



**PROMOTING HEALTH FOR A CULTURALLY DIVERSE WORKFORCE:
THE IMPACT OF RACIAL AND ETHNIC HEALTH DISPARITIES ON
EMPLOYEE HEALTH AND PRODUCTIVITY**

A WBGH Employer Leadership Forum

Sponsored by the Department of Health and Human Services
Office of Public Health and Science

January 8, 2001

PROCEEDINGS



TABLE OF CONTENTS

PURPOSE

LEADERSHIP FORUM AGENDA

PRESENTATIONS

- ❶ Racial and Ethnic Health Disparities: An Overview
- ❷ Racial and Ethnic Health Disparities in Depression Treatment: Opportunities for Employer Involvement
- ❸ Race, Ethnicity, and Medical Decision-Making
- ❹ Linguistic and Cultural Competence Measures for Health Plans: Tools for Quality Improvement and Consumer Choice
- ❺ Strategies to Address Racial and Ethnic Health Disparities

BREAKOUT GROUP DISCUSSION

CONCLUSION

ATTENDEES

PURPOSE

Recent studies have revealed that striking differences exist between minorities and whites in access to primary and preventive care, diagnosis and treatment of specific health conditions, physician decision-making, and a number of cultural and communication barriers experienced when seeking care. These differences persist even among insured populations, indicating underlying, systemic problems in both access to and delivery of care. Developing effective strategies to deal with racial and ethnic health disparities is a high priority for U.S. employers, as the workforce becomes increasingly diverse. Many of the disease conditions demonstrating the greatest disparities between minority and majority groups affect those in the current and future workforce. Employer awareness of health disparities and consideration of cultural competence when purchasing health care for employees can leverage responses from insurers and health plans, will lead to a more efficient use of health dollars, and can contribute to increased productivity and a reduction in absenteeism and disability.

In order to examine the evidence of the problem and discuss the employers' role in tackling this issue, the Washington Business Group on Health convened a meeting between experts working in the area of health disparities and business leaders. The meeting was held on January 8, 2001 in Washington D.C. and served as a forum to share information and generate a dialogue about this topic. The success of this meeting was the impetus in launching a new WBGH initiative to address the emergence of information regarding health disparities and to create new strategies that lessen the impact on employee health and productivity.

**Promoting Health for a Culturally Diverse Workforce:
The Impact of Racial and Ethnic Health Disparities on
Employee Health and Productivity**

A Washington Business Group on Health Employer Leadership Forum

**Monday, January 8, 2001
10:00 a.m. – 3:00 p.m.**

WBGH
50 F Street, NW
4th Floor Conference Rooms
Washington, DC 20001
(202) 628-9320

AGENDA

- 10:00 –10:15 am** **Welcome and Introductions**
Mary Jane England, MD *President, WBGH*
Rowena Bonoan, MPH *WBGH*
Beverly Malone, PhD, RN *U.S. Department of Health and Human Services*
- 10:15 – 10:45** **Racial and Ethnic Health Disparities: An Overview**
Beverly Malone, PhD, RN *U.S. Department of Health and Human Services*
Nicole Lurie, MD, MSPH *U.S. Department of Health and Human Services*
- 10:45 – 11:15** **Racial and Ethnic Disparities in Depression Treatment: Opportunities for Employer Involvement**
Henry Chung, MD *Pfizer, Inc.*
- 11:15 – 11:40** **Race, Ethnicity and Medical Decision-Making**
Carol Scott, MD, MEd *The Medical Education Group*
- 11:40 – 11:50** **Questions and Discussion**
- 11:50 – 12:15** **Linguistic and Cultural Competence Measures for Health Plans: Tools for Quality Improvement and Consumer Choice**
Magda Garcia, PhD *University of Texas-Houston School of Public Health*
- 12:15 – 1:00** **Lunch Break**
- 1:00 – 1:25** **Strategies to Address Racial and Ethnic Health Disparities**
Carol Scott, MD, MEd *The Medical Education Group*
Beverly Malone, PhD, RN *U.S. Department of Health and Human Services*
- 1:25 – 2:10** **Roundtable Discussions**
- 2:10 – 2:15** **Break**
- 2:15 – 2:45** **Roundtable Reports and Group Discussion**
- 2:45 – 3:00** **Wrap-up and Next Steps**

PRESENTATIONS

❶ **Racial and Ethnic Health Disparities: An Overview**

Drs. Nicole Lurie and Beverly Malone from the U.S. Surgeon General's office set the stage for morning discussions by presenting recent data on racial and ethnic health disparities in the United States. Based upon research from DHHS efforts in response to former President Clinton's Initiative on Race and Health, Dr. Lurie outlined six clinical areas (infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and immunizations) in which substantial disparities lie between the health status of minority populations and Whites.

1) INFANT MORTALITY

Infant mortality rates are 2 ½ times higher for African Americans and 1 ½ times higher for American Indians/Alaskan natives than whites. American Indians, Alaskan Natives, and African Americans are 2 times as likely to die from SIDS than Whites.

