

## The Commission

# *to End Health Care Disparities*

Unifying efforts to achieve quality care for all Americans

### Commission Secretariat

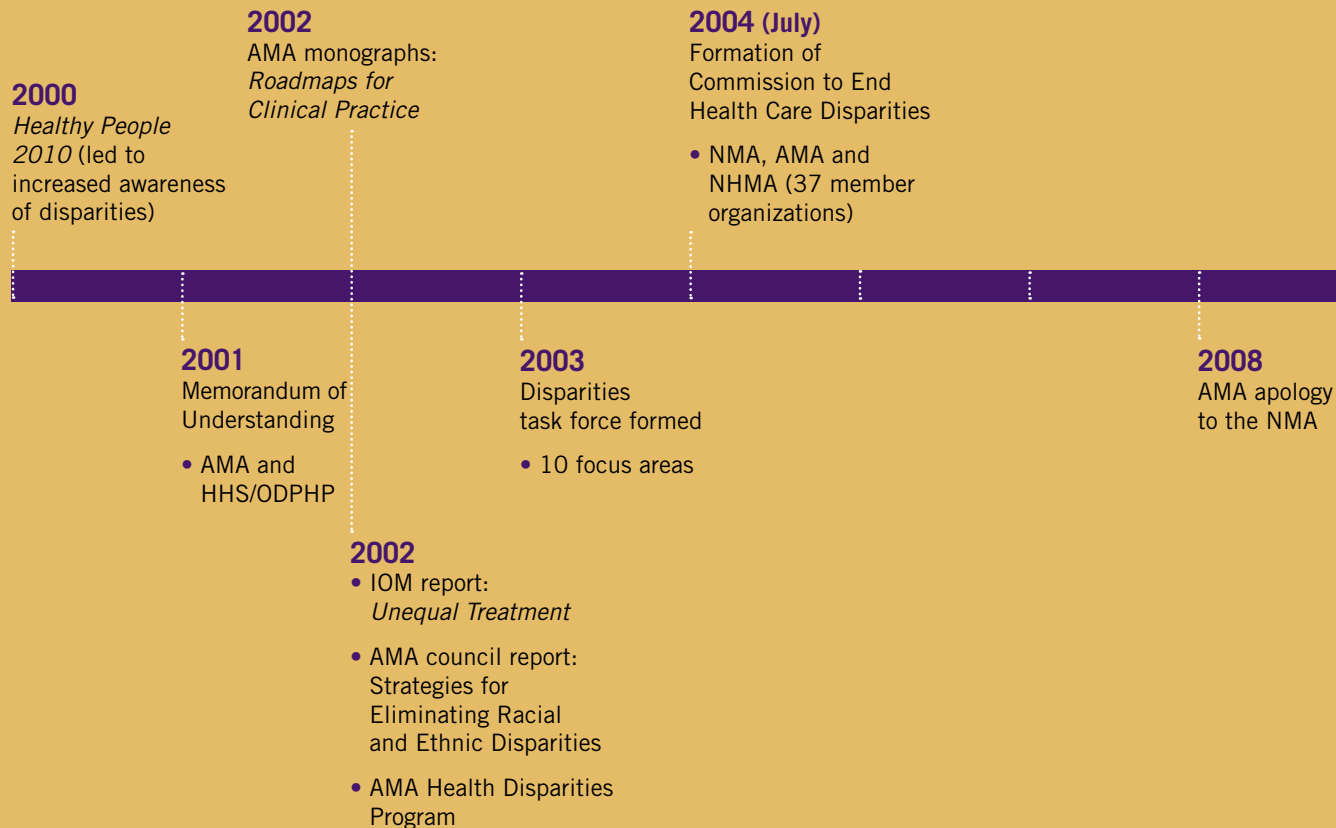
American Medical Association

National Medical Association

National Hispanic Medical  
Association

# The Commission to End Health Care Disparities

## Key initiatives and milestones



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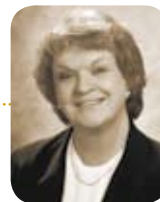
## A message from the commission leaders

### 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



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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.

