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## 2005 Annual Report

### Quality of Care for Underserved Populations



Many projects supported by the Quality of Care for Underserved Populations program evaluate health care delivery innovations that address the needs of minority and low-income patients. At La Causa Resource Center in Milwaukee, Wisc., parents are mentoring other parents to help them better manage their children's asthma—part of a trial under way at the Medical College of Wisconsin.

Photo: University of Wisconsin–Milwaukee Media Production

The Commonwealth Fund's Program on Quality of Care for Underserved Populations focuses on improving health care for minority and low-income patients—groups whose health may be compromised by a lack of care that is responsive to their particular needs, concerns, and cultural background. The program's primary goals are to improve quality of care and reduce disparities related to race, ethnicity, and income by:

- supporting models of high-performance health care for underserved populations;
- promoting patient-centered care for these populations; and
- highlighting policies that lead to improved care.

Racial and ethnic disparities in health care quality are well documented in the Institute of Medicine's report, *Unequal Treatment*, as well as in the Agency for Healthcare Research and Quality's annual National Healthcare Disparities Report.<sup>1,2</sup> While recent findings suggest that some progress has been made in closing the gaps,<sup>3</sup> significant efforts are still

needed to ensure high-quality care for all minority and low-income patients.

One of the strategies of the Underserved Program is to identify and disseminate best practices in safety net hospitals and community health centers, which serve large numbers of racial and ethnic minorities and low-income patients. Although these health systems face challenges due to lack of resources, they have demonstrated the ability to provide high-quality care.

In a Fund-supported study, Marsha Regenstein, Ph.D., and colleagues at the National Public Health and Hospital Institute found that clinical outcomes for public hospital patients with diabetes—many of whom are particularly vulnerable due to low income and lack of health insurance—were comparable to or, in some cases, even better than national averages for all hospitals.<sup>4</sup> Still, neither public hospitals nor managed care plans performed as well as the Veterans Administration (VA), a public health system that has rigorous protocols for quality improvement. The authors suggest that the VA's success in managing patients with diabetes can serve as a model for delivering high-quality care to underserved patients.

In 1998, the Bureau of Primary Health Care initiated health disparities collaboratives, which enable community health centers (CHCs) and other safety net providers to work together to improve the quality of patient care. The Fund and the Agency for Healthcare Research and Quality are cosponsoring an evaluation of these collaboratives for patients with hypertension, diabetes, and asthma to determine whether they have been effective in reducing disparities. Preliminary findings show that CHCs deliver care of comparable quality to that delivered in other sectors of the health care system, despite the challenges presented by disadvantaged populations.<sup>5</sup> There is room for improvement, however:

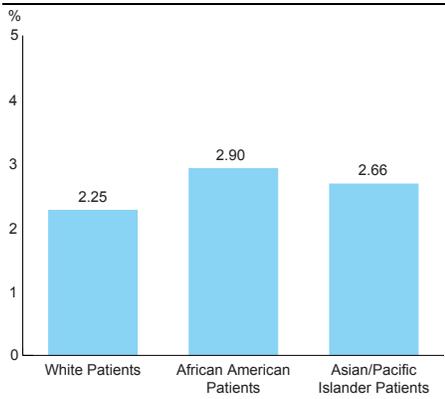
quality of care was found to vary by patient as well as health center characteristics, such as use of electronic health records.

To catalyze improvements in the health care received by minority patients in Medicaid managed care plans, the Fund is supporting the Center for Health Care Strategies (CHCS) in the development of the Best Clinical and Administrative Practices (BCAP) initiative. BCAP leaders are identifying highly effective practices used by state Medicaid agencies to improve quality and evaluating federal and state regulations that address racial and ethnic health disparities. They are also working with 12 Medicaid managed care plans in a demonstration project to improve care for minority patients. Best practices and lessons will be posted on the CHCS and Fund Web sites and disseminated to Medicaid agencies and managed care plans through the BCAP Quality Summit.

Much of the literature on health disparities finds that minority patients presenting with the same symptoms and background as white patients are less likely to receive appropriate care for their conditions.<sup>6</sup> Minority patients are also less likely than white patients to get their care from high-performing health systems, according to a Fund-supported study. Dana Mukamel, Ph.D., from the University of California, Irvine, found that when African Americans saw cardiothoracic surgeons for diagnostic or therapeutic procedures, they were less likely than white patients to go to high-quality hospitals or see high-quality surgeons.<sup>7</sup> Mukamel also found that after the release of surgeon “report cards” in New York State, black patients’ access to the best hospitals and the best providers improved.<sup>8</sup> Before the reports were available, patients chose surgeons based primarily on observable characteristics, such as years of experience or price; patients’ behavior changed, however, with the availability of explicit quality information, such as surgeons’ mortality rates for specific procedures.

