

# Reducing Health Care Disparities: Where Are We Now?

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For many years, the Robert Wood Johnson Foundation (RWJF) has been committed to finding and promoting ways to reduce racial and ethnic disparities. This issue brief gives a general overview of how the field of *health care disparities* has evolved in recent years to identify emerging perspectives, progress and current activity, and outstanding needs. The paper focuses specifically on health care disparities, while recognizing that these are obviously also intertwined with broader efforts to reduce health disparities.

Two major sources of information were used in developing this environmental scan. The first source involved a web-based search for recent literature and ongoing organizational work on this topic. The second source of information was from hour-long telephone interviews with a diverse set of eight key informants, who provided a spectrum of insights into different aspects of disparities work. Interviewees were nationally known policy-makers, researchers, and stakeholders who brought diverse perspectives to the work on disparities. (For additional information on methods, see page 6.)

## Relevance of the Issue and Stakeholder Engagement

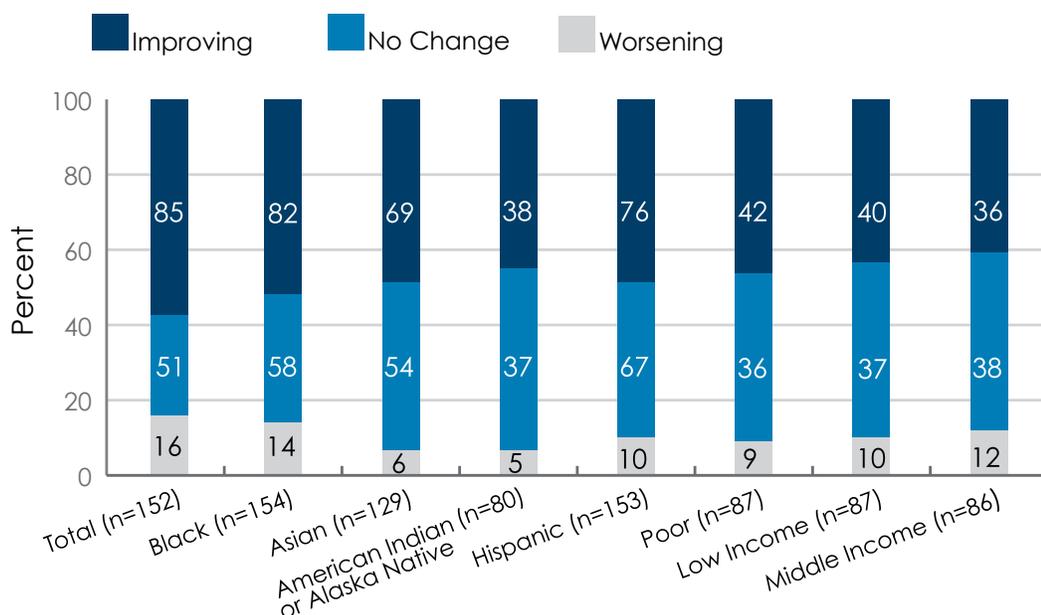
### *Disparities in Health Care Outcomes Persist*

The 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* remains a landmark reference source that raised awareness of health care disparities and the need to reduce them.<sup>1</sup> The IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care defined these disparities as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.” The report found that “racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled.”

In 2013, the U.S. Department of Health and Human Services (HHS) released its 10<sup>th</sup> annual report on this topic.<sup>2</sup> The National Healthcare Disparities Report (NHDR) includes an integrated highlights section (used in this report and also in the National Healthcare Quality Report (NHQR)),<sup>3</sup> which concluded: “health care quality and access are suboptimal, especially for minority and low-income groups.”

While the report reviews results on many types of metrics, the analysis emphasizes results for a subset of summary quality measures, compared across major racial/ethnic and income groups on a longitudinal basis. The findings show that, while overall quality is improving, access is worse and there has been no improvement in lessening disparities (Exhibit 1, page 2).

**Exhibit 1. Number and Proportion of All Quality Measures that Are Improving, Not Changing, or Worsening, Overall and for Select Populations**



**Source:** Agency for Healthcare Research and Quality. *National Healthcare Disparities Report 2012.*

**Note:** For each measure, the earliest and most recent data available to our team were analyzed; for the vast majority of measures, this represents trend data from 2000–2002 to 2008–2010.