2) CANCER SCREENING AND MANAGEMENT

African Americans, Hispanics, and American Indians/Alaskan Natives are less likely to have had a mammogram within the last two years. Asian Pacific Islanders, American Indians/Alaskan Natives, and Hispanics are all less likely to have had a pap smear in the past year, and Vietnamese women have cancer at nearly five times the rate of Whites. Hispanics also suffer elevated rates. Many minority groups suffer disproportionately from cancer, and disparities exist in both mortality and incidence rates. African American males are 50% more likely to die from cancer as whites and have a 50% higher incidence rate for lung cancer as compared to white men. Although the incidence of breast cancer is greater for White women, African American women are 28% more likely to die from it.

3) CARDIOVASCULAR DISEASE

Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. African American men suffer from heart disease at a 40% higher rate than White men, and experience strokes at almost twice the White rate.

4) DIABETES

Both male and female Native Americans suffer from diabetes at nearly three times the rate of Whites. For Hispanics, the rate is nearly double that of whites, and for Blacks, the rate is 70% higher than the White rate. Rates of complications for Native Americans, Blacks, and Hispanics are also higher than Whites for end-stage renal disease, amputations, and blindness.

5) HIV/AIDS

HIV/AIDS is increasingly becoming a disease of people of color, of women, and of the young. In 1999, the rate of new AIDS cases per 100,000 reported in the U.S. was 66 among Blacks and 7.6 among Whites. Of newly infected women, 64% were Black, 18% were White and 18% were Hispanic.

6) IMMUNIZATIONS

While 79% of white children have received the full series of vaccinations by age 2, only 74% of African American children and 71% of Hispanic children are fully vaccinated against childhood disease. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for African Americans and Hispanics, the coverage in these groups remains well below the general population.

Dr. Lurie also noted that accounting for health disparities is a complex problem and that no single cause or solution exists. Many factors may influence the presence of racial and ethnic health disparities, including the affordability of health care, geographic access, transportation, education, literacy, health beliefs and racial concordance between provider and patient, provider bias, patient attitudes and preferences, and competing demands including work and child care. Dr. Lurie emphasized, however, that after adjusting for these factors, while disparities may lessen, they do not disappear. An underlying premise of HHS interest in working with the business community is the integral role employers play as purchasers of health care for their employees. Businesses want to ensure that their investments in employee health care benefits provide equal access to high quality care for all employees. Recent studies show that this is not the case. Employers purchase health care for an increasingly diverse workforce; the possible presence of unequal treatment and/or inappropriate utilization of health care services demands attention.

Dr. Lurie concluded her presentation by discussing a recent study in the *New England Journal of Medicine* that demonstrated how the race and sex of a patient may independently influence how physicians manage chest pain. A computerized survey instrument was used to assess physicians' recommendations for managing chest pain. Actors (4 Males – 2 African American, 2 White, and 4 Females – 2 African American and 2 White) portrayed patients with particular characteristics in scripted interviews about the symptoms. A total of 720 physicians at two national meetings of organizations of primary care physicians participated in the survey. Each physician viewed a recorded interview and was given other data about a hypothetical patient. He or she then made recommendations about that patient's care. Findings suggested that physician decision-making may be an important factor in explaining differences in the treatment of cardiovascular disease with respect to race and sex.¹

❷ Racial and Ethnic Health Disparities in Depression Treatment: Opportunities for Employer Involvement

Dr. Henry Chung, Medical Director of the Depression/Anxiety Disease Management Team at Pfizer, Inc., focused his discussion on racial and ethnic health disparities and the treatment of depression. Dr. Chung described higher incidence of missed opportunities for diagnosis and treatment of depression among minority groups, specifically African Americans and Hispanics. African Americans have a higher prevalence for mental disorders, most likely due to socioeconomic status differences. Most striking, however, is that under-representation/utilization of mental health services is largest in privately financed care and outpatient care, occurring more among working and middle-class African Americans. African Americans are less likely than whites to receive antidepressant medications even after receiving diagnosis. Asian Americans have particularly low levels of mental health specialty utilization. One national sample revealed that Asian Americans were only a quarter as likely as whites, and half as likely as African Americans and Hispanic Americans to have sought outpatient treatment.

Minority groups face many barriers to seeking help, including demographic factors, a lack of culturally competent services, and patient attitudes toward a health service system that often overlooks the special needs of racial and ethnic communities. Language and financial barriers, as well as stigma, loss of face, and different cultural explanations for problems experienced may also inhibit individuals from proactively seeking care. Patient and provider-related factors can serve as barriers to diagnosis and treatment. For the patient, depression frequently amplifies physical symptoms, distracting both the patient's and the provider's attention from underlying depression. Racial/ethnic minorities may deny psychological

¹ Schulman KA, Berlin JA, Harless W, et al. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *N Engl J Med* 1999;340:618-26.

symptoms of depression, have comparatively less baseline knowledge about mental disorders and their treatability, and possess culturally specific concerns about medication effects.

