

Reform in Action: Equity in the Context of Health Reform

Insights from Aligning Forces for Quality *and* Finding Answers: Disparities Research for Change

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in 16 targeted communities, as well as reduce racial and ethnic disparities and provide tested local models that help propel national reform.

Finding Answers: Disparities Research for Change is a national program supported by the Robert Wood Johnson Foundation, focused on discovering and evaluating innovative interventions to move the disparities field beyond the documentation of racial and ethnic differences in health care toward implementing efforts to eliminate these gaps in care.

Although the quality of health care is poor for many Americans, some patients of specific racial and ethnic groups continue to experience lower-quality health care, even when access to care is equal.

The Robert Wood Johnson Foundation's **Aligning Forces for Quality (AF4Q)** and **Finding Answers** initiatives are actively studying, developing and implementing strategies to reduce racial and ethnic gaps in care.

Ten years ago, the Institute of Medicine's (IOM) landmark *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* reported that significant racial and ethnic disparities in health care existed in the United States, even after controlling for factors such as insurance coverage, socioeconomic status, and other illnesses.¹ Unfortunately, racial and ethnic inequalities in health and health care persist. Recent findings from the Centers for Disease Control and Prevention's 2011 *Health Disparities and Inequalities Report* shed light on the persistence of gaps in care:

- Large disparities in infant mortality continue. Infants born to Black women are 1.5 to 3 times more likely to die than infants born to women of other races/ethnicities.
- Black men and women are much more likely than their White counterparts to die of heart disease and stroke. This accounts for the largest proportion of inequality in life expectancy between Blacks and Whites, despite the existence of low-cost, highly effective treatment.
- Rates of hypertension are highest among Blacks, while success in controlling hypertension is lowest for Mexican Americans. People without health insurance—more than half of whom are people of color—are only half as likely to have the condition controlled.
- There are also large disparities in preventable hospitalizations. Blacks are hospitalized at a rate nearly twice that of Whites. Data from the Agency for Healthcare Research and Quality indicate that eliminating these disparities would prevent approximately one million hospitalizations and save \$6.7 billion in health care costs each year.²

Even as overall health outcomes in the general population—as measured by *Healthy People 2010* objectives—improve, less progress is being made in improving care and outcomes among some segments of the population. As the U.S. population grows older and more ethnically diverse, and household income inequality increases, disparities may worsen.³



ADDITIONAL RESOURCES

- [Hear from Marshall Chin, director of *Finding Answers: Disparities Research for Change*, about the Affordable Care Act and equity.](#)
- [Learn Five Things You Need to Know About Equity in U.S. Health Care](#)

Equity and Health Reform

A number of provisions in 2010's Affordable Care Act (ACA) directly address the goal of reducing disparities in health and health care among minority populations. Increasing access to health coverage will have a significant effect. More than half of the 46 million people who are currently uninsured are minorities.⁴

Starting in January 2014, all individuals living at or below 133 percent of the poverty level will be eligible for Medicaid. The law will prevent insurance companies from denying coverage to people with pre-existing conditions, a group in which minorities are over-represented. Hispanics and Blacks also tend to have lower rates of employer-sponsored coverage, making them more likely to benefit from health insurance exchanges, government-regulated marketplaces designed to enable more small businesses to offer employees health insurance.

While ACA does much to increase the likelihood that more minority patients than ever before will be covered by health insurance in the next few years, there is substantial evidence that coverage alone cannot reduce disparities in quality of care and outcomes.⁵ A comprehensive data collection provision builds collection and use of stratified race, ethnicity, language, gender and disability data into Medicaid, CHIP and other federally funded programs. This will identify specific disparities more accurately than in the past. Federal grants will aim to increase the number of underrepresented minorities in the health care workforce and direct funds to those who serve minority populations. The law also provides \$11 billion in support for community health centers, where the majority of patients are racial and ethnic minorities.

Using Race, Ethnicity and Language Data to Improve Quality

Efforts to improve equity in health care require valid and reliable data on race, ethnicity and language preference (R/E/L). Although collecting such data alone is not sufficient to reduce or eliminate disparities, it is a critical first step in identifying disparities and the health care needs of specific populations and planning customized interventions to address inequalities in care. The IOM's [three-step framework to identify and address disparities](#) includes 1) collecting standardized self-reported patient race, ethnicity and language data; 2) using those data to stratify quality performance measures to identify differences between groups; and 3) using these stratified data to develop quality improvement interventions tailored to specific patient populations.⁶

Communities participating in AF4Q have made consistent collection of this information a top priority. As a result of the [AF4Q Hospital Quality Improvement Collaborative](#), nearly 95 percent of participating hospital teams standardized the way they collect patient self-reported R/E/L data and now have R/E/L data for all of their patients, a powerful analytic tool that gives them the ability to look for disparities within any subgroup or any condition.⁷

AF4Q communities have also improved language services for patients who speak or understand a language other than English. As many as one in five people in the United States speaks a language other than English in the home, and this number is likely to increase.⁸ Approximately 50 million U.S. residents do not speak the same language as their health care providers.⁹ All hospitals in the United States that accept government funds are required to provide interpreter services to patients who speak a language other than English, but there has been little guidance for hospitals on the most effective, efficient ways to implement these requirements. Research shows that communication in a language the patient can understand is fundamental for receiving and providing safe, high-quality health care.

