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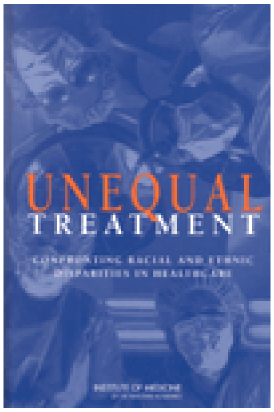

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (with CD)

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5

Interventions: Systemic Strategies

The preceding analysis of sources of racial and ethnic disparities in healthcare reveals that many participants—including patients, their providers, utilization managers, and health system administrators—make decisions on a daily basis that contribute to gaps in care. These individuals operate within many contexts, including clinical care settings and health system settings that set policies for access to and utilization of services, and at a larger level, are affected by laws and policies regulating the healthcare industry. Given the role of patient, provider, and contextual factors in shaping the quality of patient care, systemic interventions directed at multiple levels offer promise to modify conditions in which healthcare disparities occur.

Systemic interventions to improve healthcare delivery for diverse populations include organizational accommodations that may promote equity in healthcare, policies that reduce administrative and linguistic barriers to care, and practices that enhance patients' knowledge of and roles as active participants in the care process. These efforts are likely to be most effective when applied in a systematic, simultaneous, multi-level, coordinated fashion, and follow a well-developed strategic plan that has support and "buy-in" from all actors involved in healthcare, including patients, their families, and the communities in which they live; clinicians; administrative staff; and health systems leadership. Systemic interventions also include changes to healthcare law and policy that promote equality of healthcare delivery.

There are many reasons why health systems may choose to adopt comprehensive strategies to eliminate racial and ethnic disparities in healthcare. First, they may react to comply with growing state and federal guidelines that encourage, and in some cases, mandate greater responsiveness on the part of health systems to the growing diversity of the U.S. population (Brach and Fraser, 2000). Second, they may view such strategies as integral to help achieve the U.S. Department of Health and Human Services' goal of eliminating racial and ethnic disparities in health (U.S. DHHS, 2000). Third, health systems may find that developing and implementing culturally competent systems of care are consistent with the "business case" of increasing market share among racial and ethnic minority populations (Brach and Fraser, 2000). Increasingly, health plan purchasers are also finding that health system responsiveness to the needs of racial and ethnic minority patients makes good business sense. Given that over 2 of every 5 new workers is a racial or ethnic minority, many employers find that health plan efforts to improve services for these populations and narrow the healthcare gap can attract better workers and increase employee productivity (Washington Business Group on Health, 2001).

Many of these system-wide intervention objectives are reflected in the culturally and linguistically appropriate services standards (CLAS) for healthcare issued by the U.S. DHHS Office of Minority Health (OMH) in December 2000 (U.S. DHHS, 2000). These standards, which are listed in Box 5-1, are primarily directed at healthcare organizations, but OMH encourages individual providers to familiarize themselves with the standards and incorporate them into their practices.

Further, while the standards are intended to help improve care for racial and ethnic minority populations, by implication they suggest that greater attention to the importance of culture and language in healthcare settings will improve the quality of care for all populations. Noting that culture and language define how healthcare information is given and received and shape the expression and understanding of health and illness, the agency states that "healthcare is a cultural construct, arising from beliefs about the nature of disease and the human body," and that "cultural issues are . . . central in the delivery of health services treatment and preventive interventions" (U.S. DHHS, 2000, p. 80863).

A significant evidence base has accumulated for many aspects of health systems-level interventions that may improve the quality of care for minority patients. The remainder of this chapter explores several such strategies.

LEGAL, REGULATORY, AND POLICY INTERVENTIONS

As noted in Chapter 3, institutional design and legal and regulatory governance will not eliminate racial and ethnic disparities in healthcare,

BOX 5-1
U.S. Department of Health and Human Services Standards for Culturally and Linguistically Appropriate Services

1. Healthcare Organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Healthcare Organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Healthcare Organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Healthcare Organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Healthcare Organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Healthcare Organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Healthcare Organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

but institutions and law make a large difference, in that they exert a broad influence over the kinds of conditions that may foster healthcare disparities. In this section, the committee suggests how healthcare institutions, legislators, and regulators might respond pragmatically to the problem of racial and ethnic disparity even as they pursue other important policy goals.

