ALIGNING FORCES FOR QUALITY
EVALUATION

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Approaches to Reducing Health Care Disparities: A Focus on Six Multi-Stakeholder Alliances

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Introduction

In 2006, the Robert Wood Johnson Foundation launched Aligning Forces for Quality (AF4Q) – its signature effort to improve the quality of health care in targeted communities across the nation.[1] Reducing racial and ethnic disparities in health care was one of the key objectives of the AF4Q initiative. In this summary, we describe the major activities aimed at reducing disparities in care implemented across six AF4Q communities: Albuquerque, New Mexico; Cleveland, Ohio; Humboldt County, California; Memphis, Tennessee; Maine, and Washington State. These diverse communities represent a range of geographic and demographic characteristics including U.S. region, population size, race, ethnicity, and socioeconomic status (Table 1). The different approaches to reducing health care disparities undertaken by these AF4Q alliances may serve as models for other communities.

Each AF4Q community is led by a multi-stakeholder alliance of individuals and organizations that receive care, provide care, or pay for care. The alliances were provided with general guidelines and requirements regarding initial objectives related to identifying and addressing disparities in their communities (see sidebar), but were allowed leeway to develop and implement their own strategies to reduce disparities. Drawing upon data from a number of sources, including regular phone and site visit interviews with alliance leaders, staff, and community members; alliance progress reports; and a variety of AF4Q-related documents collected and organized in a project-wide tracking system from 2010 to 2013, we review common approaches to tackling health care disparities and call attention to a few less common but notable approaches to addressing disparities.

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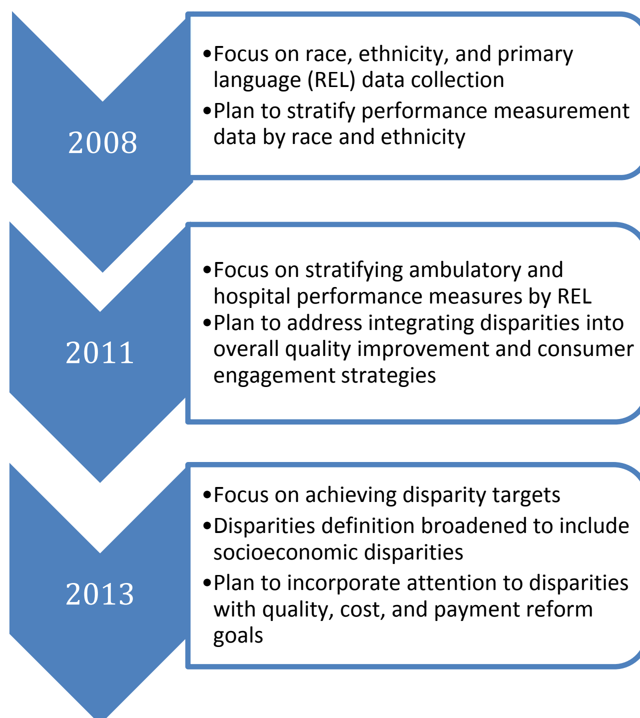

Table 1: Characteristics of Six Aligning Forces for Quality (AF4Q) Communities

AF4Q Community	Albuquerque, NM	Cleveland, OH	Humboldt County, CA	Maine	Memphis, TN	Puget Sound, WA
Total Population (N)*	555,419	390,923	134,827	1,329,192	655,141	4,323,711
Race (%)*						
White	69.2	38.4	82.4	95.1	30.9	74.6
Black	3.3	53.9	1.7	1.0	63.1	5.0
Asian	2.5	1.9	2.9	1.1	1.5	10.3
American Indian/Alaskan Native	4.3	0.3	5.1	0.6	0.3	1.0
Other^	20.6	5.5	7.9	2.2	4.3	9.1
Ethnicity (%)*						
Hispanic or Latino	46.7	10.7	10.3	1.4	6.6	9.2
% below poverty†	17.3	34.2	19.7	13.3	26.2	11.0
% uninsured†‡	16.6	26.0	26.0	14.4	26.5	22.4

*Data Source: 2012 American Community Survey 1-year estimates
^Other includes Native Hawaiian/Other Pacific Islander, Some Other Race, and Two or More Races
†Data Source: 2012 American Community Survey 5-year estimates
‡Civilian noninstitutionalized population 18 to 64 years old