Dr. Chung offered a definition of cultural competence that served as a guide for afternoon breakout discussions. Cultural competence can be defined as a set of behaviors, attitudes, and policies that enables a system to work effectively in cross-cultural situations. Cultural competence is critical because most primary care or specialty providers are not racial or ethnic minority group members. The term “competence” places the responsibility on the system and all of its employees, challenging all to become part of a process. Dr. Chung emphasized the importance of building service systems that recognize, incorporate, practice and value cultural diversity. Steps toward cultural competence can take many forms and include: consultation with cross-cultural experts and training of staff; developing a capacity to provide services in languages other than English; and creating a mechanism to actively monitor cultural competence and cultural diversity processes and outcomes. The effects of developing a culturally competent system of health care are documented by improvement in the care and treatment of racial and ethnic minorities.

Dr. Chung summarized his vision of a culturally competent system of mental health care by underscoring the need to continue to build the science base surrounding the effects of depression on people of color, and to overcome stigma and improve public awareness of effective treatment. A diverse array of mental health services and providers are necessary to ensure cultural competence. Mechanisms that ensure delivery of state-of-the-art treatment, facilitate entry into treatment, reduce financial barriers to treatment and provide treatment that is tailored to age, gender, race, and culture will go a long way to improving care for racial and ethnic minorities.

🕒 **Race, Ethnicity, and Medical Decision-Making**

Dr. Carol Scott of The Medical Education Group engaged participants in a provocative discussion that began to lay out premises for different ways that we talk about health. Using a video clip from an episode of the television series “ER,” she discussed how unconscious/subconscious racial bias can play a role in medical decision-making. Important in the discussion was the idea that while racism is part of what contributes to disparities in health between minority and majority populations, much more has to do with how individuals from different cultures define health and illness. Dr. Scott pointed out that everyone learns from their own culture/ethnic/identity groups, how to be healthy, how to recognize when one is sick, and how to be ill. She then asked the group to consider how an individual decides that he/she is too “sick” to go to work.

Dr. Scott also described four models of the physician-patient relationship to characterize interactions that often occur. Many issues come into play during the patient-doctor encounter, including the physician’s obligation, patient values, the concept of patient autonomy, and the concept of the physician’s role which is seen as everything from a technical expert and counselor to a friend, teacher, and guardian. Dr. Scott shared current research that demonstrates that patients’ desire for information is stronger than the desire to be involved in decision-making. Many physicians tend to underestimate how much information a patient wants and prescribing decisions are often guided by perceptions of patient expectations.

Dr. Scott presented evidence suggesting that the teaching of cultural issues in medical schools is for the most part limited. Only 8% of schools had a separate course with the overwhelming majority (87%) including 1-3 lectures within a larger course. Only 28% taught about African Americans, 26% about Latinos, and only 35% addressed the cultural issues of the largest minority group in their state.

Dr. Scott articulated several strategies companies might use to reduce racial and ethnic health disparities including: improving cross-cultural knowledge and skills of employer health benefits personnel; considering diversity in provider panels; organizational cultural competency of health care organizations providing care for employees; and assessing the cultural and linguistic sensitivity of current health and wellness programs. Empowering patients/employees through health education/promotion strategies that are culturally appropriate can enable individuals to develop more effective communications with providers and thus improve overall medical decision-making. Benefits from applying cultural competence in employee healthcare education include improved organizational productivity, enhanced ability to make wise health-related choices, and increased employee/family/community relations.

④ **Linguistic and Cultural Competence Measures for Health Plans: Tools for Quality Improvement and Consumer Choice**

Dr. Magda Garcia of the University of Texas-Houston School of Public Health provided for participants an opportunity to learn about her current research on the development of actual tools to measure the linguistic and cultural competence of health plans. Dr. Garcia's study looked at multiple measures of linguistic and cultural competence and sought to address the extent to which health plans included in her study had these measures readily available and/or in use. Dr. Garcia surveyed three health insurance companies in New Mexico, Michigan and Texas and administered a questionnaire that provided definitions of linguistic and cultural competence and then asked respondents to use these definitions as a guide to determine the presence/use of the aforementioned measures.

Each definition was specific in its meaning and purpose.

Linguistic Competence: Linguistic competence refers to the capability to communicate orally or in written form with individuals who speak a different language than the predominant language of a region. The purpose of this definition was to distinguish between linguistic and cultural competence and to clarify that understanding culture goes beyond the ability to communicate verbally and in written form with members of other cultures.

Cultural Competence was defined in three distinct ways.

Cultural Competence 1: Cultural sensitivity entails an acknowledgement that cultural differences as well as similarities exist, without assigning values, i.e. better or worse, right or wrong, to those cultural differences. One needs to move to another level, that of *cultural competence* to apply this sensitivity in planning, implementing, and evaluating service systems at the community level. Competence implies more than a knowledge of beliefs, attitudes, and tolerance. Competence implies skills that help to translate beliefs, attitudes and orientation into action and behavior in the daily interaction with patients (*Maternal and Child Health Bureau, 1995.*) The purpose of this definition was to make a distinction between cultural sensitivity and cultural competence.

Cultural Competence 2: Cultural competence is “the ability of a system, agency, or individual to respond to the unique needs of populations whose cultures are different from ‘mainstream society.’ A culturally competent system of care acknowledges and incorporates the importance of culture on all levels – policy, administration, practitioner, consumer” (*Cross, 1997.*) The purpose of the second definition was to clarify that cultural competence occurs at all levels of the organization.

