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Eliminating Racial and Ethnic Health Disparities; *A Business Case Update for Employers*

National Business Group on Health

Contents

Introduction: The Growing Diversity of the U.S. Workforce

The U.S. Census Bureau projects that race-based minorities, including Hispanics, African Americans and Asians, which currently represent one-third of the U.S. population, will become a majority in 2042. The working-age population is projected to become more than 50 percent minority in 2039 (up from 34 percent in 2008). By 2050, the working-age population in the United States is projected to be:

- More than 30 percent Hispanic (up from 15 percent in 2008);
- 15 percent black (up from 13 percent in 2008); and
- 9.6 percent Asian (up from 5.3 percent in 2008).[1]

Employers need to be aware of these demographic shifts and to understand that in this new environment, a "one-size-fits-all" approach to employee health benefits will not be effective.

"The causes are complicated, but the results of racial and ethnic disparities in our health care system are as clear as they are unfortunate. Verizon has long been committed to diversity, so we are proud to join the National Business Group on Health in leading the effort to address these disparities in the health care system."

— Ivan Seidenberg, Chairman and CEO, Verizon Communications

Some employers go to great lengths to attract a diverse workforce. But they may not realize that these populations have diverse health needs and may experience different treatments when they seek health care. Such employers are well intentioned: they want to improve the health of employees and their dependents, and to that end, they provide a wealth of health benefits. In so doing, however, they assume that their investments will produce equal outcomes for all employees in terms of access to care and overall health status. Research is proving otherwise. ***Disparities in health and health care exist, even among employees with equal benefits.***

Ensuring equal health care for all members of today's workforce is imperative. But the issues are complex, and achieving success will require an active strategy, rather than a reactive approach. Waiting until health problems created by disparities occur and ignoring health care disparities, rather than addressing them in advance, will be costly to the employer and less than ideal for the employee.

This *Issue Brief* will:

1. Explore key causes of health disparities in the U.S. and its workforce;
2. Make a case for why it is more important than ever for employers to address disparities in health and health care; and
3. Present steps employers can take to address health disparities.

Examples of Racial and Ethnic Health Disparities

- Members of racial/ethnic minorities, even among insured populations, are less likely to receive preventive health services than are members of the majority population.[2]
- Low-income individuals have higher mortality rates than high-income individuals, even when health insurance is universally available.[3]
- Pain of all types, and in all settings, is generally mismanaged among racial and ethnic minorities.[4]
- African-American women are more likely to die from breast cancer than white women, in part because the former have lower screening rates and are diagnosed at later stages of the disease.[5]
- American Indians and Alaska Natives die at higher rates than other Americans from tuberculosis (750 percent higher), alcoholism (550 percent higher), diabetes (190 percent higher), unintentional injuries (150 percent higher), homicide (100 percent higher) and suicide (70 percent higher).[6]
- Infant mortality rates among African Americans are twice as high as those among whites. African-American infants are almost four times as likely to die from complications related to low birth weight as white infants.[7]
- The rate of treatment for depression is significantly lower for blacks and Hispanics than for whites.[8]
- Hispanics are less likely to receive or use medications for asthma, cardiovascular disease, HIV/AIDS, mental illness or pain, as well as prescription medications in general.[9]

Addressing health disparities is a quality issue, an equity issue and a cost issue. Employers should recognize that health disparities exist among their employee populations and that these disparities have a significant impact not only on employees and their families but also on the company or organization.

II. What Are Disparities?

"Health disparities" is an umbrella term that is used to describe the following:

- *Disparities in health status*, that is, differences in health conditions and in health outcomes; and
- *Disparities in health care*, that is, differences in the preventive, diagnostic and treatment services offered to people with similar health conditions.

According to the landmark 2003 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, racial and ethnic disparities in health status persist among adults and children even when they have adequate health benefits.[10] Since the release of this report, the National Business Group on Health, in partnership with the Office of Minority Health of the U.S. Department of Health and Human Services, has formed a Racial/Ethnic Health Disparities Advisory Board. The board's mandate is to assess the progress that large employers have made in addressing disparities and to identify remaining gaps. To date, the board has found that there is some progress, which is encouraging. Nevertheless, most employers remain unaware of the problem and do not understand what role they might play in ameliorating it. Interestingly, some of the most diverse workforces are in the public sector, yet this sector, too, has ample opportunities to tackle the problems of health disparities.

