

## National Scan of CLAS and Disparities Reduction Activities

### Abstract

Little progress has been made to close the gaps in the quality of health care delivered to racial, ethnic and linguistic minorities. Recent legislation invests in cultural and linguistic competence and the elimination of disparities, with increased funding for technical assistance, research and dissemination. Now is the time to identify opportunities to reduce disparities. Here, we examined and catalogued national efforts, and we describe activities and their funding, focus, target audience, scope and impact. We also identify opportunities for greater progress and potential influence, including provisions in recent health reform bills.

### Background

Racial and ethnic disparities exist across all regions of the country, among the insured and the uninsured, and across multiple diseases and health care services. Despite efforts to close the gaps in the quality of health care delivered to racial, ethnic and linguistic minorities, little progress has been made.<sup>1-5</sup> Over the past six years, disparities between minority populations and Whites decreased on less than half of the quality measures studied in the annual *National Healthcare Disparities Report (NHDR)*.<sup>6</sup> The report noted that disparities persist in health care quality and access, across multiple priority populations, although their pattern and magnitude differs in subpopulations.

Demographic changes in the United States will increase the urgency of addressing health disparities. The Census Bureau projects that the non-Hispanic White population will decline steadily to comprise less than 50 percent of the total population by 2050, while the populations of Hispanics, Asians and Pacific Islanders will increase.<sup>7</sup> Disparities also contribute to the nation's rising health care costs. Waidman estimated that \$23.9 billion would have been saved in 2009 if minority health equaled that of Whites.<sup>7</sup> LaVeist et al estimated that over three years, the direct medical costs associated with health disparities amounted to \$229.4 billion. When indirect costs were added, the three-year total increased to \$1.24 trillion.<sup>8</sup>

Over the past decade, national reports have highlighted equity as a value for the health care system and called attention to the needs of our increasingly multicultural population. The Institute of Medicine's (IOM) two influential reports on quality and disparities (*Crossing the Quality Chasm: A New Health System for the Twenty-first Century*<sup>9</sup> and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*<sup>3</sup>) identified equity as one of the six domains of health care quality, and detailed the evidence of pervasive disparities in health care, even after controlling for differences in insurance and socioeconomic status.

The U.S. Department of Health and Human Services (DHHS) in 2000 addressed language needs and cultural competency through several policy actions. The DHHS Office of Minority Health (OMH) issued standards for culturally and linguistically appropriate services (CLAS);<sup>10</sup> DHHS issued policy guidance on language access requirements under Title VI of the Civil Rights Act<sup>11,12</sup> and made the elimination of health disparities an overarching goal of the Healthy People 2010 initiative.<sup>13</sup> The National Institutes of Health established the National Center on Minority Health and Health Disparities.<sup>14</sup> Since 2003, the Agency for Healthcare Research and Quality's (AHRQ) annual reports have tracked quality and disparities.<sup>2,4,15</sup> Still, for years there has been little federal effort to implement IOM recommendations.

Recent actions by the federal government and by an increasing number of states, suggest that at least awareness of the problem is growing. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008,<sup>16</sup> the Children’s Health Insurance Program Reauthorization Act (CHIPRA)<sup>17</sup> and the Health Information Technology and Clinical Health Act (HITECH) of 2009<sup>18</sup> contain multiple provisions addressing cultural and linguistic competence and health care disparities. The recently enacted Patient Protection and Affordable Care Act (HR. 3590) also addresses these issues, including collection and analyses of race, ethnicity and language data; national strategies for quality improvement (which include disparities reduction); and health workforce development for under-represented minorities. The enactment of the American Recovery and Reinvestment Act (ARRA), CHIPRA and the Office of the National Coordinator of Health Information Technology (HIT) provisions regarding “meaningful use” of HIT may signal the start of a more active federal role.

As these laws are implemented, accompanied by increased funding for technical assistance, research and dissemination, we must identify the greatest opportunities to reduce disparities. The objective of this report is to catalog current, national-level activities to reduce health care disparities and identify gaps and opportunities to accelerate progress in closing the quality chasm. Throughout this paper, the term “health care disparities” is intended to convey both the differences in health care services based on racial, ethnic or linguistic differences and the failure to deliver culturally and linguistically appropriate services.

## **Methods**

We conducted an Internet search of existing activities to reduce health care disparities, and interviewed experts in language access, cultural competence and disparities for their perspectives about challenges and opportunities.

We sought national-level activities using combinations of the following search terms: health care, cultural competency, language access, disparities, equity, culturally and linguistically appropriate services, multicultural, minority, underserved, vulnerable populations.

To keep our search manageable and focused on efforts with the potential for national effect, we excluded activities with a disease-specific, population-specific or organization-specific focus; activities regarding social determinants of health disparities; and activities focused on research that did not have an immediate action or implementation aim. We classified activities based on strategy, target audience, topic and funding source. We asked implementing organizations to review our information for accuracy. Iterative reviews by disparities experts identified missing activities and helped classify them.

