

Large employers have yet another incentive for working to reduce disparities in health and health care. The U.S. Bureau of Labor Statistics projects that over the next decade, racial and ethnic minorities will account for 41.5% of the workforce. Large employers, then, have a vested interest in ensuring that health care treatments and services, for which they are paying, are of the highest quality and deliver the greatest value.

Additional incentives for large employers to work to reduce health disparities include:

### *The Retention in the Workforce of Racial and Ethnic Minority Employees*

The lower quality of health care that results from disparities not only compromises the physical and emotional well-being of minority Americans, but it also likely jeopardizes their productivity and viability in the workplace. Minority workers are put at greater risk for increased absenteeism and presenteeism, and opportunities for professional growth and promotion are diminished. When affected employees leave the workforce, employers have to pay the costs associated with hiring and training new staff, as well as the possibility of disability benefits for a very long time.

### *Ensuring a Healthy Workforce in the Future*

Just as they are with adults, racial and ethnic health disparities among insured children are well documented. These disparities often leave children of color at a disproportionate risk for serious, lifetime health conditions – such as diabetes – that likely will afflict them into adulthood and affect their chances of having a decent, pain-free life. Since most employers cover eligible dependents of employees, albeit at a higher contribution level for the dependents, large employers pay for the direct and indirect costs of the lower quality of care given to some racial and ethnic minority children. Investing in the health of the future workforce is another incentive for working to reduce health disparities.

### *The Benefits to Health Insurance Companies*

As with employers and health professionals, many health plans consider the reduction in health disparities a positive end in itself. However, since they are both large employers as well as companies that sell health insurance to purchasers, there are unique, inextricably linked financial incentives for health plans to launch initiatives to eliminate health disparities. These incentives include the following:

### *Enhancing Effectiveness and Quality of Health Care Services*

In addition to retaining and attracting clients, health plans can work to reduce health disparities to increase effectiveness and quality of services. This is particularly true of health plans using a capitated payment system. Most large employers are self-funded and pay all medical claims for their covered employees and dependents, although they typically use the large health plans to pay claims and provide selected services, such as case management. Other employers pay premiums to enroll their workers and dependents in health plans. At least on a year-to-year basis, the health plan assumes the risk for the year. Additional costs associated with inadequate health care treatments and services are absorbed by health plans within that year.

### *Attracting Minority Consumers*

Most employees at large companies typically select their health plans from a range of options presented to them by their employers. Health plans that launch initiatives to reduce health disparities, then, may attract a broader, more diverse population of employees, particularly those who are most affected by disparities.

All stakeholders need to be sensitive to the unintended consequences of the impact of this. Given the costs and quality of life consequences, it is theoretically possible that being highly effective in treating minorities would attract a disproportionate number of minority beneficiaries. If the data we have seen over the past five years are indication of inappropriate underuse and overuse of services, then the best plans could have some of the highest costs as they try to change the care system and provide the right services to a traditionally underserved group. Payment policies may need to take this into consideration, possibly using risk adjustments so the better plans are not penalized. If the plan is not insured, this is less of a problem.

### *Appealing to Private Purchasers with Diverse Workforces*

The costs that large employers assume in order to provide rich health benefits packages to their employees and their families have been and are expected to continue to rise dramatically each year. Health benefits for large employers have increased an average of 50% in the five years between 1997 and 2002, have grown another 14% in 2003 and are estimated to climb another 14% in 2004. These high increases in tandem with the extensive research documenting racial and ethnic health disparities among employees and dependents suggest that employers are wasting a large portion of their health care dollars. Health plans are well positioned to remedy this critical quality of care problem and they too should benefit from these improvements.

In an extremely competitive market, in which purchasers such as large employers have a range of plans from which to choose, health insurance companies vie for business. As awareness of the cost and health implications of health disparities rises among large employers, they may weigh more heavily the quality and scope of health care services health plans offer to their diverse populations.

