

Five-year

Summary

The Commission

to End Health Care Disparities

Unifying efforts to achieve quality care for all Americans

Commission Secretariat

American Medical Association

National Medical Association

National Hispanic Medical
Association

The Commission to End Health Care Disparities

Key initiatives and milestones

<p>2000 <i>Healthy People 2010</i> (led to increased awareness of disparities)</p>	<p>2002 AMA monographs: <i>Roadmaps for Clinical Practice</i></p>	<p>2004 (July) Formation of Commission to End Health Care Disparities</p> <ul style="list-style-type: none"> • NMA, AMA and NHMA (37 member organizations)
<p>2001 Memorandum of Understanding</p> <ul style="list-style-type: none"> • AMA and HHS/ODPHP 	<p>2003 Disparities task force formed</p> <ul style="list-style-type: none"> • 10 focus areas 	<p>2008 AMA apology to the NMA</p>
<p>2002</p> <ul style="list-style-type: none"> • IOM report: <i>Unequal Treatment</i> • AMA council report: Strategies for Eliminating Racial and Ethnic Disparities • AMA Health Disparities Program 		

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A message from the commission leaders

National Medical Association
 American Medical Association
 National Hispanic Medical Association

Established five years ago by the American Medical Association and the National Medical Association, and with the National Hispanic Medical Association joining soon thereafter, the Commission to End Health Care Disparities was formed to address disparities in health care and in response to the Institute of Medicine's report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.

The Commission to End Health Care Disparities has thrived over the past five years. Representing physicians and other health care providers, our commission members and member organizations are committed to ending health care disparities by providing concrete initiatives and programs that achieve goals in the areas of data collection (both patient and physician), provider education, policy and advocacy, and work force. This five-year summary provides an update on the commission's activities to help invigorate national efforts to end health care disparities.

Commission efforts continue to make a national impact. Racial and ethnic disparities are a barrier to quality health care for all Americans, and it is imperative that action to eliminate these disparities be consistent and sustainable.



Nancy H. Nielsen, MD, PhD



Sandra Gadson, MD



Elena V. Rios, MD, MSPH

We hope this report will inspire you to learn more about the commission and join the effort to eliminate disparities. Only by working together can we improve the quality of care for everyone.

Nancy H. Nielsen, MD, PhD

Co-chair, Commission to End Health Care Disparities
 President, American Medical Association

Sandra Gadson, MD

Co-chair, Commission to End Health Care Disparities
 Past President, National Medical Association

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Five-year summary

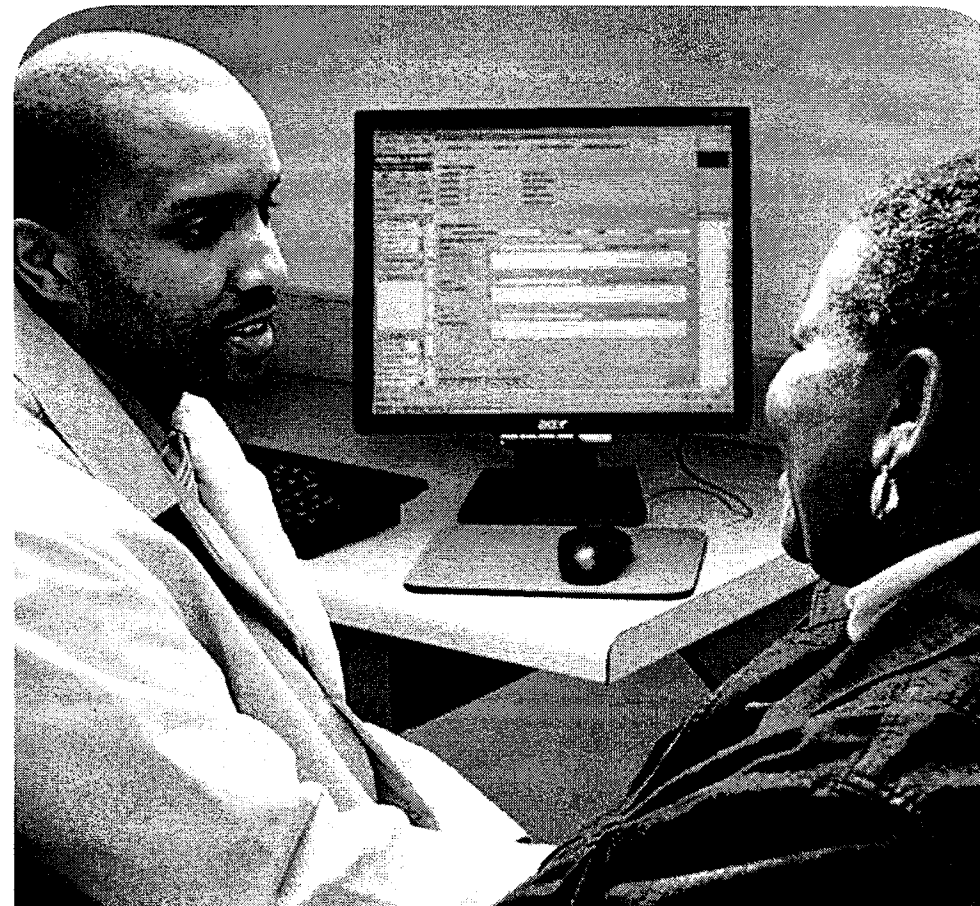
Representing five ambitious years, 2009 marks the fifth anniversary of the formation of the Commission to End Health Care Disparities. Since its inception, the commission has achieved several early objectives, including the development of workshop training to help physicians not only understand the impact of health care disparities but also improve communications with diverse patient populations. It has been no small task to accomplish so much in so short a time, particularly in such a complex and often misunderstood area of health care. It is helpful to look back at how the commission was formed to fully appreciate where the commission stands today and how its members are working to ensure future progress.

