Finding Answers: Disparities Research for Change

A Progress Report looks at this RWJF program in mid-course

INTRODUCTION

In a groundbreaking 2003 report—Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare1—the Institute of Medicine (IOM) concluded that racial and ethnic minorities often receive lower quality medical care than their white peers. These disparities contribute to adverse health outcomes, such as higher rates of disease and shorter life spans.

In 2003, the Agency for Healthcare Research and Quality began publishing annual National Healthcare Disparities Reports that measured differences in the quality of health care services that different subpopulations—such as ethnic or racial minorities or low-income populations—receive.2

In 2005, against this backdrop of research, the Robert Wood Johnson Foundation (RWJF) launched a national program, Finding Answers: Disparities Research for Change, to fund rigorous evaluations of promising clinical initiatives designed to improve the quality of health care services that ethnic and racial minorities receive. Its ultimate goal is to close the gap in quality of care between minority and white patients.

“We knew based on the research that African Americans, Latinos, and American Indians disproportionately get lower quality care,” says Debra Joy Perez, PhD, MA, MPA,3 former assistant vice president for Research & Evaluation at RWJF. “With Finding Answers, we wanted to focus on solutions—not on research that would just confirm that disparities existed.”

Finding solutions is challenging because, as the IOM report pointed out, disparities can persist even after taking into account factors such as access to care, income, and

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3 Perez was program officer for Finding Answers from 2005 to 2008. In September 2013, she left RWJF to become vice president of knowledge support at the Annie E. Casey Foundation, Baltimore.
“People often assume that disparities primarily come about because of lack of access to care. But once people have access to care, there are still problems with disparities in how care is delivered. That is where Finding Answers is focused,” explains Scott Cook, PhD, deputy director of the program.

Through funding of more than $16.7 million from January 2005 through December 2014, Finding Answers has sought to uncover promising health care and community-based solutions, encourage their replication in myriad clinical settings nationally, and create an evidence-based and practical framework to help health care providers design customized interventions to reduce treatment disparities.

To oversee day-to-day management of Finding Answers, the Foundation set up a national program office at the University of Chicago.

WHAT IS THE PROGRAM ABOUT?

When RWJF launched Finding Answers: Disparities Research for Change in 2005, a plethora of research documented the existence of racial and ethnic disparities and their impact on health outcomes. “For many different conditions, many illnesses, and many different parts of the country, there was study after study. The big void was what to do to actually reduce the disparities. It was a really, really important problem,” explains Marshall Chin, MD, MPH, national program director for Finding Answers.

“We know nationally that it has been hard to move the numbers on disparities—heart disease for example. Health care providers may be well meaning and they may want to reduce disparities, but they often don’t know where to start. Finding Answers was a first crucial step to supply some of that knowledge and know-how.”

Reducing Disparities by Closing the Quality Gap

Perez points to another important dimension of Finding Answers. “We were trying to fund interventions to reduce gaps in the quality of care minorities receive, not just health outcomes. We wanted to lift all boats and close the quality gap.”

To focus on the connection between disparities reduction and quality improvement, not just in Finding Answers but more generally, RWJF reorganized its strategic priorities in 2006.

“We were interested in positioning Finding Answers as a quality improvement opportunity for the healthcare system,” says Anne Weiss, MPP, senior program officer and director of the Quality/Equality team. “Finding Answers was our principal investment in investigating how to pursue equitable care going forward.”
“Strategically we believed that if you are going to improve health care quality, you are going to have to look at ways to improve quality for people from different ethnic and racial backgrounds and address their needs specifically.”

Chin agrees, noting that RWJF’s approach was a change from the dominant perspective in the field at the time. “For too long, you had two separate worlds: the people who think about disparities and the people who think about quality of care… If you are going to reduce disparities, improving quality of care is a major lever. If the two groups aren’t thinking together about this problem, it is going to be hard to get far in terms of quality of care.”