"De-Fragmentation" of Healthcare Financing and Delivery

Many of the studies cited earlier in this report have not taken detailed account of variations among health plans, and therefore the dispropor-

8. Healthcare Organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Healthcare Organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Healthcare Organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Healthcare Organizations should maintain a current demographic, cultural, and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Healthcare Organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Healthcare Organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Healthcare Organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

tionate presence of members of disadvantaged minority groups in lower-end health plans may be a major source of disparities in healthcare provision. As noted in Chapter 2, some racial and ethnic minorities are disproportionately represented in publicly financed health insurance programs (Phillips et al., 2000). And even within a broad federal program such as Medicare, for example, tiers of health systems exist (e.g., more than 60% of Medicare beneficiaries possess supplemental coverage), with minorities typically congregated at lower levels. Further, as noted in Chapter 3, low per capita resources associated with lower-end plans may result in differences in the intensity of care between lower and higher end health plans. Studies consistently demonstrate an association between insurance status and use of healthcare resources. For example, patients seen in emergency departments following head injury are more likely to be admitted to the hospital and have a longer length of stay if they are privately insured, rather than publicly insured or uninsured (Svenson and Spurlock, 2001), and Medicare patients without supplemental coverage are approximately 10% less likely to have influenza vaccination, cholesterol testing, mammography, or Pap smears than those with supplemental coverage (Carrasquillo, Lantigua, and Shea, 2001). Fragmentation also engenders different clinical cultures, with different practice norms, tied to varying per capita resource constraints. The relationship between racial and ethnic maldistribution in tiered health plans, differences in the intensity and the quality of care provided by these plans, and clinical outcomes should be a national research priority (see Chapter 8). Until such research is conducted, it is reasonable to surmise that efforts to reduce the socioeconomic segmentation of the medical marketplace would help to diminish racial and ethnic disparities in healthcare provision (Bloche, 2001).

Equalizing access to high-quality plans can limit fragmentation. Public healthcare payors such as Medicaid should strive to help beneficiaries access the same health products as privately insured patients. This recommendation is reflected in the IOM *Crossing the Quality Chasm* report's strategies for focusing health systems on quality, in its call to "eliminate or modify payment practices that fragment the care system" (IOM, 2001a, p. 13). Expanding access for publicly funded beneficiaries to high-quality health plans will be expensive. Rising healthcare costs, however, threaten to increase the likelihood of fragmentation, and subsequently threaten to increase the racial and ethnic gap in healthcare.

> **Recommendation 5-1: Avoid fragmentation of health plans along socioeconomic lines.**
> **Medical care financing arrangements should discourage fragmentation of healthcare provision into separate tiers of providers who adhere to different standards of care and disproportionately serve separate racial and ethnic minority segments of American society. Medicaid and other government programs that mandate enrollment of beneficiaries in managed care should be prepared to pay plans at rates that give Medicaid enrollees access to the same health plan products serving substantial proportions of privately insured patients.**

Strengthening Doctor-Patient Relationships

Several lines of research suggest that the consistency and stability of the doctor-patient relationship is an important determinant of patient satisfaction and access to care. Having a usual source of care is associated, for example, with use of preventive care services. In addition, having a consistent relationship with a primary care provider may help to address minority patient mistrust of healthcare systems and providers, particularly if the relationship is with a provider who is able to bridge cultural and linguistic gaps (LaViest, Nickerson, and Bowie, 2000). Further, as noted in Chapter 3, several lines of evidence suggest that a patient's access to clinical resources within a hospital or health plan may partly reflect his or her doctor's stature, skill, and commitment as an advocate. This suggests that minority patients may benefit from stronger bonds with physicians who understand the cultural and linguistic barriers to care faced by many minority patients navigating through health systems, and who are positioned and willing to play the advocate's role vigorously. Health systems should attempt to ensure that every patient, whether insured privately or publicly, through Medicare or Medicaid, has a sustained relationship with an attending physician able to help patients navigate the healthcare bureaucracy effectively (e.g., to help patients obtain referral and secure appropriate specialty care). This is not meant to imply that physicians should navigate health systems for their patients; rather, it is an acknowledgement that primary care providers sometimes wield great influence and leverage in helping their patients to access specialty care, clinical trials, and other healthcare resources.