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President, American Medical Association

Sandra Gadson, MD

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## Five-year summary

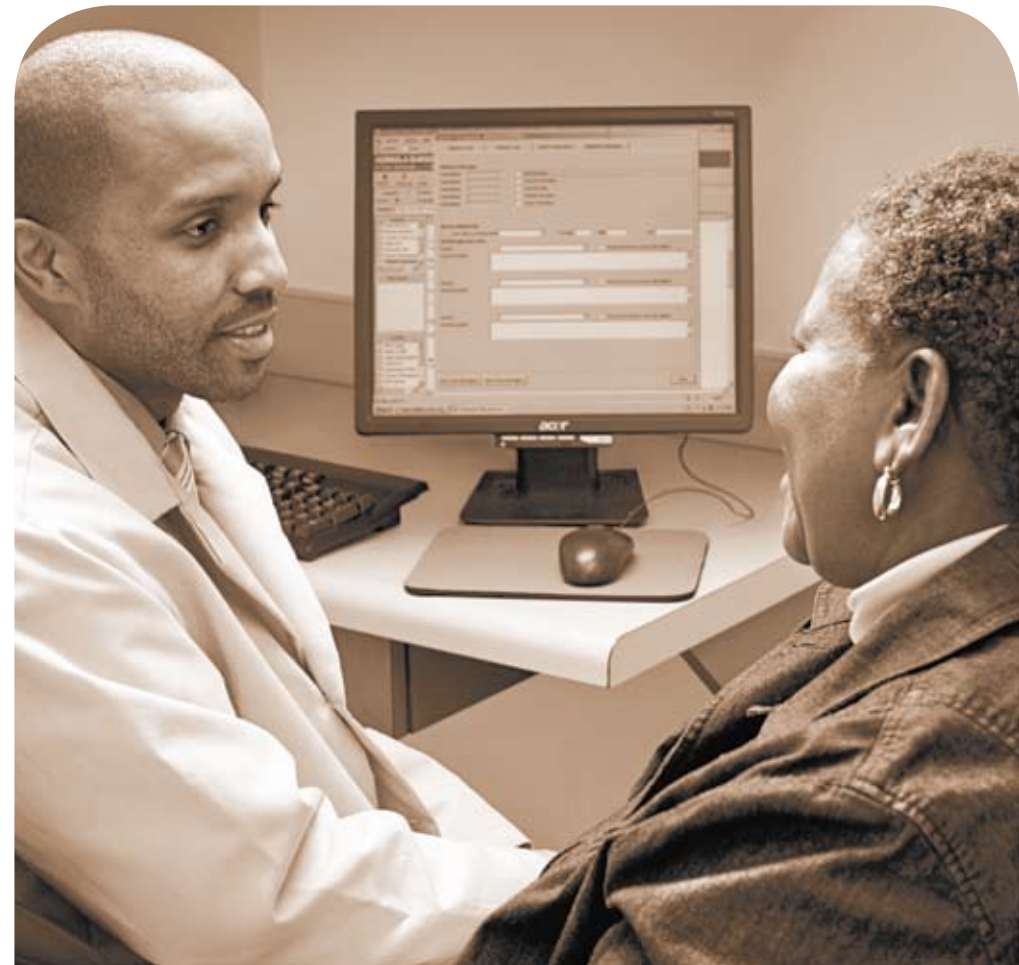
Representing five ambitious years, 2009 marks the fifth anniversary of the formation of the Commission to End Health Care Disparities. Since its inception, the commission has achieved several early objectives, including the development of workshop training to help physicians not only understand the impact 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

### Mission statement

The Commission to End Health Care Disparities, inspired by the Institute of Medicine (IOM) report *Unequal Treatment*, recognizes that health care disparities exist due to multiple factors, including race and ethnicity. We will collaborate proactively to increase awareness among physicians and health professionals; use evidence-based and other strategies; and advocate for action, including governmental, to eliminate disparities in health care and strengthen the health care system.

### Vision statement

Aided by the work of the Commission [to End Health Care Disparities] and its member organizations, physicians, health professionals and health systems will provide quality care to all people.

The commission's initial meeting was a historic event in the evolution of medical practice and collaboration among physicians in the United States: For the first time, leaders from the AMA, NMA and NHMA came together with state and specialty medical association representatives, all united in the common goal of ending racial and ethnic health care disparities.