## Chapter III: How Companies Can Make Reducing Health Disparities Their Business: *Innovative Strategies*

### Working to Reduce Disparities in Health

Many large employers already have launched health and wellness initiatives that they can build upon to help reduce disparities in health, such as worksite health fairs that screen for chronic conditions and educate employees about their individual risk factors. They should also consider the following:

- ◆ Develop and disseminate health and wellness materials that are culturally and linguistically appropriate (e.g., develop written materials in the employees' preferred languages and ensure that pictures included in written materials feature people of different racial and ethnic backgrounds). (For more information on minority health, and cultural and linguistic competence in health care, visit <http://www.omhrc.gov/omhrc/>).
- ◆ Provide employees with specific information about appropriate tests and screenings that are evidence-based and indisputably useful to all patients so the patient can be a safety check on the system.
- ◆ Include clear, concise and relevant information about racial and ethnic disparities in health to further educate employees and let them know that reducing health disparities are priorities for employers.

### Things Employers Can Do To Help Reduce Health Disparities: A Quick Checklist

- At renewal meetings with health plans, ask about their initiatives to reduce racial and ethnic health disparities and use the responses as a criteria for renewal.
- Establish a quality measurement around reducing health disparities.
- Provide employees with information about appropriate health care services that are evidence-based and useful to all patients.
- Ask employees about their experiences communicating with health care providers and use the feedback in criteria for health plan renewal.
- Launch culturally and linguistically competent health and wellness programs at the worksite.
- Develop and disseminate culturally and linguistically competent health education materials that raise awareness about health issues that disproportionately affect racial and ethnic minorities.

### Working to Reduce Disparities in Health Care

One practical and effective initiative large employers could launch to help reduce racial and ethnic health disparities is communicating health plans. At renewal meetings, large employers could ask about the plan's efforts to reduce health disparities, and incorporate the

responses as criteria for renewal. As a component of the renewal process, large employers may use discretion renewing health plans that have not implemented programs demonstrating awareness of or sensitivity to health disparities and cultural diversity. Conversely, large employers interested in ensuring that the health care services they purchase are equitably delivered may want to contract with a health plan that:

- ◆ Demonstrates more of a focus on the cultural issues affecting the makeup of their beneficiary population and how these issues affect health care delivery from a culturally inclusive perspective;
- ◆ Develops culturally and linguistically competent newsletters aimed at targeted racial and ethnic populations;
- ◆ Initiates programs that voluntarily collect racial and ethnic information from patients through surveys, health assessments and interviews;
- ◆ Collects and analyzes the racial and ethnic makeup of the provider network;
- ◆ Collaborates with minority health groups to provide members and the community with the most accurate and up-to-date, culturally-sensitive health information;
- ◆ Sponsors forums and training sessions for providers (i.e., physicians and nurses) to foster cultural competence in addressing disparities in health care, including continued medical education (CME) presentations and provider handbooks;
- ◆ Dedicates human resources to provide cultural and linguistic competence tools and training for health plan employees and other clinical providers;
- ◆ Establishes targeted disease management programs that are tailored to specific racial and ethnic groups that are at increased risk for such diseases. These programs should be linguistically and culturally competent, and include culturally-specific food and menu suggestions in several languages;
- ◆ Offers health plan dieticians to help patients develop meal plans with physician guidelines using traditional foods familiar to the member;
- ◆ Conducts analysis of HEDIS data against Medicare's racial and ethnic data;
- ◆ Implements surveys targeted to racial and ethnic minority beneficiaries to determine satisfaction with level of care; and
- ◆ Works with government study groups on further racial and ethnic health care disparities research.

The following case study details how one large communication company implemented this strategy.

## **CASE STUDY**

### **Want to Know? Just Ask: *An Innovative Strategy to Reduce Health Disparities***

Last year, a human resources manager at a major communications company – aware of the racial and ethnic differences in health care treatment as well as the need for improvements in culturally and linguistically competent health care – implemented a strategy to ensure that health plans – to whom they provide business – addressed racial and ethnic disparities in health care delivery.