Romana Hasnain-Wynia, PhD, is director of the program addressing health disparities at the Patient-Centered Outcomes Research Institute (PCORI) and a member of the Finding Answers national advisory committee. She affirms Chin’s assessment. “The program really changes the dialogue about addressing disparities by looking through a systematic quality improvement lens. Disparities reduction is integral to what a health care organization does in providing high quality care to everyone, not something that needs to be done on the side.”

**HOW DOES THE PROGRAM WORK?**

**A Different Approach to Finding Solutions That Work**

*Finding Answers* focuses on discovering and evaluating innovative interventions to move the disparities field beyond the documentation of racial and ethnic differences in health care to actually implementing efforts to eliminate these gaps. It focuses specifically on reducing disparities in cardiovascular disease, diabetes, and depression—where the evidence of racial and ethnic disparities is strong—and on evaluating projects that are under way in a variety of health care settings, such as community clinics and hospitals.

*Finding Answers* was structured differently from other RWJF research initiatives in a number of ways. First, as Perez points out, foundations often fund demonstration projects that let grantees use a substantial portion of their grant for implementation of the intervention. *Finding Answers* was different. “We prioritized funding the evaluation of the demonstration project. We said, ‘You can only use up to 25 percent of your grant to fund the actual implementation.’”

Another way *Finding Answers* was different was its emphasis on a strong, equitable partnership between the organization implementing the intervention in the “real world” and the academic partner that conducted the rigorous evaluation.

“It had to be a community-driven strategy to really work because truly only the community knows what would work best in a community versus a research entity that
may not even be located there,” explains Rachel A. Gonzales-Hanson, who chairs the national advisory committee and is chief executive officer of a health center serving low-income and uninsured people in Uvalde, Texas.

According to Scott Cook, a typical Finding Answers partnership has at least two principal investigators (PIs)—one from the academic partner and one from the organization that delivers the services.

“We did this so we could give the frontline organization more of a say and more control than the third-party academic evaluator. If we had a PI just at the academic institution doing the hardcore quantitative evaluation and if that person didn’t have a close relationship with the community other than just getting the data, we were afraid we would lose some of the implementation details.”

Trust is key as exemplified by the partnership between PIs Sandral Hullett, MD, MPH, former CEO of Cooper Green Mercy Hospital in Birmingham, Ala., and Jeroan Allison, MD, MS, former professor at the University of Alabama, School of Medicine, in Birmingham. Cooper Green implemented the intervention—a peer storytelling program to improve blood pressure among African American clinic patients. The University of Alabama was the hospital’s academic partner.

“I think it is really unusual to have a CEO as your research partner,” says Allison, but Sandral and I had a long-standing professional relationship that evolved into us jointly submitting a proposal to RWJF. I had worked at Cooper Green as a physician and got to know and care for the patients. Finding Answers fit naturally with my feelings of social responsibility and my research interest in health disparities.”

For more on the Cooper Green intervention and its evaluation, see the section Learning From What Works—and What Doesn’t.

Finally, Finding Answers is pragmatic. It looks for details that will encourage other health care organizations to tailor and implement successful interventions in their settings. As Chin puts it, Finding Answers asks about the practical aspects of implementation. “What did the grantee learn about the facilitators and barriers that would then help someone who was trying to replicate the intervention in their own environment?”

He also wanted to make sure that “someone implementing the intervention would have some sense of what it would cost” so research findings had to include economic as well as clinical outcomes—such as the business costs of running the intervention in addition to reductions in blood pressure.
Spreading the Word About Promising Interventions

Many health care organizations—not just those funded by Finding Answers grants—are positioned to address racial and ethnic disparities as part of their ongoing quality improvement (QI) efforts. Therefore, in addition to awarding and managing research grants, Finding Answers staff conducted systematic literature reviews on diseases that have worse quality of care among minorities and/or lead to worse health outcomes or earlier death. The goal was to capture information on promising strategies from disparities work conducted by other researchers and organize it into a widely available, searchable database.