The importance of viewing health disparities as a quality issue cannot be overstated. Aetna is a corporate pioneer in the area of addressing health disparities and reports a critical success factor in their work: "Addressing disparities through a quality improvement framework is promising and can be viewed as good medicine and good business."[11] By addressing health disparities, employers send the message that they are committed to ensuring that their employees and dependents receive high-quality health care, thus improving their health, productivity and quality of life.

Key Factors Contributing to Disparities

Even when they have the same health insurance benefits and socioeconomic status, and when comorbidities, stage of presentation and other confounding variables are controlled for, members of racial and ethnic minority groups in the United States often receive lower-quality health care than do their white counterparts.[10]

Many factors contribute to health disparities. The IOM organizes these factors into three categories: patient-level, health care systems-level, and care process-level variables.[10]

Patient-Level Variables

Patient-level variables are the characteristics of a patient that contribute to health disparities.[10] Patient-level variables are manifested in such behaviors as delays in seeking care, poor adherence to treatment regimens and refusal of health care services. These variables include:

- **Socioeconomic status** (SES) factors, which are measured by wealth, poverty, education, literacy and occupation. One study found that low SES was a major contributor to increased cancer mortality risk among racial/ethnic minorities, suggesting an interaction between SES and race/ethnicity.[12]

- **Language barriers**, which can create disparities. "Inadequate patient-provider communication negatively influences medication compliance, self-management of chronic disease, and overall health outcomes." [9] For example, when non-English-speaking Asian parents are asked to assess their children's health care, they report the lowest ratings of all racial and ethnic groups. English-speaking Asian parents, on the other hand, report experiences similar to those of whites. This same finding holds true for Asian adults' ratings of their own care.[13]

- **Poor health literacy** plays a key role in health disparities. According to recent statistics from the Agency for Healthcare Research and Quality, only 12 percent of the 228 million adults in the United States have the skills to manage their own health care proficiently.[14] These "skills" refer to a person's ability to obtain and use health information to make appropriate health care decisions.[15] According to the American Medical Association, "People from all ages, races, income and education levels are challenged by this problem. Individuals with limited health literacy incur medical expenses that are up to four times greater than patients with adequate literacy skills, costing the health care system billions of dollars every year in unnecessary doctor visits and hospital stays."[16]

According to the American Medical Association, poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level, and race"[17] The National Assessment of Adult Literacy found that 48% of American Indian/Alaska Natives, 58% of blacks and 66% of Hispanics have only basic or below-basic literacy levels, compared to 28% of whites.[18]

Other patient-level variables that have an impact on health disparities include cultural norms and beliefs (**see text box 1**), distrust of the health care system and lack of knowledge about how to navigate the health care system.

Text Box 1

Cultural beliefs and preferences can affect health status and health care decisions. For example:

- Some Hispanic men believe diabetes is a "death sentence."
- In some Asian cultures, cancer is taboo. As a result, some cancer patients are reluctant to seek or heed medical advice.
- Muslim women may prefer to see providers who are of Arab descent. Muslim women also prefer female practitioners because women are required to be clothed in front of men.
- Asking questions of health care providers is seen as disrespectful in some cultures.
- Some American Indian cultures believe that talking about an illness will cause the illness to occur.

Lack of cultural competency within the health care system is a problem. The U.S. Department of Health and Human Services' *Think Cultural Health* website (www.thinkculturalhealth.org) provides various examples of culture-specific beliefs. Providers who are not aware of cultural differences and how to appropriately address them may not be able to provide quality care.

Health Care Systems-Level Variables

Health care systems-level variables are characteristics that make it difficult for individuals to navigate the health care system and therefore reduce the chance that they will receive quality care. Examples include:

- The organizational complexity of a health care system;
- The financial complexity of the system; and
- The geographic location of the health care facility.

Other systems-level factors include a lack of diversity within the health care system, a lack of minority providers and unavailability of translation services. Consider what happens, for example, when translation services are not available and a child becomes the default translator for a family member. This may lead to confusion in the communication of health information that could have serious repercussions.

Care Process-Level Variables

Care process-level variables refer to characteristics of an individual provider that contribute to disparities. Physicians are human; like anyone, they have shortcomings, which may include racial or ethnic biases. Side effects of these behaviors have been widely reported. One study reported that physicians rate their African-American patients as being less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to not follow medical advice and less likely to participate in cardiac rehabilitation than their white patients.[19] These assumptions have an impact on the provision of care.