Several strategies can help to promote the stability of patient and provider relationships in publicly funded health plans. Federal and state performance standards for Medicaid-managed care plans, for example, should include guidelines for the stability of patients' assignments to primary care providers and these providers' accessibility. These guidelines should also encourage reasonable patient loads per primary physician and time allotments for patient visits. Regulations governing health plans' participation in Medicare should include similar guidelines, as should private accrediting bodies' prerequisites for all health plans (Bloche, 2001).

Recommendation 5-2: Strengthen the stability of patient-provider relationships in publicly funded health plans.

Policies that strengthen provider-patient relationships in publicly funded health plans and that promote the consistency of these relationships should be adopted. These include guidelines for:

- **the stability of patients' assignments to primary care providers and these providers' accessibility;**
- **reasonable patient loads per primary physician; and**
- **reasonable time allowances for initial and follow-up patient visits (and health providers' flexibility to take additional time when needed to communicate adequately).**

Strengthening patient and provider relationships will also benefit from greater racial and ethnic diversity in the health professions. Racial concordance of patient and provider is associated with greater patient participation in care processes, higher patient satisfaction, and greater adherence to treatment (Cooper-Patrick et al., 1999). In addition, racial and ethnic minority providers are more likely than their non-minority colleagues to serve in minority and medically underserved communities (Komaromy et al., 1998b). Evidence of these benefits of diversity in health professions fields weighs in favor of robust commitment to affirmative action in medical school admissions, residency recruitment, and professional specialty training. This is not intended to suggest, however, that racial concordance of patients and providers should be encouraged as a matter of policy. Rather, it is expected that the benefits of diversity in the health professions will accrue broadly, as this diversity helps to expand the disciplines' ability to conceptualize and respond to the health needs of increasingly culturally and linguistically diverse populations.

> **Recommendation 5-3: Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.**
> **To the extent legally permissible, affirmative action and other efforts are needed to increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.**

Patient Protections

Much of the political focus on Capitol Hill in the summer of 2001 was devoted to managed care regulation. To one extent or another, the various bills debated all would extend protections to enrollees in private managed care organizations, providing avenues for appeal of care denial decisions, improving access to specialty and emergency department care, and providing other legal remedies to resolve disputes. These bills were crafted on the assumption that due process protections of patient choices were necessary, despite a lack of empirical evidence that overall quality of care is inferior in managed care plans relative to fee-for-service systems. Extensive reviews of the literature do not establish whether the quality of care provided within managed care plans is worse (or better) than other health systems. However, there is some evidence that managed care may provide better care for some patient populations. For example, results of a review by Miller and Luft (1997) suggest a significantly better quality of care for some subsets of managed care enrollees, such as patients in the intensive care unit, elderly Medicare patients, and patients with acute appendicitis or cancer.

As discussed in Chapter 3, however, there are reasons and empirical evidence to be concerned about how financial incentives and decision-making within managed health plans may differentially affect racial and ethnic minority groups. Some evidence indicates that low-income and ethnic minority patients enrolled in managed care plans are less likely to have a regular provider than similar patients in fee-for-service plans (Leigh, Lillie-Blanton, Martinez, and Collins, 1999), are more likely than whites to be denied claims for emergency department visits (Lowe et al., 2001), and are less satisfied with many aspects of the care they receive in managed care settings (Phillips et al., 2000). Other studies find that the intensity of care is lower for some populations within managed care settings relative to other care systems. Tai-Seale, LoSasso, Freund, and Gerber (2001), for example, found that prenatal care use was lower among women enrolled in Medicaid managed care systems relative to women in fee-for-service systems.

Given that many minorities are disproportionately represented among the publicly insured who receive care within managed care organizations, extending the same due process protections proposed in current legislation may help to address these disparities. Other factors, however, may also justify extending the same protections, regardless of payor source. Extending legal protections only to those enrolled in private managed care plans raises concerns about the unequal application of law. As Hashimoto (2001) writes, "The [current proposals'] emphasis on individual choice, due process protections, and limiting its jurisdiction to private health plans will result in an important regulation that largely benefits the employed middle class . . . it is unfair to guarantee special legal protections to members of private managed care plans while failing to provide these same guarantees to members of publicly financed managed care programs" (Hashimoto, 2001, pp. 83-84).

Recommendation 5-4: Apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees.