The manager asked the health plans at renewal meetings about their awareness of racial and ethnic disparities in health care and efforts to reduce health disparities among their membership population. The following questions were asked:

1. **Is your health plan familiar with the Institute of Medicine's or other reports describing racial and ethnic disparities among the insured?**
2. **Identify any of your disease management programs that include culturally targeted components and briefly describe the cultural component of the program.**
3. **Describe how your communication materials specifically address cultural health concerns.**
4. **Explain whether or not and how your health plan collects racial and ethnic data for the purpose of targeting culturally sensitive programs or initiatives.**
5. **Has your plan addressed disparities within your network? If so, what culturally sensitive practices have your physicians incorporated?**
6. **Describe the minority makeup of your physician network (African American, Asian/Pacific Islander, Hispanic, Native American) in terms of percentages.**
7. **List any additional efforts that your health plan is involved in to reduce disparities in healthcare delivery.**

The answers were used to identify which plans were actively looking at and working to reduce health disparities and incorporated as a factor in the decision making process for renewing a health plan. This strategy lets health plans know that attracting the business of large employers today will require an ability to demonstrate effective diversity strategies in health care delivery.

Additional strategies large employers could implement to reduce racial and ethnic health disparities include the following:

- ◆ Obtain the National Business Group on Health's resource, **An Employer Toolkit – Reducing Racial and Ethnic Health Disparities**. This comprehensive toolkit was designed to provide large employers with pertinent information about and practical strategies to assess and reduce racial and ethnic health disparities among their workforces.
- ◆ Establish a venue for and encourage feedback from employees about their experiences with their health plans and in communicating with health care providers.
- ◆ In existing surveys that ask employees about their experiences using health care services and interacting with providers, employers may consider asking employees the well-tested questions in instruments like the CAHPS survey. (For more information, visit <http://www.cahps-sun.org>).

Additional questions may include the following:

- Are you able to communicate with health care providers in your preferred language?
- Do you feel that your health care provider is sensitive to your race and ethnicity?

- ❑ Do you feel adequately involved in the decision making about your health care treatment options?
- ❑ Do you feel that your health care providers disrespect or ignore you?

Employers may want to use the survey findings to address employees' concerns with the health plans at renewal meetings or incorporate the survey findings into the health plan renewal criteria. They should also make plan performance data from HEDIS and CAHPS available in easy to use formats to help employees when they make their health plan choices. If the employer is large enough, it might be helpful to analyze plan performance data, including member satisfaction data, in areas with large minority populations (since race and ethnicity data are typically not available for cross classifications) to gain some insights about performance among racial and ethnic minority populations.

- ◆ Develop and disseminate culturally and linguistically competent materials, such as "Healthy Tip Sheets", to educate employees about proper standards of screening, diagnostic, and treatment services for chronic conditions such as cancer, cardiovascular disease and diabetes. For example, African-Americans could be informed of their two- to three-fold increased risk, compared to whites of the same age, of having a stroke and having the stroke leave them paralyzed for life.<sup>47</sup> The Tip Sheet could:

- ✓ Recommend that African-Americans have their blood pressure checked by a physician every 6 months or as medically indicated;
- ✓ List dangerous blood pressure levels (e.g., 130 to 139 over 80 to 89 is considered pre-hypertension and levels that are equal or greater than 140 over 90 are considered high)<sup>48</sup>;
- ✓ Encourage African-Americans with high blood pressure to seek active treatment; and
- ✓ Recommend that those with elevated blood pressure adhere take their medications and exercise regularly, make healthy food decisions, and achieve and maintain a healthy body weight.

Additionally, encourage employees to question providers who do not follow the appropriate standards of care, which they would know because they were given "tip sheets" showing the evidence-based practice standard.