## Moving forward

Six months after it was formally organized, the Commission to End Health Care Disparities convened its second meeting in January 2005 in Washington, D.C. This gathering was an opportunity for each of the advisory committees to offer progress reports, and for the commission to contemplate the most effective ways to ensure a meaningful, long-term impact on ending health care disparities.

Members of the Professional Awareness Committee advised the commission to develop a brand so that messages disseminated to practicing physicians would be consistent, and so that the commission would be recognized as a trusted, authoritative source of information. The committee also suggested the development of a slideshow to explain the history and future directions of the commission, as well as a tagline to effectively convey its vision. An AMA staff project already under way—creation of a disparities speakers' kit—provided an opportunity for the committee to assist with that awareness-building effort, and to plan the formation of a speakers' bureau to represent the commission.

By the time of the 2005 meeting, the Data/Information Gathering Committee had contacted 2,000 physicians—1,500 located in ZIP codes where minorities make up 50 percent of the population and 500 from non-minority ZIP codes—from the AMA Physician Masterfile for its survey on physicians' experiences with disparities. Meanwhile, the Education and Training Committee had evaluated a number of cultural competency programs that commission members could share with their organizations to train their key leaders. The committee also had assessed the pros and cons of mandated cultural competency training. For example, mandates tied to licensure would ensure that physicians received training; however, state medical societies feared that over-regulation could result. In addition, mandates might be perceived as punitive. In response to these concerns, committee members suggested that incentives such as CME credits or discounts for recertification should be used instead of mandates to encourage physicians to take cultural competency courses.

The Workforce Diversity Committee, which had focused its efforts on increasing minorities in training programs by taking an in-depth look at how medical schools' admissions processes affect minority student enrollment, indicated that the first step would be to examine the racial and

ethnic composition of admissions and selections committees, and factors involved in their first-tier selection process. Next, a broader assessment would be made of the differences between schools that enroll higher proportions of minority students compared with those that enroll lower proportions. The committee also discussed plans to convene key stakeholders—educators, organizations representing minorities, financial groups, government agencies and the media—in 2006 with the goal of implementing some of the 37 recommendations of the highly regarded report *Missing Persons: Minorities in the Health Professions*. This 2004 report was released by the Sullivan Commission on Diversity in the Healthcare Workforce, which was named for its chair, former U.S. Secretary of Health and Human Services Louis Sullivan, MD. Recommendations in the report addressed the underlying reasons why minorities are underrepresented in the health professions in spite of the country's increasingly diverse population.

During this meeting, a press conference at the National Press Club publicly announced the formation of the Commission to End Health Care Disparities. Dr. Nelson, then AMA president, spoke about the need to raise physicians' awareness of disparities. Randall Maxey, MD, PhD, then immediate past president of the NMA, pointed out that further research could lead to new interventions and practices to eliminate disparities. Elena Rios, MD, MSPH, president of the NHMA, discussed the importance of cultural competency training. Dr. Sullivan also attended the press conference and spoke about the need for a more racially and ethnically diverse health care work force.

After the press conference, the commission addressed organizational details. Recognizing areas of overlap, the commission combined objectives of the Data/Information Gathering and of the Education and

Training Advisory committees into one project. The goal would be the development of evidence-based recommendations on system interventions that physician group practices could use to address disparities. The commission's discussions also turned to the elimination of disparities as part of quality improvement initiatives rather than as a separate issue, in recognition of the fact that quality care applies the same high standards in treatment for all patients, regardless of race or ethnicity. The commission determined that one of its most important functions could be to serve as the entity that develops a consistent package of recommendations for quality improvement strategies to eliminate disparities.

### Commission's ripple effect

Since the commission's initial meeting as the Task Force on Disparities in Health Care, more than two dozen new member organizations have joined the effort. Today more than 60 organizations are represented in the commission's membership. This growth has created a more expansive network through which the commission can disseminate information on disparities and gather new ideas and additional input toward solutions that will eliminate disparities. Its leadership calls the commission a clearinghouse that members use to learn new strategies they can share with their own organizations. Member organizations, in turn, disseminate the information to their members, creating a ripple effect that has reached thousands of physicians throughout the country.

