

Case Study: Cincinnati

Reaching Spanish-Speaking Patients for Better Diabetes Control

“We knew we wanted to work on improving care for our growing population of Spanish-speaking patients,” says Kyle Vath, BSN, RN, clinical coordinator at Cincinnati’s [Crossroad Health Center](#).

Ninety-five percent of the patients at Crossroad Health Center have incomes at or below 200 percent of the federal poverty level. Forty percent of its adult patients are uninsured. Each year, Crossroad provides care to more than 6,500 patients who otherwise would not be able to afford care. The majority of Crossroad’s patients are racial and ethnic minorities. Twelve percent speak Spanish.

As a federally qualified health center and level 3 patient-centered medical home, Crossroad has a good handle on its performance data and patient outcomes. When Vath and his colleagues heard about the opportunity to get technical assistance to work on a disparities reduction project through the [Health Collaborative](#), Cincinnati’s *Aligning Forces for Quality* (AF4Q) site, they jumped at the chance. A closer look at practice data revealed differences in blood sugar control between the practice’s Spanish-speaking patients and its patients as a whole. “It wasn’t a crisis, but it was a disparity,” says Vath. “We needed to investigate.”

At first, the numbers looked good. Compared with the Center’s overall patient population, fewer Hispanic patients showed hemoglobin A1c levels higher than 9 percent. Looking more closely, the team realized that even though slightly fewer Hispanic patients had A1c levels higher than 9 percent, many more had levels between 8 and 9 percent, a sign of poor control. Hispanic patients were also underrepresented among those patients with the lowest levels of A1c.

Help creating a strategy to intervene came from the experts at [Finding Answers: Disparities Research for Change](#), a national program of the Robert Wood Johnson Foundation based at the University of Chicago that focuses on projects aimed at reducing racial and ethnic disparities in health care. The team from Finding Answers helped Crossroad determine how to take the project on, looking at the practice’s needs and available resources and walking them through a stepwise intervention design framework. The Finding Answers team and Crossroad staff determined that a Spanish-speaking nurse volunteer already working with Crossroad might be able to make a difference.

“I went to nursing school to offer help in just this way,” says former health advocate Xiomara Faulkner, RN. “I enjoy narrowing that gap that still exists.” As a one-day-a-week volunteer at Crossroad, she reaches out to 40 Spanish-speaking patients with diabetes, helping them set self-management goals, learn to monitor A1c levels, and understand the nutritional aspects of diabetes care. “To me, every patient who comes to a diabetes education class is a success story,” says Faulkner. Every week, Faulkner reviews the list of patients and calls those who need to make an appointment and those with the highest A1c levels.

As a result of this intervention, Crossroad saw an increase from 40 percent to 54 percent in the proportion of Hispanic patients with HbA1c below eight (positive outcome). This was likely due to the concerted focus on those with very high HbA1c levels (greater than nine); their proportion reduced from 30 percent to 18 percent. Due to broader quality improvement efforts, Crossroads also saw their D5—Optimal Diabetes Care—rates double, from 7 percent to 14 percent.

Looking ahead, Vath and the team at Crossroad are hard at work on the program’s sustainability, hoping to get local health systems to sponsor the program. They are also working on other projects that embed community partners, such as the local area agency on aging and cultural advocacy groups, in the practice. “Consolidating access to information and resources in the primary care medical home can only benefit our patients,” Vath concludes.

Aligning Forces for Quality

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8%

GOAL: **Increase** the number of **Spanish-speaking** patients with hemoglobin A1c levels below 8 percent.



Spreading Best Practices in Blood Pressure Control for African American Patients

All practices participating in *Better Health Greater Cleveland* collect and submit data on patients' race, ethnicity, and primary language every six months. The alliance stratifies ambulatory measures along several categories, enabling it to identify and address disparities in care and outcomes. One of the routine analyses of *Better Health's* data center identifies differences in the rates of blood pressure control among Whites, Hispanics, and Blacks, the three dominant racial and ethnic groups in Northeast Ohio. While rates of control for each group have increased, good control is improving faster in Whites and Hispanics than in Blacks.

Better Health is working to speed the pace of improvement for Black patients. The alliance's latest report counts over 136,000 Northeast Ohio residents living with high blood pressure, treated in 56 practices in eight health systems. Achieving *Better Health's* 70 percent goal for region-wide blood pressure control for African American patients would improve this crucial measure for more than 2,800 patients.

A year ago, *Better Health's* data center noted that the top 10 sites in the region succeeding in controlling high blood pressure in Black patients were in the Kaiser Permanente Ohio network (now HealthSpan). When *Better Health* reached out to the network's clinical leaders to find out what the practices had done, it learned that Kaiser had implemented an intervention that had been effective in another region of the health system.

