

Finding Answers Solving Disparities.

Discovering what works —
and what doesn't — to resolve
racial and ethnic disparities
in health care.

- Eliminating disparities requires action on multiple fronts and *Finding Answers* will help empower providers, payers and health plans.

Since 2005, *Finding Answers*, a national program of the Robert Wood Johnson Foundation, has been testing a variety of quality improvement initiatives to find out what works — and what doesn't — to eliminate racial and ethnic disparities in health care. The *Finding Answers* project team, based at the University of Chicago, has also synthesized the body of intervention research in several high-impact disease areas to inform disparities reduction efforts that will affect large numbers of minority patients.

In 2010, *Finding Answers* became a technical assistance provider to *Aligning Forces for Quality*, the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities and provide models for national reform. *Aligning Forces* asks the people who get care, give care and pay for care to work together toward common, fundamental objectives to lead to better care.

Eliminating disparities requires action on multiple fronts and *Finding Answers* will help empower providers, payers and health plans. Because some of the 33 *Finding Answers* projects will ultimately reduce disparities and some will not, the insights and lessons learned from each of their efforts will provide a solid foundation for developing, executing, adapting and evaluating successful quality improvement initiatives that meet both quality and equity goals. As organizations and communities collect race, ethnicity and language data to identify gaps and inequities in care and to publicly report these findings, *Finding Answers* is poised to help with tools, resources and best practices to inform disparities-reduction efforts and increase their chances of success.

To learn more about *Finding Answers* and what your organization can do to reduce disparities, visit www.solvingdisparities.org

To improve and sustain high-quality, patient-centered and equitable care, we need to recognize disparities and take responsibility for reducing them. Racial and ethnic disparities in health care exist in both care processes and health outcomes. While the causes for these inequalities vary and are often influenced by factors outside the traditional health care delivery system, we can make a difference. By building equity into an existing quality improvement infrastructure, health care organizations can make a profound impact.

Based on our work with 33 disparity-reduction projects around the country and systematic reviews of the literature, we have identified promising strategies to improve the quality of care for minority patients managing chronic diseases such as diabetes, cardiovascular disease and depression. What have we learned?

The solutions to health disparities are as multifaceted as the causes.

Crafting successful interventions means looking beyond the clinical encounter. The strategies most likely to succeed are those that are customized to the patient population, equity goals, practice structure and capacity for change. They intervene at multiple points in the continuum of care, and often involve engaging not only health care clinicians and patients, but also payers, administrators, policy-makers and community organizations.

Understanding and meeting the needs of a target population requires more than good intentions.

Despite best intentions, many programs that aim to improve care for minority patients fail because they do not accurately assess their target population's values, needs or behaviors. No longer does translating a brochure from English to Spanish or placing a stock photo of an African-American family on a poster count as "cultural tailoring" — although it's a start. The field has evolved to define "culture" as much more than mere race and ethnicity. The most accurately targeted strategies are also the most successful in increasing patient knowledge and understanding of self-care, decreasing barriers to access, and improving the cultural competence of health care providers. Involving patients in developing and planning interventions — and not accepting others as proxies for the target group — helps to ensure that a program is culturally appropriate from beginning to end.

Team-based care holds promise.

Team-based care is one of the most consistently successful strategies to reduce disparities. Unfortunately, current payment structures often do not support its sustainability. Including non-physicians, such as nurses, community health workers, peer educators and translators in the care team can mean more face-time with patients, better care coordination and improved self-management. Nurses are in a unique position to effect change, and nurse-led programs show great promise. Integrating community health workers and other peers into the health care team also helps build important community-patient-health care system linkages that have been shown to improve outcomes.

Equity will not be achieved through marginalized or stand-alone disparities projects, and it will not be achieved overnight. With sustained effort and commitment, we can ensure that quality care is equitable care.