Cultural Competence 3: Cultural competence is “the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy” (*Lavizzo-Mourey and Mackenzie, 1996.*) The purpose of the third definition was to emphasize that there are not only differences in health beliefs among cultures, but also differences in the epidemiology of disease and differences in the efficacy of treatments among cultural groups. This knowledge is essential to designing effective health programs.

Dr. Garcia’s looked at the following measures of linguistic and cultural competence:

LINGUISTIC COMPETENCE:

- Availability of interpreter services;
- Number of “nurse on call” phone staff, physicians, and plan staff who are bilingual;
- Level of proficiency of Spanish-speaking providers and staff;
- Number of clinic sites with one or more Spanish-speaking staff;
- Bilingual forms and educational materials;
- Availability of information in Spanish describing treatment options;
- Patients’ reports of satisfaction with communication.

CULTURAL COMPETENCE:

- Mechanisms that promote diversity of staffing and physicians;
- Number of African American and Hispanic physicians;
- Demographic description and credentials of minority physicians by specialty;
- Health-plan staff and provider training in cultural competence;
- Number of community representatives on plan’s board;
- Provider acceptance of cultural beliefs;
- Evidence of provider respect for patient preferences;
- Survey data on domains of respect.

The results of Dr. Garcia’s research showed that the health plans included in the study had some of the linguistic and cultural competence measures in place but that improvement was necessary. Among the linguistic competence measures readily available were the number of Spanish-speaking plan staff and patient reports of general satisfaction with provider communications and with interpreter services, as measured in the 1998 Consumer Assessment of Health Plans (CAHPS). Health plans studied also indicated the presence of bilingual forms and educational materials in Spanish as well as availability of interpreter services, and instructions given to plan members on how to access interpreter services.

Several cultural competence measures were also included in health plan documentation including:

- The demographic background of the physician (sex, education);
- Evidence that the plan staff has attended cultural sensitivity training;
- Number of community representatives on the board;
- Credentials of physicians by specialty in the aggregate form, i.e. for all physicians in the network;
- A general measure of providers’ respect for the patient from CAHPS.

Information not currently available by the health plans in the study were:

- Number of African American physicians;
- Number of Hispanic physicians;
- Diversity of Staffing;
- Credentials of minority physicians by specialty.

There are no measures for provider acceptance of cultural beliefs nor specific aspects of respect. Therefore, the health insurance companies did not assess whether providers show respect by:

- Considering the patient's use of cultural remedies or alternative medicine;
- Keeping the patient informed about health issues;
- Considering the preferences of the patient;
- Considering the patient's personal values or religion;
- Considering the patient's opinion;
- Being courteous to the patient's family and friends;
- Asking for the patient's preference to be accompanied by an adult family member.

Dr. Garcia's data indicate that health plans have made notable progress toward achieving linguistic competence, a required first step toward achieving cultural competence. Medicaid contract requirements have generated many of the changes, but more changes have to be made to progress toward the goal of delivering culturally competent services. Health plans have yet to develop methods of quality improvement to monitor their own progress toward becoming culturally competent and additional incentives are required to evaluate the effectiveness of current measures. Governmental and accreditation agencies will continue to play an important role in the progress health plans make in the future to provide more linguistically and culturally competent services to their members. Next steps in Dr. Garcia's research include determining the relationship between high levels of cultural competence or linguistic competence and the processes of care, outcomes of care, and member satisfaction.

⑤ Strategies to Address Racial and Ethnic Health Disparities

In this presentation, Dr. Carol Scott described a project with three schools that sought to implement a school-based health and wellness program for school employees. Important in this process was a needs assessment guided by several principles including the promotion of culturally relevant health and wellness program components, collaboration with community resources, and measurable outcomes linked to risk reduction, wellness, and productivity. Schools were asked to participate in several steps to create a program specific to the needs of participants. Three-fourths of respondents were African-American, three-fourths were women, and three-fourths had a bachelor's degree or higher. Half of respondents were teachers, 11.4% were teacher's assistants, and thirty-five percent of other respondents were support staff, such as cafeteria and custodial personnel and administration. The mean age was 45 years and the mean weight 169 pounds.

Program components centered upon asking participants to define health and wellness for themselves, as well as developing a mechanism to both disseminate and reinforce accurate, culturally relevant information about health and disease. To assess the current health status and behaviors of faculty and staff at all schools, a questionnaire was distributed that included demographic information and self-identification of health conditions and/or behaviors including obesity, exercise, blood pressure, cholesterol, asthma, breast self-exams and mammograms. Participants also completed the standard short-form health survey (SF-36) and answered questions regarding their own preventive health behaviors. A unique feature of Dr. Scott's program was the effort made to identify mentorship opportunities for those who share a similar health condition. This type of activity, called "looping", acknowledges the benefits of supportive strategies to empower healthy behaviors, and helps individuals best manage their disease. A majority of respondents who had asthma, high blood pressure, or were overweight replied that they would engage in "looping behavior" and model health practices. Others articulated their desire for support groups for weight control and relaxation.