Commission roots linked with *Healthy People 2010*

The Commission to End Health Care Disparities held its first formal meeting in San Diego on July 30, 2004. Prior to this meeting, the commission went through a developmental stage for several years, beginning in 2000 when the U.S. Department of Health and Human Services (HHS) launched *Healthy People 2010* (HP 2010). With a set of more than 400 national health objectives, HP 2010 had two broad goals: to improve the overall health status of Americans, and to eliminate racial and ethnic health care disparities. Explicit in this effort was the need to address disparities in access to health care and in the quality of health services delivered to at-risk communities.

The enormous task of meeting these goals prompted officials from HHS to reach out to a variety of professional groups in the public and private

sectors to help mobilize action. Among these groups was the American Medical Association (AMA). HHS officials said the AMA was ideally positioned to bring national leadership to initiatives in disease prevention and health promotion while working to eliminate health care disparities. In December 2000, former AMA President Randolph Smoak Jr., MD, and former U.S. Surgeon General David Satcher, MD, PhD, signed the first Memorandum of Understanding (MOU) between the AMA and the HHS Office of Disease Prevention and Health Promotion (ODPHP) in support of HP 2010.



Thomas A. Mason, MD, of Near North Health Services, a founding member of the Alliance for Chicago Community Health Services, has used measures from the AMA-convened Physician Consortium for Performance Improvement® in an electronic health record system for more than five years to improve the care of vulnerable, underserved populations in the Chicago area

In signing this historic memorandum, the AMA agreed to raise physicians' awareness of disparities and the importance of understanding culturally competent health care and health literacy. The AMA made a commitment not only to help educate practicing physicians but also to work with state medical societies, medical schools, medical students and policymakers to close the gaps in existing health disparities. In 2001 the AMA hired a senior scientist in its Medicine and Public Health unit specifically to coordinate activities in support of the MOU. Almost immediately, the AMA and ODPHP engaged in discussions on the importance of bringing together the state, county and specialty medical societies represented in the AMA House of Delegates to address HP 2010 goals, including the elimination of health disparities.

Partnerships between the AMA and other organizations to develop programs to educate physicians about disparities followed. Early AMA efforts included working with the U.S. Centers for Disease Control and Prevention Task Force on Community Preventive Services, partnering with the University of Illinois and the Chicago Medical Society to plan a conference addressing health disparities in Chicago, and serving in a liaison role on the Institute of Medicine (IOM) panel on ensuring the health of the public in the 21st century.

Efforts gain momentum

By 2002 viable strategies and organizational efforts to tackle disparities were gaining momentum. The AMA became co-sponsor of an initiative launched by the Henry J. Kaiser Family Foundation and the Robert Wood Johnson Foundation to heighten physicians' awareness of disparities in health care, beginning with cardiac care. Collaboration between the AMA and HHS also produced *Roadmaps for Clinical Practice*, a series

of primers and monographs designed to help physicians and other health professionals develop strategies to eliminate disparities by integrating disease prevention and health promotion into routine medical care.