With leadership from Christopher Hebert, MD, of HealthSpan, and Shari Bolen, MD, of The MetroHealth System, *Better Health* has adapted the intervention from Kaiser's established curriculum into six monthly, hour-long training sessions to be delivered in clinics across the *Better Health* alliance. The curriculum includes instruction on strategies to improve provider-patient communication with Black patients by focusing on the beginning and end of the visit, alleviating patient concerns, and demonstrating empathy. "It's about learning to meet patients where they are and learning to ask questions that help you better understand what motivates them," Bolen says. "Fitting that into a short visit can be challenging, so we work on that. It's all part of building trust."

The curriculum also covers use of a Kaiser-developed treatment algorithm that is sensitive to both medication cost and adherence. In 2014, the *Better Health* team of physicians and practice coaches expects to roll out the demonstration project in at least five sites in five health care systems, including two federally qualified health centers. The participating sites, which have predominantly low-income Black populations, have the lowest levels of blood pressure control in the region, contributing to the regional disparity.

"What's great about this project is that it's a very tangible and concrete way to try to improve disparities in care in the region within a short timeframe," says Bolen.

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70%

GOAL: **70 percent** or better **blood pressure** control among **Black patients** in the region.



Patients Get the Message Across

The Greater Detroit Area Health Council (GDAHC) is taking an innovative approach to reducing disparities in care. Through locally produced videos, the collaborative is leveraging local voices to increase understanding of race, ethnicity, and language (REL) data collection and to improve blood pressure control among Black patients with hypertension.

GDAHC's peer storytelling video was inspired by a similar and successful project supported by [Finding Answers: Disparities Research for Change](#), a national program of the Robert Wood Johnson Foundation focused on discovering and evaluating innovative interventions to reduce racial and ethnic disparities in health care and providing technical assistance to health care organizations attempting to reduce disparities. 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 to understand their level of trust in the health care system, their values and beliefs about health and health care, and what motivates them to make difficult changes that are necessary to improve their health. The intervention improved blood pressure control. According to Finding Answers, to succeed, cultural tailoring must do more than simply use images of minority patients in promotional materials or translate 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. Cooper Green's videos not only featured patients talking about their understanding of heart disease and strategies that they used to manage it, the videos also helped local patients overcome the distrust of the health care system cited in focus groups as a reason patients deviated from recommended care plans. In Alabama, patients who watched the videos experienced decreased systolic and diastolic blood pressure over the six- to nine-month intervention.¹

To recreate the program in Detroit, GDAHC first built community support through its multi-stakeholder race, ethnicity, and language (REAL) committee, comprised of representatives from community-based organizations, providers large and small, payers, consumers, and state officials. Providers recommended patients for focus group discussions, which also served as a place to identify strong candidates to 'star' in the videos. Though the stories are still in production, positive outcomes are already being reported from the focus group sessions:

- Black men, a group that is historically hard to reach, have had exceptional representation in the focus groups.
- Providers are acknowledging that their approach is lacking and are recognizing the value of health messages coming from peers.
- Family members are sharing information about hereditary issues in hypertension and stories about personal successes in managing their condition.

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The peer storytelling project builds on other video outreach projects at GDAHC. Earlier in 2013, the REAL committee recognized patients' discomfort with disclosing their race, ethnicity, and language to health care providers, and created a public service video to increase patients' comfort level. Using Belle Isle Park and the Detroit skyline as backgrounds, the video confronts issues of confusion and discomfort with providing this information by outlining what REL data are and why doctors are asking about them, and presenting an example that illustrates how the data are used. Says REAL committee chair Kimberlydawn Wisdom, MD, MS, "We know that in order to achieve health care equity we need to be able to provide care that does not vary in quality based on personal characteristics such as race, ethnicity, sex, or geographic location. Gathering information about your race, ethnicity, and language helps us understand what conditions you are at risk for. That information better equips us to care for you." The three-and-a-half-minute video is narrated by a REAL committee member, who explains, "My mom is Korean, my dad is African American, and I can't tell you how many times I've been categorized as White. That means that vital health information about my family history could be overlooked, or a condition that could be hereditary or misdiagnosed." The video plays in waiting rooms at practices within the Henry Ford Health System, and Trinity Health Care System has adapted the video for use nationwide for training purposes.

80%

CONTEXT: More than **80 percent** of patients in Detroit are Black.²

60,000

GOAL: More than **60,000 patients** will have access to **GDAHC's REAL and peer storytelling videos.**

1 *Peer-Based Storytelling*. Chicago: Finding Answers, 2014, <http://www.solvingdisparities.org/research/interventions/peer-based-storytelling> (accessed January 2014).

2 Rastogi S, Hoeffel EM and Drewery MP. *The Black Population: 2010*. Washington: U.S. Census Bureau, 2011.