Survey results generated a series of interventions based on the needs outlined by participants, including: professional development sessions focusing on health and wellness, discounted health club memberships for staff and faculty, walking clubs, a lecture series on health topics such as lowering cholesterol, hypertension, and breast self examination, yoga, and counseling services. Goals for the future included intervention and support programs on nutrition, exercise, developing a looping program for asthma, reducing high blood pressure, reducing the risk of heart disease, continuing support for a walking club, and addressing violence, particularly youth violence.

Dr. Scott also described a study based at Harvard Pilgrim Health Care that examined the impact of an Interpreter Training Program for employees. Seventy-nine percent of patients indicated interpreters influenced their decision to stay at their health center. Sixty-three percent of patients indicated that interpreter services influenced their decision to come to health centers. Education for interpreters yielded improvements in medical terminology interpretation from 52% to 90%. The service included encounter interpreters, phone interpreters for corporate services, translations, and community outreach. Satisfaction improved across all ethnic groups measured.

BREAKOUT GROUP DISCUSSIONS

Forum participants generally acknowledged that the increasing accumulation of data regarding racial and ethnic health disparities is troublesome. To the extent that disparities are a result of inappropriate health care and/or use, their existence can affect employee productivity, absenteeism and disability. Throughout the discussions, several questions reappeared:

- What impact can the employer actually have?
- How do we make the business case for employers to address racial and ethnic health disparities?
- The “threshold issue” - is there enough at stake in these differences? Are employers willing to pay more for increased quality? What is the return on investment?

Barriers and Challenges

The current absence of data and a means to collect data on race and ethnicity accurately and “safely” to determine the extent of racial and ethnic health disparities within the workforce emerged as a primary concern for employers. Several groups admitted that there is a presumption of guilt with regard to the collection of data and identified the Patients’ Bill of Rights and the recently released Privacy Regulations as having an impact on employer willingness to engage in data collection. Some questions asked include:

- What questions should be asked when collecting race and ethnicity data?
- How should data be coded to inform program decisions?
- What protections are needed so that information is used safely and correctly?
- How can employers/employees avoid perceptions of discrimination?

One group indicated potential difficulty in capturing indirect costs due to lost productivity, disability and workers compensation because if companies managed these three areas internally, collection or use of data may be problematic. Employers also expressed having a limited amount of knowledge of standards for cultural competence or how to measure health care providers and quality of care within these parameters. Overall, a general need for more science-based research regarding the impact of racial and ethnic health disparities on functional outcomes was articulated by all groups. New metrics that will look beyond the impact of health disparities on current costs need to be developed. Other groups articulated

specific challenges in reaching out to spouses, children and retirees when thinking of racial and ethnic health disparities.

Potential Solutions

Employers/forum participants were creative in their efforts to propose possible solutions and opportunities for employer involvement in the reduction of racial and ethnic health disparities. Data collection concerns could be addressed by looking at population and employee aggregate data and using third party administrators to remove individual references. Several groups felt that utilizing employee focus groups or advisory groups might be helpful to inform how employers might collect data on race, ethnicity, health behaviors, and health status, and to explain to employees the reasons behind collection of data.

Using information and strategies from existing diversity training and diversity work teams may aid in addressing fears associated with the discussion of race/ethnicity and health. Tailored marketing/communication with employees (possibly through intranet websites) about health risks and/or cultural needs for particular ethnic groups was recognized as a means to raise employee awareness. All groups felt that identification of an internal champion at the corporate leadership level would be integral to focus resources and time on disparity initiatives.

One group felt that development of a business strategy with a focus on short-term goals would be more feasible than trying to change corporate culture. More immediate actions possible for employers include gathering data about provider diversity from health plans, as well as looking at internal staff nurses/providers to ensure diversity and appropriate matching with employees when necessary. Many employers felt that the message of racial and ethnic health disparities needs to be shared with purchaser coalitions and that they could be used to measure results of initiatives that are implemented. Small, medium, and large companies could be engaged to inform the development of practical tools that could prove useful in employer health care purchasing strategies and in the design of worksite health promotion programs.

Employers identified many entities that would be helpful as resources in understanding health disparities and as potential partners. They include: churches, local Chambers of Commerce, JCAHO/NCQA, professional provider associations, unions, volunteer advocacy groups in the community, community health centers/Medicaid providers, the VA system, local/state public health agencies, boards of education, colleges, universities, and medical schools, foundations, hospitals and organizations with a specific interest in ethnicity and diversity. Most employers also felt that tools developed to measure linguistic and cultural competence of health plans would be useful, particularly if they could demonstrate long-term gains by both saving dollars and improving health care delivery to employees.

CONCLUSION

Developing effective strategies to deal with racial and ethnic health disparities is a high priority for U.S. employers, as the workforce becomes increasingly diverse. Many of the disease conditions demonstrating the greatest disparities between minority and majority groups affect those in the current and future workforce. Employer awareness of health disparities and consideration of cultural competence when purchasing health care for employees can leverage responses from insurers and health plans, will lead to a more efficient use of health dollars and can contribute to increased productivity and a reduction in absenteeism and disability.