Civil Rights Enforcement

The committee believes that education and training of healthcare providers, administrators, and consumers is an important first step as part of a comprehensive, multi-level intervention strategy to address racial and ethnic disparities in healthcare. Enforcement of regulation and statute is also an important component of such a strategy, but unfortunately has been too often relegated to low-priority status. The U.S. DHHS Office for Civil Rights (OCR) is charged with enforcing several relevant federal statutes and regulations that prohibit discrimination in healthcare (principally

Title VI of the 1964 Civil Rights Act). The agency, however, has suffered from insufficient resources to investigate complaints of possible violations, and has long abandoned proactive, investigative strategies (Smith, 1999). Complaints to the agency have increased in recent years, while funding has remained constant in actual dollars but has decreased in fiscal year 2000 to less than 60% of fiscal year 1981 funding, after adjusting for inflation (U.S. Commission on Civil Rights, 2001). This decrease in spending power has severely and negatively affected OCR's ability to conduct civil rights enforcement strategies, such as on-site complaint investigations, compliance reviews, and local community outreach and education. The agency should be equipped with sufficient resources to better address these complaints. In addition, OCR should resume the practice of periodic, proactive investigation, both to collect data on the extent of civil rights violations and to provide a deterrent to would-be lawbreakers. As will be discussed in Chapter 7, LaVeist and Gibbons (2001) suggest a two-tiered strategy in which routine data collection and monitoring can be used to identify health systems that display persistent disparities, followed by field investigations—possibly by trained, paired testers.[1] While audits of healthcare facilities are largely untested and methodologies must be developed for fair and appropriate assessment of discrimination in healthcare settings, such a strategy offers a promising "last line" of defense against civil rights violations.

> **Recommendation 5-5: Provide greater resources to the U.S. DHHS Office for Civil Rights to enforce civil rights laws.**
> **Congress and the U.S. Department of Health and Human Services should provide adequate funding to the U.S. DHHS Office for Civil Rights to expand the agency's capabilities to address civil rights complaints and carry out its oversight responsibilities.**

HEALTH SYSTEMS INTERVENTIONS

Research suggests that a variety of interventions applied at the level of health systems may be effective as a part of a comprehensive, multilevel strategy to address racial and ethnic disparities in healthcare.

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[1] Paired testing strategies, in which auditors of differing race, ethnicity, or gender are matched for a variety of socioeconomic and personality characteristics, have been used successfully to identify discrimination in housing, employment, and mortgage lending practices. This strategy is discussed in Chapter 2.

Evidence-Based Cost Control

As discussed in Chapter 3, medical science has made tremendous advances that have transformed clinical practice. Many innovations are available to healthcare providers, and the use of evidence-based practice guidelines to improve and standardize care has increased. Despite these developments, variations in practice patterns are still observed across geographic areas and types of healthcare institutions, and utilization managers still exert considerable discretion in making decisions regarding healthcare resource allocation. To the extent possible, given the gaps in knowledge about medical care's efficacy and the difficulty of anticipating all clinical contingencies, clinical practice and utilization decisions should be based on evidence-based guidelines. Such application of evidence to healthcare delivery can help to address the problem of potential underuse of services resulting from capitation or per case payment methods, as noted in the IOM *Quality Chasm* report (IOM, 2001a). Practice guidelines may be a useful tool in the effort to eliminate racial and ethnic disparities in healthcare, given the advantages of guidelines over general, discretionary standards—including consistency, predictability, and at least the appearance of objectivity.

A pragmatic balance must be sought, however, between the advantages and limitations of guidelines. The goal of standardized care must be weighed against the need for clinical flexibility. One means to address this balance—disclosing health plans' clinical protocols—would aid both private sector and public efforts in balancing the virtues of rules and discretion. Private accrediting entities and state regulatory bodies could require that health plans' clinical practice protocols be published—with supporting evidence—and thus open them to professional and consumer review.

Clinical guidelines that are not backed by evidence and argument should not be entitled to deference in administrative or legal proceedings that involve challenges to health plans' application of such guidelines. But where guidelines do have empirical support, even if the evidence is at best debatable, administrative and legal decision makers should give substantial weight to the social importance, in a racially and culturally diverse nation, of making allocative choices in a manner that achieves some consistency in appearance and practice (Bloche, 2001).

Recommendation 5-6: Promote the consistency and equity of care through evidence-based guidelines.
To the extent possible, medical care allocative decisions should be driven by evidence-based clinical guidelines to insure consistency of care. These guidelines should be published, along with their supporting evidence base, to allow public and professional scru-

tiny, and used to examine the quality of care for racial and ethnic minorities.