**Key:** n = number of measures

**Improving** = Quality is going in a positive direction at an average annual rate of greater than 1% per year.

**No Change** = Quality is not changing or is changing at an average annual rate of less than 1% per year.

**Worsening** = Quality is going in a negative direction at an average annual rate of greater than 1% per year.

### *Reducing Health Care Disparities to Achieve More Equitable Health Care Outcomes Remains a Goal of U.S. Public Policy*

In its review of where disparities fit into its five-year strategic plan,<sup>4</sup> HHS identifies three specific goals:

- **Achieve health equity** as outlined in the HHS Action Plan (discussed below) and through actions that help better link patients to a usual primary care source, increase the number of patient-centered medical homes (PCMHs), and enhance support for community health centers.
- **Ensure access to quality, culturally-competent care for vulnerable populations** by improving the cultural competency and diversity of the health care workforce and addressing disparities in access to care.
- **Improve data collection and measurement** of health data by race, ethnicity, sex, primary language, and disability status, as well as other efforts in planning for the collection of additional data.

In 2011, HHS released its *Action Plan to Reduce Racial and Ethnic Health Disparities* under the leadership of the Office of Minority Health.<sup>5</sup> Its vision is a “nation free of disparities in health and health care.” Overarching secretarial priorities involve heightening the impact of all HHS actions to achieve this goal, particularly by improving the availability, quality, and use of data; measuring disparities in health care; and providing incentives to improve health care for minorities. Concurrent with the release of the Action Plan, HHS also released a national stakeholder strategy to reduce disparities, developed through the National Partnership for Action to End Health Disparities, which it helped convene.<sup>6</sup>

### *More Tools Now Exist to Support Measuring Disparities and Undertaking Interventions*

**Enhanced capacity for subgroup analysis.** In response to the limitations in available national data for monitoring race and ethnic disparities in health care as well as new Affordable Care Act (ACA) requirements in this area, on October 31, 2011, HHS released new, refined standards for capturing race, ethnicity, sex, and primary language or disability in individual person-level surveys.<sup>7</sup> The standards for demographic data apply to HHS-sponsored surveys

in which respondents (knowledgeable informants) self-report information. While such standards do not apply to administrative data, providers have additional incentives to collect such data if they want to receive Medicare and Medicaid incentive payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Stage 1 requirements in place since 2010 include, among the core standards, recording patient demographics as structured data. Such demographics need to include preferred language, gender, race, ethnicity, and date of birth.

***New metrics exist for assessing cultural competency and language services.*** New consensus metrics are beginning to become available for assessing whether training and other developments are generating changes in the availability of those culturally-competent care and language services viewed as critical to reducing disparities in health care. The National Quality Forum (NQF) is a public-private partnership that works on a consensus basis across stakeholders to agree on appropriate measures for endorsement. In 2012, NQF issued its first endorsements specifically addressing health care disparities and cultural competency. After several years of work, the panel endorsed 12 of the 16 measures under consideration.<sup>8</sup> These standards cover areas such as office practice communications infrastructure, patient reports on health literacy and cultural competency, patient receipt of language services, and implementation of cultural competency standards. HHS continues to work with its partners on the implementation of policy and practice standards regarding culturally and linguistically appropriate services (CLAS). The National Committee for Quality Assurance (NCQA), a national nonprofit organization that works extensively in the area of health care quality, has developed voluntary accreditation standards for CLAS that include the collection and use of race, ethnicity, and language data.<sup>9</sup>

### *Stakeholders Are Working to Support Better Capturing of Data Required to Assess Health Care Disparities*

***Hospitals.*** In 2007, the Health Research and Educational Trust (HRET) released a toolkit that hospitals can use to collect race, ethnicity, and language data on their patients. The American Hospital Association (AHA) platform for performance improvement is “Hospitals in Pursuit of Excellence,” or HPOE, formed in 2011. An AHA national survey showed that only 18 percent of hospitals in 2011 were collecting race, ethnicity, and language data at the first patient encounter, even though these data are needed to assess gaps in care. Under HPOE, a coalition of organizations—AHA, the Association of American Medical Colleges, the Catholic Health Association of the United States, the American College of Healthcare Executives, and America’s Essential Hospitals (formerly the National Association of Public Hospitals and Health Systems)—are working together with the goal of increasing the collection of race, ethnicity, and language data (REAL) from a baseline of 18 percent (2011) to 75 percent (2020); increasing cultural competence training from a baseline of 81 percent (2011) to 100 percent (2020); and increasing diversity in governance and leadership from 14 percent and 11 percent, respectively, at the baseline (2011) to 20 percent and 17 percent (or reflective of community served), respectively (2020). In August 2013, HPOE released an Equity of Care document aimed at helping hospitals and health systems improve the way they collect and use race, ethnicity, and language data.

***Physicians.*** The American Medical Association (AMA) Commission to End Health Disparities—which first formed in 2004 in collaboration with the National Medical Association and was joined by the Hispanic Medical Association soon afterward—is working to encourage physicians to be concerned with health care disparities. According to its most recent strategic plan, the group has 71 affiliated organizations.<sup>10</sup> Its focus is to educate health professionals on disparities and cultural competency, increase the diversity of the workforce, advance policy and advocacy initiatives in this area, and improve data collection and research to identify and eliminate disparities. The work appears to be a member-led activity, with an agenda that is broad, although not highly resourced.