African Americans and Asian/Pacific Islanders are more likely to be treated by physicians with higher average risk-adjusted mortality rates.

**Average risk-adjusted mortality rate of physicians treating...**



Note: The mortality rate statewide for all patients was 2.44% in 1996 and 2.22% in 1997.

Source: B.M. Rothenberg et al. "Explaining Disparities in Access to High Quality Cardiac Surgeons," *Annals of Thoracic Surgery* 78 (July 2004): 18-24.

The Fund is also supporting work to identify high-performing health systems for racial and ethnic minorities by using the 10 hospital quality measures adopted by the National Voluntary Hospital Reporting Initiative. Researchers at the Health Research and Educational Trust are working with the private University HealthSystem Consortium to collect and analyze the quality data, which are stratified by race, ethnicity, and primary language to measure disparities in inpatient care. The research team is also conducting case studies to assess how individual hospitals respond to reporting quality data by race/ethnicity. Another research team, based at George Washington University, is developing protocols for using the reporting framework at six major public hospitals that treat large minority populations.

Patients who have limited proficiency in English or difficulty comprehending physician instructions and health information often experience problems accessing care. Many also receive lower-quality care or underutilize appropriate health services. With support from the Fund, Glenn Flores, M.D., from the Medical College of Wisconsin, found that parents with limited English proficiency (LEP) are three times more likely than English-proficient parents to have a child in fair or poor health, and twice as likely to have had a child spend one or more days in bed with an illness in the past year.<sup>9</sup>

Flores concluded that parental LEP is a more precise measure of language barriers in health care than the primary language spoken at home—and recommends that health plans routinely collect information on their patients' English proficiency to measure demand for interpreter services.

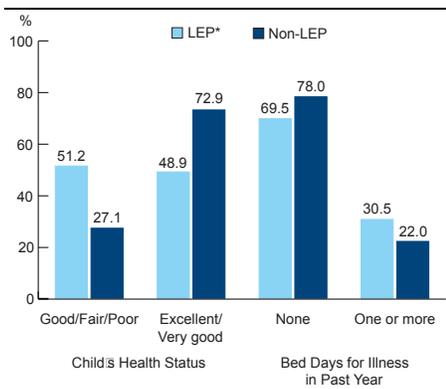
Although the importance of having well-trained medical interpreters is widely recognized, there are few national standards of practice. With support from the Fund and the California Endowment, the National Council on Interpreting in Health Care has laid the groundwork for creation of such



Glenn Flores, M.D.  
Medical College of Wisconsin

Limited English proficiency of parents can negatively affect children's health status.

**Percent**



Source: G. Flores, M. Abreu, and S.C. Tomany-Korman, "Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers Are Measured Matters," *Public Health Reports* 120 (July/August 2005): 418-30.

Note: P-values (from chi-square test): child health status, <0.001; bed days for illness in past year, 0.004.

\* LEP=Limited English Proficiency

standards.<sup>10</sup> In a Council report reviewing interpreting standards in the United States and around the world, Marjory Bancroft, founder and director of CrossCultural Communications, found that conference, legal, and sign-language interpreting are far more developed than community or health care interpreting.

Health care providers who would like to offer translation services to their LEP patients must find qualified interpreters and secure resources to pay for their services. This can be particularly challenging in solo or small group practices, in which nearly 60 percent of physicians practice. The Fund provided support to the National Health Law Program to identify promising models for providing language services in small group settings.<sup>11</sup> The innovative practices identified include designating a staff member to direct language access planning; determining language needs at first point of contact with patients; and hiring bilingual mid-level practitioners or dedicated staff interpreters.

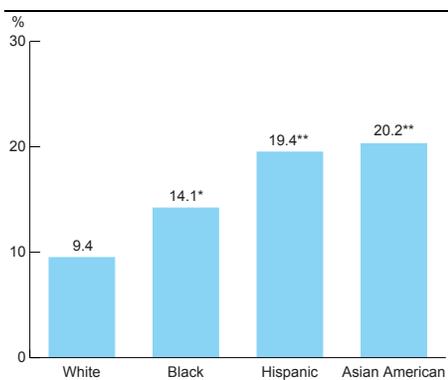
The Underserved Populations program is also supporting the dissemination of the National Quality Forum's safe practice regarding informed consent, whereby patients are asked to "teach back" their comprehension of a surgical procedure and its risks.<sup>12</sup> So far, a number of hospitals have implemented this practice among patients with limited English proficiency or low health literacy.