Financial Incentives in Healthcare

As discussed in Chapter 3, financial factors, such as capitation and plan incentives to providers to practice frugally, can pose greater barriers to racial and ethnic minority patients than for whites, even among patients insured at the same level. Low payment rates inhibit the supply of physician (and other healthcare provider) services to low-income groups, disproportionately affecting ethnic minorities. Inadequate supply takes the form of too few providers participating in plans serving the poor, and provider unwillingness to spend adequate time with patients. In Chapter 4, the committee linked this time pressure to the underlying problem of poor information exchange between physicians and members of minority groups. Where employers have an interest in providing an attractive benefit package, market forces protect middle and upper income groups against health plans "going too far" in rationing care. These protections are not available to all low-income groups, who must rely on balanced public policy to induce adequate supply of care.

More finely crafted provider incentives can have a positive role in efforts to reduce disparities in care. Greater economic rewards for time spent engaging patients and their families can contribute to overcoming barriers of culture, communication, and empathy. Payment schemes that reward providers for high scores on measures of patient satisfaction would further encourage the bridging of barriers related to racial and ethnic difference. Incentives to adhere to evidence-based protocols for frugal practice and to engage in age- and gender-appropriate disease screening would generally encourage efficient, quality care and penalize deviations regardless of race or ethnicity. Further, payment linked to favorable clinical outcomes, where reasonably measurable (e.g. control of diabetes, asthma, and high blood pressure), would provide additional such encouragement. Industry movement toward more nuanced incentive schemes along these lines could be catalyzed by private accrediting bodies, encouraged by business and professional leaders, and even initiated by public payors. Again, this recommendation is consistent with the IOM *Quality Chasm* report, which called for healthcare organizations, clinicians, purchasers, and other stakeholders to "align the incentives inherent in payment and accountability processes with the goal of quality improvement" (IOM, 2001a, p. 10).

Recommendation 5-7: Structure payment systems to enhance available services to minority patients, and limit provider incentives that may promote disparities.

Payment systems to providers should ensure an adequate supply of services to racial and ethnic minority patients. Financial incentives to restrict care and pass liability to providers should be limited, to reduce conditions in which racial and ethnic stereotypes and biases may be exacerbated or reinforced.

Recommendation 5-8: Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.
Economic incentives should be considered for practices that enhance provider-patient communication and trust, and that reward appropriate screening, preventive, and evidence-based clinical care.

Interpretation Services

As noted in Chapter 2, nearly 14 million Americans are not proficient in English. In 1995, the Commonwealth Fund estimated that language differences are problematic for 21% of racial and ethnic minority group members who receive healthcare (Commonwealth, 1995). This percentage is almost certainly higher today given recent increases in immigration to the U.S. from many parts of the world. Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, and ethical compromises, such as difficulty obtaining informed consent (Woloshin et al., 1995). In addition, low English reading proficiency may disproportionately and negatively affect many racial and ethnic minority patients' ability to read and understand written material from health plans and healthcare providers if appropriate translation is not provided. As discussed in Chapter 3, there is significant evidence that language affects variables such as follow-up compliance and satisfaction with services (Carrasquillo et al., 1999). Linguistic difficulties may present a barrier to the use of healthcare services (Derose and Baker, 2000), decrease adherence with medication regimes and appointment attendance (Manson, 1988), and decrease satisfaction with services (Carrasquillo et al., 1999; David and Rhee, 1998). For example, a recent survey of Spanish-speaking Latinos and English speakers of varying ethnicities who used emergency department services found that among patients who reported at least one physician visit in the previous three months, Latinos with fair or poor English proficiency reported 22% fewer visits than English-speaking non-Latinos, after controlling for reason for the visit (Derose and Baker, 2000). These associations were similar for patients in poor health, those with no usual source of care, and those without insurance. Other investigators have found independent effects of language concordance on health outcomes, such that having a physician who spoke Spanish resulted in higher ratings of physical and psychological well being, higher health perceptions, and lower perceptions of pain (Perez-Stable, Napoles-Springer, and Miramontes, 1997).

