

## What We're Learning: Reducing Disparities in the Quality of Care for Racial and Ethnic Minorities Improves Care

### The Challenge

Your health care depends on who you are. Race and ethnicity continue to influence a patient's chance of receiving many specific health care procedures and treatments. A thorough review of health quality data shows that racial and ethnic minorities continue to receive lower-quality care than Whites. These differences persist even when insurance status and socioeconomic factors like education and income are taken into account. In its *2012 National Healthcare Disparities Report*, the [Agency for Healthcare Research and Quality](#) suggests that disparities in quality of care are common.

### *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 across America. These briefs distill some of the key lessons learned by these regional alliances of providers, patients, and payers as they work to transform their local health care and provide models for national reform.

40%

**Blacks received worse care than Whites**, and Hispanics received worse care than non-Hispanic Whites, for about 40 percent of quality measures.<sup>1</sup>

33%

**American Indians and Alaska Natives received worse care** than Whites for one-third of quality measures.<sup>2</sup>

25%

**Asians received worse care** than Whites for about one-quarter of quality measures, but better care than Whites for a similar proportion of quality measures.<sup>3</sup>

Changing demographics make addressing these inequalities urgent:

- A changing population: Racial and ethnic minorities represent about one-third of the U.S. population and will become the majority of the population by 2043.<sup>4</sup>



Inequities in health not only create a tragic human burden in shortened lives and increased illness, they also create an economic burden:

\$60B

**The cost of disparity:** Excess costs associated with disparities in health were estimated at \$60 billion in 2009.<sup>5</sup>

Identifying and acting to reduce disparities in care for racial and ethnic minorities has been a core goal of *Aligning Forces for Quality* (AF4Q) since its inception. In communities across the country, diverse stakeholders are at work sharing data, encouraging collaboration, and making patients and consumers part of improving quality for all.



### What's Working

**Reporting Leads the Way.** In order to reduce disparities in care, organizations and regions must first understand where disparities exist, the scope of the disparities, and the root cause of these disparities. Unless measured, disparities in care can go unnoticed, even as organizations seek to improve care. Data transparency is beginning to have an impact in many AF4Q communities where access to data stratified by race, ethnicity, and language (REL) has spurred organizations to recognize areas where disparities exist and to take action. What gets measured gets managed. AF4Q provided intensive technical assistance to support the collection of REL data in hospitals and clinics. These efforts raised awareness of equity as a key component of quality and drove more in-depth analyses of disparities in care.

In Cincinnati, the [Health Collaborative](#) invested heavily in getting REL data collection off the ground, and the result is consistent, actionable, exchangeable data about differences in care. Early on, the group focused on getting every affiliated hospital in the region to agree to report the same categories for race and ethnicity, and trained registration staff in patient self-reporting methodology. Launching REL data collection regionally took three years, and was capped by “[We Ask Because We Care](#),” a public-facing campaign that introduced the rationale behind this new kind of reporting. “The public-facing campaign was very helpful,” recalls Lisa Sloane, a consultant to the Health Collaborative. “What we found was that while you may get a patient here and there who does not want to answer questions, what you have for the most part is registration staff who feel uncomfortable doing something new. Once people got comfortable with REL data collection, it became second nature.” For Sloane, the most important lessons include the value of involving health system IT departments and making sure coding and categories line up across systems. Training across systems, validating the integrity of data, and planning for sustainability required extensive collaboration between organizations. Like the rollout of REL data collection, the insights and changes made possible by the data are emerging over time. Thus far, the data show pockets of disparity in the region in terms of overuse of the emergency department. Clinics and health systems are analyzing their own data, and Atrium Medical Center has added an equity category to its public report cards.