Good patient-provider communication is an important component of health care providers' "cultural competency," but there is more to it than that. Cultural competency involves responsiveness to all aspects of a patient's culture, enabling providers to promote greater engagement of patients in managing their medical conditions.

Fund-supported research has found that perceptions of disrespect affect whether patients heed doctors' advice or return for treatment. In an analysis of the 2001 Health Care

Percentage of patients who felt they were looked down upon/treated with disrespect by their doctors.

**Percent**



Source: J. Blanchard and N. Lurie, "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice* 53 (Sept. 2004): 721.

\*  $p \leq 0.10$   
\*\*  $p \leq 0.001$

Quality Survey, George Washington University's Janice Blanchard, M.D., and RAND's Nicole Lurie, M.D., found that minorities are significantly more likely than whites to report being treated with disrespect by their providers.<sup>13</sup>

Respondents who reported disrespectful treatment were more likely to report not following their doctors' advice and putting off needed medical care.

As a first step toward developing standards for cultural competency training, implementation, and assessment, the Fund has commissioned a series of papers exploring aspects of cultural competency and patient-centered care for minorities. Using the papers as a basis for discussion, the Fund will host a roundtable meeting of experts to determine next steps in this effort.

The Fund also seeks to promote awareness of health care disparities, and of federal and state policies that can help reduce them. Support for press conferences and a congressional briefing, for example, enabled the Summit Health Institute for Research and Education, Inc., to inform key policymakers about findings from the Institute of Medicine's *Unequal Treatment* report and the Agency for Healthcare Research and Quality's National Healthcare Disparities Reports. Summit also provided information and technical assistance to national advocacy organizations that promote policies addressing health disparities.

In June 2005, the Fund and the Alliance for Health Reform sponsored a roundtable discussion, "Leveraging Quality Data to Eliminate Disparities," that explored ways of using quality data to identify disparities and applying these methods to publicly funded health programs. One of the panelists, Bruce Siegel, M.D., a professor at the George Washington University School of Public Health and Health Services, presented Fund-supported work showing that public hospitals are able to report quality indicators stratified by race

and ethnicity. Siegel showed that this can help hospitals identify areas where quality improvement efforts can not only improve care but also reduce inequities in the care delivered.

In response to studies documenting widespread failings in access to care and quality of care for millions of minority children, Senior Program Officer Anne C. Beal, M.D., published a *Health Affairs* article outlining federal interventions that may reduce racial disparities in pediatric care.<sup>14</sup> These policies include broadening health care coverage, adopting common quality improvement efforts, improving the training of health care providers, and boosting the ranks of minority clinicians. The recommendations from this paper have been reported to the Department of Health and Human Services Office of Minority Health and the Congressional Black Caucus Health Braintrust.

In addition, John McDonough, Ph.D., of the consumer health advocacy organization Health Care For All prepared a Fund report<sup>15</sup> that provided state policymakers with a menu of disparity-reduction policy interventions implemented at the state or local level. He identified a number of key strategies that should be considered, from establishment of minimum standards for culturally competent health services to greater minority representation within the health care workforce. The New England Coalition for Health Equity sponsored a symposium focused on implementation of McDonough's recommendations.

## **Fellowship in Minority Health Policy**

Improving the health care system's capacity to address the needs of minority and disadvantaged populations is the goal of the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy. Directed by Harvard Medical School's Joan Reede, M.D., the program offers an intensive, one-year, full-time program of study to future physician-leaders who

intend to pursue careers in minority health care or health policy. Approximately five fellows each year complete academic work for a master's degree in public health or public administration.



Dora L. Hughes, M.D., a 1999–2000 Minority Health Policy Fellow, is currently a legislative assistant to U.S. Senator Barack Obama.

Most of the 46 alumni physician fellows hold appointments at schools of public health or medicine, and several have assumed leadership roles in public health departments or community health centers. Past fellows also serve on numerous local and national advisory committees related to minority health.

Over the past year, several alumni of the fellowship have seen their research published in peer-reviewed journals. For an issue of *Health Affairs* devoted to health care disparities, Amal Trivedi, M.D., described a disparities report card he developed for states, which he based on Fund-sponsored work by John McDonough, Ph.D. In the same issue, Joseph Betancourt, M.D., reported that fostering “cultural competence” has been gaining attention, not only as a strategy to reduce racial and ethnic disparities but more broadly as a means of improving the quality of health care. In addition, Yvette Roubideaux, M.D., authored a Fund report documenting health care disparities among American Indians and Alaska Natives (AIANs) and progress made in the last five years to reduce gaps in care. She concluded her paper with 10 recommendations for future action.