A few studies examining the effectiveness of interpretation services have been conducted, with mixed results. Although mostly uncontrolled, some studies suggest that the use of interpreters for patients with limited English skills results in greater satisfaction (as compared to patients who said an interpreter should have been used; Baker, Hayes, and Fortier, 1998) and better medical outcomes (Tocher and Larson, 1998). However, in the investigation by Baker and colleagues (1998), while patients who used interpretation services rated their care as better than patients who would have liked services and did not receive them, they still rated their provider as less friendly, less respectful, less concerned, and felt less comfortable than patients who did not need an interpreter. These results suggest that interpretation services are necessary, but that both interpreters and providers should be aware that the mere availability of the service may not be adequate to improve satisfaction and outcomes. It has also been suggested that the use of remote language services, in which the interpreter is not physically in the room, may be preferable (for both patients and providers) to in-person interpretation services (Hornberger et al., 1996). While outcomes are somewhat variable, it is generally agreed that professional interpreters are necessary for many patients and that the use of family members, minors, or friends should be avoided as it may represent a breach of confidentiality, inhibit the patient from fully expressing symptoms or difficulties, or lead to errors in transmitting medical information.

The importance of interpretation services is underscored in guidelines offered by the Office for Civil Rights of the Department of Health and Human Services (U.S. DHHS) to prevent discrimination against limited-English proficient persons (U.S. DHHS, 2000). These guidelines pertain to any entity that receives direct or indirect financial assistance from HHS. Four key elements for compliance with the guidelines include: an assessment of the needs of the population; comprehensive written policies on language access (including hiring of bilingual staff and interpreters, arranging for telephone interpreters); training of staff; and monitoring of programs to ensure people with limited English proficiency are adequately served. Further, if the covered entity/agency suggests, requires, or encourages the use family members, minors, or friends as interpreters, it may expose them to liability under Title VI. Similarly, as noted above, the Office of Minority Health's national standards on culturally and linguistically appropriate services (CLAS) in healthcare also emphasize the importance of language access services.

An important issue for future consideration is the establishment of minimum standards for training of translators and interpreters. Significantly, the U.S. DHHS and some accreditation bodies are beginning to assess the feasibility of establishing minimum standards for interpreters and interpretation services. Selected federal laws and regulations, such as the Disadvantaged Minority Health Improvement Act, require the development of interpreter programs to increase the access of limited English proficient individuals to healthcare services. In addition, associations such as the Massachusetts Medical Interpreter Association (MMIA) in conjunction with Education Development Center, Inc., have published standards of practice focused on areas of interpretation, cultural interface, and ethical behavior. The recently established National Council on Interpretation in Healthcare has charged its Standards, Training and Certification (STC) Committee to draft standards, recommendations and informational materials concerning the interpreter role and performance as well as interpreter services and programs of interpreter education and assessment. Similarly, the California Healthcare Interpreters Association (CHIA) has recently released draft standards of ethical principles, protocols, and guidance for healthcare interpreters within the state.

Finding 5-1: As a result of the increasing linguistic diversity in the United States, professional interpretation services are increasingly needed to assist low-English proficient racial and ethnic minority patients in healthcare settings.

Recommendation 5-9: Support the use of interpretation services where community need exists.
Professional interpretation services should be the standard where language discordance poses a barrier to care. Greater resources should be made available by payors to provide coverage for interpretation services for limited-English proficient patients and their families. Future research should identify best practices where the availability of interpretation services is limited.

Community Health Workers

Community health workers have been acknowledged participants in healthcare systems since the 1960s (Witmer et al., 1995). These individuals, often termed lay health advisors, neighborhood workers, indigenous health workers, health aids, consejera, or promotora, fulfill multiple functions in helping to improve health outcomes. They have been defined as being "community members who work almost exclusively in community settings and who serve as connectors between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care" (Witmer et al., 1995). The training of lay health workers varies and typically depends on the nature of services they will provide. Generally, the length of training varies from a few weeks to six months and includes lectures and supervised practical/field experiences (for review see Jackson and Parks, 1997; Witmer et al., 1995). One of the greatest assets of lay health programs is that they build on the strengths of community ties to help improve outcomes for its citizens.