While the AMA and other organizations continued to focus attention on health care disparities, the IOM, as mandated by Congress in 1999, compiled an expansive report on racial and ethnic disparities in health care. When the report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, was published in 2002, its findings alarmed many health care professionals.

Unequal Treatment documented the existence of racial and ethnic health care disparities, even when insurance status, age, income and illness severity were taken into account. The report noted that health care disparities occur in a broader context of discrimination that persists in many aspects of American society. Within the health care system, *Unequal Treatment* pointed to such organizational factors as cost-containment incentives that may limit services, low-cost health plans with restrictions on spending as well as services that may disproportionately enroll more minorities, and inadequate translation services that create disparate health care environments.

Unequal Treatment also suggested that although health professionals dedicate themselves to providing the highest quality of care possible to every patient, they also might harbor unconscious biases and stereotypes that affect their decision-making and attitudes toward minority patients. For example, the report cited a study published in the *New England Journal of Medicine* in 1999 that revealed physicians were significantly less likely to refer black women for cardiac catheterization than black and white men and white women, even when they had the

same symptoms. In a proactive response to the IOM's report, the AMA Council on Scientific Affairs—now named the AMA Council on Science and Public Health—prepared a report entitled *Racial and Ethnic Disparities in Health Care* for review by AMA House of Delegates (HOD) in 2002. The report defined disparities in health care as “racial and ethnic differences in the quantity or quality of health care that are not due to clinical needs, patient preferences, or the appropriateness of the intervention.”

The AMA report explored the long history of studies documenting disparities in health status and health care. Specifically, it noted racial and ethnic disparities in morbidity and mortality from a number of diseases, including heart disease, stroke, cancer, diabetes, asthma and HIV/AIDS. The report also noted an important distinction: In addition to having higher disease-specific morbidity and mortality rates, racial and ethnic minorities receive “lower quality and intensity” of health care and diagnostic services—including mental health care, rehabilitation services, long-term care and pain management—compared with non-Hispanic whites.

In 2002 the Commission to End Health Care Disparities reached a milestone. Based on the AMA Council on Science and Public Health report, the AMA-HOD voted to support creation of a health disparities program within the AMA's Medicine and Public Health unit. The program's staff would be instrumental in guiding the implementation of future initiatives, eventually leading to the establishment of today's commission.

Also in 2002, the AMA-HOD approved a resolution that asked the AMA to make the elimination of racial and ethnic disparities in health

care a high-priority issue. Combined with the growing attention to the issue of health care disparities, the resolution acted as a catalyst in establishing an early framework for the commission. During a meeting, national experts and AMA representatives joined to delineate a more specific direction for the AMA in its work to eliminate health care disparities. This group advised the AMA to focus on four main areas:

- Study health system opportunities for and barriers to eliminating health care disparities.
- Raise awareness of disparities within the profession and advocate for equity in payment across health plans.
- Increase minority representation within the profession.
- Equip physicians as leaders in addressing disparities in health care through the development and promotion of tools and training.

Discussions during this meeting shaped the early development of the AMA's health disparities program as well as ongoing AMA initiatives in clinical quality improvement, ethics and other areas. These initiatives included participation on an HHS committee addressing disparities in treatment of tuberculosis in the southeastern United States; collaboration with the American Hospital Association to develop a uniform framework for collection of health care data by race, ethnicity and primary language; collaboration with the IOM of Chicago to convene a conference exploring solutions to health disparities in that city; and creation of the AMA Ethical Force Program to improve patient-centered communication for vulnerable populations.