## **Findings**

### **Description and Distribution of Activities**

We included 74 national activities whose characteristics are summarized in Exhibit 1. Full findings are available in Appendix 1.

### **Strategy**

Much of the activity focused on data collection and research or training and education. Few national activities addressed partnership and community building, implementation of CLAS or disparity-reduction practices, or institutionalization of such practices through systems of accountability. Seven activities developed standards of performance, including standards for collection of race, ethnicity and

language data in health care; certification of medical interpreters; and advancing effective communication, cultural competence and patient-centered care in various health care settings.

We found eight activities designed to institutionalize effective practices through systems of accountability. Three of these are recently-enacted legislation, and only one—the National Business Coalition on Health’s (NBCH) *eValue8* tool, which purchasers use when selecting health plans—was fully implemented. The disparities-related provisions of the new legislation and the *eValue8* tool are relatively minor components of larger efforts, and the disparities-focused accountability activities are all new or still developing.

### **Audience**

Activities targeted all audiences, but the majority of activities targeted health care delivery organizations. Many activities targeted health plans, health care professionals, researchers and policy-makers. Among clinicians, most activities targeted physicians rather than nurses or other staff. Only 10 activities targeted purchasers and 9 targeted consumers.

### **Topic**

Over half the activities focused on measuring or reducing disparities, improving language access or cultural competency. Many also addressed data collection. Fewer activities addressed access or workforce diversity.

### **Funding**

Most of the activities were conducted by private entities and funded through grants from a few private foundations.

### **Analysis**

Based on our review and interviews, we observed three key themes.

- 1. There is increasing awareness of disparities but limited commitment of resources**
- 2. Leadership in disparities efforts is diffuse and efforts are fragmented**
- 3. Key stakeholders are largely absent from the conversation**

### **Increasing Awareness, Limited Commitment**

A number of activities undertaken in recent years are now reaching fruition.<sup>19,20,21,22</sup> Health care stakeholders are becoming more aware of disparities. Our scan found a significant number of national activities that involved different stakeholders, but commitment of resources to national activities has been limited. There have been federal efforts: the 40 local Racial and Ethnic Approaches to Community Health (REACH) 2010 projects; the requirement to address health care disparities or the provision of CLAS in the 2003 Medicare+Choice Quality Assessment and Performance Improvement (QAPI) project; and the development of cultural competency training modules for physicians, nurses and emergency responders.<sup>23,24</sup> But the government’s role has been largely passive and sporadic, offering training and some demonstration grants, but little ongoing financing.

Our scan found few national collaborative efforts, and all but one were privately funded. Many activities were supported by a small number of private foundations, a financing model that is not sustainable.

Other research documents the limited progress among employers, hospitals, community health centers and physicians, in providing CLAS and reducing disparities. Two national health care purchasing coalitions have engaged in efforts to address disparities, with limited uptake by their members.<sup>25,26</sup> The

National Business Group on Health (NBGH) has tried to inform and motivate employers about health care disparities.<sup>26</sup> Many purchasers do not fully recognize disparities as a problem, and many cannot make a business case for action.<sup>27</sup> The NBGH surveyed its members twice (2003, 2008) about health care disparities.<sup>26,28,29</sup> The surveys were not directly comparable, but showed that the level of concern about health care disparities remains very low, though it is increasing.<sup>28,29</sup> The 2008 survey reported that 97 percent of respondents addressed diversity in hiring and employment, but 70 percent were not aware of company strategies to reduce health care disparities and only 33 percent rated reducing disparities as “very important.”

Employers appear less likely to dismiss disparities as unimportant, but greater awareness of the issue has not resulted in a corresponding change in behavior. This is also true, to some extent, for health plans and health care delivery organizations. Many of our informants felt that to gain visibility, the reduction of disparities should be tied to more pressing concerns, such as health care cost.

Nationally, health plans are overwhelmingly aware of health care disparities, but only about half are working to address them.<sup>27</sup> America’s Health Insurance Plans (AHIP), the national trade association for health plans, has conducted research and education on disparities and recently assumed responsibility for the National Health Plan Collaborative, whose aim is to develop tools and resources to aid health plans in addressing disparities.<sup>30</sup> Since 2006, The National Committee for Quality Assurance has issued annual awards to health plans for innovations in multicultural health care<sup>31</sup> and other organizations have sought to stimulate and catalog health plan efforts to improve CLAS and reduce health care disparities.<sup>32,33</sup> But even with national-level efforts targeting health plans, only half of health plans collect data on member race and ethnicity. 41 percent of plans use data to analyze clinical performance by race and ethnicity, and only 27 percent use race and ethnicity data to analyze patient satisfaction.<sup>27</sup>

Although some health plans have implemented best practices to address disparities,<sup>34</sup> physicians lag in their attention to the issue.<sup>5</sup> Reschovsky reports that of physicians with patients who speak languages other than English, just over half provide some interpreter services, and only 40 percent provide patient materials in other languages or received training in minority health.