Identifying Disparities in the Community

As called for by the AF4Q program guidelines, the alliances first assessed which disparities were present in the community by stratifying hospital quality measures, ambulatory quality measures, and/or public health data by race, ethnicity, and primary language (REL). Alliances obtained REL and quality data from a variety of sources, including health plans, electronic health records, and health departments (Table 2). Most of the alliances faced formidable barriers to collecting REL data, which have been described in detail elsewhere.[2] Nonetheless, five of the six alliances succeeded in stratifying quality measures by REL (Table 2). These stratified reports were used for internal review by the alliances' participating organizations. Three alliances also made the stratified data available for public review. Three of the alliances moved beyond the standard racial and ethnic categories to identify other groups at risk for disparities in their community: Maine examined disparities by socioeconomic status, as initial data revealed few disparities by race or ethnicity; Cleveland examined disparities by insurance type; and Albuquerque, with a population that is nearly 5% American Indian/Alaskan Native, has prepared to collect tribal affiliation data. Thus, alliances have taken various approaches to identifying disparities according to their local needs and demographics.

Interventions Targeting Disparities

The alliances implemented a diverse range of interventions to reduce disparities within their communities, but common strategies pursued by several of the alliances include health care system redesign and capacity building, strengthening communication with priority populations, and promoting patient activation and self-management support (Table 2).

Table 2: Data Collection and Disparities-related Activities for Six Aligning Forces for Quality (AF4Q) Communities

AF4Q Community	Albuquerque, NM	Cleveland, OH	Humboldt County, CA	Maine	Memphis, TN	Puget Sound, WA
Detecting Disparities						
Data Source	1. Medical Records	1. Medical Records	1. Medical Records 2. Public Health Data	1. Health Insurance Claims Data	1. Medical Records	1. Health Insurance Claims Data 2. Public Health Data
Stratified Data Report	X	X	X	X	X	
Disparity-targeted Activities*						
Health care system redesign and capacity building						
PCMH Implementation**	X	X		X		
Learning collaboratives	X	X	X	X	X	X
Strengthening linkages between health care providers and other community/social service resources		X	X			
Strengthening communication with priority populations						
Cultural Competency Training	X	X			X	
Improving communication with limited English proficiency (LEP) and low health literacy populations	X	X	X	X	X	X
Patient activation and self-management support						
Self-management support; health care system-based	X	X	X		X	
Self-management support; community-based					X	

* Each x may not represent a separate program. Some programs are multicomponent and may fall under different categories
** PCMH: Patient-centered Medical Home

Health care system redesign and capacity building

Several alliances aimed to bolster the capability of their primary care systems to deliver comprehensive and coordinated care as a key strategy for reducing health care disparities. Toward this end, several alliances implemented the Patient-Centered Medical Home (PCMH) model among practices serving large numbers of minority, low income, and/or uninsured patients. The PCMH is a care delivery model that aims to provide improved quality, access to care, and care coordination, particularly for patients with chronic medical problems.[3-5] Maine's alliance, for example, believed that a strong primary care system was key to addressing the large disparities identified among their low income and uninsured populations. They focused on the implementation of the PCMH

model for practices serving large proportions of their Medicaid population. Also, as part of this effort, the alliance supported the implementation of Community Care Teams to provide even more intensive care coordination and care management to the most high-need and high-cost patients in the community.

To build local capacity for addressing disparities, all six communities established their own learning collaboratives or encouraged their members to participate in established regional or national collaboratives. These learning collaboratives provide infrastructure for peer-to-peer learning across primary care practices or hospitals regarding best practices for reducing disparities. In response to the lower performance of Black, Hispanic, and American Indian/Alaskan Native patients on diabetes clinical process measures (e.g., hemoglobin A1C testing and screening for diabetic kidney disease), Washington's alliance launched their own learning collaborative to promote the exchange of effective strategies to improve these measures. In addition, the alliance produced a series of "Health Equity Bright Spots" that were featured on their website to highlight successful interventions and to spread this information among participating practices. Members of Memphis' alliance, on the other hand, benefited from participation in the Equity Quality Improvement Collaborative, a learning network of hospitals from across the country that tested disparity reduction strategies and shared lessons learned. As part of this 18-month experience that began in 2009, one of the safety net hospitals in Memphis collaborated with local businesses, the faith community, and civic leaders to examine the socioeconomic factors contributing to the observed racial disparities in readmissions among patients who had suffered a heart attack or heart failure exacerbation. As a product of this collaboration, they developed an instrument to elicit the socioeconomic factors impacting self-management for heart failure and heart attack patients, raised community awareness about health disparities, and brainstormed local approaches to tackling health disparities.