During its first five years, the commission also tracked its progress by developing objectives and documenting the ways in which these objectives have been met. To date, the commission has set five strategic objectives and described its accomplishments toward meeting each objective.

**1 Initiate and influence federal, state and local government actions that assist in the elimination of disparities in health care.**

A major step toward fulfilling this objective came with the August 2007 publication of *Addressing Health Care Disparities: Recommended Goals, Guiding Principles, and Key Strategies for Comprehensive Policies*. In this concise document, the commission describes the single goal—high-quality care for all that is free from medically irrelevant gaps in service—that should drive disparities-related policy development. Also included are 10 core principles that should guide policy development and implementation, as well as several key strategies to move closer to the elimination of disparities in health care.

The commission also established an ad hoc Committee on Advocacy and Policy (now a permanent, standing committee) to comment on legislation and policy development at the local, state and national levels. Some of the committee's work is conducted by staff of the member organizations, which monitor legislative, policy and regulatory actions and then notify the committee of those that are related to disparities. For example:

- The committee drafted letters for the commission to send to Sen. Edward Kennedy, D-Mass., and then-Sen. Bill Frist, R-Tenn., supporting their bipartisan proposal, the Minority Health Improvement and Health Disparity Elimination Act of 2006.
- Another letter from the commission to the HHS encouraged federal action to reduce or eliminate sodium in many foods, particularly processed foods. Lower sodium intake can help reduce hypertension, which disproportionately affects African Americans.

Elena Rios, MD, president of the National Hispanic Medical Association, addressing students during a Doctors Back to School visit

**2 Increase engagement by medical students, physicians as well as other health professionals and organizations in efforts to eliminate health care disparities.**

Some of the strategies the commission considered to achieve this objective involved raising awareness of disparities and their causes, as well as identifying practical, evidence-based solutions to eliminate disparities in specific conditions, diseases and clinical practices. The Professional Awareness and the Education and Training advisory committees developed a slide kit and DVD that discuss disparities and offer solutions focused on improving patient-physician communication. Designed to be presented in three-hour workshops, these materials use vignettes of patients from a variety of racial and ethnic backgrounds to break down stereotypes and demonstrate how language and cultural beliefs can affect the delivery of health care. Articles and references are provided for background information. The workshop can be tailored for physicians in different specialties and different geographic areas. To date, the workshop has been offered at seven state and local medical organization meetings.



**3 Create an environment that fosters effective health care practitioner and organizational efforts to eliminate disparities.**

Strategies to achieve this objective focused on the following:

- Collect patient data.
- Identify factors that help or hinder practitioners and organizations in their efforts to eliminate disparities.
- Gather physician and patient data on race, ethnicity and language.
- Determine factors that will prompt physicians to implement quality improvement initiatives intended to eliminate disparities, such as recognition or monetary incentives.

Led by the efforts of the Data/Information Gathering Committee, the commission collected the necessary data to answer these questions and prepared them for publication in a number of professional journals. For example, the committee's survey work on physician experiences and environments yielded material for three journal articles published in 2007 in *Health Services Research*, the *Journal of the National Medical Association* and the *Journal of Health Disparities Research and Practice*. Another article, on the impact of pay-for-performance and quality reporting on health care disparities, appeared in a 2007 issue of *Health Affairs*. Additional papers under preparation address the business aspects of quality improvement and elimination of disparities that are important for small medical practices; the use of emerging technology to reduce health disparities; and statistics on race, ethnicity and preferred language in small medical practices.

Two issue briefs have been developed and are posted on the AMA Web site (visit [www.ama-assn.org/go/enddisparities](http://www.ama-assn.org/go/enddisparities) to view the briefs).

The first describes how dietary sodium reduction can help prevent heart disease and stroke in African Americans. The brief explains that African American men are 30 percent more likely to die from heart disease than non-Hispanic white men and that African Americans are 20 percent more likely than whites to have a stroke and 45 percent more likely to die from one. Based on similar recommendations issued previously by the AMA, the brief recommends restricting sodium intake and advocating for a 50 percent reduction in sodium in processed foods, fast food products and restaurant meals over the next decade.