Joining With Aligning Forces for Quality to Replicate Innovative Practices

Finding Answers also aims to replicate and sustain innovative interventions, ultimately disseminating them to health care organizations nationwide. Integration with RWJF’s Aligning Forces for Quality program is helping to achieve this goal. Launched in 2006, Aligning Forces is the Foundation’s signature effort to lift the quality of care, reduce disparities, and provide a model for health reform. The national program office is located at the George Washington University School of Public Health and Health Services in Washington.

Since 2009, Finding Answers’ staff has provided technical assistance to the 16 communities participating in Aligning Forces for Quality. Marcia Wilson, MBA, PhD, Aligning Forces for Quality’s associate director for regional support, describes the relationship between the two programs.

“At George Washington University, we had known about Finding Answers since 2005. The staff had been our colleagues. When we launched Aligning Forces for Quality, we used our expertise in data collection to help providers, but we knew that was only a piece of the pie. Finding Answers was going further, going into communities and thinking about how you were going to do this in the actual practices.”

Claire Gibbons, PhD, a former RWJF program officer, stresses the importance of the connection between the programs from the perspective of the Foundation’s quality/equality strategy. “I worked with the national program staff of both Finding Answers and Aligning Forces for Quality to integrate the two programs as much as possible so they became much more related to that specific strategy.”

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4 Gibbons was program officer for Finding Answers from 2008 to 2012. She left the Foundation in 2012 to become senior operations manager-policy research at the Robert Graham Center, Washington.
A Diverse National Advisory Committee

A national advisory committee has supported the national program office, reviewing grant applications, attending site visits for grant finalists, and making recommendations about which applications to fund.

“What I so appreciated about RWJF was that the advisory committee was so diverse. We had researchers. We had clinicians. We had people who had been involved in community health and were doing community health. When we looked at a grant application, there was a balance,” the advisory committee chair Gonzales-Hanson says. A list of advisory committee members with brief profiles is available on the Finding Answers website.

The national program office staff also manages the diversity well, in the opinion of committee member Russell E. Glasgow, PhD, deputy director of implementation science at the Division of Cancer Control and Population Sciences at the National Cancer Institute, Bethesda, Md. “They created an atmosphere of trust and respect and made sure everyone was heard and different perspectives were equally weighted. They looked to building common ground.”

WHAT ARE THE MOST SIGNIFICANT RESULTS TO DATE?

In four rounds of funding (2006, 2007, 2008, 2009) Finding Answers awarded 33 grants ranging from $195,000 to $400,000 to evaluate health care and community-based interventions in diabetes, hypertension, and depression. (See the Finding Answers website for a list and brief descriptions of the 33 interventions.)

Finding Answers has been “really critical because it helped to take the research work out of the academic realm and put into the delivery realm, evaluating what was possible, what was effective, and even thinking about scaling,” says advisory committee member Hasnain-Wynia.

Learning From What Works—and What Doesn’t

“Not all of our [funded] interventions were effective, but a pretty impressive number reached at least some of their hoped-for outcomes,” says Gibbons. “Even interventions that were less effective added to the disparities research field’s knowledge base. In the course of testing all of these interventions, we have learned a lot about what to do and what not to do. I think that that is really significant.”

Examples include:

- A culturally tailored storytelling intervention improves blood pressure control in low-income African American patients. In a randomized controlled trial, 299 African American patients at Cooper Green Mercy Hospital in Birmingham, Ala., received either usual care for their high blood pressure or were asked to watch three
DVDs in addition to usual care. The DVDs featured the patients' peers talking about their personal struggles to control their blood pressure; lessons learned about interacting with the health care system; and strategies to improve their adherence to medication, diet, and exercise regimens.

When results were compared, patients in the intervention group were better able to control their blood pressure over time than those in the usual care group. The difference in blood pressure reduction between the two groups was greatest among those who had uncontrolled blood pressure at the start of the study.