This January session highlighted that while employers have not traditionally been considered as stakeholders in the elimination of health disparities, they recognize the importance of understanding and addressing cultural competence as it pertains to health care. Participants articulated a strong desire to examine the issues surrounding health disparities further and seek solutions that can be implemented at the worksite and through their health care purchasing.

The Board of Directors of WBGH recognizes the need for employer leadership in the area of racial and ethnic health disparities. As a result, WBGH is launching a new initiative to address the growing need for information and new strategies to address the impact of health disparities on employee health and productivity. The Health Disparities Initiative consists of several components, which are being developed both to aid employers in addressing health disparities among their workforces and, most importantly, to improve health outcomes.

1. WBGH COUNCIL ON HEALTH DISPARITIES

- ❖ This Board-sponsored council will provide an opportunity for leadership and discussion on health disparities in the workforce. This forum will be used to develop strategies to address disparities and share best practices.

2. WBGH EMPLOYER SURVEY

- ❖ WBGH will design and disseminate a survey among the employer community to determine employer perceptions on the impact of health disparities, identify existing health programs or processes that address minority populations at the work site, and ascertain what information is needed to increase employer understanding and facilitate strategies to reduce disparities.

3. FRAMING THE BUSINESS CASE FOR EMPLOYER INVOLVEMENT IN THE REDUCTION OF HEALTH DISPARITIES

- ❖ WBGH will write a white paper/monograph that lay out the magnitude and determinants of racial and ethnic health disparities, review and translate current research for the employer community, describe recent prevention and intervention strategies and policies, and set forth the business case for employers. The purpose of this paper would be to serve as a source for the employer's perspective on health disparities.
- ❖ This white paper will be translated into a Power Point presentation that can be disseminated at meetings and conferences.

4. INTERACTIVE TOOLS TO RAISE EMPLOYER AWARENESS

- ❖ WBGH will continue previous work to raise awareness among employers of health disparities and their impact on the workforce in a variety of formats:
 - Employer forums
 - A national conference that will include both public and private purchasers, regional business groups on health, researchers, clinicians, and policymakers

5. CREATE A WEB-BASED RESOURCE CENTER FOR EMPLOYERS

❖ This web-based component will serve as an information clearinghouse and include:

- Health Disparities white paper/monograph
- Health Disparities Power Point presentation
- Links for employers to other pertinent information, such as: the development of culturally competent health systems, health risk appraisals, linguistic and cultural competence performance measures for health plans, education materials for their employee population, and best practices or model programs that address disparities in the workforce

6. TAKE-HOME TOOLKIT FOR EMPLOYERS

❖ WBGH will develop a toolkit that will provide technical assistance for employers and will contain these main components:

- *Summary of Laws and Standards*
Analyses of existing rules, laws, and standards regarding cultural competence and the collection of race and ethnicity data that may impact the employer community
- *Purchasing Guidelines*
Development of model purchasing specifications for health plans that include measures for linguistic and cultural competence
- *Disease-specific case study model*
A model for an Employer/Community Initiative to manage and reduce the impact of cardiovascular disease at the workplace
- *Training modules*
A module that can be used for company “diversity caucuses,” corporate diversity-HR resources, and employee assistance programs to disseminate information to employees
- *Best Practices Dissemination*
WBGH will work to identify and disseminate information about model employer programs that reflect culturally appropriate services
- *Issue Briefs*
An ongoing series of short issue briefs will investigate disease conditions of particular concern for employers and their employee populations, translate academic research, and report on current trends, legislation, and national initiatives that address racial and ethnic health disparities

WBGH is designing the Health Disparities Initiative and its components to be a multi-funded effort. Through collaboration with a diverse group of partners, we hope to provide a comprehensive mechanism for employers to understand racial and ethnic health disparities and address their impact on the productivity and health of the workforce.

For more information about the WBGH Health Disparities Initiative, please contact:

Julianna Gonen, Ph.D.
Director, Family Health
(202) 628-9320
gonen@wbgh.org

Rea Pañares, M.H.S.
Manager, Family Health
(202)585-1800
panares@wbgh.org

ATTENDEES

Patricia Malanos
Manager, Employee Benefits
Alcoa, Inc.
201 Isabella Street,
Pittsburgh, PA 15212
(412) 533-2356 office
(412) 533-4916 fax
patty.malanos@alcoa.com

Larry Green, MD
Director
American Academy of Family Physicians
2023 Massachusetts Avenue, NW,
Washington, DC 20036
(202) 986-5708 office
(202) 986-7034 fax
lgreen@aafp.org

Kae Livsey
Public Policy and Advocacy Manager
American Association of Occupational Health Nurses, Inc.
2920 Brandywine Road, Suite 100
Atlanta, GA 30341
(770) 455-7757 x104 office
(770) 455-7271 fax
kae@aaohn.org

Joann T. Kasniak
Registered Nurse
Bank One
611 Woodward Ave., Suite 8072
Detroit, MI 48226
(313) 225-1693 office
(313) 226-0866 fax
JoAnn_Knasiak@Bankone.com

Stephen Sullman
Associate Director, Patient Advocacy
Bayer Pharmaceuticals
400 Morgan Lane,
West Haven, CT 6516
(203) 812-3708 office
(203) 812-6516 fax
steve.sullman.b@bayer.com