***Health plans.*** Health plan work centers most visibly around the National Health Plan Collaborative (NHPC). It began with nine large national and regional firms in the industry, whose efforts were co-sponsored by the Agency for Healthcare Research and Quality (AHRQ) and RWJF from 2004 to 2008. The NHPC has been based within America’s Health Insurance Plans (AHIP) since its external funding support ended. As with providers, data collection to identify, monitor, and track progress on health care disparities is an ongoing challenge. While such data collection practices are not tracked routinely, AHIP, with the support of RWJF, has surveyed its members to identify the status and trends of such data collection. The most recent results from a 2010 survey have been profiled to highlight both accomplishments and ongoing challenges.<sup>11</sup>

## Gauging Progress and Accomplishments

### *Continued Relevance of Capturing Data on Race, Ethnicity, Language, and Other Metrics*

Both interviewees and our review of the literature reinforce the ongoing relevance of data collection in seeking to reduce health care disparities. We were told by interviewees that “measurement is still very much an issue” and “this is still a BIG ISSUE.” Even those who sought progress observed that “we have a long way to go.” More progress has been made in capturing disparities data through surveys than in administrative records, including provider and health plan data.

Among the barriers to better data collection on race, ethnicity, and other factors, two appear to have particular policy relevance. First, interviewees said that collecting such data requires an organization to be committed to its pursuit. With many demands on their time and resources, providers and health plans will find the “business case” for such collection to be weaker to the extent that important customers (e.g., regulators, purchasers) do not make collection and use of such data a condition of doing business. Second, inconsistencies and the lack of operational specificity in existing tools limit the usability and quality of the data collected.

### *A Desire to Move Toward Effective Intervention*

Many of the interviewees expressed impatience with data collection that does not lead to intervention, viewing data as just one piece of an ongoing infrastructure for disparities reduction. In addition, in an increasingly multicultural society, interviewees said it is relevant to consider how refined metrics must be, given that individuals vary on so many dimensions. But they also noted that without data, it is very difficult to assess priorities or progress in reducing disparities in quality and outcomes.

Most of those interviewed felt that while more research on effective interventions could always be valuable, sufficient knowledge is available at this point to take steps to intervene effectively; they encouraged progress in this direction. The literature lends some support to this view.<sup>12</sup>

One area of tension around intervention concerns “evidence.” A number of interviewees stressed the contextual dependence of intervention design and strategy. A second issue involves assumptions about causal logic. Our interviews suggest that there is some debate regarding interventions to improve health care disparities over whether the problem is unequal treatment within a practice, or the effect race/ethnicity has on the providers’ availability and quality of care. In reality, both are probably at work.

### *Linking Disparities to Quality of Care, Delivery System Change, and Payment Policy*

Interviewees and the literature clearly link health care disparities to a quality agenda. National tracking efforts now more clearly allow for integrating analysis of quality with a disparities focus because the same metrics are used for both, and a common summary is used across the NHDR and NHQR. Interviewees noted that in delivery settings, disparities initiatives also tend to be located in quality improvement offices. Most interviewees, however, thought that the link was more theoretical than real. The main reason is because stratification of quality metrics by race and ethnicity is not central to most quality improvement or monitoring efforts.

Interviewees had a similar reaction to the role delivery system and payment policy change could have in reducing disparities. In general, interviewees were very supportive of changes in payment policy to reward better separate reporting by race or ethnicity (subject to sample size constraints) but did not see many policy initiatives that do so. Few interviewees believed that disparities were now on the radar screen of PCMHs and accountable care organizations (ACOs), for example. According to interviewees, the Centers for Medicare & Medicaid Services (CMS) is not a major player in the disparities field at this time. However, some expressed the hope that this would change and thought some internal activity might be underway that could expand interest in this area.

### *Trade-Offs Exist in Expanding the Focus of Disparities Efforts*

Our review of current activity makes clear that federal policy, and many organizations across the board, increasingly

view health care disparities broadly. HHS's strategic plan, for example, identifies many groups for attention based on race, ethnicity, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation, gender identity, geographic location, and other factors. There also appears to be a shift from the concept of disparities to one of equity. The shift provides more focus on action and social justice relevant to a wide variety of subpopulations.

Those we interviewed saw advantages in reframing the issue this way. Probably the most relevant from the perspective of race and ethnic disparities is that reframing has the potential to increase relevance and broaden population support because more people could see the relevance of equity to them. There are potential downsides, however. While most interviewees attributed to others the concerns that a broad equity agenda could diffuse the focus on particular subgroups and tax available resources, many of them also mentioned this issue.