Under Dr. Reede’s leadership, the fellowship program in the past year has established connections with state and local health departments and sought post-fellowship support from several organizations. It has also created a national advisory committee, which mentors fellows and identifies possible employment opportunities.

*2005–06 Fellows in Minority Health Policy*



- **Kansky Delisma, M.D.**, emergency room attending physician at the Veterans Administration Medical Center in Connecticut. Dr. Delisma is particularly interested in migrant health issues, especially those relevant to the rapidly growing Haitian American community.



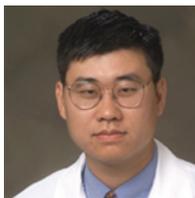
- **Jean LeClerc Raphael, M.D.**, chief resident of pediatrics at Boston Medical Center. Dr. Raphael has a keen interest in poverty and chronic disease, as well as health care in the juvenile justice system. He aims to combine a career of clinical medicine with active engagement in the policy and legislative arenas.



- **Sarah Perez McAdoo, M.D.**, chief resident in obstetrics and gynecology at Baystate Medical Center, Massachusetts. Her interest focuses on adolescent reproductive health and teenage pregnancy prevention. She is particularly interested in becoming an advocate for the health of Latinas.



- **Anthony L-T Chen, M.D.**, lead family physician at the International Community Health Services, Holly Park Medical & Dental Clinic; and clinical assistant professor at University of Washington Department of Family Services. Dr. Chen has a strong interest in cross-cultural medicine and cultural competency in health care, community-oriented primary care, and Asian health issues.



- **Don Suk Lee, M.D.**, internal medicine resident at Aurora Sinai Medical. Dr. Lee will focus his research on developing an efficient health care delivery system in an urban, underserved area, with particular emphasis on serving minority and disadvantaged populations.

## NOTES

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<sup>1</sup> B. D. Smedley, A. Y. Stith, and A. R. Nelson (eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: The Institute of Medicine, 2002).

<sup>2</sup> Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, National Healthcare Disparities Report (Washington, D.C.: AHRQ, 2004).

<sup>3</sup> A. N. Trivedi, A. M. Zaslavsky, E. C. Schneider et al., "Trends in the Quality of Care and Racial Disparities in Medicare Managed Care," *New England Journal of Medicine*, Aug. 18, 2005 353(7):692–700.

<sup>4</sup> M. Regenstein, J. Huang, L. Cummings et al., *Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems* (New York: The Commonwealth Fund, June 2005).

<sup>5</sup> J. Hicks et al., "Determinants of Quality of Chronic Disease Management Among Community Health Centers in the United States," manuscript under review.

<sup>6</sup> K. A. Schulman, J. A. Berlin, W. Harless et al., "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization," *New England Journal of Medicine*, Feb. 25, 1999 340(8):618–26.

<sup>7</sup> B. M. Rothenberg, T. Pearson, J. Zwanziger et al., "Explaining Disparities in Access to High-Quality Cardiac Surgeons," *Annals of Thoracic Surgery*, July 2004 78(1):18–24.

<sup>8</sup> D. B. Mukamel, D. L. Weimer, J. Zwanziger et al., "Quality Report Cards, Selection of Cardiac Surgeons, and Racial Disparities: A Study of the Publication of the New York State Cardiac Surgery Reports," *Inquiry*, Winter 2004/2005 41(4):435–46.

<sup>9</sup> G. Flores, M. Abreu, and S. C. Tomany-Korman, "Limited English Proficiency, Primary Language Spoken at Home, and Disparities in Children's Health and Healthcare: How Language Barriers Are Measured," *Public Health Reports*, July/Aug. 2005 120(4):418–30.

<sup>10</sup> M. Bancroft, *The Interpreter's World Tour: An Environmental Scan of Standards of Practice for Interpreters* (The California Endowment, Mar. 2005).

<sup>11</sup> M. Youdelman and J. Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (New York: The Commonwealth Fund, May 2002).

<sup>12</sup> National Quality Forum, *Learning from Early Adopters: Improving Patient Safety Through Informed Consent in Limited English Proficiency/Low-Literacy Populations*, NQF Policy Brief (Dec. 2003).

<sup>13</sup> J. Blanchard and N. Lurie, "R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care," *Journal of Family Practice*, Sept. 2004 53(9):721.

<sup>14</sup> A. C. Beal, "Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care," *Health Affairs*, Sept./Oct. 2004 23(5):171–79.

<sup>15</sup> J. E. McDonough, B. K. Gibbs, J. L. Scott-Harris et al., *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities* (New York: The Commonwealth Fund, June 2004).