Physicians call on peers to take action

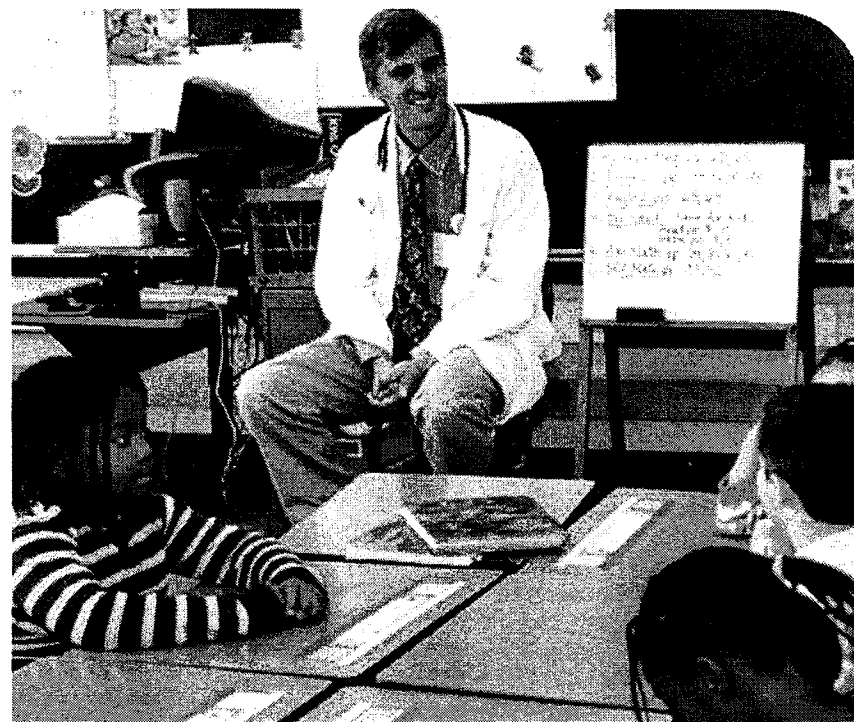
In 2003 the AMA-HOD approved an AMA Board of Trustees report—Strategies for Eliminating Racial and Ethnic Disparities—which directed the AMA to intensify its work in eliminating health care disparities by working with public health agencies and other appropriate organizations to increase medical student, resident physician and practicing physician awareness of disparities and of professional obligations to reduce them.

A major step toward achieving those goals and the eventual formation of the Commission to End Health Care Disparities took place Oct. 7, 2003, when the AMA convened a meeting of the Task Force on Disparities in Health Care, which included leaders from 25 state medical associations and national medical specialty societies. This meeting was the culmination of efforts that began with the early work under the MOU supporting the goals of HP 2010. During the meeting, John C. Nelson, MD, MPH, who then was president-elect of the AMA, emphasized the moral and ethical obligations of all physicians to take action to end health care disparities.

The task force heard presentations from a panel of experts who summarized key areas in eliminating health care disparities. Risa Lavizzo-Mourey, MD, MBA, president of the Robert Wood Johnson Foundation, discussed the importance of collecting and reporting data on access to health care and utilization of health care services by patients' race, ethnicity, socioeconomic status and, if possible, primary language. Georges Benjamin, MD, executive director of the American Public Health Association, explained that comprehensive, high-quality care could help achieve the elimination of health care disparities and pointed to the need for new tools that

would help patients and their physicians engage in candid discussions about care and treatment options. Marsha Lillie-Blanton, DrPH, vice president of the Kaiser Family Foundation, described some of the causes of disparities and ways for physicians to address them, while Helen Burstin, MD, MPH, then director of the Center for Primary Care Research at the Agency for Healthcare Research and Quality, discussed ways to reduce health system factors that contribute to disparities.

For some task force members, the presentations were eye-openers into the pervasiveness of health care disparities and the extensive amount of work needed to eliminate them. The speakers' messages reinforced what some in the group already knew: One of the group's biggest challenges would be making physicians aware of disparities that exist in their own practices or the facilities in which they provide patient care.



Matthew K. Wynia, MD, MPH, director of the AMA Institute for Ethics, addressing middle school students during a Doctors Back to School visit

Following the presentations, members of the task force developed a comprehensive set of objectives for the work that lay ahead:

- Frame the issue of disparities in the context of quality improvement and evidence-based improvement, including data collection at local levels.
- Target priority chronic conditions and diseases, such as cardiovascular disease, depression and obesity, that have the greatest potential for improvement.
- Identify a strategy for promoting effective patient-physician communication, including cultural competence and trust.



- Identify innovative strategies for promoting collaborations among medicine, public health providers and institutions.
- Promote physician leadership, especially at the community level, and incorporate incentives in designing solutions.

From these objectives, the task force then created 10 specific recommendations that addressed how to meet the ultimate goal of eliminating racial and ethnic disparities in health care. Recommendations prioritized the following activities:

1. Increasing awareness

Educational resources would have to be developed for physicians. Several useful tools would include training programs, videos, speakers' kits, Internet-based materials, print materials and conferences. A business case model would also be needed to educate medical professionals and their employers on workplace changes that contribute to the elimination of disparities. All medical societies would be encouraged to incorporate disparities elimination into their strategic planning processes.