[Minnesota Community Measurement \(MNCM\)](#) has published health care disparities reports for the Minnesota Department of Human Services annually since 2007. What began as a state-level effort to report on the Healthcare Effectiveness Data and Information Set for patients enrolled in Minnesota Health Care Programs compared with those insured by other purchasers has, with support from AF4Q, expanded to include wider, clinic-level reporting of race-stratified performance data. Before this report became available, national and state-level reports of differences in care were available, but information wasn't presented at an actionable level. MNCM's report supplies objective data and brings accountability to medical groups and clinics, allowing them to reflect on their own disparities and identify areas for improvement within their systems. Anne Snowden, MPH, CPHQ, director of performance measurement & reporting at MNCM, is particularly proud of how Minnesota clinics have rallied around the report and voluntarily submitted data on race, ethnicity, preferred language, and country of origin. In highlighting related equity/disparities reporting initiatives, Snowden noted, “You don't need a state mandate to get community buy-in. You need perseverance and community

*“Improving equity involves data, it involves training staff, and it involves actual execution through interaction with patients. The REL data collection effort we've done here is a small demonstration of how all of those pieces can be achieved and how difficult it is to achieve that work across a region. It takes time, it takes diligence, and it takes a willingness for systems and providers to work cooperatively for the good of patients. That's what our equity work has taught us.”*

—LISA SLOANE,  
CONSULTANT TO THE HEALTH  
COLLABORATIVE, CINCINNATI

champions and the diligence to keep it going.” Though some gaps in the core measures included in the Health Care Quality Report are narrowing, each report continues to identify nuanced areas of inequality. In addition, MNCM is currently leading an effort to bring together eligible clinics and community health workers to help address community-level diabetes disparities through customized tools and trainings on chronic disease self-management.

Like MNCM, the [Washington Health Alliance](#) has begun by basing its disparities reports on Medicaid data stratified by race, ethnicity, and language. The Alliance’s [Disparities in Care 2013 Report](#) reveals that Medicaid enrollees receive lower rates of effective care compared with commercially insured populations across a number of quality care domains and diabetes care showed larger areas for improvement among Hispanic/Latino populations and American Indian/Alaskan Native populations, when compared to other racial/ethnic groups. The Alliance advocates for engaging providers, consumers, and community agencies in improving Washington’s disparities results. The Alliance activates providers through private medical group-level Disparities in Care Reports and through convening medical directors to discuss improvement strategies. Already, the report has gained the attention of key stakeholders, and it is the Alliance’s hope that the report will serve as a call to action and a foundation for more targeted and effective quality improvement efforts that incorporate equity throughout the state. In several states, local reports on health care equity are serving as tools that drive the development of policy and priorities at the state level.



**Moving From Data to Action.** The inherent structure of the AF4Q initiative is a major strength of its approach to disparities reduction: multistakeholder coalitions of consumers, providers, and payers are vital to reducing regional health and health care disparities. In community after community, they have made clear that disparities are unacceptable and must be prioritized. Because disparities are the result of complex interactions, collaboratives can help provide technical assistance, establish practice-level patient and community advisory boards, and nurture partnerships between practices and community-based organizations.

[Better Health Greater Cleveland’s](#) efforts to move the dial on blood pressure control among Black patients is an example of such efforts. A demonstration project that brings a communications curriculum and treatment algorithm to the clinics working to improve blood pressure control is being supported by and deployed at clinics belonging to the four major health systems in the region. Bringing a wide variety of partners to the table has made [Better Health](#) a powerful convener.

[Greater Boston Aligning Forces for Quality](#) is collaborating with the Boston Public Health Commission to pilot the Health Equity Dashboard that will offer a better understanding of health disparities regionally, while it simultaneously provides data to underpin the alliance’s Healthier Roxbury initiative. Focused on one of Boston’s most ethnically diverse neighborhoods, Healthier Roxbury brings together a broad set of community-based stakeholders to tackle disparities in key health care measures such as emergency department visits for children with asthma and hospitalizations for adults with diabetes.