While many hospitals—particularly public hospitals—are aware of the persistence of health care disparities and the need for CLAS for their diverse patients, there have been few coordinated activities at the national level. Several national hospital organizations have issued conceptual frameworks for addressing these issues.<sup>35,36</sup> Many hospitals have made significant strides in improving their language services and addressing disparities, but even among the leaders, there is room for improvement.<sup>37-39</sup> Some of the most significant gains in CLAS have been spearheaded at the state level; for example, in California.<sup>40-42</sup>

Community health centers often see diverse patients, yet relatively few of their activities focus specifically on disparities reduction.<sup>43-45</sup>

### **Diffuse Leadership and Fragmented Efforts**

The scan found a multitude of independent activities, but with a few exceptions, the activities are uncoordinated. The federal government has not provided strategic leadership or a comprehensive approach to the problem. There were a few national collaborative activities, such as the National Health Plan Collaborative, initiated by the Center for Health Care Strategies and now sponsored by AHIP; the Health Resources and Services Administration (HRSA) Community Health Center Collaboratives; and the Robert Wood Johnson Foundation’s major effort, Aligning Forces For Quality. These collaborative activities raise the profile and usefulness of activities that would otherwise happen on a private, state or

local scale, providing vehicles for spreading lessons learned across a larger number of participants and bringing national visibility. But they are limited in number, and only one is government sponsored.

Consistent with our findings about the fragmentation of activity, we discovered significant specialization. With the notable exception of the national collaborative activities, both research and practice tended to focus on fewer, more narrowly focused strategies. Activities to reduce disparities were conducted primarily by health plans, providers and trade associations, which also provided cultural competence training and activities to improve language access. Language professionals and consumer advocates engaged in language access and service quality efforts. Training and educational activities addressed a range of issues, from disparities, to language, to cultural competence. The issue of cultural competence was addressed almost exclusively through training and educational activities.

In addition to specialization, there is fragmentation among disciplines. Saha, Beach et al have written about the different origins of the cultural competency and patient-centered care movements, describing significant areas of overlap and areas of concern unique to each.<sup>46,47</sup> They recommend collaboration between these two fields while maintaining the important features of each movement. Many experts we interviewed suggested the potential for reducing disparities by implementing more patient-centered care principles, specifically in “medical homes.”

Several experts remarked that our scan omitted health literacy activities. Health literacy as a field has grown independently of other language services, such as interpretation and translation services, despite its relevance to cultural and linguistic minorities. Our scan failed to identify any health literacy activities, reinforcing our finding of fragmentation and specialization.

### **Absent Stakeholders**

Health care purchaser concerns about disparities have grown, but continue to lag.<sup>28,29,48</sup> Rosenthal et al report that while nearly half of employers believe they can affect health plan efforts to reduce disparities, only 3 percent considered such efforts when selecting health plans or analyzed health plan performance by race or ethnicity. Although NBCH provides the *eValue8* common request for information (RFI) to its members, and the NBGH has been engaged in a multiyear effort to raise member awareness of opportunities to reduce disparities, relatively few purchasers have prioritized disparities issues in a way that leverages significant response from health plans.

Our scan found that consumers were largely absent from the discussion of health care disparities. They are not significant actors in activities to reduce disparities, nor are they targets of information campaigns about the issue. Consumer engagement is extremely limited, except for certain advocacy organizations, most prominent in California. Some national consumer advocacy organizations have addressed disparities, but this typically takes a back seat to other issues.

### **Explanation of Findings**

There are a number of possible explanations for our findings. Findings may reflect a normal development process for the nature and magnitude of change contemplated. The different geographic, racial, ethnic and linguistic identification of the population of interest may create barriers to developing a powerful, unified interest group. Variation in the geographic distribution of minority groups may argue in favor of local solutions rather than national. And the challenge of making a business case for health care quality may impede efforts to address this specific dimension of quality.

The business case for quality overall must precede the justification for one dimension of quality. Given the continuing challenge to make a persuasive business case for quality generally, it is not surprising that many stakeholders—especially health care administrators and purchasers—ask for it for CLAS and disparities reduction.<sup>49-52</sup> While there is emerging evidence of the cost of inaction on issues of disparity, we need more research and development of a stronger business case for investments in "equitable" and "patient-centered care."<sup>7,8</sup> The recently enacted health care reform legislation and its additional support for the development of medical homes and accountable health care organizations will contribute to evidence that quality, equity and patient-centered care can be appropriate business-driven goals for our health care system.

