Closing the Health Care Disparities Gap: Turning Evidence into Action

Carolyn M. Clancy

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TURNING EVIDENCE INTO ACTION

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INTRODUCTION

As one of the agencies within the U.S. Department of Health and Human Services (HHS), the mission of the Agency for Healthcare Research and Quality (AHRQ) is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. To measure America's performance in these areas, AHRQ publishes the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR). These comprehensive reports, mandated by Congress, track the state of health care quality in America and our progress towards eliminating disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations.

Priority populations, specified in AHRQ's authorizing statute, include women, children, the elderly, low-income urban populations, racial and ethnic minorities, persons residing in rural areas, individuals with chronic illness and disabilities, and persons at the end of life.[1] The content of both reports, informed by national leaders convened by the Institute of Medicine, are based on identical measures of health care quality.[2]

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1. Healthcare Research and Quality Act of 1999, Pub. L. No. 106-129, § 901, 113 Stat. 1653, 1654 (1999) (codified as amended at 42 U.S.C. §§ 299(c)(1)(A)-(B) (2000 & West Supp. 2003)).

2. COMM. ON NAT'L QUALITY REPORT ON HEALTH CARE DELIVERY, INST. OF MED., ENVISIONING THE NATIONAL HEALTH CARE QUALITY REPORT 22 (Margarita P. Hurtado et al. eds., 2001); COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 31(Brian D. Smedley et al. eds., 2003) [hereinafter UNEQUAL TREATMENT]. Both sources rely upon a definition of health care quality as "the degree to which health services for individuals and

When the first NHQR and NHDR reports were issued in 2003, they drew from a strong body of evidence compiled over the last decade that points to a single conclusion: the improvement of health care quality in America, as a whole, is inextricably linked to eliminating racial, ethnic, and socioeconomic disparities in health status.[3] Until all Americans have full access to high quality health care, the quality of the overall health care system will be compromised.

Moreover, focusing on disparities associated with individual characteristics without examining the overall quality of the health care system is short-sighted. Disparities will not be eliminated by conquering inequalities in specific geographic locations or categories of care. Meaningful change will require that disparities be addressed through organizational quality improvement and the development of performance assessment tools that can measure disparities at the organizational level.[4]

Along these lines, a growing consensus is developing that recognizes the reduction of disparities in the quality of care as an essential component of redesigning the U.S. health care system. Data from the 2004 Medical Expenditure Panel Survey (MEPS) released by AHRQ underlines the extent of the challenge from a population-wide perspective.[5] According to the survey, 48 million people under the age of sixty-five, 19% of the population, were estimated to be without health insurance.[6] About one in seven white non-Hispanics was uninsured, and 10% had only public insurance.[7] About one in five black non-Hispanics was uninsured, and 28% had only public insurance.[8] The proportion of uninsured was highest among Hispanics, at more than 33%, and 25% had only public health insurance.[9] Furthermore, 36% of all uninsured children under age eighteen are

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populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." UNEQUAL TREATMENT, *supra, citing* INST. OF MED., MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 21 (1990).

3. *See* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2004 NATIONAL HEALTHCARE DISPARITIES REPORT 3-4 (2004), *available at* http://www.qualitytools.ahrq.gov/disparitiesreport/documents/nhdr2004.pdf (citing HHS's *Healthy People 2010* report and IOM's *Unequal Treatment*); UNEQUAL TREATMENT, *supra* note 2, at 29-30, 77 (citing numerous studies supporting the conclusion that "racial and ethnic minority patients are found to receive a lower quality and intensity of healthcare and diagnostic services across a wide range of procedures and disease areas").

4. *See* Kevin Fiscella et al., *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 JAMA 2579 (2000).

5. JEFFREY A. RHOADES, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, THE UNINSURED IN AMERICA, 2004: ESTIMATES FOR THE U.S. CIVILIAN NONINSTITUTIONALIZED POPULATION UNDER AGE 65, at 1 (2005), *available at* http://www.meps.ahrq.gov/papers/st83/stat83.pdf.