Sean P. Flanagan
Director of Government Relations
Catholic Health Initiatives
St. Joseph Medical Center
7601 Osler Drive,
Towson, MD 21204
(410) 337-4546 office
(410) 337-3907 fax
seanflanagan@chi-east.org

Lori de Ravello, MPH
Public Health Advisor
Centers for Disease Control and Prevention
4770 Buford Highway NE, MS-K22
Atlanta, GA 30341-3717
(770) 488-5211 office
(770) 488-5240 fax
leb8@cdc.gov

William C. Popik, MD
Sr. Vice President & National Medical Director
CIGNA HealthCare
900 Cottage Grove Road, A-136
Hartford, CT 06152
(860) 726-5744 office
(860) 726-6482 fax
william.popik@cigna.com

Ray Wernitz
President
Consumer Health Education Council
2121 K Street, NW,
Washington, DC 20037
(202) 775-6302 office
(202) 775-6312 fax
wernitz@healthCHEC.org

Miles Snowden, MD, MPH
Medical Director-Occupational Health
Delta Airlines
1050 Delta Blvd.,
Atlanta, GA 30320
(404) 773-3000 office
(404) 715-6576 fax
miles.snowden@delta-air.com

Joan Hunter
Public Health Service
Division of Federal Occupational Health
(301) 594-0259 office

Mark Delowery, DO, MPH
Vice President, Clinical Services
Federal Occupational Health
150 S. Independence Mall West, Suite 368
Philadelphia, PA 19106
(215) 861-4114 office
(215) 861-4121 fax
mdelowery@email.foh.dhhs.gov

Silvana Stankus
Absence Management, Business Practice Leader
HealthDirect, Inc.
74 Swampscott Road,
Farmington, CT 06032
(860) 321-3557 office

Sandra Santiago
Human Resources Program Manager
IBM
North Castle Drive,
Armonk, NY 10504
(914) 765-4301 office
(914) 765-4480 fax
santiasl@us.ibm.com

Hossain Saadi, MD
Senior Manager, Health Economics and
Reimbursement
Knoll Pharmaceutical Co.
3000 Continental Drive North,
Mount Olive, NJ 7828
(973) 426-5469 office
(973) 426-5680 fax
saadih@knoll-pharma.com

Amy Moore
Director, Benefit Resources
Marriott International, Inc.
Marriott Drive, Dept. 52/935.62
Washington, DC 20058
(301) 380-7279 office
(301) 380-5330 fax
amy.moore@marriott.com

Jill A. Berger
Director, Benefit Plan Quality Management
Marriott International, Inc.
Marriott Drive, Dept. 52/935.61
Washington, DC 20058
(301) 380-5712 office
(301) 380-1175 fax
jill.berger@marriott.com

Wakina Scott
Research Assistant
National Health Policy Forum
2131 K Street, Suite 500
Washington, DC 20006
(202) 833-7915 office
(202) 862-9837 fax
kinal@gwu.edu

David Jones
Sr. Director Prevention & Children's Mental
Health
National Mental Health Association
1021 Prince Street,
Alexandria, VA 22314-2971
(703) 838-7548 office
(703) 797-4313 fax
djones@nmha.org

Richard Levy, PhD
Vice President of Scientific Affairs
National Pharmaceutical Council
1894 Preston White Drive,
Reston, VA 20191
(703) 714-2767 office
(703) 476-0904 fax
rlevy@npcnow.com

Freddie L. Johnson
Manager, Comprehensive Disability Management
Nationwide
One Nationwide Plaza, 1--24--03
Columbus, OH 43215-2220
(614) 249-7187 office
(614) 249-9794 fax
johnsof@nationwide.com

Michael Tarre
Corporate Director of Compensation
Occidental
10889 Wilshire Boulevard,
Los Angeles, CA 90024
(310) 443-6021 office
(310) 443-6821 fax
Michael_Tarre@OXY.com

Henry Chung, MD
Medical Director-Depression/Anxiety Disease
Management Team
Pfizer, Inc.
235 East 42nd Street, MS235-10/20
New York, NY 10017
(212) 733-4522 office
Henry.Chung@pfizer.com

Duane Putnam
Manager, Employer Initiatives
Pfizer
4501 Lowell Street NW,
Washington, DC 20016
(202) 244-0507 office
(202) 244-0387 fax
duane.c.putnam@pfizer.com

Alberto Colombi, MD, MPH
Corporate Medical Director
PPG Industries
One PPG Place,
Pittsburgh, PA 15222
(412) 434-3111 office
(412) 434-2014 fax
colombippg.com

Eric Goplerud
SAMHSA
Room 10-99
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2817 office
(301) 443-8711 fax
egopleru@samhsa.gov

Bruce L. Douglas, MD, MPH
Chief Medical Adviser
Sedgwick CMS
175 West Jackson,
Chicago, IL 60604
(312) 356-1975 office
bdouglas@SedgwickCMS.com

Gerald Richerson
Human Resources Manager
Southern Company
241 Ralph McGill Boulevard, BIN 10146
Atlanta, GA 30308
(404) 506-6026 office
(404) 506-1630 fax
gtricher@southernco.com