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● Provider Engagement That's All Carrot — No Stick

At Hudson Health Plan, where 80 percent of members are Latino or African-American, performance incentives are helping raise physician awareness of diabetes care. Practices earn up to \$300 annually for every patient whose care complies with standards. To encourage work with all patients, even the most non-adherent, Hudson makes partial payment if key indicators improve but do not reach goals. Performance reports are delivered to each participating practice in person. “The program has really made a difference in the tenor of the interaction between Hudson and affiliated practices around quality of care,” says Nancy Walter, Vice President of Ambulatory Services at Hudson River Health Care in Yonkers,

N.Y. “The program has afforded an opportunity for dialogue about clinical performance measures that encourages even the smallest practices to continually improve.”

“By rewarding patient-centered care over population-wide results, basing incentive payments on both absolute and relative patient-level clinical measures, and rewarding improvement,” says Janet (Jessie) Sullivan, M.D., Hudson’s Chief Medical Officer, “pay-for-performance structures like the ones we tested can reduce disparities without undesired consequences such as cherry-picking or only rewarding already well-resourced organizations.”



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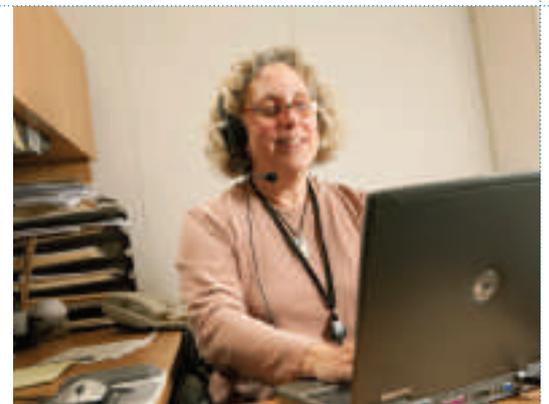
● Nurses Lead the Way

“The most satisfying thing are the ‘aha’ moments. It’s as if a light bulb goes off: patients start to grasp portion size, or to see the way exercise can help lower blood sugar,” says Pamela Gentry, R.N. “Over the phone, patients are more relaxed, more open to asking questions. It’s also so much more efficient — I’m able to help more people than I would through office visits.”

With support from nurses like Gentry, primary care practices affiliated with Duke University Medical Center are reducing the risk of cardiovascular disease among African-American patients with diabetes and encouraging them to become more engaged in managing their health. Patients receive educational materials and monthly calls from a nurse. The patients’ primary care providers receive concise updates on patients every three months. Initial results show lower levels of HbA1c, systolic blood pressure and LDL

cholesterol over 12 months. “What we’re seeing is that it’s working,” says investigator Hayden Bosworth, Ph.D. “What’s clear too is that people appreciate the program. Patients appreciate the contact, and providers serving underrepresented groups are very enthusiastic about the additional care case manager nurses can provide.”

The project’s future looks bright. Funding and legislation are coming together to make prevention and disease management financially sustainable. In the past, reimbursement for telephone support was not always available. Realizing that projects like this one can increase efficiency and reduce utilization, North Carolina’s federally funded Medicaid program plans to bring the program to the state’s 1.25 million Medicaid recipients. “It’s our hope,” says Bosworth, “that this will become the standard of care.”



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● Community Engagement Plants Seeds for Change

Can social service providers work together to reshape how and where health care is delivered? UCLA's Michael Ong, M.D., Ph.D., and the research team from Community Partners in Care (CPIC) knew that many African-American and Latino patients in Los Angeles were not receiving necessary care for depression. The CPIC team knew they needed to work across sectors to get more people more consistent, higher-quality care. What the team didn't predict was just how overburdened many local primary care providers would be, or how hard it would be to anticipate when and where patients from three geographically distinct neighborhoods would seek care.