The second brief discusses the impact of pay-for-performance programs on the quality of care for minority patients and suggests ways to keep these programs from becoming disincentives for physicians who care for large numbers of minority patients. The brief offers guidelines that help promote rather than impede quality care for racial and ethnic minority patients.



Glenn Alden Harrison, MD, demonstrating to a student how to write orders as a physician during a Doctors Back to School "Day As a Doctor" visit



#### **4 Identify ways to increase the diversity of the health professional work force.**

Efforts in this area have produced some of the commission's most popular and far-reaching endeavors. The commission's member organizations are actively involved in the Doctors Back to School (DBTS) program, which the AMA Minority Affairs Consortium launched in 2002. Minority physicians and medical students who volunteer in the DBTS program act as role models by visiting elementary and high schools to talk with students, particularly those in underrepresented racial and ethnic groups, about careers in medicine. The program demonstrates to minority students that a medical career is well within their reach. To date, 10 commission organizations have sponsored 150 DBTS visits that have reached more than 17,000 students. Nine regional coordinators will be working with the commission to expand the program. Three medical schools also have committed to supporting DBTS visits. The overall goal is to reach 100,000 students by the end of 2009 and equip them with the knowledge and tools to pursue careers in health care and, ultimately, help create a more diverse health professional work force.

In addition to the DBTS program, commission members are active in the Sullivan Alliance, which is working to improve work force diversity through development of collaborations with undergraduate colleges and medical schools, such as the Virginia-Nebraska Alliance. They are also involved in the AMA Initiative to Transform Medical Education, a project to reform medical education and physician professional development, which focuses on key areas including how to better equip medical students to advocate for disadvantaged and diverse patient populations.

#### **5 Promote collaboration on disparities between medicine and private industries.**

Recognizing the need to cast a wider net to attract more stakeholders in efforts to eliminate health care disparities, the commission created corporate memberships and welcomed eight new members: AstraZeneca Pharmaceuticals; Blue Cross and Blue Shield of Florida; the Coca-Cola Company; Eli Lilly and Company; Medtronic; the Pharmaceutical Research and Manufacturers of America; Pfizer Inc.; and Purdue Pharma. The involvement of corporate entities broadens the commission's ripple effect by building awareness of disparities that goes beyond the walls of hospitals and physician practices and into health plan policy—as well as pharmaceutical research and development. Membership dues from corporate members also help fund the commission's activities.

### **Making amends**

The commission's work was not designed to produce a statement of contrition on behalf of any particular organization or to any specific racial or ethnic group. However, during its fall 2007 meeting in Chicago, the commission heard a discussion of the history of African American membership in the AMA and organized medicine. The discussants included members of the Panel of Experts Charged With Examining the Historical Roots of the Black-White Divide in U.S. Medicine, which was organized and supported by the AMA to compile a comprehensive history of racial bias in organized medicine in the United States. The topic is, perhaps, one of the most sensitive in the annals of the AMA.

As the commission was well aware, physicians in the United States were racially polarized until the civil rights era of the 1960s ushered in profound changes throughout the country. The AMA, founded in 1847, had excluded the racially integrated National Medical Society from its annual meeting in 1870, and subsequently determined that delegations to AMA meetings be limited to state and local medical societies, some of which were openly segregated. In effect, most African American physicians were excluded from the AMA. In 1895 the NMA formed so that African American physicians would have their own forum. For decades, the AMA did not act to combat segregation in medical societies or segregation in hospitals receiving federal funding, and it failed to openly support the Civil Rights Act of 1964.

In recent decades, however, the AMA has taken action to recognize underrepresented groups in medicine—including women, international medical graduates, and gay, lesbian, bisexual or transgender physicians. With joint leadership from the AMA and NMA, the commission's formation helped pave the way for a formal recognition of the painful past that existed for both organizations. During its fall 2007 meeting, the commission served as a sounding board on choosing an effective way to present the panel's massive data collection.

In July 2008 the AMA issued a formal organizational apology to the NMA. The panel's historical account, tracing more than a century of racial segregation among physicians that perpetuated persistent racial and ethnic health care disparities, appeared in the *Journal of the American Medical Association (JAMA)*. A commentary by the late Ronald M. Davis, MD, then the immediate past president of the AMA, was published in the same issue of *JAMA* and explained the rationale behind the apology. Dr. Davis wrote:

Group apologies are especially important. Although current members of a group might bear little or no responsibility for past actions, a group apology makes clear the group's current moral orientation. Acknowledging past wrongs lays a marker for understanding and tracking current and future actions.