III. How Disparities Affect Employers

Disparities in the Most Common Health Conditions

Since 2003, research on identifying and tracking disparities in health and health care has greatly expanded. This research suggests that some progress has been made in reducing racial/ethnic disparities in health status. For example, as the 2007 National Healthcare Disparities Report indicates, the disparity in health status between Asians and whites who had a usual primary care provider was eliminated in 2004, and the disparity in health status between black and white hemodialysis patients who were receiving adequate dialysis was eliminated in 2005.[14]

However despite some success, major disparities remain. Below is a sampling of current health disparities as reported by the Office of Minority Health (http://www.omhrc.gov). These disparities are of particular importance to employers because they are closely associated with major drivers of mortality, morbidity, disabilities and health care costs.

Heart Disease

- In 2005, African-American men were 30 percent more likely to die from heart disease than non-Hispanic white males.
- Compared with whites, Mexican Americans experience higher rates of overweight and obesity, two of the leading risk factors for heart disease.
- Premature death was higher for Hispanics (23.5 percent) than non-Hispanics (16.5 percent) in 2001.
- In 2006, 31.6 percent of African Americans had hypertension compared with 22.4 percent of whites.

Cancer

- Cancer was the top killer of Asians and Pacific Islanders in 2004.
- African Americans are 33 percent more likely to die from cancer than whites.

Asthma

- African-American children have a 60 percent higher prevalence of asthma than white children and visited the emergency room for asthma-related services 4.5 times more often than white children in 2004.
- Asthma rates among Puerto Rican Americans are almost three times as high as those of the overall Hispanic population.

Diabetes

- Diabetic complications (e.g., end-stage renal disease and amputations of the foot or lower leg) are more common among African Americans than members of other groups.
- American Indians and Alaska Natives are 2.3 times as likely to have diabetes as non-Hispanic whites of similar age.
- In 2005, the mortality rate from diabetes in Hispanics was 60 percent higher than that of non-Hispanic whites.

Stroke

- African-American adults are twice as likely to have a stroke as their white adult counterparts.
- American Indian/Alaska Native adults are 60 percent more likely to have a stroke than their white adult counterparts.

The Rationale for Employer Efforts to Address Disparities

As the IOM has noted, "Businesses must realize there are real bottom-line costs associated with health disparities."[1] In light of the rapidly diversifying workforce, U.S. employers cannot afford to continue shouldering the costs and consequences (e.g., employee disability and premature death) of unnecessary or unequal health care.

The full cost of disparities to employers is unknown. What is known is that U.S. businesses spent a staggering $496 billion on health services and supplies in 2006 alone. By addressing health disparities, these employers stand to benefit in both direct and indirect ways.

Direct Benefits

Direct benefits include the following:

- Decreases in utilization and medical costs (though costs may rise initially as programs to reduce disparities are designed, as preventive services are utilized to a greater extent and as newly identified chronic conditions create a need for major management); and
- Decreases in medical claims costs for serious conditions avoided by better screenings, treatments and preventive care.

Heart disease, hypertension, diabetes, cancer, musculoskeletal problems and asthma are among the costliest conditions to employers, in terms of both direct and indirect costs.[20] More than 40 percent of the U.S. population live with one or more chronic conditions, and management of these conditions accounts for 75 percent of all personal medical care spending in this country.[21]

Indirect Benefits

Indirect costs associated with unscheduled absences, and productivity losses associated with family and personal health problems, cost U.S. employers $225.8 billion annually.[22] Add disparities to these already-unmanageable costs, and the problem becomes even more complex and expensive.

For the employer, indirect benefits of addressing health disparities include the following:

- Increased employee and dependent satisfaction with health care benefits;
- Decreased absenteeism and presenteeism and increased productivity;
- Less turnover, i.e., greater employee retention;
- Increased organizational intellectual capacity;[23]
- Increased employee loyalty and workforce stability;[24]
- Increased competitiveness in attracting and retaining talent;
- Increased longevity and quality of life because of earlier detection of disease and better management of chronic conditions;
- Decreased short- and long-term disability costs; and
- Decreased workers' compensation claims.[25]

It is imperative to understand how to offer programs that respond to the needs and cultural preferences of members of a diverse workforce. Employers invest millions of dollars in the health and well-being of their employees by providing disease-management and wellness programs. If these programs fail to take into account racial and ethnic differences among their intended populations, employers miss opportunities to maximize the return on their investment. For example, if a wellness program that offers nutrition counseling for diabetics fails to address food choices and customs native to particular cultures, the message is most likely lost on members of that culture, and a positive impact is highly unlikely.