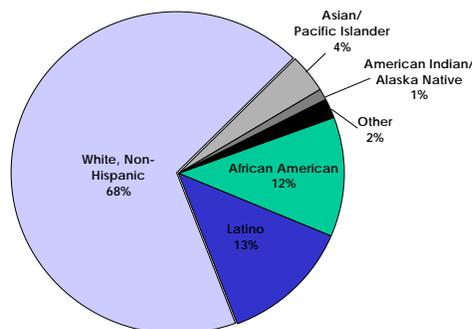
## Conclusion

Some employers have launched efforts to reduce health disparities and serve as examples for other companies interested in or currently planning to implement strategies to reduce health disparities. Large employers may opt to effect change in the health care system by leveraging resources as purchasers to ensure that diverse populations receive the same high quality of health care. They also may launch culturally and linguistically competent health awareness initiatives. Either way, large employers have compelling incentives to play an integral role in helping to surmount the challenges of racial and ethnic health disparities.

## Chapter IV: Cultural and Linguistic Competence in Health Care: *A Vehicle to Help Reduce Disparities*

Nearly one in three people in the United States is a member of a racial and ethnic minority group. Latinos – the largest racial and ethnic minority group – and African Americans represent more than one-half of all racial and ethnic minorities in the United States.<sup>49</sup> The population will continue to diversify, with the greatest growth occurring among Asian Americans/Pacific Islanders and Latinos, who will comprise 6% and 17%, respectively, of the total U.S. population by 2020.

**Percent Distribution of U.S. Population  
by Race/Ethnicity, 2000**



U.S. Census Bureau, Census 2000 Redistricting Data

### Cultural and Linguistic Competence in Health Care: *The Rationale*

Stakeholders around health disparities identified the key, systemic inadequacies in the U.S. health care system that leave the health care needs of racial and ethnic minorities inadequately met.

◆ *Lack of Linguistically-Appropriate Services*

Language barriers compromise health care quality by reducing the ability of patients with limited English proficiency to clearly communicate with health care providers and leading to:

- Increased likelihood of errors in collecting medical histories;
- Decreased use of preventives services;
- Increased use of diagnostic testing; and
- Increased risk of drug complications.<sup>50</sup>

**One in every three Latinos and more than one in every five (27%) Asian Americans report extreme problems communicating with health care providers.**

Source: Flores, G. U.S. DHHS, OMH Consensus Building Meeting, March 24, 2003.

With diversity increasing, the inability of patients to effectively communicate with health care providers is likely to worsen. Linguistically appropriate services – such as bilingual medical staff or interpreters – may help reduce the racial and ethnic health disparities by improving health care quality.

- ◆ Lack of Cultural Competence

Research on provider bias reveals that some white physicians hold prejudicial attitudes and assumptions about racial and ethnic minorities.

- ◆ African Americans were more likely than whites to be assessed as less intelligent, more likely to abuse drugs and alcohol, less educated, and less likely to comply with medical advice.<sup>51</sup>
- ◆ African-American patients were significantly less likely than Whites to be perceived as someone with whom the physicians surveyed could envision him/herself being friends.<sup>52</sup>

Many of these assumptions are likely due to a lack of diverse cultural exposure. Cultural competency among medical and health care staff, therefore, is a critical component in a strategy to reduce racial and ethnic stereotyping and ensure that health care services are administered equitably and appropriately to diverse populations.

- ◆ Lack of Diversity in the Health Care Industry Workforce

Although they represent a growing proportion of health care purchasers and patients, racial and ethnic minorities are grossly under-represented as professionals working in the health care industry. Roughly 7% of physicians, 3% of nurses, 3% of medical school faculty members and 2% of senior-level executives in health care management are members of racial and ethnic minority groups.<sup>53</sup> While white physicians are capable of providing adequate health care to diverse populations, racial and ethnic minorities often tend to be more comfortable seeing a provider of a similar racial and ethnic background.<sup>54</sup> Linguistically- and culturally-similar backgrounds between patients and providers may afford better communication, adherence to medical advice, health care experiences and, by extension, better health outcomes. Increasing the diversity in the health care workforce, therefore, may help reduce racial and ethnic differences in health care treatments and services.<sup>55</sup>

## Cultural Competency 101

The dearth of culturally and linguistically appropriate services in the health care industry lead a new component to incorporate in the health care system: **culturally and linguistically appropriate health care** (commonly referred to as cultural competency).