Measuring Disparities and Cultural Competency

The National Quality Forum (NQF) recently endorsed 12 quality measures focused on health care disparities and culturally competent care for racial and ethnic minority populations.

These measures are the first endorsed by NQF that specifically address health care disparities and cultural competency, and include two measures—providing language services from a qualified medical interpreter, and screening for each patient's preferred spoken language—developed and field tested through RWJF initiatives. NQF has also screened more than 500 of its 700+ endorsed measures for disparities sensitivity. A new portfolio of disparities-sensitive measures will be available in NQF's [Quality Positioning System](#) in November 2012.

ADDITIONAL RESOURCE

- [Aligning Forces for Quality Tools for Standardizing the Collection of Race, Ethnicity and Language Data](#)

Disparities may happen more frequently in communications-sensitive services—such as discharge instructions—when receiving care depends on providers and patients communicating clearly. Hospitals participating in AF4Q worked to improve the efficiency of language services, screened 1.5 million patients for preferred spoken language, and screened more than half a million for preferred written language. More than 4,500 patients had qualified interpreters at both initial assessment and discharge. Ninety-five percent of participating hospital teams improved their screening rates to determine a patient’s preferred spoken language for health care.¹⁰

Moving from Data Collection to Action

AF4Q in Action

- [Hear from Associate Director Marcia Wilson about the need to move from data collection to action.](#)

Across 16 AF4Q communities, implementing a standardized system for collecting self-reported R/E/L data gave quantifiable insight into patient populations and the quality of care they were receiving. Communities are taking action to address the gaps identified:

In **Memphis**, [Healthy Memphis Common Table](#) produced a [health equity report](#) in 2011, the first of its kind in the region.¹¹ The report revealed startling health inequalities, especially in care for Black patients with diabetes. If you are Black and live in Memphis, you are more than three times more likely to have your leg amputated due to complications from diabetes than if you are not Black. Data from the Dartmouth Atlas of Health Care showed that standard measures for the management of diabetes were not performed as regularly for Black patients as they were for White patients. The report showed equity in core measures of cardiac care, but revealed other disparities. At Methodist North Hospital, for instance, Black heart attack and heart failure patients were discharged earlier than White patients. Black patients hospitalized for heart failure were an average of 15 years younger than White patients; those hospitalized for heart attack were 9 years younger than White patients. While survival rates were higher for Black patients, they were also more likely to experience sudden collapse outside the hospital and to die at a younger age than White patients. As a result, Healthy Memphis Common Table worked closely with the Congregational Health Network to raise awareness about premature death in the Black population and educate people about the wide range of heart attack symptoms. A recent analysis indicates that community education is making a difference, and the racial disparity in rates of sudden collapse is shrinking.¹²

AF4Q in Action

- [See how the Memphis alliance discovered problems with access to care for Black men with heart disease.](#)

In **Minnesota**, performance data stratified by race, ethnicity and language helped [Minnesota Community Measurement](#) find a gap in breast cancer screening for Somali women. Patient focus groups revealed that the need to schedule a return appointment was a significant barrier. In response, clinics began to schedule same-day mammography and screening rates improved.¹³

In **Detroit**, the [Greater Detroit Area Health Council’s Race, Ethnicity and Primary Language and Data Collection Committee’s](#) efforts are evolving into projects that act on early findings. Oakwood Healthcare System is now working with a more accurate portrait of the patients they serve. The Dearborn health system’s large Middle Eastern patient population had always been acknowledged, but more accurate R/E/L data collection revealed that 20 percent of the system’s patients were Black and 12 to 15 percent were patients with limited English proficiency.¹⁴ That finding has helped deploy additional resources in areas where the needs of these newly measured populations are greatest, such as maternity and diabetes care. At Trinity Health’s St. Joseph Mercy Oakland hospital in Pontiac, Mich., clinical staff and administrators now have access to a real-time dashboard that highlights any disparities in the hospital’s performance on CMS core measures.¹⁵

Resources from Finding Answers

- **The Roadmap to Reduce Disparities** offers a framework for the design and implementation of disparities interventions, from the need to create a culture of equity to tips for pilot-testing disparities interventions. Three AF4Q alliances—Minnesota, Wisconsin and Kansas City—are currently using the Roadmap. Following the Roadmap's recommended steps allows organizations to ensure that they follow a comprehensive, systematic process that is tailored to the unique challenges of the organization's patient population.
- In **How to Start: 4 Tips for Improving Equity**, *Finding Answers* Director Marshall Chin, MD, identifies key steps that institutions — and individuals — can take to reduce disparities.