IV. Employers as Part of the Solution

National Business Group Employer Survey

In the summer of 2008, the National Business Group on Health surveyed members about their awareness of health disparities, with the goal of identifying employers' current initiatives to address this problem. Employers were asked about strategies for accommodating diversity, their

awareness of disparities as drivers of direct and indirect health costs and actions they had taken to reduce disparities.

Key findings included the following:

- The majority of employers were unaware of disparities as a business issue.
- Only one-third of respondents believed that reducing disparities was an "important" or "very important" issue.
- Few employers have undertaken efforts to make employees aware of strategies they have implemented to reduce health care disparities.
- The primary barrier to developing or implementing a disparities-reduction program was lack of data identifying the problem.
- Few respondents had a strategy or program for addressing health disparities within their organizations.
- The potential for reducing disparities was not generally a criterion for selecting health plans.

In 2003, the National Business Group on Health released *Reducing Health Disparities: Why and How Companies Are Making It Their Business.* As a follow-up to that document, in 2008, the National Business Group on Health joined forces with the National Partnership for Action for Eliminating Racial and Ethnic Disparities in Health (NPA). An advisory board of employers, researchers and experts in the field of health disparities is now taking the employer perspective to the next level by providing information to employers on strategies to overcome health disparities in their workforces.

Action Strategies: What Can Employers Do?

When considering health disparities in an employee population, employers frequently express concerns such as:

- Difficulty accessing health disparity data;
- Overcoming cultural sensitivities inherent in addressing health disparities;
- Limited resources;
- Not knowing how to get started; and
- Reluctance to acknowledge the impact of health disparities on their organization.

Each of these concerns can be addressed and overcome, provided the employer is willing to develop and implement a well-planned, step-wise strategy.

Step 1. Understand Legal Myths and Realities.

As a first step, the employer must understand the legal myths and realities around collecting racial/ethnic data and addressing disparities. Many employers mistakenly fear that targeting disparities means that the employer is treating people differently, which would violate the Employer Retirement Income Security Act [ERISA]. As Sara Rosenbaum of George Washington University, one of the nation's leading experts on this topic, has noted, "Collecting this data is not only in line with the law, but introduces more clarity into the process to ensure that disparities are quickly recognized and effectively addressed."

Step 2. Know Your Data.

Identifying the problem is the second step to addressing disparities. This requires collecting data. The purpose of data collection is to identify where health disparities are, or could be, within an organization. This also makes it possible to compare data from one's own organization with similar data from other sources, both national and local. Employers should benchmark where they are and where they want to go.

Data collection entails:

- **Determining what data to collect.** Important elements to consider include race/ethnicity, gender, age, salary/job category, employee status (full-/part-time), ZIP code of employees' places of residence, language preference and patient preferences/perceptions regarding health care services and providers.

  If it is not possible to get data on an employee population, indirect data collection methods, (e.g., geomapping or surname analysis) may be used. Data can also be extrapolated from Centers for Disease Control and Prevention (CDC) information on chronic diseases, categorized by race, age and region. CDC data can serve as a benchmark; employers can compare data from their employee populations with data for the U.S. population as a whole. Employers should also benchmark data against that of other employers in the same industry sector. This can be achieved using Employer Measures of Productivity, Absence and Quality (EMPAQ). More information can be found at: www.empaq.org.

- **Determining what to measure.** Examples include emergency room utilization rates, disease-management data, prevention utilization measures and chronic care management and specialist referrals. In areas where there are substantial minorities, employers should ask their analysts to cross-tabulate all health services and health risk data by race and ethnicity since the more an employer understands about what is happening (or not happening, as the case may be), the better a designed program is likely to be.

- **Collecting the data.** Data collection should be hardwired into an employer's operations. The more standardized and integrated the data in an employer's current systems, the better. It's important to educate managers and employees about data collection efforts and to be clear about what the data will be used for. Always emphasize steps taken to ensure employee privacy.

- **Using the data.** Now it is time to build a case for addressing any identified health disparities and to develop possible interventions to present to senior management. The most successful efforts occur in organizations whose senior leaders are involved in addressing disparities. Once data are analyzed for evidence of problems, tailored programs and strategies can be developed and implemented. Since there is no *one* cause of health disparities, an effective action plan should be multifaceted.

Recognition of health disparities should be woven into everyday work. Changing the culture to address disparities should be an integral part of mission and vision of values-driven organizations. Efforts to reduce disparities must be part of the organization's overall quality improvement process; it should not be thought of as a separate, "philanthropical" thing to do.