### *What is cultural competence in health care?*

Cultural competence in health care is the promotion, assurance, administration, and measurement of culturally-sensitive and linguistically-appropriate health care services to Whites as well as racial and ethnic minorities. The Department of Health and Human Services, Office of Minority Health, however, offers a more comprehensive definition:

*Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language,*

*thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.*

Although a relatively new concept, cultural competency is championed as a feasible strategy to equitably administer diagnostic-, preventive-, and treatment related services to diverse populations. However, defining and establishing standards to measure and ensure culturally and linguistically appropriate services can be challenging. The U.S. Department of Health and Human Services, Office of Minority Health (OMH), in collaboration with Resources for Cross Cultural Health Care (RCCHC) and the Center for the Advancement of Health, developed a set of 14 national standards for culturally and linguistically appropriate services (CLAS) in health care. (The full list of CLAS standards are listed in Appendix I).

### *The Promise of CLAS*

Because cultural and linguistic competence in health care is a new discipline, conclusive evidence of a direct link between adherence to CLAS standards and improved health outcomes among racial and ethnic minorities does not yet exist. However, there are sound reasons to believe that upholding the standards of culturally and linguistically appropriate services will play an integral role in reducing differences in health care treatment – and therefore reduce disparities – in an increasingly diverse population.

- ◆ **When patients and physicians clearly communicate, the patient-provider relationship is strengthened.** Adhering to the CLAS standards may help establish important communication networks in cross-cultural health care settings. Healthy patient-provider relationships result in favorable health care experiences and an increased likelihood in adherence to medical advice. This may lead to improved health outcomes and, as a result, a reduction in health care needs and services.
- ◆ **Ensuring cultural competency among providers and other health care staff through the CLAS standards has the potential to debunk some of the myths providers and health industry staff hold about some racial and ethnic minority Americans and afford increased effectiveness in the health care treatment in cross-cultural situations.** Many physicians subconsciously attribute negative characteristics to racial and ethnic minorities' intellectual capability, lifestyle choices and likelihood of following medical advice. Because the providers' perceptions of a patient likely play a role in affecting the quality of health care that patient receives, biases likely contribute to some of the racial and ethnic differences in some health care services.
- ◆ **Increasing the diversity in the health care industry workforce could increase the proportion of racial and ethnic minority Americans who interact with, provide care to, and make health care-related decisions about an increasing number of racial and ethnic minority patients.** While no study confirms or even suggests that whites are incapable of communicating with or providing care to people of color, studies do suggest that minority Americans – perhaps because of racial and ethnic commonality – are more comfortable and report more favorable experiences receiving health care counsel and services from other minority Americans. Additionally, because cultural competence is extraordinarily difficult to teach, a health care provider, administrator or technician of a racial and ethnic minority background likely

will be better equipped and feel a more personal incentive than whites to ensure that they are providing culturally and linguistically appropriate health care. Adhering to the CLAS standards related to increasing diversity through efforts that attract, retain and promote racial and ethnic minorities in all facets of health care may bolster the cultural and linguistic competence of health care staff members and help reduce health disparities.

### **Employer Initiatives to Support the CLAS Standards**

While the CLAS guidelines established by U.S. Department of Health and Human Services, Office of Minority Health focus heavily on ensuring the quality of culturally and linguistically competent health care at the service level, there is a role for large employers and health plans to assume to ensure that the CLAS standards are upheld.

### **Health Plans Ensuring CLAS Standards**

Some health plans have implemented programs according to the CLAS standards.

- ◆ One health plan developed an innovative cultural competency model to ensure that CLAS standards and guidelines were followed. The model included introducing CLAS-adherent techniques singly and in combination – such as providing interpreter services as well as education about cultural health beliefs and practices – as a means to modify the manner in which health care providers, administrators and technicians interacted with racial and ethnic minority patients.