In accepting the apology on behalf of the NMA, Nelson L. Adams, MD, president of the NMA, commended the AMA “for taking this courageous step and coming to grips with a litany of discriminatory practices that have had a devastating effect on the health of African Americans.”

### Current efforts

Although the commission takes great pride in all it has accomplished over the past five years, its members are well aware that the work is far from finished. Health care disparities are as old as the United States itself—a point emphasized in the IOM's *Unequal Treatment* report, and one the commission is often reminded of during its semiannual meetings.

Held in various locations throughout the country, the meetings allow commission members to share progress reports, determine next steps and learn more about how health care disparities affect local communities nationwide. The commission also serves as a barometer for medical environments and how society is faring in efforts to end health care disparities.

In the spring of 2008 the commission meeting was held in Oklahoma City, where experts in Native American health provided some startling statistics. Speakers at the meeting noted that the U.S. government

guarantees health care for 564 recognized tribes; however, funding for the federal Indian Health Service (IHS) is less per capita than the amount spent on health care for inmates in U.S. prisons. Care from the IHS is available on reservations, but 67 percent of Native Americans live in urban areas and do not have access to the IHS clinics. Furthermore, federal food programs, relocation programs and environmental hazards have negatively affected the health of many Native Americans.

The semiannual commission meetings also offer ideas for future initiatives. A 2007 meeting in Waltham, Mass., hosted by the Massachusetts Medical Society, became a forum for the commission to learn more about how the state's comprehensive health care reform can play a role in eliminating disparities. For example, reform legislation in Massachusetts requires hospitals to report health care data on patients' race, ethnicity and language. In addition to tying Medicaid rate increases to performance benchmarks that include reducing disparities, this legislation created a state Health Disparities Council to recommend appropriate legislative action to eliminate disparities. The commission recommended that the Massachusetts delegation to the AMA sponsor a resolution before the AMA House of Delegates asking the AMA to support the development of state commissions and task forces to reduce health care disparities.

Members within the commission's leadership would like to see the commission advocate actively for more states to create health care disparities councils. One possibility is for states to develop disparities councils that could work with state health departments to examine the causes of disparities in each state and find solutions. Another area for future

improvement is the DBTS program. The commission has set an ambitious goal of reaching 100,000 students over the next three years. If a student follow-up mechanism is implemented, the commission could obtain a clearer understanding of the program's effectiveness, and determine ways in which it may be improved.

A major part of moving any group forward is recognizing that making progress and setting new objectives is an ongoing process. The commission's first five years were marked by a series of incremental steps that have produced growth and built awareness of the need to eliminate racial and ethnic disparities in health care. As its vision expands over the next five years, the commission is optimistic that its efforts eventually will lead to a U.S. health care system that provides effective, high-quality medical care not just for some, but for all.



**Burnetta Herron, MD, sharing lunch with a young student during a Doctors Back to School visit**

## Future directions

### **Priorities include provider awareness and education, data collection and quality improvement, policy and advocacy, and work force diversity**

In its brief existence, the Commission to End Health Care Disparities has accomplished much. It also has devised an ambitious agenda for the future. Moving from data to solutions, the future of the commission is in serving as an advocate at the national level and on the front lines of health care.

#### **The 2009–2011 strategic objectives for the commission are:**

- 1** Promote leadership development to educate current physicians and physicians-in-training on issues of diversity and solutions identified thus far to eliminate disparities.
- 2** Influence the immediate environmental factors that affect physicians' ability to deliver quality care to all and to eliminate racial and ethnic disparities in health care.
- 3** Influence federal and state governmental actions through advocacy for policy that facilitates the elimination of racial and ethnic disparities in health care.
- 4** Encourage the recruitment of diverse individuals into the health professional work force through various programs, within member organizations and beyond, as a strategy for sustaining work force diversity and strengthening medicine's commitment to eliminating racial and ethnic disparities in health care.