PI Allison explains how this approach differs from other studies. “Often researchers take the attitude that a population is ‘doing stuff wrong, and I am going to go in there and fix it for them.’ Our approach is diametrically opposite to that.” Using peer spokespeople who have tackled a medical problem, such as high blood pressure, “is really a grassroots approach where you find examples of what is going right in a community.”

- **A telephone-based intervention to improve cardiovascular disease risk factors among African Americans with type 2 diabetes shows mixed results.** In this randomized controlled study, nurses delivered self-management training modules during monthly telephone calls to an intervention group of 182 patients of the Duke Family Medical Centers in Durham, N.C.

- Using electronic scripts to guide the conversation based on patients’ responses, the nurses talked about how to eat a healthy diet, limit alcohol use, quit smoking, exercise regularly, and take medications properly. They also contacted primary care providers quarterly with information about patients’ medication adherence, home monitoring of blood pressure, and blood sugar.

When asked about their medication adherence, patients in the intervention group reported better results than a comparison group of 177 patients who had received usual care. However, the two groups did not differ significantly with respect to other outcomes, such as control of blood sugar, blood pressure, or cholesterol.

Even with these mixed results, the program is helpful to patients, 38 percent of whom make less than $10,000 a year, explains the project’s PI, Hayden Bosworth, PhD, a research professor at Duke University School of Medicine. “Our patients are struggling with a lot of issues, and they can’t come into a clinic. So a telephonic intervention that helps them with their diet and exercise and medication adherence is something that they deemed very helpful.”

Despite the mixed results, the intervention has been replicated elsewhere, and at least some patients with diabetes have improved clinical outcomes. For example, 140 Medicaid patients in the North Piedmont region of North Carolina, who received at least two phone calls in 2012, reduced their blood sugar levels by an average of 1 percent.
The scripts and other intervention materials are available electronically to all Medicaid health care providers in North Carolina. As of June 2013, they had been provided to at least 1,000 patients, according to Bosworth. And as part of a demonstration grant from the Centers for Medicare & Medicaid Services (CMS), Duke University Medical School plans to deliver the intervention to more than 1,000 diabetic Medicaid patients in North Carolina, West Virginia, and Mississippi.

- **A depression intervention for low-income Latinos struggles to reach participants.** This qualitative study evaluated the feasibility and effectiveness of a telephone-based depression intervention for Latino members of the Neighborhood Health Plan of Rhode Island. The intervention was a modification of an earlier version, developed for a predominately white population. In the modified version, materials were rewritten and bilingual case managers hired to deliver the 12-week intervention.

Researchers found that low-income Latinos were more reluctant to participate in the program than the white population. After a year, only 38 members had enrolled out of a total of 929 who were potentially eligible. “The patients weren’t participating. They wouldn’t even answer their phones, or if they answered, they wouldn’t talk,” says Cook.

So the researchers “took a step back.” They held focus groups with Latinos who had participated in the program and asked them why others were not enrolling and sought the advice of leaders at community based Latino organizations. Feedback indicated that, while those who enrolled were satisfied with the program, it failed to recruit many participants for two reasons:

- The low-income patients—many were migrant workers—had no-contract, pay-as-you-go cell phones. “They used their phones for mission-critical daily communication, making sure they could call their kids or reach their husbands at work. They did not want to take calls from the case managers because they just didn’t have the money to pay for the minutes,” Cook explains.

- Patients were uncomfortable taking calls from people they did not know.

In reporting these mixed results, researchers concluded that the program may be promising, but better ways of reaching those who might find it helpful were needed. They noted strategies for improving recruitment suggested by focus group participants—such as face-to-face rather than telephone contact.