6. *Id.*

7. *Id.* at 2; Press Release, Agency for Healthcare Research & Quality, AHRQ Issues New Data on the Uninsured (Aug. 9, 2005), *available at* http://www.ahrq.gov/news/press/pr2005/mepstatspr.htm.

8. RHOADES, *supra* note 5, at 2; Agency for Healthcare Research & Quality, *supra* note 7.

9. Agency for Healthcare Research & Quality, *supra* note 7.

Hispanic.[10] These statistics reinforce the conclusion that when a large proportion of the population cannot access the health care system because of a lack of insurance coverage, large gaps in the quality of care will persist.

Through the diligence and dedication of the health services research community and its many partners in government, the health care industry, academic centers, and philanthropic organizations, our nation now has a better understanding of the challenge of health care disparities than ever before. The development and dissemination of disparities-related evidence continues to be vitally important to inform decision-making, establish priorities, share best practices, and direct resources appropriately. We have a growing list of positive examples and promising initiatives. Now, we need to connect, sustain, and spread these practices and initiatives—and do it with a sense of urgency—as we seek to improve health care quality and access to health care across the United States.

Health services researchers have performed well in describing the scope and scale of the disparities dilemma. By adapting and applying many of the same tools and techniques, we have a significant opportunity to make meaningful and measurable progress to rectify the problems we identify and build bridges across the racial, ethnic, and socioeconomic divide that separates so many Americans from the health care services they need and deserve.

The impact of the hurricanes on over one million people residing in the Gulf Coast underscores the urgency of this task.[11] Many of the same factors that put the residents of New Orleans and other devastated communities in harm's way, such as poverty, lack of insurance, and community neglect, contribute to health disparities for poor and minority children and adults across the United States. As two of my AHRQ colleagues, David Atkins and Ernest Moy, note in an editorial for the *British Medical Journal*, "being poor in America, and especially being poor and black in a poor southern state, is still hazardous to your health."[12]

I. MEASURING AND MONITORING PROGRESS

The body of evidence documenting the persuasiveness of disparities in the American health care system has been growing for decades. In 1985, the *Report of the Secretary's Task Force on Black and Minority Health*, presented by then-Secretary of Health and Human Services Margaret Heckler, underscored the

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10. *Id.*

11. *See* Press Release, U.S. Census Bureau, Fast Facts on Areas Affected by Hurricane Katrina (Sept. 6, 2005), http://www.census.gov/Press-Release/www/releases/archives/hurricanes_tropical_ storms/005672.html (estimating the population for the New Orleans metropolitan area alone at 1,317,541 people).

12. David Atkins & Ernest M. Moy, Editorial, *Left Behind: The U.S. Hurricane Puts the Health Effects of Poverty and Race in Plain View*, 331 BRIT. MED. J. 916, 916 (2005).

federal government's commitment to address documented disparities in health status for the racial and ethnic groups in the nation.[13]

In 2003, the Institute of Medicine published *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.[14] The core paradox presented in the IOM study still resonates: how could well-meaning, highly educated health care professionals, working in their usual conditions, with diverse patient populations, create a pattern of care that appears to be discriminatory? In 2003 and 2004, AHRQ's publication of the NHDR began to answer critical questions about differences in health care and provide a more complete perspective of health care in the United States.[15] Along with the NHQR, the NHDR describes the current status of disparities and quality of American health care, and assesses how disparities and quality are changing over time.[16] In this context, the NHDR provides a useful tool for policymakers, payers, administrators, clinicians, and others to inform discussion, planning, and decision-making.

In addition, the research, reporting, and assessment tools used to create the NHDR are made available to health care providers and payers and local and regional communities. By applying these tools to their own data, decision-makers can compare their performance against the national benchmarks, identify where gaps exist, and focus efforts more effectively to close these gaps.

The 2004 NHDR, consistent with other studies and reports that address disparities-related research found that[17]:

- There is a substantial gap between the best possible quality and that which is routinely delivered;
- The gaps are larger still for individuals who are ethnic or racial minorities, poor, less well educated and geographically isolated;
- The magnitude of the gap for both quality and disparities differs according the clinical area, community, and other variables studied.