## Resources

### Organizations with a focus on disparities

- Commission to End Health Care Disparities  
[www.ama-assn.org/go/commission](http://www.ama-assn.org/go/commission)
- American Medical Student Association  
[www.amsa.org](http://www.amsa.org)
- Centers for Disease Control and Prevention Office of Minority Health  
[www.cdc.gov](http://www.cdc.gov)
- Institute of Medicine  
[www.iom.edu](http://www.iom.edu)
- Medscape Health Diversity Online Resource Center  
[www.medscape.com](http://www.medscape.com)
- National Medical Association  
[www.nmanet.org](http://www.nmanet.org)
- National Hispanic Medical Association  
[www.nhmamd.org](http://www.nhmamd.org)
- Student National Medical Association  
[www.snma.org](http://www.snma.org)
- The Sullivan Commission on Diversity in the Healthcare Workforce  
[www.jointcenter.org](http://www.jointcenter.org)
- U.S. Office of Minority Health  
[www.omhrc.gov](http://www.omhrc.gov)

### Publications and educational programs

- Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2004*. [www.ahrq.gov/qual/nhdr04/nhdr04.htm](http://www.ahrq.gov/qual/nhdr04/nhdr04.htm). Accessed February 19, 2009.
- Smedley BD, Stith Butler A, Bristow LR, eds. *In the Nation's a Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Washington, DC: National Academies Press; 2004. [www.iom.edu/CMS/3740/4888/18287.aspx](http://www.iom.edu/CMS/3740/4888/18287.aspx). Accessed February 19, 2009.
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- American Academy of Family Physicians. Quality Care for Diverse Populations [online training program]. [www.aafp.org/online/en/home/cme/selfstudy/qualitycarevideo.html](http://www.aafp.org/online/en/home/cme/selfstudy/qualitycarevideo.html). Accessed February 19, 2009.
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- Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. National Academies Press; 2002. [www.iom.edu/report.asp?id=4475](http://www.iom.edu/report.asp?id=4475). Accessed February 19, 2009.

### Toolkits (not intended to be a comprehensive list)

- Better Diabetes Care Improving Cultural Competency  
[www.betterdiabetescare.nih.gov](http://www.betterdiabetescare.nih.gov)
- Delivering Culturally Effective Care for Patients with Diabetes  
[www.vlh.com](http://www.vlh.com)
- Family Physician's Practical Guide to Culturally Competent Care  
[www.ccm.thinkculturalhealth.org](http://www.ccm.thinkculturalhealth.org)
- Health Resources and Services Administration Cultural Competence Resources for Health Care Providers  
[www.hrsa.gov](http://www.hrsa.gov)
- Quality Interactions: The Patient-Based Approach to Cross-Cultural Care  
[www.criticalmeasures.net](http://www.criticalmeasures.net)
- Physician's Practical Guide to Culturally Competent Care  
<http://cccm.thinkculturalhealth.org>
- Unified Health Communication: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency  
[www.hrsa.gov](http://www.hrsa.gov)

### Funding organizations (not intended to be a comprehensive list)

- California Endowment Foundation  
[www.calendow.org](http://www.calendow.org)
- Kaiser Family Foundation  
[www.kff.org](http://www.kff.org)
- The Robert Wood Johnson Foundation  
[www.rwjf.org](http://www.rwjf.org)

## Member and affiliated organizations

Alliance of Minority Medical Associations  
Gary Puckrein, PhD

American Academy of Allergy, Asthma  
and Immunology  
Christine L.M. Joseph, PhD

American Academy of Dermatology  
Association  
Sandra W. Peters, MHA

American Academy of Family Physicians  
Larry Fields, MD

American Academy of Ophthalmology  
Mildred M.G. Olivier, MD

American Academy of Pediatrics  
Frances Dunston, MD, MPH

American Academy of Physician Assistants  
Robert Wooten, PA-C

American Association of Public Health  
Physicians  
Arvind K. Goyal, MD, MPH

American College of Cardiology  
Paul L. Douglass, MD

American College of Emergency Physicians  
Lynn Richardson, MD, FACEP

American College of Obstetricians  
and Gynecologists  
Raymond L. Cox, MD, MBA

American College of Physicians  
Charles K. Francis, MD, FACP

American College of Preventive Medicine  
Robert A. Gilchick, MD, MPH

American College of Surgeons  
N. Joseph Espot, MD, MS, FACS

American Medical Association  
Nancy H. Nielsen, MD, PhD  
Ronald M. Davis, MD, MPH  
John C. Nelson, MD, MPH