In addition to increasing access to services, some evidence suggests that lay health workers can help improve the quality of care and reduce costs (Witmer et al., 1995). Lay workers can facilitate community participation in the health system, serve as liaisons between patients and providers, educate providers about community needs and the culture of the community, provide patient education, promote consumer advocacy and protection, contribute to continuity and coordination of care, assist in appointment attendance and adherence to medication regimens, and help to increase the use of preventive and primary care services (Brownstein et al., 1992; Earp and Flax, 1999; Jackson and Parks, 1997). Programs that utilize lay health workers have sought to improve healthcare delivery for a variety of conditions including stroke and hypertension (Richter et al., 1974), breast and cervical cancer screening (Brownstein et al., 1992; Dignan et al., 1998; Earp and Flax, 1999), and the use of prenatal services (Meister et al., 1992). Lay health workers have also been used to address broader issues such as improving healthcare organizations' ability to identify needs of the community (Baker et al., 1997) and improve general wellness through informing community members about resources and facilitating their access to and negotiation through services (Rodney et al., 1998).

During its inception, the concept of using lay health workers included collaborations between lay health workers and public health departments, homeless programs, and community health centers (Richter et al., 1974). More recently, partnerships have been formed with academic medical centers (see for example, Levine et al., 1994). This movement has been accompanied by increased efforts to evaluate the effectiveness of lay workers in improving patient satisfaction and increased use of services. Results indicate that use of lay health workers can increase awareness of and screening for breast cancer (Bird et al., 1998; Navarro et al., 1998; Slater et al., 1998) and cervical cancer (Bird et al., 1998; Dignan et al., 1998; Navarro et al., 1998). For example, among a population of Vietnamese-American women in California, the use of lay health workers significantly increased women's awareness of and utilization of Pap smear and mammography (Bird et al., 1998). The use of lay health workers in a diabetes education program improved completion, regardless of financial status or language spoken, over conducting the education program without lay health workers (Corkery et al., 1997). However, the health workers did not have a significant effect on diabetes knowledge, self-care behavior, or glycemic control, although the small sample size (*n* = 64) may have limited the investigators' ability to find statistically significant relationships with these outcomes.

In order for community health worker programs to be successful, they must be designed properly and workers must be adequately trained and supervised. Barriers to their effective use have included a lack of consistent, widely accepted definition of who they are and what services they can provide (e.g., scope of practice, qualifications), lack of consideration by degreed health professionals for their services, and lack of consistent funding for lay health programs (Witmer et al., 1995). Some literature provides guidance regarding the design of community health worker programs (Brownstein et al., 1992; Giblin, 1989; Jackson and Parks, 1997; Richter et al., 1974; Witmer et al., 1995), but rigorous evaluations of specific program components and their impact on service utilization are needed.

Finding 5-2: Community health workers offer promise as a community-based resource to increase racial and ethnic minorities' access to heathcare and to serve as a liaison between healthcare providers and the communities they serve.

Recommendation 5-10: Support the use of community health workers. Programs to support the use of community health workers (e.g., as healthcare navigators), especially among medically underserved and racial and ethnic minority populations, should be expanded, evaluated, and replicated.

Multidisciplinary Teams

Research demonstrates that multidisciplinary team approaches—utilizing physicians, nurses, dietitians, and others—have proven effective in optimizing risk reduction strategies. This effect is found in randomized controlled studies for patients with coronary heart disease (Multiple Risk Factor Intervention Trial Research Group, 1982), hypertension (Hypertension Detection and Follow-up Program Cooperative Group, 1979), and other diseases (SHEP Cooperative Research Group, 1991; Pedersen et al., 1994; Treatment of Mild Hypertension Study Research Group, 1993), and has extended to strategies for reducing risk behaviors such as smoking and sedentary lifestyle and managing obesity (Hill and Miller, 1996). Multidisciplinary teams coordinate and streamline care, enhance patient adherence through follow-up techniques, and address the multiple behavioral and social risks that patients face, particularly racial and ethnic minority patients. They may save costs and improve the efficiency of care by reducing the need for face-to-face physician visits and improve patients' day-to-day care between visits. Further, such strategies have proven effective in improving health outcomes of minorities previously viewed as "difficult to serve" (Hill and Miller, 1996). Multidisciplinary team approaches should be more widely instituted as strategy for improving care delivery, implementing secondary prevention strategies, and enhancing risk reduction.