- **Cultural competency training raises clinician awareness of racial disparities in diabetes care, but does not improve clinical outcomes among Black patients.**

This randomized, controlled trial, conducted by Harvard Vanguard Medical Associates, involved 124 primary care clinicians at eight ambulatory health centers in eastern Massachusetts. The physicians cared for some 7,500 patients with diabetes, 36 percent of whom are Black. Intervention clinicians received cultural competency
training and monthly race-stratified performance reports that highlighted racial differences in control of blood sugar, cholesterol, and blood pressure.

After 12 months, the study measured clinician awareness of racial differences in diabetes care and rates of achieving clinical control targets among Black patients. “The intervention improved provider awareness of disparities but wasn’t enough to actually move the clinical outcome numbers,” Chin says.

Vanguard Associates is not discouraged by the results and is combining cultural competency training and the race-stratified performance reports with other interventions designed to help patients manage their diabetes. “It is an example of how the knowledge from what was in some ways a negative study has been very important for guiding the next generation of disparities work in an organization,” Chin says.

**Systematic Reviews and a Searchable Database**

National program office staff completed 11 systematic reviews of the disparities literature. Nine were on medical conditions that disproportionately impact racial and ethnic minorities; two were reviews of policy approaches designed to reduce disparities in the delivery of health care services (culturally tailoring interventions to specific populations and pay-for-performance incentives). Each review described the types of interventions, results, and lessons learned.

The reviews were published in two sets. The first set (on cardiovascular disease, diabetes, depression, breast cancer, and the two policy approaches) was published in 2007 in *Medical Care Research and Review*. The second set (on asthma, cervical cancer, colorectal cancer, HIV prevention, and prostate cancer) was published in a 2012 supplement to the *Journal of General Internal Medicine*.

The two supplements and review articles are available for downloading from the *Finding Answers* website. They are also listed in Appendix 2 of this report.

Based on the reviews, the national program office staff also created the FAIR (Finding Answers Intervention Research) database containing 388 journal article summaries. Users can search by disease category; racial/ethnic group targeted; level of organization implementing the intervention (e.g., community group or health system); and strategy, such as increasing testing or screening rates or enhancing health literacy.

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5 *Medical Care Research and Review*, 64(Suppl. 7), 2007. Available online.
A Roadmap for Reducing Disparities

In addition to evaluating health care and community-based interventions and producing systematic literature reviews, Finding Answers addressed a third question, according to Hasnain-Wynia: “Was it possible to take some of the findings from the work the program funded and disseminate them to other organizations to adopt?”

The answer is “yes,” according to Program Director Chin, who points to a key Finding Answers product—a six-step roadmap for reducing racial and ethnic disparities in health care—as evidence of how far the field has come. “When we started eight years ago and people asked what works for reducing disparities, we really didn’t know. The field wasn’t at a point where we could come out with a logical answer. In our roadmap, we tried to take everything we have learned across our grantees and across our systematic reviews and say, ‘Here are best practices.’”

Advisory committee member Hasnain-Wynia adds: “The program office did a really nice job of trying to synthesize and tell a cohesive story across all of the funded projects—pulling out the emergent themes and putting forth an overarching principle or framework that others could use going forward.” These themes and principles—insights about what works and what does not—are distilled into the roadmap’s six steps:

- **Recognizing disparities and committing to reducing them.** Stratifying clinical performance data by patient race/ethnicity and cultural competency training for staff members fit in this category. It is also crucial to create an organizational culture in which leadership and staff are accountable to identify and reduce disparities.

- **Implementing a basic QI structure and process.** In this step, an organization selects a formal quality improvement method to follow, a leader to spearhead the process, and organization-wide improvement goals.

- **Making equity an integral part of quality improvement efforts.** "When they do think about disparities, many organizations tend to do something stand-alone or marginalized, such as a community fair outside in the neighborhoods. It’s a lot different to say, 'In everything we do to improve quality, let's think about how we can improve quality for all of our patients—whether they are rich or poor, black or white, rural or urban,'" Chin explains.