American Medical Association Council  
on Ethical and Judicial Affairs  
Regina Benjamin, MD, MBA

American Medical Association  
Council on Medical Education  
Baretta R. Casey, MD

American Medical Association  
Council on Science and Public Health  
Carolyn B. Robinowitz, MD

American Medical Association  
Minority Affairs Consortium  
Ada Stewart, MD

American Medical Association  
International Medical Graduates Section  
Nestor Ramirez-Lopez, MD

American Medical Association  
Women Physician Congress  
Lynn C. Epstein, MD, FAACAP, DFAPA

American Osteopathic Association  
Hector Lopez, DO

American Psychiatric Association  
Annelle Primm, MD

American Public Health Association  
Georges C. Benjamin, MD, FACP

American Society of Addiction Medicine  
Lawrence Brown Jr., MD, MPH

American Society of Clinical Oncology  
Edith Perez, MD

Association of American Indian Physicians  
Phillip Smith, MD, MPH

Association of American Medical Colleges  
Ann Steinecke, PhD

Association of Clinicians for the Underserved  
Kyu Rhee, MD, MPP

Association of Minority Health Professionals  
Schools  
L. Eric Jerome, MD

AstraZeneca Pharmaceuticals\*\*  
Anne Berry  
Paul G. Alexander

BlueCross BlueShield Association\*  
John M. Montgomery, MD, MPH,  
FAAFP, CPE

California Medical Association  
Anmol S. Mahal, MD

California Medical Association Foundation  
Diana Ramos, MD

Chicago Medical Society  
William McDade, MD, MBA

Coca-Cola North America\*\*  
Lauventria Robinson

Eli Lilly & Company\*\*  
Jacqueline K. Giovanoni

Florida Medical Association  
Glenda Henderson

Gay and Lesbian Medical Association  
Joel Ginsberg, JD, MBA

Illinois State Medical Society  
William E. Kobler, MD

Massachusetts Medical Society  
Alice Coombs, MD

Medical Society of New Jersey  
Robert C. Like, MD, MS

Medical Society of the State of New York  
Anthony A. Clemendor, MD

Medtronic  
Eric M. Winston

Michigan State Medical Society  
Willie Underwood III, MD

Multicultural Healthcare Education  
Foundation

Jose Rodriguez Diaz, MD

National Alaska Native American Indian  
Nurses Association\*  
Beverly Patchell, RN, MS, CNS

National Association of Hispanic Nurses\*  
Norma Martinez

National Black Nurses Association\*  
Azella C. Collins, MSN, RN, PRP

National Hispanic Medical Association  
Elena Rios, MD, MSPH

National Medical Association  
Carolyn Barley Britton, MD, MS  
Sandra L. Gadson, MD  
Randall W. Maxey, MD, PhD

National Minority Organ Tissue Transplant  
Education Program  
Cleve Callendar, MD

Network of Ethnic Physician Organizations  
Arthur Fleming, MD, FACS, FCCP

National Pharmaceutical Council\*  
Richard Levy, PhD

Ohio State Medical Association  
Molly A. Katz, MD

Pfizer\*\*  
Candace S. Howell  
Michael Flescher

PhRMA\*\*  
Marieli Colon-Padilla

Purdue Pharma\*\*  
Pamela Bennett, BSN, RN

Society of Critical Care Medicine  
Errington Thompson, MD

Texas Medical Association  
Andrew Eisenberg, MD, MHA

The CHEST Foundation  
Allen I. Goldberg, MD, MBA, Master FCCP  
Sheik N. Hassan, MD, FCCP

Uniformed Services University  
Evelyn Lewis, MD, MA

United Healthcare Foundation  
Arthur J. Puff, MD, FACEP

White House Initiative on Asian Americans  
and Pacific Islanders\*  
Akshay Desai, MD, MPH

W. Montague Cobb Health Institute–NMA  
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