2. Patient-physician communication and trust

Central to improving communication is sensitizing physicians to the fact that nearly half of all adults in the United States have low health literacy, and that non-English-speaking patients, in particular, may have low health literacy. Developing community networks could help provide patients with understandable, respectful, and culturally and linguistically appropriate information.

Sandra Gadson, MD, co-chair of the Commission to End Health Care Disparities and past president of the National Medical Association, addressing students during a Doctors Back to School visit

3. Leadership for the elimination of disparities

Increasing political activity, obtaining cooperation from the Centers for Medicare & Medicaid Services in eliminating disparities and creating a unified message that includes local-level solutions to address disparities would be key activities.

4. Cultural competence of physicians

Physicians would have to examine their own attitudes in order to recognize prejudice and avoid or eliminate biased medical decisions. Educational tools, mentoring programs and health care disparities content in continuing medical education (CME) offerings could help build cultural competence.

5. Creating a diverse professional work force

A closer examination of how provider diversity relates to improved patient satisfaction and health care outcomes would be needed. Ways to attract and recruit more underrepresented minorities into medical and other health professions should be examined, including provision of information and strategies for students to achieve successful entry into medical schools. The creation and maintenance of a diverse work force changes the cultural experience of non-minority students and exposes those students to a culturally rich learning environment. Incentives such as loan-repayment programs could help reduce physician shortages in underserved communities.

6. Improving quality

Another goal is to help physicians recognize that inconsistent health care across different populations is a quality issue, and that disparate care affects patient safety. Physicians should be educated to recognize that cultural competence is related to technical competence. Conditions such as cardiovascular disease, which present greater opportunities for

improvement, should be prioritized. Incentives (for example, discounts on medical liability premiums) could enhance the success of quality improvement initiatives, such as the use of practice-based assessment tools. Increased minority representation on accrediting bodies such as the Joint Commission also could help improve quality.

7. Addressing cultural diversity

A core curriculum on health care disparities could be developed and made a requirement for medical students and medical school accreditation. Medical students would benefit from more interactions with ethnically and racially diverse faculty and patients. Medical student selection committees should understand the role of provider diversity in meeting patients' needs and increasing patient safety.

Residency and fellowship selection committees should consider the importance of recruiting underrepresented minorities. Program chair meetings should address identification of racial and ethnic disparities and strategies to reduce or eliminate them.

Health disparities or cultural competence education should be required in states that have CME requirements. Disparity and diversity issues should be included in certification examinations.

8. Focused research

Race, ethnicity and language proficiency should be incorporated into clinical quality performance measures. Health care disparities could be an important area for the AMA-convened Physician Consortium for Performance Improvement® to consider in its efforts to develop and test evidence-based clinical performance measures. Additional research in health care disparities would be needed to refine teaching techniques to improve cultural competence.

9. Collaboration with other organizations to reduce disparities in care

Collaboration could be established with health plans, centers of excellence, health and medical organizations (including the American Heart Association and the American Cancer Society), the U.S. Department of Veterans Affairs, the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education, the American Board of Medical Specialties (focusing on its role in recertification), and community and religious organizations that serve minority communities.

10. Interventions and tracking

Creation and dissemination of toolkits for health professionals on ways to identify and reduce health care disparities is an important intervention that could energize physicians to implement initiatives to monitor and track target diseases (including heart disease, stroke, cancer, diabetes, asthma and HIV/AIDS). In addition, distribution of toolkits could enable state medical societies to offer front-line support. Programs that improve the image of physicians could help build trust with minority patients. A calendar of organized medicine's events that address health care disparities could encourage physician participation and act as a planning guide.

Organized medicine responds to the call for action

During its first meeting, the Task Force on Disparities in Health Care agreed on some basic tenets describing what it hoped to achieve in the future. From the beginning, the intent was clear—not merely to reduce disparities but to eliminate them. Members of the task force sought quality health care services for all Americans.

Their emphasis was on *health care disparities* rather than the broader, complex landscape of *health disparities*. Different racial and ethnic groups have poorer health status for many reasons that are not directly linked with health care delivery. Even the most active leadership group would not be able to address such widespread challenges as patients who live in poverty, lack transportation or do not reside within reasonable proximity to a physician's office, while also trying to transform the current health care system into one that is more culturally sensitive and diverse. The heart of their mission, the participants decided, was to attack disparities from the perspective they knew best: clinical medicine. Even though an array of social problems contributes to health care disparities, physicians can fulfill their roles in society most effectively by providing high-quality care regardless of patients' racial or ethnic backgrounds.