Creating a Plan for Action

Since 2005, *Finding Answers: Disparities Research for Change* has been engaged in charting a path to equity through quality improvement by conducting rigorous large-scale literature reviews, funding research on disparities interventions at 33 sites nationwide, and working directly with AF4Q communities. Their work affirms the need for a comprehensive, multi-level strategy.

Promising Disparities-Reduction Strategies from *Finding Answers*

Based on 11 systematic reviews of nearly 400 published articles on health care disparities interventions, and detailed evaluations of funded projects, *Finding Answers* has identified several promising strategies with the potential to reduce disparities:¹⁶

Multifaceted interventions

Crafting successful interventions means looking beyond the clinic. The efforts that are most likely to succeed are those customized to the patient population and health care setting, and that encourage not just patients to change, but also providers, payers, administrators, policy-makers and community organizations.

Example: At [Duke University Medical Center](#), patients at community-based primary clinics received monthly calls from nurses to discuss their cardiovascular disease risk management. The nurses' discussions focused on teaching the dangers of poor disease control, and explaining risk factors clearly. Nurses then contacted the patients' providers with updates on the patient and to facilitate medication management.¹⁷

Culturally tailored interventions

Cultural tailoring is more than simply using images of minority patients in promotional materials or translating patient education documents into another language. Interventions relevant to a patient's cultural context have the potential to improve patient-provider communication, increase patient knowledge and understanding, and improve outcomes.

Example: Researchers at [Cooper Green Mercy Hospital](#) in Birmingham, Ala., created a video series featuring local patients sharing their experiences with hypertension treatment. This peer-to-peer storytelling approach came about as a result of engaging patients in focus groups and understanding their level of trust in the health care system. The intervention improved blood pressure control.¹⁸

Multidisciplinary team-based care

Changing the composition of health care provider teams can enhance care delivery. Adding nurses, pharmacists, peer educators and patient navigators holds promise. Because nurses often spend more time with patients and can provide critical care coordination, they are in a unique position to affect change.

Example: In North Carolina, [East Carolina Health/Bertie All-County Health Services](#) redesigned primary care practices to include a "circuit rider": a certified diabetes educator nurse, pharmacist or dietician who rotates between clinics and acts as a care manager. At the same time, physicians received decision-support reminders as part of an electronic health records disease registry system.¹⁹

Interactive, skills-based education

Interactive patient education and skills training are more effective than traditional approaches in which the patient is a passive learner.

Example: Primary care patients at clinics affiliated with the [University of Pennsylvania](#) received disease management support from both a health educator and a peer coach. The peer coach served as a role model and provided phone support, while the health educator offered face-to-face, interactive and skills-based education on medication adherence, exercise and diet.²⁰

Patient navigation and family/community programs

Patient navigation offers the individual support necessary to help patients overcome organizational, communication and cultural barriers to care. It has been shown to improve the quality of care and reduce disparities, as have interventions that actively involve family and community members.

Example: At [Lancaster General Health](#) in Lancaster, Pa., pregnant women at high risk of depression receive the services of a dedicated care manager who provides culturally competent and linguistically appropriate support, connects patients to resources, and helps them navigate the health care system.²¹

Moving Forward

According to *Finding Answers*, health care organizations need to openly recognize disparities and take responsibility for reducing them. This means making equity and the reduction of disparities an integral part of all quality improvement efforts, as equity and quality are interrelated and interdependent. While the causes of inequalities are varied—and often influenced by factors outside the clinic setting—the health care system has the potential to make a significant difference. Long-term solutions need to be broad-based and local, and require everyone in the health care system to commit to eliminating disparities. For example, showing health care providers their own clinical performance data broken down by the race of their patients can help motivate providers to reduce disparities in their practices, but motivation is not enough. Providers also need support to identify the most effective interventions for their patient population. With sustained effort and commitment, and through the use of evidence-based frameworks like *Finding Answers*' Roadmap to Reduce Disparities, high-quality care can be equitable care.

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Resources from Finding Answers

- The [FAIR Database](#) is a searchable tool containing 388 journal article summaries, distilled from 11 systematic reviews of the published health disparities literature. The systematic reviews identify best practices in disparities interventions for asthma, cervical cancer, colorectal cancer, HIV, prostate cancer, cardiovascular disease, depression, diabetes and breast cancer, as well as cultural leverage and pay-for-performance incentives. You can use the FAIR database to create a customized list of interventions that match your interest by disease area, racial/ethnic population, organizational setting and intervention strategy.

For more information about *Aligning Forces for Quality*, visit www.rwjf.org/qualityequality/af4q.

For more information about *Finding Answers*, visit www.solvingdisparities.org.



Robert Wood Johnson Foundation

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