> **Recommendation 5-11: Implement multidisciplinary treatment and preventive care teams.**
> **Multidisciplinary teams offer promise as a means to improve and streamline care for racial and ethnic minority patients, and therefore should be more widely implemented.**

PATIENT EDUCATION AND EMPOWERMENT

Skill-building and training for providers of healthcare has been a traditional avenue for helping to improve outcomes (see for example Roter and Hall, 1994; Roter et al., 1995; Williams and Deci, 2001), increase patient satisfaction with care (Roter et al., 1996), and decrease the incidence of lawsuits (Levinson et al., 1997; Mock, 2001). However, as issues of improved patient-provider communication/relationship have moved to the forefront, patient education, participation, activation, and empowerment have received more attention. Information that flows in both directions is deemed important for increasing patient cooperation, engagement, and adherence to medical regimes (Korsch, 1994).

Patient education has taken many forms including provision of books, pamphlets, in-person instruction, CD-ROM, and Internet-based information. Books such as that by Korsch and Harding (1998) help guide patients through typical office visits and provide information about asking the right questions, communicating with the provider when instructions are not understood or cannot be followed, and being an active participant in decision making. The guide also helps patients understand the nature of medical training and its impact on provider behavior. Other mediums such as entertainment television (Cooper, Roter, and Langlieb, 2000) and computer-based education programs (McRoy, Liu-Perez, and Ali, 1998) have been initiated. In addition, private and academic institutions offer information systems to assist patients in navigating healthcare systems. For example the Bayer Institute has developed a program called PREPARE, a six-step program using a self-administered audiotape and guidebook to help patients prepare for office visits. Complementary materials were also developed for use by providers of healthcare to support and encourage use of the program. In addition, some medical institutions, such as the Ohio State University Medical Center and Cincinnati Children's Hospital Center, have established Internet-based programs to help answer patient questions about topics such as pain management, medications, medical procedures, nutrition, and health promotion.

As patient education approaches become more widely used, efforts to evaluate their effectiveness have increased, and have demonstrated positive results. In one of the earliest papers examining the beneficial effects of patient education, Roter (1977) assessed the effects of a health education intervention to increase patient question-asking during office visits. In this study, which was conducted with an urban and predominantly black population, patients were randomly assigned to intervention and non-intervention groups. There were also two non-randomized control groups. Results indicated that patients in the intervention group asked more direct questions and fewer indirect questions than did non-intervention group patients. However, within the intervention group, there was more negative affect, anxiety, and anger in the patient-provider interaction, while in the placebo group, patient-provider interaction was characterized as mutually sympathetic. In addition, the intervention group patients were less satisfied with care received in the clinic on the day of their visit than were placebo patients, but they demonstrated higher appointment-keeping (accounting for average number of appointments made) during a 4-month prospective monitoring period. These results suggest that efforts directed at increasing patient activation must also target physician behavior and how providers receive and respond to patients' increased participation.

A recently developed CD-ROM reproductive health education program for adolescents with diabetes has been evaluated for its effectiveness in altering knowledge, attitudes, skills, and behaviors. Initial results indicate that the use of the CD-ROM was associated with changes in knowledge, attitudes, and beliefs over the use of a self-instruction packet or standard care. Similarly, an individual education and coaching program in pain self-management for cancer patients was demonstrated to improve ratings of pain severity over patients who did not receive the intervention. However, no changes were observed in functional impairment resulting from pain, frequency of pain, or pain-related knowledge.

In a review article, Roter and colleagues (1998) summarized results of 153 studies evaluating the effectiveness of interventions to improve patient compliance. Many of these studies were patient education-based and included strategies such as individual and group teaching, use of written and audiovisual materials, mailed materials, and telephone instructions. Overall, the most striking results were seen for behavior strategies (e.g., skill building, practice activities, modeling and contracting, rewards, mail and telephone reminders) and those that combined education and behavior strategies. In general, interventions that combined strategies were more successful than single-focus interventions. Significant results, though varied in magnitude, were found for refill records, pill counts, utilization, and improved health outcomes. While most studies cited were not specifically targeted toward communities of color, positive results from patient education programs offer promise for their use with racial and ethnic minority patients. However, it is crucial that interventions be adapted with cultural and linguistic considerations in mind and also address physician responses to their patients' increased activation, to ensure collaborative interactions.

Finding 5-3: Culturally appropriate patient education programs offer promise as an effective means of improving patient participation in clinical decision making and care-seeking skills, knowledge, and self advocacy.

Recommendation 5-12: Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions.
Culturally appropriate patient education programs tailored to specific racial and ethnic minority populations should be developed, implemented, and evaluated.