### **Limitations of methods**

Some findings reflect methodological limitations. Our selection of national activities excluded local activities and national health plan or health system activities, which may be more directed to consumers or more focused on implementing change than the national activities included in the scan. There are hundreds—perhaps thousands—of activities underway in communities, hospitals and health plans, with the broad focus of improving care to disadvantaged populations, or with the narrower focus of improving quality and usability of translated documents or reducing disparities in care for a specific condition or population subgroup. Activities are underway to address the social determinants of disparate health outcomes. While the activities are excluded from our scan, they are important indicators of the growing concern about health care disparities.

### **Policy Implications and Opportunities**

Public and private sector efforts are needed to coordinate and sustain activities for improving cultural competence and reducing disparities, particularly as health care reform provisions are implemented.

The federal government should use its legislative authority to focus on disparities. OMH's authority should be strengthened, and the Director should be elevated to Assistant Secretary for Minority Health, with responsibility for coordinating federal disparity-reduction efforts. Enforcement of Title VI antidiscrimination provisions can support better access to language services, and use of a standardized approach for race, ethnicity and language data collection consistent with Office of Management & Budget requirements will allow more complete and coordinated data collection within federal agencies. Implementation of MIPPA provisions to require compliance with the OMH standards for CLAS in Medicare Advantage plans will encourage faster adoption and set a model for implementation in the private sector.

The availability of billions of dollars in federal funding under the HITECH Act will catalyze unprecedented, widespread adoption of HIT over the next five years and an equally unprecedented opportunity to implement recent recommendations for collection and use of race, ethnicity and language data. With improved HIT capabilities, health care providers and systems will have new opportunities to collect, analyze and act on the data needed to reduce disparities. For example, proposed regulations for federal funding require collection of race, ethnicity and language data on 80 percent of the patients that an eligible health care provider serves, and require that such data be included and considered in quality improvement activities.<sup>53</sup> Knowing the language needs of at least 80 percent of patients will result in better planning of language assistance services and improved language access.

Stratifying quality and outcome data by race and ethnicity will allow focus on health care disparities and development and implementation of targeted interventions to reduce them. Unlike one-time or externally

funded activities, HIT-enabled capabilities that are built into the routine operations and ongoing quality improvement activities of hospitals and clinicians will ensure their sustainability and institutionalization. HIT extension centers should provide tools and supports for disparities reduction and cultural competence.

Across the country, efforts to reform the health care delivery system are underway, with patient-centered medical home demonstrations in numerous states, to new delivery system demonstrations authorized under the Patient Protection and Affordable Care Act. These demonstrations must consider multicultural populations as part of adapting to patient and family needs. Redesign activities should focus on areas with the greatest minority populations and align incentives so that health care providers serving minority populations are not disadvantaged. Incorporation of disparities reduction and CLAS into broader quality improvement activities at community health centers may be a promising strategy.

Efforts must convene diverse stakeholders to coordinated goals, rather than competing programs. The National Priorities Partnership (NPP), a coalition of leading stakeholders and organizations that joined to establish priorities in health quality measurement and improvement, is a model of this type of collaboration among stakeholders with competing interests and common goals. In particular, a similar model could be used to educate consumers about disparities and motivate action. It is also important to leverage recent research demonstrating the cost of disparities to make the case for purchasers, regulators and policy makers.<sup>7,8</sup>

Moreover, equity should be recognized as a crosscutting goal in each of the NPP's six priority areas—patient engagement, overuse, palliative care, care coordination, safety and population health. As we monitor progress on these priorities, it is critical to evaluate whether gains are shared across vulnerable populations.

## **Conclusions**

There are many potential sources of leverage, but sustained investment in quality improvement and practice transformation, together with increased engagement of the federal government, purchasers and consumers, will ultimately be necessary to effect significant progress in reducing health care disparities. Investment and engagement depend on demonstrating the link between disparities and stakeholder priorities, a challenge for continued research and communication. There are significant opportunities to learn from local activities by bringing them under the umbrella of a collaborative learning group.

The consumer voice is fragmented by individual racial, ethnic, linguistic and immigration status groups and interests. Each group may have its own advocacy channels, consistent with the fragmentation of other stakeholders. While some organizations play an important role in pressing for increased government and private sector action, few have been able to form the strategic partnerships that would ensure their effectiveness. One promising model for a strategic partnership that can leverage change is the National HIT Collaborative for the Underserved, a partnership of Summit Health Institute for Research and Education, OMH, Healthcare Information and Management Systems Society (HIMSS) Foundation's Institute for E-health Policy and other stakeholders.<sup>54</sup>

As evidence of the problem of health care disparities and the feasibility of potential solutions matures, strategies will naturally shift from exploration and gathering information to strategies for implementing, and then institutionalizing, effective change.

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