"The community engagement approach we first thought would work was one aimed at boosting the capacity of providers in these communities," says Ong. "The lesson we learned is that

it's not always that straightforward." What the CPIC team soon found was that in Los Angeles, where people get care often does not correlate to where they live. In response, the CPIC high-intensity intervention team convened local service organizations to create a depression clinic that offers care when and where patients need it. Participating agencies are collaborating and cooperating in new ways by allowing their counselors and care managers to accept clients from other sites and offer them depression care services.

The clinic offers clients the option of obtaining case management for depression by phone, group cognitive behavioral therapy, or resiliency classes to promote wellness. "Community engagement is a slow process and the outcomes are never certain," says Ong, "but these are the seeds we need to plant for change."



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● Stories Help Lower Blood Pressure

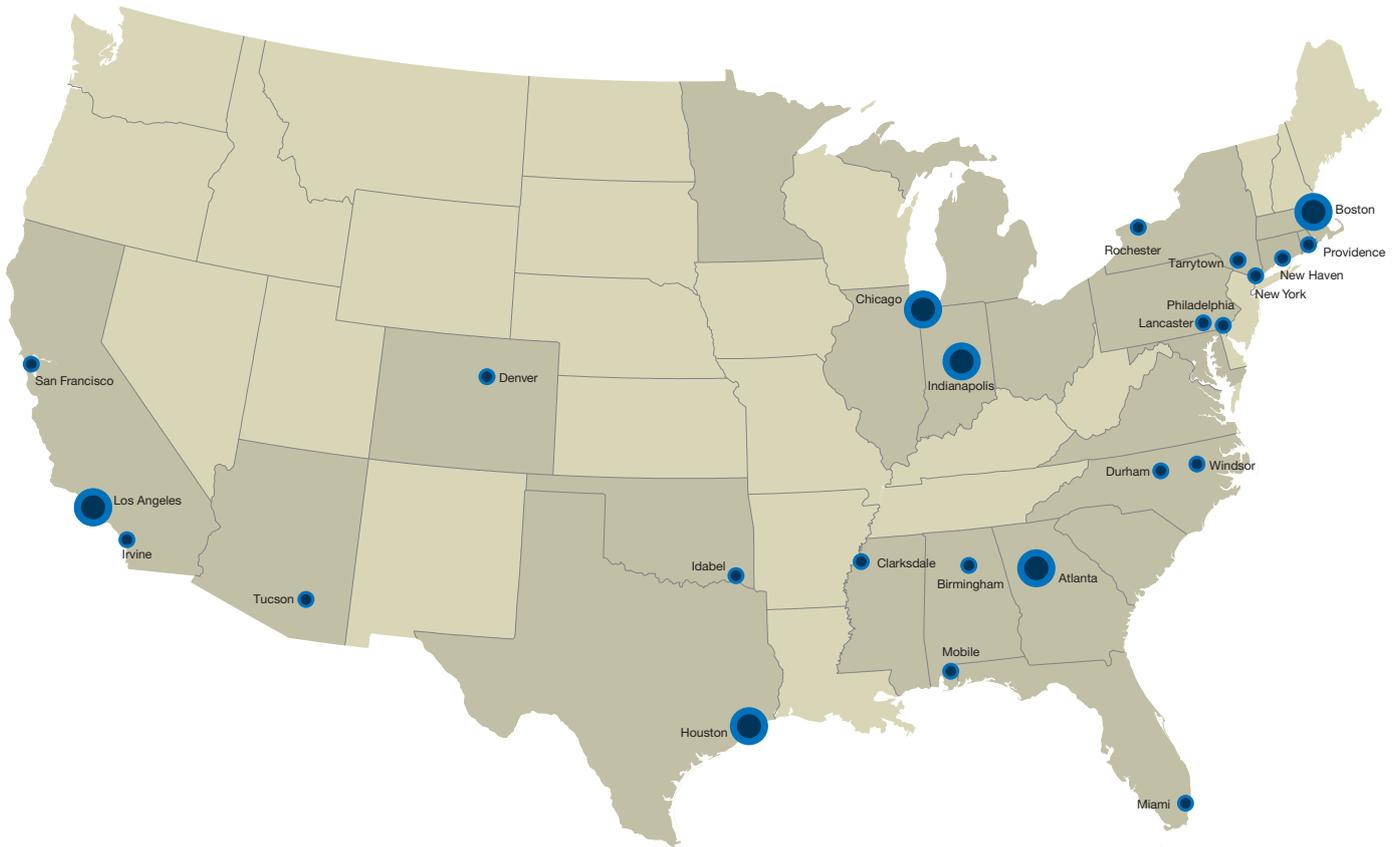
"It feels good to know that I had something to do with this," says patient storyteller Teresa Purifoy. Part of a study at Birmingham, Alabama's Cooper Green Mercy Hospital, Purifoy is one of a handful of local patients with hypertension who shared their own experiences on video in an effort to reach their peers.