While most of the interventions and programs advanced by the alliances focused on improving coordination within or between traditional health care institutions, some interventions aimed to improve coordination between health care institutions and other social service programs. For example, Humboldt County's alliance developed a system for health care providers to give patients electronic referrals to community services, including housing programs, food banks, and other social services. Thus, the alliance sought to equip providers with tools to help address the social determinants contributing to poor health outcomes.

Strengthening communication with priority populations

As part of their strategy to reduce disparities, all six of the alliances addressed communication challenges faced by patients with low English proficiency or limited health literacy. Three communities implemented cultural competency training programs to improve provider communication with racial and ethnic minorities. For example, Cleveland's alliance trained physicians and nurses to be more culturally sensitive, address blood pressure management concerns that may be common within the Black community, and communicate information more effectively as part of a multifaceted intervention to reduce the disparity in blood pressure control between Black and White patients. Other common steps taken by the alliances were to ensure that patient educational materials, whether in print or online, were available in multiple languages, were appropriate for individuals with low health literacy, or were tailored for specific racial or ethnic groups. Humboldt County, for example, developed Our Pathways to Health, a free program that includes workshops to promote patient education and self-management support for individuals with chronic conditions. These workshops are offered in both English and Spanish, and provide attendees with tools and information to improve their communication with providers, gain confidence in managing their symptoms, and live a healthy lifestyle.

Patient activation and self-management support

Improving patient self-management skills and patient activation were common goals for the alliances, and these goals were pursued in various ways. Albuquerque's alliance disseminated self-management support materials in both English and Spanish that were developed and tested through the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services, such as "Quick Tips – When Talking with your Doctor" and "Taking Care of Myself: A Guide for When I Leave the Hospital." Self-management support was also an important component of the Cleveland alliance's multifaceted initiative to reduce racial disparities in blood pressure control.

Most patient activation and self-management support activities were implemented within traditional health care settings, but a notable exception to this approach was observed in Memphis. As part of the Healthy Memphis 2010 initiative, the alliance partnered with community leaders, including church pastors, to address the disparities in health outcomes they observed between the city's Black and White residents. Church pastors and other trusted community members promoted regular general health checks, cancer screening, and diabetes screening among Black community members and worked to identify ways to encourage community members to be more engaged and active in their health care.

Summary and Lessons Learned

The early experiences of the AF4Q alliances to measure and address local health disparities reveal several important lessons. Despite serving communities that differ greatly in sociodemographic characteristics, the alliances employed several common strategies to reduce health disparities. These include strengthening the primary care delivery system through the implementation of the PCMH model, developing the infrastructure to support learning collaboratives to advance the dissemination of best practices among providers and health care institutions, supporting effective communication with patients with limited English proficiency or low health literacy, and promoting patient activation and self-management support. In addition, most of the AF4Q communities focused their attention and resources on providers serving large proportions of minority, Medicaid, or uninsured patients. Finally, while a few alliances developed their own programs, many alliances applied programs that had been previously tested by other entities, and tailored them to their particular population or setting.

While the alliance leaders universally conceded that it was hard to impact health disparities without addressing socioeconomic factors, relatively little attention was focused on addressing the social determinants of health by most of the alliances during the early years of the AF4Q program. Likewise, most programs and initiatives targeted health care settings, rather than neighborhood or community-based settings. Some notable exceptions to this pattern were seen in at least two communities: Humboldt County developed an electronic referral system to link patients to housing, food, and other social services and Memphis' alliance collaborated with church pastors and other community leaders to promote cancer screening, diabetes screening, and other prevention-oriented health care utilization behaviors.

Eliminating health disparities is a courageous goal but may seem like an overly daunting task for many communities. These six AF4Q communities, however, illustrate how beginning with local data and working collaboratively with multiple stakeholders can enable communities to form a strong foundation for future disparity-targeted interventions. Drawing from the early experiences of this diverse subset of AF4Q communities as they sought to remedy local health disparities, health care leaders from other communities can build their own blueprint for tackling health disparities at the local level.

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The Aligning Forces for Quality (AF4Q) is a 10-year initiative of the Robert Wood Johnson Foundation to improve health care, reduce disparities, and create national models for health reform. The initiative provides funding and technical assistance to 16 multi-stakeholder alliances across the U.S. to implement a variety of health care interventions, including efforts to improve quality in health care delivery at the community level.

This research summary was produced as part of the the AF4Q Evaluation, also funded by the Robert Wood Johnson Foundation, to measure the impact of the AF4Q initiative and describe key lessons learned.

For more information about the AF4Q initiative visit aligningforces.org

For more information about the AF4Q Evaluation visit www.hhdev.psu.edu/CHCPR/alignforce

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