Three key themes are highlighted in the 2004 NHDR that relate to the differences Americans experience in access to high quality health care:

- Disparities are pervasive;

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13. SEC'Y'S TASK FORCE ON BLACK & MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH 1-2 (1985).

14. UNEQUAL TREATMENT, *supra* note 2.

15. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2004 NATIONAL HEALTHCARE DISPARITIES REPORT (2004), *available at* http://www.qualitytools.ahrq. gov/disparitiesreport/documents/nhdr2004.pdf.

16. *Id.* at 7.

17. *Id.* at 1-21.

- Improvement is possible;
- Gaps in information exist, especially for specific conditions and populations.[18]

As reported by the NHDR, the pervasiveness of health care disparities is observed in almost all aspects of health care. For example, for measures tracked in 2000 and 2001[19]:

- Blacks received lower quality of care than whites for about two-thirds of quality measures and had worse access to care than whites for about 40% of access measures;
- Asians received lower quality of care than whites for about 10% of quality measures and had worse access to care than whites for about a third of access measures;
- American Indians and Alaska Natives received lower quality of care than whites for about a third of the quality measures and had worse access to care than whites for about half of access measures;
- Hispanics received lower quality of care than non-Hispanic whites for half of quality measures and had worse access to care than non-Hispanic whites for about 90% of access measures;
- Poor people received lower quality of care for about 60% of quality measures and had worse access to care for about 80% of access measures than high income people.

When the 2005 NHDR is released in March, 2006, it will continue to measure and monitor our progress in the areas of quality and access to care, and provide another comprehensive set of plot points to help determine trends, evaluate progress, and inform strategies for closing the gaps. Scientific evidence related to specific diseases also illuminates the scope of the disparities issue. For example, in a recent AHRQ study, researchers found that blacks and Hispanics with diabetes are more likely than whites to require repeat hospitalization for complications related to their disease.[20]

The body of evidence related to improvement is less developed but continues to grow. Improvement-related research seeks to answer questions with important implications, such as, "Has the magnitude of racial disparities changed over time?"

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18. *Id.* at 1.

19. *Id.* at 2-3.

20. H. Joanna Jiang et al., *Racial/Ethnic Disparities in Potentially Preventable Readmissions: The Case of Diabetes*, 95 AM. J. PUB. HEALTH 1561, 1566 (2005).

In an August 2005 study published in the *New England Journal of Medicine* by AHRQ grantees, researchers compared the quality of care for elderly white and black Medicare beneficiaries based on an analysis of Health Plan Employer Data and Information Set (HEDIS) measures from 1997 to 2003.[21] It included 1.8 million individual-level observations from 183 health plans.[22] The results of the study indicated that clinical performance improved on all HEDIS measures for both white and black patients, and the gap between these patients narrowed in seven of the nine measures.[23] For example, the percentage of heart patients prescribed a beta-blocker drug within seven days of hospital discharge increased from 64% to 93% for black patients and from 76% to 94% for white patients.[24] This progress narrowed the prescription gap between blacks and whites to only one percentage point.

However, in two categories, the gaps increased. The gap between white and black patients increased from 4% to 7% in the category of blood sugar control among patients with diabetes, and from 14% to 17% for cholesterol control among patients with cardiovascular disorders.[25] Based on their findings, the researchers recommended that future research should examine the factors that contributed to closing of racial disparities on some measures and focus on interventions that can eliminate persistent disparities in the quality of care.

But what about specific medical conditions? Can efforts to improve the quality of care for a major medical problem, such as kidney disease, also reduce disparities in care related to race and ethnicity? Studies along these lines are still scarce, but very helpful in identifying opportunities for improvement. For example, a 2003 study published in the *Journal of the American Medical Association* showed that while quality improvement methods are promising, they are insufficient to eliminate disparities in health care among kidney dialysis patients.[26] As part of a quality improvement project for the Centers for Medicare and Medicaid Services (CMS), the research team evaluated data from 58,700 randomly selected dialysis patients.[27] The objective was to determine the effect of quality improvement efforts on race and gender disparities.[28]

21. Amal N. Trivedi et al., *Trends in the Quality of Care and Racial Disparities in Medicare Managed Care*, 353 NEW ENG. J. MED. 692, 692 (2005).