While the medical community recognizes and has tried to bridge the racial gap in blood pressure control, social and cultural barriers may continue to contribute to higher rates of uncontrolled high blood pressure and resulting complications among African-American patients. In the Cooper Green study, patients with uncontrolled hypertension who viewed three DVDs that presented stories of real patients lowered their systolic pressure by an average of 11 points and their diastolic pressure by an average of 6 points.

"I think this is part of the expanding body of literature about the value of storytelling for assisting people in managing their health conditions," says investigator Thomas Houston, Ph.D, M.P.H. Storytelling may offer a unique opportunity to communicate evidence-based disease management choices in a culturally appropriate way. "The DVDs, they are motivation, and really, that's what most people need — motivation," says patient Sheila Bozeman. "You look at that person on that video and you realize, 'I'm not that far from them. I'm like them.'"



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Alabama

Cooper Green Mercy Hospital (Birmingham)
 Mobile County Health Department (Mobile)

Arizona

University of Arizona (Tucson)

California

Olive View–UCLA Education Research Institute (Los Angeles)
 Sutter Health (San Francisco)
 University of California–Irvine (Irvine)
 University of California–Los Angeles (Los Angeles)
 University of Southern California (Los Angeles)

Colorado

Denver Health and Hospitals Foundation (Denver)

Connecticut

Yale School of Medicine (New Haven)

Florida

University of Miami (Miami)

Georgia

CIGNA HealthCare (Atlanta, Mid Atlantic Region, includes DC, MD and VA)
 Morehouse School of Medicine (Atlanta)

Illinois

University of Illinois (Chicago)
 National Program Office (University of Chicago)

Indiana

Indiana University School of Medicine (Indianapolis)
 WellPoint, Inc. (Indianapolis, includes sites in CA, GA, NY, OH and VA)

Massachusetts

Boston Medical Center (Boston)
 Brigham and Women’s Hospital (Boston)
 Harvard Vanguard Medical Associates (Boston)
 Massachusetts General Hospital (Boston)
 Massachusetts League of Community Health Centers (Boston)

Mississippi

Aaron E. Henry Community Health Services Center, Inc. (Clarksdale)

New York

The Fund for Public Health in New York, Inc. (New York)
 Hudson Health Plan (Tarrytown)
 Westside Health Services, Inc. (Rochester)

North Carolina

Duke University Medical Center (Durham)
 East Carolina Health / Bertie All-County Health Services (Windsor)

Oklahoma

Choctaw Nation Health Services Authority (Idabel)

Pennsylvania

Lancaster General Health (Lancaster)
 University of Pennsylvania (Philadelphia)