- **Designing an intervention. Six widening levels of influence affect clinical outcomes.** They begin with the patient and provider, embrace the entire patient care team and health care organization, and ultimately include the community where the patient lives and the public policies that determine his or her lifestyle choices. Each level represents a different leverage point that can be addressed to reduce disparities.

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Promising interventions also make use of six common elements, or themes. They:

- Address more than one level of influence
- Are culturally tailored to the specific patient population
- Involve community health workers or navigators who help patients bridge the health care system and their lives at home.
- Involve a team of caregivers
- Include family members and/or other nonmedical community partners
- Involve an interactive skills-based approach to education—not just lectures and handouts

- **Implementing an intervention.** The roadmap also identifies specific intervention strategies that program planners can apply in targeting different levels of influence. Common intervention strategies include delivering education and training, restructuring the care team, increasing patient access to testing and screening, and using technology to improve quality (by placing computer kiosks in patient waiting areas, for example).

According to Chin and Cook, “Implementation is an iterative process and organizations are unlikely to get the perfect solution on their first attempt. Evaluation of the intervention and adjustments to the program based on performance data stratified by race, ethnicity, and language are integral parts of the implementation process.”

- **Sustaining the intervention.** Organizations need to ask how they will institutionalize the intervention, so that it becomes part of their operating practice. “This includes an understanding of the financial model. What are the business costs and potential revenues?” Chin notes.

A toolkit on the *Finding Answers* website helps organizations implement the roadmap.

**Test Driving the Roadmap**

“*Aligning Forces for Quality* was where *Finding Answers* got to field test—to drive—the six-step framework with select medical practices,” says *Aligning Forces*’ Marcia Wilson.

Chin describes how it works: “At *Aligning Forces for Quality*, much of the disparities work was focused on helping practices learn how to collect performance data on race, ethnicity, and language. They might see their disparities and they might be motivated, but they didn’t know where to start. That is where the roadmap plus the experience with our specific grantees’ interventions and the review articles could help *Aligning Forces* sites be more concrete about what to do next once they had the data.”
Gibbons adds, “What we have done with *Aligning Forces* is skip the many years of testing and retesting on the research side. Instead we said, ‘We can’t wait around. We have real problems in our health care system, and we have some clues about how to design interventions.’”

To help health care providers involved in *Aligning Forces for Quality* implement solutions to identified disparities, *Finding Answers*’ national program staff worked with the *Aligning Forces* national program staff and the staff of one of its technical assistance providers, the Center for Health Care Strategies, to develop the Equity Improvement Initiative. It begins with a six-session webinar series on the roadmap followed by technical consulting to help ambulatory medical practices research, design, and implement a disparities-reducing initiative.

In June 2013, the *Finding Answers* team completed a first round of consulting with two medical practices in Wisconsin, one in Minnesota, and one in Kansas City that are all located in communities engaged in *Aligning Forces*. These practices are using the roadmap to implement interventions evaluated by *Finding Answers*. In Wisconsin, for example, Wheaton Franciscan Healthcare is adapting and incorporating a community health worker model into the patient care team, based on the work of five *Finding Answers* grantees.

The community health workers in these models typically are members of a racial or ethnic group who tap into their first-hand knowledge of the local culture to help teach others how to live a healthy lifestyle. They often have the same medical condition and a history of successfully managing their own care and navigating the health care system. At Wheaton Franciscan Healthcare, community health workers reach out to their peers with diabetes and connect them to local resources for education and support. They also are a liaison between the diabetic patients and the health system.

“We provided Wheaton Franciscan with best practices for a community health worker program, based on the lessons learned across all of the *Finding Answers* community health worker programs,” Cook says. “They did not replicate a specific model but created one that best matched their specific needs and the needs of their patient population.”