22. *Id.*

23. *Id.*

24. *Id.* at 694, 696.

25. *Id.* at 696-97.

26. Ashwini R. Sehgal, *Impact of Quality Improvement Efforts on Race and Sex Disparities in Hemodialysis*, 289 JAMA 996, 1000 (2003).

27. *Id.* at 996.

28. *Id.*

In 1993, the first year studied, 46% of white patients and 36% of black patients received an adequate hemodialysis dose.[29] Seven years later, 87% of the white patients and 84% of the black patients received an adequate dose.[30] While the proportion of patients receiving better hemodialysis care almost doubled, there still remained a 3% gap between black and white kidney patients.[31] During the same period, the gap between male and female patients decreased from 23% to 9%.[32] Based on these findings, the author of the study concluded that race and sex disparities be targeted as part of quality improvement activities.[33] The outcomes of whites, blacks, men, and women should be monitored separately, and population-specific quality improvement methods should be developed when appropriate.

In an editorial that followed this study, I, along with my co-author, Kaytura Felix Aaron, M.D., observed that:

> Appropriate collection and use of racial and ethnic data are essential to evaluate progress in minimizing inequality in quality of care . . . The rising tide of quality improvement may lead to improvements for all patients. But failure to examine the distribution of benefits may also wash away undiscovered information about the intersections of disease, individual characteristics, and health care delivery that are essential for eliminating disparities in health care and continuing to develop effective treatments.[34]

To focus on the underlying causes of health care inequities, and identify and implement strategies for reducing and eliminating them, AHRQ launched its EXCEED program in September 2000.[35] EXCEED, or Excellence Centers to Eliminate Ethnic/Racial Disparities, is a five-year program that involves nine projects organized around these themes[36]:

- Access and Quality of Care for Vulnerable Black Populations (Morehouse School of Medicine, G.A.)

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29. *Id.* at 998.

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.* at 1000.

34. Kaytura Felix Aaron & Carolyn M. Clancy, Editorial, *Improving Quality and Reducing Disparities: Toward a Common Pathway*, 289 JAMA 1033, 1034 (2003).

35. AGENCY FOR HEALTH CARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., PROGRAM BRIEF: EXCELLENCE CENTERS TO ELIMINATE ETHNIC/RACIAL DISPARITIES (EXCEED) 2 (2001), *available at* http://www.ahrq.gov/research/exceed.pdf.

36. *Id.* at 2-3.

- Health Disparities in Minority Adult Americans (University of Pittsburgh, P.A.)
- Improving the Delivery of Effective Care to Minorities (Mount Sinai School of Medicine, N.Y.)
- Overcoming Racial Health Disparities (University of North Carolina-Chapel Hill, N.C.)
- Promoting Effective Communication and Decision Making for Diverse Populations (University of California-San Francisco, C.A.)
- Racial and Ethnic Variation in Medical Interactions (Baylor College of Medicine, T.X.)
- UCLA/Drew/RAND Program to Address Disparities in Health (University of California, Los Angeles, C.A.)
- Understanding and Eliminating Health Disparities in Blacks (Medical University of South Carolina, S.C.)
- Understanding and Reducing Native Elder Health Disparities (University of Colorado Health Sciences Center, C.O.)

As an example of how EXCEED programs are translating research into real-world programs, the Baylor project team has launched a "How to Talk to Your Doctor" program in Houston, Texas, as part of the Texas Medical Center's Health Information Kiosk Project.[37] A network of health information kiosks has been built to serve members of underserved communities, and provides interactive information in five languages.[38]

AHRQ looks forward to sharing the lessons learned from these projects. The practical tools and strategies to eliminate disparities that come out of EXCEED will be widely applicable for minority and priority populations around the country. Wherever possible, AHRQ seeks to support programs that translate disparities-related research into practice at the community level.