The first Task Force on Disparities in Health Care meeting in fall 2003 featured high-profile speakers and participants in medical leadership positions from around the country. Their initial discussions were just the beginning of a long-term process in which organized medicine would create strategic implementation plans to eliminate health care disparities.

The task force met a second time, in April 2004. The AMA and the National Medical Association (NMA) served as co-chairs of the meeting, which attracted representatives from 37 organizations. With a full slate of prioritized activities vetted during their first meeting, task force members chose to focus their efforts on four areas:

- Increase awareness of disparities.
- Promote better data gathering related to race, ethnicity and language.

- Promote work force diversity.
- Increase education and training around disparities.

During the second meeting, the task force also began to build a structure for its ongoing governance. The members formed a steering committee and established advisory committees to address each of the four priority areas. A new name—the Commission to End Health Care Disparities—was adopted to illustrate unity in a continuing effort to eliminate health care inequalities based on race and ethnicity. A one-year planning grant from the Robert Wood Johnson Foundation gave the commission resources to begin its work. The grant was intended to help the group develop a formal structure and identify long-term initiatives and shorter-term projects that would foster cooperation and partnerships among member organizations.



Uniting efforts, the commission is called to order

On July 30, 2004, the formally organized Commission to End Health Care Disparities convened its first meeting. With much of the work in outlining an agenda and recommendations for action completed, members of the newly formed commission worked to refine its structure and to adopt language for new mission and vision statements.

Commission members agreed that the presidents of the AMA and the NMA would serve as co-chairs. The commission also determined that the steering committee would have eight members: representatives from the AMA, NMA and the National Hispanic Medical Association (NHMA); the chairs of each of the four advisory committees (Professional Awareness, Data/Information Gathering, Workforce Diversity, and Education and Training); and a member at large. Membership in the commission would be open to any state, county or specialty medical society represented in the AMA House of Delegates and to other appropriate groups working toward the elimination of health care disparities. A secretariat composed of staff from the AMA, NMA and NHMA and coordinated through the AMA would provide administrative support for the commission.

The commission's advisory committees set clear goals from the beginning. The Professional Awareness Committee focused on developing tools for physicians, including speakers' kits, educational sessions and promotional campaigns. The Data/Information Gathering Committee determined that its first project would begin with an analysis of health outcomes data by ZIP code to find ethnically diverse areas of the country

Earl E. Fredrick Jr., MD, talking with an elementary school student during a Doctors Back to School visit

that were performing particularly well or poorly with regard to health care disparities. Using the data, the committee planned to survey practicing physicians in those areas regarding their awareness of disparities, their role in addressing disparities and whether they felt that they could eliminate disparities. Those with compelling personal stories would be interviewed or perhaps videotaped to create teaching materials that would show how “real docs” addressed local health care disparities.

The Workforce Diversity Committee considered a number of resources that could help inform the Commission to End Health Care Disparities about work force issues. One possibility was inviting a representative from the AAMC to serve on the commission. To help educate commission members, the committee also circulated an NMA journal article on discrimination in the work force and shared copies of California legislation that requires race and ethnicity data collection on physicians for licensure and recertification. The committee advised the commission to:

- Develop a statement on the need for more data on work force diversity.
- Launch a “Career Day” event to raise awareness of the need for more diverse student recruitment to the medical profession.
- Support reauthorization of Title VII of the Public Health Service Act, which fosters health professionals’ training and service in underserved areas through loans, loan guarantees and scholarships, as well as grants and contracts for academic institutions and nonprofit organizations.

The Education and Training Committee posed two questions: whether training in health care disparities should be standardized to ensure uniformity, and whether the National Board of Medical Examiners and medical schools should require certification in cultural competence. Committee members felt that one of their responsibilities was to identify skill sets that would enable physicians to effectively interact with culturally diverse patients.

The commission’s meeting in 2004 included the development of mission and vision statements. Even with all of the early efforts to define the commission’s scope and some of the activities it would pursue, developing two brief statements that all members could agree upon proved challenging. Some members felt that issues such as socioeconomic status and health care access should be included in a mission statement. However, the commission decided to dedicate its work to identifying steps that physicians could take directly to eliminate health care disparities. After edits and revisions, the commission approved these statements:



From left: Randall W. Maxey, MD, PhD, John C. Nelson, MD, MPH, Louis Sullivan, MD, and Elena Rios, MD, MSPH, at a press conference announcing the Commission to End Health Care Disparities in January 2005