3. Work with Employees.

- **Instill hope.** Psychosocial characteristics (e.g., stress, low control at work or home and lack of social support and social integration) and economic deprivation can produce health inequalities.[26] Instilling hope in the organization and the community can have enormous protective effects on health. Essentially, everyone benefits when no one is left behind.

- **Elicit feedback on issues of access and quality of care.** Employers may find it helpful to get feedback from diverse employee groups about their experiences as health care consumers. Focus groups and employee surveys may be useful for this purpose. This can be an opportunity to explore whether employees feel they have adequate access to care and to gain insight into their level of comfort with their health care providers. Affinity and advocacy groups can be very helpful both in identifying opportunities and in helping to test solutions.

  Ensuring access to care is more complicated than it may seem. For example, simply hiring Spanish-speaking providers in a provider network doesn't necessarily mean that those providers will be located in the areas where they are most accessible to the employees that need them. Employers need to identify employee race/ethnicity by region or ZIP code. Another example of the complexity of access relates to preventive services. Offering no-cost preventive services is key to improving access, because for a low-wage worker, even a modest co-payment can pose a barrier to care. A nominal co-pay to one employee may be an insurmountable obstacle to another. By offering no-cost prevention services, employers increase the likelihood that all employees will seek them.

- **Focus on health literacy.** Employers should work with employees to understand whether they can complete needed paperwork and comprehend instructions given by doctors and pharmacists. Field testing communications materials or holding focus groups to assess language comprehension may be helpful. Also consider making resources available to employees that explain questions they should be asking their providers (see "Ask Me 3" and "Speak Up" in the Resources section).

- **Communicate.** Failure to communicate appropriately with employees of diverse backgrounds can have a strong negative impact on how these employees use company-sponsored benefits and services. Are current programs and services being used differently by different populations? Does the organization have a way to measure this? Is the communication of these programs tailored to various cultural groups, or is it a "one-size-fits-all" approach? Communicate in many languages, at various levels and in many ways, making sure everyone is reached at his or her level.

  To create an environment of support, consider organizing affinity groups or diversity groups. Employees with common backgrounds and interests can share health care experiences, identify common problems and propose solutions.

- **Tailor programs.** Make certain your programs and services are designed to meet the needs of a diverse population. Consider how the full spectrum of services and programs offered by your health plan may be affected by disparities. For example, some pharmaceutical products have been proven more effective for certain populations than for others. Consider placing these drugs on formularies or on a lower tier for greater access. Employers may want to work with pharmacy benefit managers to ensure that effectiveness research is considered in the formulary decision-making process.

4. Work with Health Plans and Other Health Vendors.

Member companies of America's Health Insurance Plans (AHIP) are taking on the challenge of health care disparities. Health insurance plans are organized to focus on areas of greatest need; collecting data on the race, ethnicity and primary language of enrollees; developing quality improvement programs to address health disparities among populations; creating member materials that are culturally and linguistically appropriate; and improving care for all enrollees. Many of the lessons learned and actions taken by health plans can be transferrable to employers.

As health care purchasers, employers are well positioned to be catalysts for substantial reductions in health disparities. To that end, they should work with all health care partners, particularly

their health plans, to require changes to the plans' structure, health professional recruitment and training and offerings to tackle disparities. Now more than ever, health plans are realizing that disparities exist and are working to address them. Strategies include the following:

- **Inquire about health plan efforts to reduce disparities.**

  Possible questions to explore include the following:

  - Does the plan offer continuing medical education programs on cultural competency or disparities reduction for providers in its network?
  - How can racial/ethnic data analysis be incorporated into plan quality improvement initiatives?
  - Look for STEEP. Using the IOM's STEEP acronym, aim for all health care to be Safe, Timely, Effective, Efficient, Equitable and Patient- centered.[27]
  - Is the health plan taking action to diversify its provider network to reflect the composition of the member population?
  - How is the plan addressing its members' language and translation needs?
    - Does the plan offer interpretation and translation services?
    - Do members have access to materials in languages other than English?
    - Are materials culturally adapted rather than simply translated?
  - What is the plan doing in the local community to address disparities?

- **Partner with health plans on data collection.**

  In collaboration with health plans, review data to determine potential gaps in care and services. If plans are collecting racial/ethnic data, discuss how they are using it (e.g., to design programs, for case management, for customer service efforts, to improve communication, etc.).

  Employers can also use their data integrator as a source for identifying disparities.