Practice-Based Research Networks (PBRNs) have established an outstanding track record of producing research findings that are immediately relevant to primary care physicians and more easily assimilated into everyday practice.[39] A significant share of the work being done by AHRQ-supported PBRNs is devoted to disparities-related issues, with much of it focused on using health information

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37. E-mail from Coreen Domingo, EXCEED Program Grant Coordinator, Baylor College of Medicine, to Andrea Vaughn, Staff Editor, *Journal of Health Care Law and Policy* (Oct. 27, 2005, 10:37:44 CST) (on file with the *Journal of Health Care Law & Policy*); Press Release (draft), Agency for Health Care Research and Quality, Texas Medical Center (Spring 2005) (on file with the *Journal of Health Care Law & Policy*).

38. AGENCY FOR HEALTH CARE RESEARCH & QUALITY, *supra* note 35.

39. AGENCY FOR HEALTH CARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., FACT SHEET: PRIMARY CARE PRACTICE-BASED RESEARCH NETWORKS 1 (2001), http://www.ahrq.gov/research/pbrnfact.pdf.

technology to improve recordkeeping and support clinicians and patients in rural health care settings. For example, of the thirty-six PBRN projects funded by AHRQ in 2002, sixteen projects addressed ways to reduce health care disparities.[40] PBRNs will continue to be an important part of AHRQ's commitment to finding practical solutions to the disparities challenge.

In addition to PBRNs, other models for conducting disparities-related research in close proximity to clinical settings are developing across the United States. One of the most promising initiatives was launched this summer at Massachusetts General Hospital with the creation of its new Disparities Solution Center.[41] Envisioned as a "living laboratory," the Center will involve front-line physicians, academic researchers, and patients in efforts to learn what works—and what doesn't work—when it comes to eliminating disparities in health care between racial and ethnic groups.[42]

II. BUILDING DISPARITIES-RELATED RESEARCH CAPACITY

Even as more evidence accumulates about the disparities in health care quality and access, gaps in information exist, especially for specific conditions and populations. For example, the 2004 NHDR pointed out that there are few measures for conditions like quality of H.I.V. care and mental health care, and few measures that are unique but critical to specific populations.[43] In addition, there was limited data to address specific population groups, such as children, the elderly, persons with disabilities, rural residents, and others.[44] Not enough information was available to address Hispanic and Asian subpopulations and barriers related to language and literacy, and the knowledge required to understand why disparities exist and how they can be eliminated is incomplete.[45]

Adhering to the long-held maxim of "that which can be measured can be changed," AHRQ is stepping up efforts to fill gaps in disparities-related research. In 2003, AHRQ realigned its organizational structure and established the Division of Priority Populations Research (DPPR) within the new Office of Extramural Research, Education, and Priority Populations.[46] The DPPR advises the Agency

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40. *See* AGENCY FOR HEALTH CARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., NEW PRIMARY CARE PBRN AWARDS (2002), http://www.ahrq.gov/research/pbrnproj.htm (listing PBRN projects funded by AHRQ).

41. Stephen Smith, *MGH Seeks to Bridge Racial Gap*, BOSTON GLOBE, July 26, 2005, at A1.

42. *Id.*

43. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2004 NATIONAL HEALTHCARE DISPARITIES REPORT 5 (2004).

44. *Id.*

45. *Id.*

46. Statement of Organization, Functions, and Delegations of Authority, 68 Fed. Reg. 44,084, 44,086-87 (July 25, 2003).

on ways to improve the quality, safety, and effectiveness of health care for priority populations, develops research agendas, and coordinates health care improvement efforts with other organizations.[47]

AHRQ is also working with many others in the health services research community to frame research questions in ways that can speed up the process of finding and testing methods that can reduce disparities and inequities in the U.S. health care system. By determining when evidence should be broad-based or focused on specific populations and medical conditions, researchers can move beyond a "gee whiz, this is a big problem" reaction to asking—and answering— specific questions, such as:

- Why and how do disparities occur in the health care system?
- What share of these disparities can be improved?
- When should evidence be broad and when should it be population-specific?
- How do we collect relevant data respectfully?
- For practical purposes, how precise does the data have to be? Is it enough to identify subgroups at the highest risk of poor quality by geographic coding?
- How can we link evidence of a problem to possible solutions?