*“Having leadership for all the different health systems in the region involved makes it easier to make changes that have impact. It makes it easier to say, ‘Let’s share what we are doing in a way that is collaborative rather than competitive.’ That’s important in any quality improvement work, but that commitment is especially important in reducing disparities.”*

—SHARI BOLEN, MD, MPH,  
ASSISTANT PROFESSOR OF  
MEDICINE AND PROFESSOR  
OF EPIDEMIOLOGY AND  
BIostatISTICS, CASE  
WESTERN RESERVE  
UNIVERSITY; PHYSICIAN,  
DIVISION OF INTERNAL  
MEDICINE, METROHEALTH  
MEDICAL CENTER, CLEVELAND



**Patients at the Table.** A patient’s cultural background influences both their experience of care and their health behavior.<sup>6</sup> Understanding each patient’s cultural identity is necessary for effective care.<sup>7</sup> A handful of AF4Q communities have been working with experts from *Finding Answers: Disparities Research for Change* and the Center for Health Care Strategies to identify and act on disparities in the populations they serve. In several communities, the Equity Improvement Initiative has resulted in demonstration projects designed to bring patients and communities to the table to help design programs to reduce disparities. Enabling patients to voice their concerns and identify challenges has helped change the approach to chronic disease management in several locales. The *Greater Detroit Area Health Council* is adapting a model tested by Finding Answers that makes local patients “stars” in patient education videos focused on addressing the challenges of living with chronic disease. Such *peer-to-peer storytelling* has been shown to have a marked effect on patients’ ability to adhere to recommended treatment and lifestyle changes as well as patients’ actual health outcomes.<sup>8</sup>

**“Working so closely with our Somali patients has raised our awareness of how necessary it is to hear from each patient population about what they think is most important. It reminds us of the necessity of asking key questions, and of having patients identify their own barriers, desires, and goals.”**

—SHAJUANA SMITH, PA, CDE,  
JERICHO ROAD COMMUNITY  
HEALTH CENTER, BUFFALO

Work that brings patients to the table to create solutions for diabetes self-management has been particularly widespread. In Cincinnati, *Crossroad Health Center*, part of the Health Collaborative, identified a disparity in blood sugar control among Spanish-speaking patients with diabetes. They are working with a Spanish-speaking nurse who is a former patient advocate to address barriers to self-management among this group. In Buffalo, the Jericho Road Community Health Center (formerly Jericho Road Family Practice), part of the *P<sup>2</sup> Collaborative*, is working with groups of Somali patients to design an intervention that will help Somali patients live better with diabetes. Already, Jericho Road is working on helping these patients gain better access to exercise and community support. The health center has partnered with the local YMCA to provide low-cost exercise classes to their Somali patients, on-location at the Jericho Road and according to patient cultural preferences, in gender-separated sessions. In Wisconsin, Wheaton Franciscan Healthcare gained understanding of the root causes of poor outcomes in diabetes among Black patients through implementation of a five-year plan to improve equity. As part of the plan, Wheaton Franciscan conducted a series of focus groups. With this patient input, Wheaton Franciscan chose to develop a community health worker program led by someone from the local community—an example of how letting patients and communities be heard can speed culture change and win support for equity improvement initiatives.

- 1 *2012 National Healthcare Disparities Report*. Washington: Agency for Healthcare Research and Quality, May 2013.
- 2 *ibid.*
- 3 *ibid.*
- 4 “U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now,” U.S. Census Bureau, December 12, 2012. <https://www.census.gov/newsroom/releases/archives/population/cb12-243.html>
- 5 *The State of Urban Health: Eliminating Health Disparities to Save Lives and Cut Costs*. Washington: National Urban League Policy Institute, 2012.
- 6 Finbinder LC and Schulman KA. “The Effect of Race on the Referral Process for Invasive Cardiac Procedures.” *Medical Care Research and Review* 57(1s):162–77, 2000. [http://mcr.sagepub.com/content/57/4\\_suppl/162.abstract](http://mcr.sagepub.com/content/57/4_suppl/162.abstract)
- 7 Fisher T, Burnet DL, Huang ES, et al. “Cultural Leverage: Interventions Using Culture to Narrow Racial Disparities in Health Care.” *Medical Care Research and Review* 64 (5s): 243S–82S, 2007.
- 8 Houston TK, Allison JJ, Sussman M, et al. “Culturally Appropriate Storytelling to Improve Blood Pressure: A Randomized Trial.” *Annals of Internal Medicine* 154(2):77–84, 2011.