Other plans strive to adhere to the CLAS standards by working to ensure that the physicians covered in their networks represent a diversity of racial and ethnic backgrounds.

- ◆ In an effort to promote and retain the racial and ethnic minority physicians in their network, one national health plan annually develops and disseminates calendars that showcase a total of 12 providers' professional accomplishments and contributions to ensuring culturally competent health care.
- ◆ One health care organization established a partnership with a historically black college and launched a scholarship program in an effort to increase diversity in the medical profession by increasing the number of African Americans who pursue careers as care providers.
- ◆ Recognizing the dearth of nurses of racial and ethnic minority backgrounds, another health plan worked closely with a national nursing advocacy organization to establish scholarships to encourage more men and women of color to pursue careers in nursing.

CLAS-adherent efforts that other plans recently have undertaken include the following:

- ◆ Some health plans developed and disseminated culturally and linguistically competent health information. These materials not only were made available in Spanish as well as the common languages preferred by some Asian Americans, but also included pictures of diverse populations in culturally sensitive scenarios.
- ◆ Other health care organizations, in an effort to develop and disseminate culturally competent information on healthy eating, included culturally

appropriate recipes for different audiences of racial and ethnic minorities. The materials developed for an African-American audience, for example, included healthy versions of recipes for traditional soul foods and the materials intended for a Latino audience included healthy alternatives to preparing common dishes eaten by members of this community.

### *Other Large Employers' Strategies to Ensure CLAS Standards*

Large employers have a vested interest in working to uphold CLAS standards, particularly if these standards are a possible vehicle to reduce health disparities. A reduction in racial and ethnic differences in diagnostic-, preventive-, and treatment-related health care services may translate into a reduction in possible direct and indirect health care expenditures.

While some large employers are convinced by evidence documenting racial and ethnic health disparities and understand that they theoretically could leverage their resources as health care purchasers to effect changes in the health care system, few actually engage in efforts to accomplish this.<sup>56</sup> Many large employers struggle to identify feasible solutions to this complicated challenge and indicate that they would reward health plans that ensure CLAS standards, but lack adequate quality measurement tools to determine differences in the quality of health care. However, as evidence of racial and ethnic health disparities continue to emerge, increasing weight likely will be placed on the feasibility of ensuring CLAS standards as an effective means to reduce these disparities. Presumably, an increasing number of large employers – as the major purchasers of health care – will begin to consider that the health- and cost-savings of ensuring CLAS standards outweigh the health and cost repercussions of not ensuring them.

### **Conclusion**

Culturally and linguistically appropriate health care services – and the standards that the U.S. Department of Health and Human Services OMH established to ensure and measure such services – is an innovative approach to surmounting the challenges posed by health disparities. The comprehensiveness of the CLAS standards affords all stakeholders in this issue – from health care consumers and providers, to administrators and purchasers – an opportunity to identify where and how to play a role in ensuring that the health care system affords culturally and linguistically appropriate services and treatments. Additionally, CLAS guidelines are particularly relevant to health care purchasers because they focus on strategies to ensure the provision of services *after* patients of diverse backgrounds access the health care system. This latter point is especially useful for large employers who may want to consider using the CLAS guidelines as a foundation from which to develop and implement strategies to reduce health disparities among their workforces.

## Appendix I: The Standards of Culturally and Linguistically Appropriate Services (CLAS) of Health Care

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The U.S. Department of Health and Human Services, Office of Minority Health, developed fourteen standards of culturally and linguistically appropriate services (CLAS) of health care. To ensure that the systemic linguistic and cultural inadequacies in the health care system are being addressed, the 14 CLAS standards that fall into three main categories: 1) culturally competent care; 2) language access services; and 3) organizational support for cultural competency.

### Standards for Culturally Competent Care

#### *Standard #1:*

Health care organizations should work to ensure that their staffs – physicians, nurses, technicians and administrative support – provide patients of all racial and ethnic backgrounds respectful, understandable and effective care that is compatible with the patient’s cultural health beliefs and practices as well as preferred language.