**WHAT CHALLENGES IS FINDING ANSWERS FACING?**

In interviews conducted in summer 2013, RWJF program officers, national program office staff, and national advisory committee members reflected on the challenges confronting those working to close the disparities gap, whether researchers, health care providers, or policy-makers. They point out that some obstacles are stubborn and likely to persist, while others are more solvable.
Measuring progress is a formidable obstacle, as advisor Hasnain-Wynia notes. “Evaluating disparities interventions is really difficult, especially since it is not just about showing improvement. The goal is to also show a closing in the gap. I think that in and of itself is a challenge. Sometimes showing improvement can be done, but it takes a longer time frame to actually show a closing of the gap.”

Before a project can begin, providers must first locate differences in the quality of care within their organizations by collecting information on the race and ethnicity of all their patients and then storing it in the medical record. “If you don’t have information linking patients’ race and ethnicity to the rest of their care, you can’t find out if there are differences in the care received by patients from different backgrounds,” RWJF’s Weiss says.

But it is difficult for providers to put in place the systems and procedures required to collect information on patients’ racial and ethnic background, and to train their employees to feel comfortable asking for what may be perceived as sensitive information. “And these difficulties are greater in the ambulatory setting,” according to Weiss. “Hospitals are big institutions so once you train employees and change policies, you get a lot of the information. There are thousands of doctor’s offices, so trying to standardize data collection and make it routine is difficult.”

Another challenge in reducing disparities is the multi-faceted nature of the problem. “It is very hard to say that disparities in health care are driven by the lack culturally competent providers versus begin driven by segregation or how we finance health care. I don’t think it is any one of those things. I think they all play a role,” Hasnain-Wynia says.

Expanding the Timeframe

A more tractable problem involved the timeframe of the evaluations. “We were asking the grantees to do an awful lot in a short period of time with a modest budget…They were expected to do their project, get results, have clinical and economic outcomes and implementation advice—all in two years,” Chin says.

As a solution, Finding Answers extended the time frame to three years in the fourth grant cycle, decreased the number of grantees, and increased the amount of money each one received. These changes were based on an outside evaluation conducted by the Urban Institute in 2008 and 2009. The evaluators based their recommendations on interviews with national program staff, site visits to nine grantees, an analysis of grantees’ written materials, and attendance at an annual grantees meeting.
Using the Roadmap to Craft Tailored Local Adaptations

Another dilemma facing those who want to translate intervention research into practice is whether or not to faithfully replicate a promising model or, instead, adapt it to local needs and conditions. *Finding Answers* showed that the mantra of the manufacturing sector—quality improvement through exact replication—does not always work for initiatives aimed at reducing disparities in the delivery of health care services.

“There is often an assumption that the highest quality care means providing care in the exact same way for every patient,” Cook says, “but a quality improvement intervention may impact different racial and ethnic groups differently. The idea that a quality improvement initiative is going to raise quality indicators for every patient may not be true. It may raise them for some patient groups, but for others it may not raise them, or it may actually lower them.

“For example, the Cooper Green intervention worked so well that they were able to improve a health outcome and write it up for a high-quality journal.\(^8\) It has actually gotten some press nationally and was written up in a blog in the *New York Times*. But we can’t tell another organization that if you do this intervention, it is for sure going to work in your community—say in inner-city New York.”

In that spirit, the *Finding Answers* team is helping seven federally qualified health centers in the *Aligning Forces* Detroit alliance to customize the Cooper Green intervention. “We had a recent conference call with them and one of the Cooper Green principal investigators to answer their current questions and provide more guidance,” Cook says.

Chin sums up what the team has learned about finding a balance between replication and local adaptation. “Eight years ago, I think we had a little more of a magic bullet type of hope. We would do these calls for proposals and find successful interventions that then we would disseminate. I think it is actually much more complex than that because the end goal is to improve patient outcomes in real world settings that have their own challenges.”

The roadmap addresses these challenges by taking into account the needs and preferences of the different levels—patient, provider, organization, community—that influence the outcomes of an intervention. “Involving patients in intervention design is important, especially when the intervention asks a patient to change or asks staff to change how they interact with patients. If patients are not involved in helping staff think through what will work for them, the intervention may not be logical to them,” Cook explains.