Two years ago, AHRQ took steps to require that researchers consider the inclusion of minorities and women as research subjects where scientifically appropriate, and encouraged investigators to consider children as well.[48] This policy is designed to ensure that AHRQ's research portfolio encompasses priority populations. It also will enable better tracking of results over time and facilitate the identification of critical gaps in knowledge and implementation.

Since most health care in the United States is delivered through employer-provided health plans, data from these plans is needed for health service researchers to track our progress on disparities reduction. However, according to a 2004 report from America's Health Insurance Plans (AHIP), almost half of health plan enrollees surveyed belong to a health plan that does not collect data on race and ethnicity.[49] We need to collect and analyze more racial and ethnic data from health plans and insurers so this data can be used to help improve patient care.

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47. Office of Extramural Research, Education, & Priority Populations, U.S. Dep't of Health & Human Servs., Mission Statement (2003), http://www.ahrq.gov/about/oerep/oerepmiss.htm.

48. Agency for Healthcare Research & Policy, *Invitation to Comment: AHRQ Preliminary Policy on Inclusion of Priority Populations in Research* (Apr. 1, 2002), http://ahrq.gov/fund/prioritypop.htm.

49. AMERICA'S HEALTH INSURANCE PLANS, COLLECTION OF RACIAL AND ETHNIC DATA BY HEALTH PLANS TO ADDRESS DISPARITIES: FINAL SUMMARY REPORT 1, 3 (June 1, 2004), *available at*

Fortunately, the leaders of many of America's largest health plans recognize that, to make measurable progress on reducing disparities, they need to gather and disseminate sufficient data on the race and ethnic background of their enrollees. To this end, AHRQ is sponsoring a National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality.[50] This collaborative includes ten of America's foremost health plans, including Aetna, Anthem, Cigna, Harvard Pilgrim, HealthPartners, Highmark, Kaiser Permanente, Molina UnitedHealth Group, and Wellpoint.[51] To further the aims of this unique collaboration, AHRQ has joined with the Robert Wood Johnson Foundation and the RAND Foundation, AHIP, and the Blue Cross and Blue Shield Association.[52] Working together, these organizations will develop ways to improve the collection of race and ethnicity data and develop interventions that can reduce disparities in treatment of diabetes and other chronic conditions.

The importance of collaborative efforts to eliminate disparities, especially at the community level, cannot be overstated. In the political world, pundits often say, "all politics are local." In the same vein, all disparities are local, and efforts that will drive meaningful change ultimately need to happen at the level of cities, towns, and neighborhoods. When speaking at the Inaugural Health Education Research Disparities Summit, my colleague, Ernest Moy, who leads the AHRQ team that publishes the National Healthcare Disparities Report, shared these insights on the critical role of communities in finding solutions:

> [People] don't want to know about the national level or the state level; they want to know what's happening in their communities. I think it's really important to acknowledge, they have unique disparities populations and unique conditions that are most importantly [sic] to them, they have unique causes probably in their community and they have unique resources that are available to them which will lead them to different solutions . . . I think communities can capture disparities information about themselves much more efficiently than we can at the federal level, and what we try in the reports to do is to develop tools that communities can apply for themselves. Use these tools, look at my own data this way, and then have a standardized format. If they can do that, they'll have national and state standards with which to compare themselves.[53]

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http://www.rwjf.org/files/research/080504AHIPFinalSummary.pdf   [hereinafter   FINAL   SUMMARY REPORT].

50. Press Release, Agency for Healthcare Research & Quality, Major Health Plans and Organizations Join AHRQ to Reduce Racial and Ethnic Disparities in Health Care (Dec. 14, 2004), http://www.ahrq.gov/news/press/pr2004/dispcolpr.htm.