#### *Standard #2:*

Health care organizations should launch initiatives to recruit, retain and promote – at all organizational levels – staff and leadership with diversity that is representative of the service area.

#### *Standard #3:*

Health care organizations should ensure that they provide all members of their staff with consistent, ongoing training and education in culturally and linguistically appropriate service delivery.

### Standards for Language Access Services

#### *Standard #4:*

Health care organizations should offer and provide language assistance services, which include bilingual staff and interpreters, to all patients with limited English proficiency at all stages of their interaction with the health care system. Additionally, these services should be free of charge and provided in a timely manner during all hours of operation.

#### *Standard #5:*

Health care organizations should provide patients, in their preferred language, with verbal and written offers, notifying them of their right to receive language assistance services.

#### *Standard #6:*

Health care organizations, rather than rely on a patient’s friend or family for interpretation services, should instead ensure that their bilingual and interpreter staff members are linguistically competent enough to communicate clearly and appropriately with patients with limited English proficiency.

#### *Standard #7:*

All materials disseminated by health care organizations to patients with limited English proficiency – from health education materials to posted information – should be made available in an easily-understood, linguistically-appropriate manner to commonly encountered groups or those represented in the service area.

## Standards for Organizational Support for Cultural Competency

### **Standard #8:**

Health care organizations, to ensure the consistent provision of culturally and linguistically appropriate services, should conceptualize, write, implement and promote a strategic plan that clearly outlines specific goals, policies, operational plans, management accountability and oversight mechanisms that cumulatively serve as a means to this end.

### **Standard #9:**

Health care organizations should conduct ongoing organizational self-assessments of CLAS-related activities and incorporate CLAS measures into their performance improvement programs, internal audits, patient satisfaction assessments and outcomes-based evaluations.

### **Standard #10:**

Health care organizations should implement and update systems to collect data on patients' race, ethnicity and spoken and written language preferences in health records, and organizational management information systems.

### **Standard #11:**

Current demographic, epidemiological and cultural profiles of the communities served as well as a needs assessment plan to provide culturally and linguistically appropriate services to meet the needs of the communities served should be maintained by health care organizations.

### **Standard #12:**

Collaborative partnerships between health care organization and communities should be established to use formal and informal mechanisms to encourage community and patient involvement in the development and implementation of CLAS-related initiatives.

### **Standard #13:**

Health care organizations should ensure that conflict and grievance processes are culturally and linguistically appropriate and fully able to identify, prevent and resolve cross-cultural complaints by a diversity of patients.

### **Standard #14:**

Information on their progress in ensuring culturally and linguistically appropriate services as well as innovative strategies to adhere to CLAS-related standards should be made available by health care organizations to the public. Additionally, health care organizations should inform the public on how they can access this information.

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**Written by:**

Britt Weinstock, MA, Manager of the Center for Prevention and Health Services at the National Business Group on Health.

**About the Health Disparities Initiative**

In response to research documenting racial and ethnic disparities in health and health care, the National Business Group on Health launched the Health Disparities Initiative in 2001. Through multiple components, the Initiative will raise awareness about this critical health issue among large employers, identify the incentives for large employers to leverage their resources as purchasers to affect changes in the way health care services are delivered among diverse populations, and propose practical, innovative solutions that large employers can consider implementing to help reduce health disparities.

For more information, visit <http://www.wbgh.org/programs/cphs/disparities> or contact Britt Weinstock at [weinstock@wbgh.org](mailto:weinstock@wbgh.org).

**About the National Business Group on Health**

The National Business Group on Health (formerly known as the Washington Business Group on Health) is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The Business Group represents 175 members, primarily fortune 500 companies and large public sector employers, who provide health coverage for more than 40 million U.S. workers, retirees, and their families. The Business Group fosters the development of a quality health care delivery system and treatments based on scientific evidence of effectiveness. The Business Group works with other organizations to promote patient safety and expand the use of technology assessment to ensure access to superior new technology and the elimination of ineffective technology.

For more information on the Business Group, visit <http://www.wbgh.org>.