The roadmap addresses another challenge the national program office faced in providing technical assistance to *Aligning Forces* communities—the need to meet organizations

\(^8\) Houston et al.
“where they are” with regard to quality improvement. “The sites we are assisting range widely in their capability and readiness to change,” says Chin.

“Some are well put together, have strong leadership buy in, and are ready to roll; others less so. Thinking about how we can be effective with practices that have different needs and are at different places on the spectrum of readiness can be a challenge,” Chin says. But with the roadmap, “it doesn’t matter where you are—there is going to be some place to start along the six different steps.”

The Finding Answers team tailors their coaching “to the issues that are relevant to any given site,” Chin says. They help staff of medical offices understand “the root causes of disparities in their particular patients and brainstorm about what approaches would be a good match, given the challenges of their clinic and patient population.”

WHAT DOES THE FUTURE HOLD?

The Finding Answers team will continue providing technical assistance to Aligning Forces for Quality sites. A second round of consulting began in February 2013 with three medical practices in western New York. In addition to working directly with medical practices, the team is deploying a train-the-trainer model in Memphis, Tenn., and Puget Sound, Wash. In those sites, they are working directly with the local alliance staff, who in turn will train providers in their regions.

The team is also expanding its technical assistance work outside of Aligning Forces for Quality as part of a CMS pilot project in seven health care markets. CMS plans to share with primary care providers any cost savings they earn through improvements in quality and efficiency. “We are incorporating our lessons learned and the roadmap into helping those practices reach the required milestones and to also incorporate equity into reaching those milestones,” Cook says.

Once funding for Finding Answers ends in December 2014, “the next step is for us to understand the state of the field, and the most promising strategic opportunities,” RWJF’s Weiss says. The Foundation plans to answer that question, in part, through a scan of the disparities research field that expands beyond racial and ethnic minorities to embrace other vulnerable populations—such as people with dementia or other cognitive issues, physical disabilities, very limited financial means, or who live in rural areas.

“There are a lot of different patient characteristics that might interfere with getting high quality care. We are trying to make sure we can have a health care system that provides high quality care to all kinds of patients—no matter what situation they might have coming into care. I think it is time to look a little bit more broadly at what disparities

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9 Three medical practices in Cincinnati also expressed interest, but at the time of this report, had not sought specific technical assistance.
really means,” says RWJF’s Katherine Hempstead, PhD, MA, who succeeded Gibbons as program officer for *Finding Answers*.

While broadening the scope of inquiry, disparities researchers still need to evaluate interventions targeted specifically at racial and ethnic minorities. This is particularly true, says Chin, “as the health care system transitions to a financial reimbursement structure based on pay-for-performance incentives and global budgeting.” He sees “a whole new set of questions about what will reduce disparities in this new health care environment where there are stronger financial incentives for improving care for populations of patients and for integrating what happens in the health care system with what happens in the community.”

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APPENDIX 1

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APPENDIX 2

Systematic Reviews of the Disparities Literature

The Finding Answers team published their systematic reviews of the disparities literature in two journal supplements.

Medical Care Research and Review. Articles in this 2007 supplement covered six topic areas (cardiovascular disease, diabetes, depression, breast cancer, and the two policy approaches.) The supplement also included an overview led by Finding Answers National Program Director Chin.


Journal of General Internal Medicine. Articles in this 2012 supplement covered the road map and asthma, cervical cancer, colorectal cancer, HIV prevention, and prostate cancer.


Glick SB et al. “Cervical Cancer Screening, Diagnosis and Treatment Interventions for Racial and Ethnic Minorities: A Systematic Review.” Available online.

Naylor K et al. “Interventions to Improve Care Related to Colorectal Cancer Among Racial and Ethnic Minorities: A Systematic Review.” Available online.