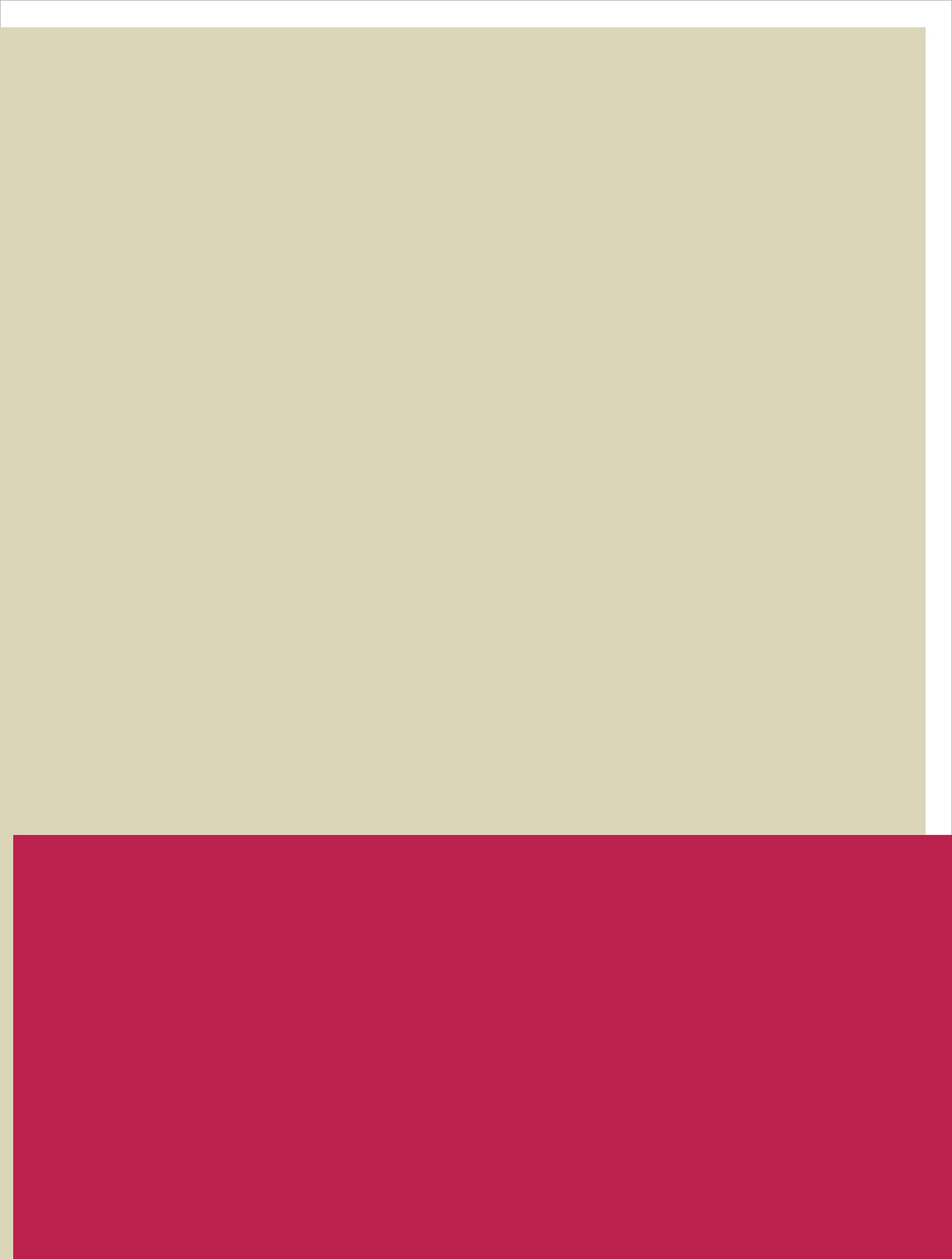
Rhode Island

Neighborhood Health Plan of Rhode Island (Providence)

Texas

Baylor College of Medicine (Houston, includes sites in AL, CT, GA, MA, MI, MN, MS, OK, RI, SC and TX)
 The University of Texas MD Anderson Cancer Center (Houston)





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Disparities Research for Change


Robert Wood Johnson Foundation