Robert Shaw
Chief Medical Officer
Texaco
2000 Westchester Avenue
White Plains, New York 10650
(914) 253-7424 office
(914) 253-4281 fax
ShawR@Texaco.com

Janet Solomon
Health and Wellness Director
Texas Instruments
7839 Church Hill Way, Mail Stop 3905
Dallas, TX 75265
(972) 917-7254 office
(972) 917-6495 fax
jsolomon@ti.com

Bernellyn Carey
Manager, Health Promotion
The Board of Pensions of the Presbyterian Church
2000 Market Street, 4th Floor
Philadelphia, PA 19103
(215) 587-7443 office
Bcarey@pensions.org

Sharon Ray
Benefits Consultant
The Coca-Cola Company
One Coca-Cola Plaza,
Atlanta, GA 30313
(404) 676-1321 office
sharay@na.ko.com

Wendy Manners
Director, Integrated Benefits
The Hartford
225 Asylum St., 16th Floor
Goodwin Square
Hartford, CT 6103
(860) 520-1901 office
(860) 520-2503 fax
wendy.manners@thehartford.com

Carol Scott, MD, MSED
President
The Medical Education Group
2014 Jolly Road,
Baltimore, MD 21209
(410) 336-7894 office
(410) 366-6212 fax
cscott@erols.com

Marcy Trainer-Zawha
Manager, Medical Programs
Union Pacific Railroad
1416 Dodge Street, Room 908
Omaha, NE 68179
(402) 271-6454 office
(402) 271-4616 fax
MLTRAINE@UP.com

Magda Garcia, PhD
Research Associate, Health Policy Institute
University of Texas
Houston School of Public Health
1200 Herman Pressler, Suite E903K
Houston, TX 77030
(713) 500-9497 office
(713) 500-9493 fax
mgarcia@sph.uth.tmc.edu

Lisa Teems
Director of Employee Assistance Programs
US Department of Health and Human Services
200 Independence Avenue, SW, R-536E
Washington, DC 20201
(202) 690-8229 office
(202) 690-8328 fax

Felicia Collins, MD, MPH
Clinical Coordinator
U.S. Dept. of Health & Human Services
Bureau of Primary Health Care
4350 East West Highway, 7th Floor
Bethesda, MD 20814
(301) 594-3732 office
(301) 594-4986 fax
FCollins@hrsa.gov

Beverly Malone, PhD, RN
Deputy Assistant Secretary for Health
U.S. Dept. of Health & Human Services
Office of Public Health and Science
200 Independence Avenue, SW, Room 716-G
Washington, DC 20201
(202) 690-7694 office
(202) 690-6960 fax
bmalone@osophs.dhhs.gov

Nicole Lurie, MD, MSPH
Principal Deputy Assistant Secretary for Health
U.S. Dept. of Health & Human Services
Office of Public Health and Science
200 Independence Avenue, SW, Room 716-G
Washington, DC 20201
(202) 690-7694 office
(202) 690-6960 fax
nlurie@osophs.dhhs.gov

Matt Guidry, Ph.D.
Deputy Director for External Affairs
Office of Disease Prevention and Health
Promotion
U.S. Department of Health & Human Services
200 Independence Ave., S.W. Rm 738G
Washington, DC 20201
mguidry@osophs.dhhs.gov

Tanya Morrow
Program Analyst
U.S. Office of Personnel Management
1900 E Street, N.W.,
Washington, DC 20415
(202) 606-0745 office
(202) 606-0036 fax
tmmorrow@opm.gov

Kris Apgar, JD
Director
Washington Business Group on Health
50 F Street NW, Suite 600
Washington, DC 20001
(202) 628-9320 office
(202) 628-9244 fax
apgar@wbgh.org

Rowena Bonoan, MPH
Manager, Family Health
Washington Business Group on Health
50 F Street NW, Suite 600
Washington, DC 20001
(202) 628-9320 office
(202) 628-9244 fax
bonoan@wbgh.org

Michael Britt, MS
Manager, Family Health
Washington Business Group on Health
50 F Street NW, Suite 600
Washington, DC 20001
(202) 628-9320 office
(202) 628-9244 fax
britt@wbgh.org

Mary Jane England, MD
President
Washington Business Group on Health
50 F Street NW, Suite 600
Washington, DC 20001
(202) 628-9320 office
(202) 628-9244 fax
england@wbgh.org

Julianna Gonen, PhD
Director, Family Health
Washington Business Group on Health
50 F Street NW, Suite 600
Washington, DC 20001
(202) 628-9320 office
(202) 628-9244 fax
gonen@wbgh.org

Kathy King
Vice President
Washington Business Group on Health
50 F Street NW, Suite 600
Washington, DC 20001
(202) 628-9320 office
(202) 628-9244 fax
king@wbgh.org

Janice Pushaw
Director, Benefits Planning and Vendor
Management
Whirlpool
2000 M 63, Mail Drop 2900
Benton Harbor, MI 49022
(616) 923-6269 office
(616) 923-4652 fax
janice_pushaw@email.whirlpool.com