- **Tailor your requests for proposals.**

  Employers can insert language requiring efforts to address health disparities in their requests for proposals and use the subsequent recontracting process to require more documentation from carriers regarding their approach to training, educating and hiring practices that reflect diversity. (See information on the National Committee for Quality Assurance "Recognizing Innovations in Multicultural Health Care" award in the Resources section.)

V. Conclusion

Health disparities affect all employers, and failure to address them will seriously hurt the health, productivity and quality of life of their employees and dependents. By addressing disparities, employers can improve the value of the services their employees are receiving through their health benefits and health and productivity programs and services. Today, as our nation deals with the fallout of the worst economy in 70 years and employers struggle to maximize the productivity and health of their employees and to help care for their dependents, the need to take on the challenge of reducing health disparities has never been greater.

As part of its effort to provide information and tools for employers to address disparities, the National Business Group on Health will publish an *Issue Brief* on results from the 2008 employer interviews that will also include case studies and will outline steps employers are taking to address disparities. This *Issue Brief* will be available in the spring of 2009 on the Business Group website (http://ww.businessgrouphealth.org).

National Partnership for Action for Eliminating Racial and Ethnic Disparities in Health

In 2008, the National Business Group on Health joined forces with the National Partnership for Action for Eliminating Racial and Ethnic Disparities in Health (NPA). Created by the Office of Minority Health, NPA is a public/private partnership network to mobilize and coordinate disparities-reduction activities at the community, state, regional and national levels. The NPA recognizes the crucial role employers play in the elimination of health disparities. The National Business Group on Health's involvement is intended to further define the employer's role in eliminating health disparities and to develop effective strategies that employers can use in this effort.

For more information on the NPA, go to: http://www.omhrc.gov/npa/.

Resources

For Employees

Ask Me 3: Partnership for Clear Health Communication
National Patient Safety Foundation
http://www.npsf.org/askme3
Resources for patients, providers and employers specific to good communication strategies for healthy patients.

Speak Up. Understanding Your Doctors and Other Caregivers
The Joint Commission
http://www.jointcommission.org/PatientSafety/SpeakUp/sp_understanding.htm
Brochures and posters encouraging patient safety.

For Providers

Think Cultural Health
Free resources to caregivers to promote cultural competency in health care are available at http://ww.thinkculturalhealth.org.

The National Diabetes Education Program provides educational materials and tools on diabetes awareness and maintenance tailored for Hispanic populations.
http://www.ndep.nih.gov

Health Literacy Toolkit
American Medical Association Foundation
http://www.ama-assn.org/ama/pub/category/8115.html
A primary tool for informing physicians, health care professionals and patient advocates about health literacy

Health Disparities Information

2007 National Healthcare Quality and Disparities Report
Agency for Healthcare Research and Quality
http://www.ahrq.gov/qual/qrdr07.htm

Agency for Healthcare Research and Quality
State Snapshots
http://statesnapshots.ahrq.gov/snaps07/index.jsp
For state-level (snapshot) data analysis, the technical assistance e-mail is info@ahrq.gov. The state snapshots provide state-specific health care quality information, including strengths, weaknesses and opportunities for improvement. The goal is to help state officials and their public and private sector partners better understand health care quality and disparities in their states.

Working with Health Plans

National Committee for Quality Assurance
http://ww.ncqa.org
Offers an annual "Recognizing Innovations in Multicultural Health Care" award to health plans that have implemented initiatives to improve culturally and linguistically appropriate services and reduce health care disparities.

National Health Plan Collaborative (NHPC) Toolkit
http://ww.rwjf.org/qualityequality/goto/nhpctoolkit
Designed to help readers implement strategies similar to those used by the NHPC. Makes the case for overcoming disparities in health services and outcomes for plan members nationwide.

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Written by:

Leah C. Trahan
Program Manager, Center for Prevention and Health Services
Pamela Williamson
Program Associate, Center for Prevention and Health Services

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Center for Prevention and Health Services
50 F Street N.W., Suite 600 • Washington. DC 20001
Phone (202) 628-9320 • Fax (202) 628-9244 • www.businessgrouphealth.org
Helen Darling, President, National Business Group on Health

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Additional Contributors: David Mann, **Maryland Department of Health and Mental Hygiene**; Ben Steffen, **Maryland Health Care Commission**; Rodney Taylor, **Maryland Health Care Commission**; Tawara Goode, **National Center for Cultural Competence Georgetown University Medical Center**; Lauren Darensbourg, **Office of Minority Health**.

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