There are some practical challenges to a broader definition of disparities, at least in monitoring and interventions. Data to define disparities are currently much more limited for some subgroups than others; LBGT and disability status data lag behind other data. Further, while many people portray a variety of characteristics, the logical chain of processes that leads to disparities based on particular characteristics is likely to differ by particular characteristic. An obvious example relates to disability, where care is challenged by potential physical and other barriers.

Among subgroups, race/ethnicity and income or socioeconomic status have the longest historical link; indeed they often are thought of as interrelated concepts. Some interviewees thought that recent ACA-related eligibility rules for coverage might enhance the availability of income data, at least at the bottom of the distribution. Others said that education could serve as a proxy. In an ACA environment, considerable interest was expressed in looking at the extent to which reduction in disparities might be associated with coverage, and what the remaining disparities might indicate about the role of other factors.

### *Perspectives on Gaps and Useful Future Work*

Those we interviewed brought different perspectives to the disparities issue. Their perspectives on gaps and future work were shaped by whether they were based mainly within a national policy, operational and local delivery, or research perspective. Suggestions for future activity often drew upon that individual's experience and organizational base, stressing areas in which support would be useful to their interests in health care disparities. Generally, interviewees tended to see four major gaps in current work.

- ***Cross-Cutting Leadership to “Connect the Dots.”*** While many initiatives are underway in the health care disparities field, interviewees felt that less attention was being paid to the broader context and logic of work to reduce health care disparities regarding how various initiatives or interventions relate to one another, and why they are important.
- ***Aligning Policy and Payment with Disparities Goals.*** While there is more attention than in the past to encourage work around disparities within the operational setting, various interviewees thought that policies stating that such work is both feasible and necessary were still limited. Such policies could be linked to requirements that providers report performance metrics by race and ethnicity. More broadly, interviewees felt that payment is needed to support sustainable interventions. For example, an initiative might pay navigators to improve care for minorities, but the intervention will not be sustainable if the payment system does not generate ongoing support to maintain such a presence after the pilot ends.
- ***Support for Building Infrastructure for Effective Local Interventions.*** Interviewees actively engaged with provider and community-based interventions felt there still was insufficient support for effectively applying local interventions in the marketplace. They also were interested in bringing greater knowledge of social determinants to effective local interventions. Some wished funders would place more emphasis on those efforts oriented toward mobilizing action versus trying to teach researchers how to translate research into action.
- ***Leveraging Opportunities of the ACA.*** With both coverage expansion and delivery reform high on the nation's radar screen as ACA implementation moves forward, some interviewees saw this general awareness as possibly leading to opportunities for focusing on work on health care disparities. For example, given that the ACA is likely to expand coverage, what will be the short- and long-term effects of such change on health care disparities? How will the ACA's expanded payments for primary care affect Medicaid beneficiaries, many of whom are minorities? Will the movement to medical homes encourage work with community organizations and focus more attention on the role of social determinants in affecting health outcomes? Another interviewee saw a need to increase the emphasis on how to implement ACA provisions to improve equity and reduce disparities by encouraging best practices.

In sum, there is a need for work both at the national policy and local care delivery levels in communities. In both cases, there is value in working to integrate disparities into a broader set of goals by encouraging measurement, priority setting, and interventions sensitive to the most vulnerable members of society. Further, community-based interventions will be more effective if they take into account both community and medically focused forces that influence health outcomes, so that the two are self-reinforcing. None of this work is easy, and all of it is likely to require a prolonged commitment.

## Methods

The project spanned a four-month period starting on August 15, 2013. The emphasis was on recent activity and perspectives related to health care disparities—generally work from around 2009. Consistent with the thrust of the work of RWJF and many previous efforts in the United States, we placed special emphasis on examining work on racial and ethnic disparities in health care, including efforts at measurement and interventions. The review sought to place this work in the context of health care disparities work in general, however, including recent efforts to broaden its scope to other population subgroups and link disparities to emerging work on quality improvement overall.

Two major sources of information were used in developing this environmental scan. The first source involved a web-based search for recent literature and ongoing organizational work on this topic. The intent was to identify seminal efforts and examples of activity underway by various key stakeholders, rather than provide an exhaustive and comprehensive review of the literature and all ongoing activity.

The second source of information was from hour-long telephone interviews with a diverse set of eight key informants, who provided a spectrum of insights into different aspects of disparities work. We identified those to be interviewed in consultation with RWJF. Interviewees were nationally known policy-makers, researchers, and stakeholders who brought diverse perspectives to the work on disparities. A semi-structured protocol, sent to interviewees in advance, guided the interviews. We told interviewees that the facts regarding their work might be shared in attributed form but the perspectives they provided would not be identified individually. All of those who were solicited agreed to participate.

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## Endnotes

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