51. *Id.*

52. *Id.*

53. Ernest Moy, Address at the Inaugural Health Education Research Disparities Summit (Aug. 8, 2005), *available at* http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&

III. BUILDING MOMENTUM TO ELIMINATE THE GAPS

In light of all the research available on the subject of disparities, and the considerable extent in which disparities are observed in our nation's health care system, the continued existence of disparities, and lack of faster progress on closing the gaps, are simply unacceptable. We no longer have the luxury of time for more studies showing that disparities exist. The health services research community, and its partners in the public and private sector, need to organize and support studies that show how to reduce and eventually eliminate the gaps.

A convergence of trends and technologies is making the first decade of the twenty-first century a fortuitous time for redoubling our commitment to reducing disparities in heath care. One of the most powerful enablers is the long-awaited migration of our health system from a paper-based system to a networked system based on health information technology. The President and the Secretary of Health and Human Services have made electronic health records for most Americans by the year 2014 a top health information technology (health IT) priority.[54]

The implications of health IT on disparities-related research and knowledge dissemination are profound. More information will be available and accessible to researchers on populations and specific conditions, as a health IT system comes on-line that protects patient confidentiality while it gathers important information on priority populations that is now missing. Health IT promises to speed the flow of information, not only between payers and clinicians, but also to patients and consumers, who will have greater access to health information and be empowered to make more informed choices about their health care.

For over a decade, AHRQ has supported research to help build the technical and operational foundation of health IT in clinical settings. Now we are supporting research projects that promote access to health IT across America. During the next five years, we will be directing the investment of over $139 million through over 100 grants to communities, hospitals, providers, and health care systems to help in all phases of development. These grants will be active in forty states, with a special focus on small and rural hospitals and communities, which have a disproportionate share of underserved populations. Examples of AHRQ-sponsored health IT projects include:

- The implementation of a community-wide Electronic Health Records (EHR) system to improve asthma care for inner-city children in Connecticut;

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54. Mike Leavitt, Sec'y, U.S. Dep't of Health & Human Servs., Address Before the Health Information and Management Systems Society Conference (June 6, 2005), *available at* http://www.hhs.gov/news/speech/2005/050606.html.

- An emergency department EHR system for Louisiana's critical access hospitals;
- An electronic radiology initiative to serve three hospitals in rural Maine;
- A Computerized Physician Order Entry System (CPOE) to serve an inner-city, minority community in Ohio;
- A patient-centered medication information system to improve health of chronically ill elders in rural Oregon.

As health IT transforms our health care system, AHRQ is developing a strategic framework that can concurrently reduce health care disparities and harness public and private sector resources to build momentum for change. While this framework is still evolving, it includes the following objectives:

- Diffuse health information technology more equitably to ensure that priority populations and the clinicians that serve them are wired into the emerging national health IT system;
- Refine reimbursement strategies and target capital investment to reward initiatives that can reduce disparities;
- Improve the cultural competency of providers through training that prepares clinicians to care for diverse populations;
- Celebrate champions at all levels of organizations that implement practical solutions for closing health care gaps for priority populations.

This framework for progress is also based on expanding partnerships with other governmental and non-governmental organizations committed to bridging the chasm caused by health care disparities. For example, AHRQ is working closely with the Health Resources and Services Administration (HRSA) and the National Cancer Institute (NCI) on a Health Disparities Collaborative project to improve the quality of care delivered to members of racial and ethnic minority groups being treated for cancer. Twenty-one teams are involved in implementing the cancer collaborative, along with three pilot studies on health center inventories, tool evaluations, and chart audits. AHRQ is also partnering with leading philanthropic organizations, such as the Robert Wood Johnson Foundation and the Commonwealth Fund, to use the NHDR as a blueprint for disparities reduction and involve the expertise of these organizations in broader efforts that address disparities-related issues.

IV. ROLE OF THE LEGAL PROFESSION

The legal profession has an important role to play, especially when it comes to addressing the pervasive socioeconomic and environmental conditions that make it more difficult for priority populations to receive health care. There are many examples of the legal profession's commitment to eliminating health care disparities, but for the purposes of this discussion, two examples illustrate how lawyers and legal educators can make a significant difference at the family and community level.

Since 1993, the Boston Medical Center (BMC) has provided free legal assistance to economically disadvantaged families with children who are patients at the Center.[55] Working out of weekly walk-in clinics at the Center and at four neighborhood locations, BMC's Family Advocacy Program (FAP) lawyers help parents address socioeconomic problems that compromise the health care and the ongoing health of their children.[56] For example, FAP's lawyers handle issues related to immigration status, domestic violence, and access to appropriate health care, welfare, disability, and food stamp benefits.[57] FAP attorneys also help the families of BMC patients resolve sub-standard or unsafe housing problems, and find ways to restore utility services that have been cut off due to non-payment of bills.[58]

Working in partnership with BMC pediatricians, FAP attorneys have successfully advocated change through policy reform initiatives. FAP staffers and volunteers train health care providers, social workers, mental health providers, and other health care professionals in a variety of advocacy topics and strategies.[59] Legal advocacy programs based on the FAP model have also spread to Connecticut, Illinois, New Jersey, Rhode Island, and Washington, D.C.[60]

At the University of Michigan Law School in Ann Arbor, Michigan, legal educators believe that providing legal advocacy to low-income families with sick children also provides significant learning opportunities for clinical law students. Through its new Pediatric Advocacy Clinic (PAC), established in 2003, University of Michigan law students, under the tutelage of law professors, work with doctors, nurses, and social workers to help families lower barriers to their children's health.[61]

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55. Boston Medical Center Pediatrics, http://www.familyadvocacyprogram.org/family_services.html (last visited Mar. 5, 2006).

56. *Id.*

57. Family Advocacy Program, Boston Medical Pediatrics, http://www.familyadvocacyprogram.org/family_services.html (last visited Mar. 5, 2006).

58. *Id.*

59. Family Advocacy Program, *supra* note 57.

60. *Id.*

61. Press Release, University of Michigan News Service, Law School develops collaborative pediatric advocacy clinic (Jan. 28, 2005), http://www.umich.edu/news/?Releases/2005/Jan05/r012805.

Children who live in poverty are vulnerable to a range of health and developmental risks, such as exposure to lead paint, asbestos, diesel fumes, and other asthma triggers. Law students involved with the Clinic provide a range of advocacy interventions to address these and other health issues, and help families navigate through the system to find the public resources they need for housing, health care, education, and other needs.[62] Wherever possible, the focus of the UM Law School PAC is to take a preventive rather than reactive approach to legal advocacy.[63]

CONCLUSION

As the evidence continues to accumulate about the impact of health care disparities on the quality of U.S. health care, a growing number of health care professionals, including clinicians, educators, and researchers, are engaged in understanding the challenge and finding solutions. Nevertheless, the scope of the disparities challenge is so wide that the active participation of professionals beyond the health care sphere is also essential to making progress in closing the gaps.

Ultimately, the key to bridging the racial divide in U.S. health care and the catalyst for turning evidence into action is collaboration. As a nation, we need to build and maintain working partnerships between health care, legal, and social work professionals, governments at all levels, the business community, philanthropic organizations, advocacy groups, and other entities committed to removing the barriers that prevent so many Americans from accessing and receiving quality medical care.

AHRQ is proud of its tradition of supporting groundbreaking research to identify racial, ethnic, and socioeconomic disparities in the delivery and outcomes of health care services in the United States. We will continue to improve how we gather and disseminate the evidence required to monitor and track improvements. We will report on a regular basis how and where progress is being made, and where gaps need to be closed. We will build new partnerships, explore new ideas, test solutions, and share our successes. Step by step, measure by measure, community by community, we will continue the journey, until the promise of quality health care becomes a reality for all Americans.

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62. *Id.*
63. *Id.*