



PRIMER

# Reducing Health and Health Care Disparities: Implementation Lessons and Best Practices for Health Care Organizations

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## I. Introduction

While many health care organizations are motivated to identify and reduce racial and ethnic disparities in the health and health care of their patients, most lack the tools and resources to do so effectively. This paper shares the lessons learned of nine health care organizations that implemented innovative programming to address disparities in their patient populations. It includes concrete recommendations that other health care organizations can use to improve the quality of their health care delivery systems and implement interventions to address inequities in patient care and outcomes.

The health care organizations described in this report are part of *Aligning Forces for Quality* (AF4Q), the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities (termed "Alliances"), reduce racial and ethnic disparities, and provide models for national reform. AF4Q asks the people who get care, give care, and pay for care to work together toward common, fundamental goals of better care. AF4Q partnered with Finding Answers: Disparities Research for Change (Finding Answers) and the Center for Health Care Strategies (CHCS) to develop and implement the Equity Improvement Initiative (EQuII), involving a total of nine outpatient practices and their Alliances over an 18-month span.<sup>1</sup> The initiative was meant to support Alliances and practices that had race, ethnicity, and language (REL)-stratified performance data, but had not yet taken concerted steps to apply these data toward quality improvement and disparities reduction efforts. By the end of the initiative, all practices reported feeling that they had enhanced the culture of their organization, made great progress in their ability to identify disparities in their patient population, and designed—or laid the groundwork for—appropriate interventions to address them. However, many also experienced key challenges and organizational constraints that are important for other health care organizations to understand when implementing similar efforts.

## II. Equity Improvement Initiative (EQuII)

It can take two to three years of planning, implementing, and sustaining an intervention before statistically significant changes in health outcomes or disparities are observed.<sup>2</sup> As EQuII was designed to be an 18-month pilot, its goal was not tied exclusively to data-based outcomes, but rather to building capacity among health care organizations to establish a sustainable culture of equity. Specifically, EQuII's aims for the participating organizations were to: 1) learn how to identify one or more disparities among their patients; 2) develop effective quality improvement and community programming to reduce gaps; 3) put processes in place to evaluate progress; and 4) master the knowledge and skills necessary to address new or different disparities effectively in the future.

### About *Aligning Forces for Quality*

*Aligning Forces for Quality* (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at [www.forces4quality.org](http://www.forces4quality.org). Learn more about RWJF at [www.rwjf.org](http://www.rwjf.org).

Finding Answers and CHCS facilitated this learning process by using an evidence-based framework called *The Roadmap to Reduce Disparities* (the Roadmap). The Roadmap (see Exhibit A for a high-level summary) is based upon findings from systematic reviews of the disparities reduction literature and experiences of a wide variety of health care organizations that have addressed disparities in their patient population.<sup>3</sup> The primary goal of the Roadmap is to provide health care organizations guidance and a process to follow to avoid key strategy and implementation errors when using their standard quality improvement approach for equity work. The Roadmap is designed to help organizations integrate disparities reduction into all health care delivery efforts and encourages them to implement equity-focused quality improvement programs simultaneously or in parallel with other high-priority quality improvement activities. However, it is neither a strict checklist nor a set of steps to be implemented in a prescribed order. The Roadmap is meant to be used flexibly, based on available resources, and adapted as needed for specific interventions or broader capacity building.

In addition to educational and coaching webinars to teach the Roadmap, Finding Answers and CHCS provided technical assistance over the course of 18 months to facilitate practice implementation, including:

- Webinars on analysis, interpretation, and communication of REL-stratified quality data;
- Monthly calls to monitor progress and troubleshoot issues related to intervention planning and implementation;
- Development of tools and resources to address specific concerns and build the practices' skills in requested content areas (e.g., data interpretation, community engagement, patient surveys); and
- In-person meetings to facilitate in-depth technical assistance and peer learning.

Practice project teams included a mix of frontline staff from quality improvement, care management, and patient engagement, as well as key leadership (e.g., chief medical officer, director of operations, and office manager). Finding Answers and CHCS regularly engaged the practices' regional Alliances as well to maximize their contributions as conveners and resources for change in the local AF4Q community. Engaging the Alliances was also intended to support future sustainability and spread of the practices' experiences to other health care organizations in the region.

# The Roadmap to Reduce Disparities

A GUIDE FOR HEALTH CARE ORGANIZATIONS

From **Finding Answers:**  
Disparities Research for Change



**STEP 6** **Start small.** Small changes help build momentum. Look for low-hanging fruit.

**Measure change.** You'll need evidence that you have made a difference. Create a timeline for evaluation and measurement.

**Be adaptable.** Strike a balance between adhering to your plan and adapting it as needed. Equity improvement is a continuous process.



**STEP 1**  
Equity is intrinsic to quality improvement. Even when access to care is equal, racial and ethnic minority patients tend to receive lower-quality care than Whites. Even when health outcomes improve across the entire patient population, disparities between racial/ethnic groups can remain or even worsen.



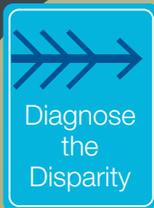
**STEP 2**  
It's not enough for people to know that disparities are a problem; they need to recognize that disparities exist among their own patients and take responsibility for addressing those disparities. That's the beginning of all equity work.

**STEP 5**  
Buy-in is a commitment demonstrated through action. You are more likely to succeed if you have the concrete support of all stakeholders. Be specific in what you ask and walk away with a pledge.



**STEP 4**

Designing an equity program requires creativity and innovation. It means linking what you have learned in a root cause analysis to your institutional resources. There is no single right answer!



**STEP 3**  
It's important to understand why disparities exist and determine which causes of disparities can be tackled. Consider the issues relevant to your patient population that might contribute to differences in care and outcomes. Assemble a team that includes patients, institutional leaders and frontline staff to conduct a root-cause analysis. Also make sure to recognize and support equity champions in your organization.

The Roadmap's six-step framework helps integrate reducing disparities into all health care quality improvement efforts. It is designed to be flexible: organizations can get on the road where they need to. Its goal is to support a thoughtful and comprehensive approach to achieving equity, even though the causes of disparities may vary across regions or patient populations.

The Roadmap draws upon lessons learned from *Finding Answers'* 33 grantee projects and 11 systematic reviews of the disparities-reduction literature.

[www.solvingdisparities.org](http://www.solvingdisparities.org)



Robert Wood Johnson Foundation

## EQull Organizations

Nine outpatient practices from a total of four Alliances participated in EQull. The practices varied in structure, size, and patient population, but all had a mission to care for the underserved. Exhibit B highlights key characteristics of each of the nine health care organizations, including: organizational type; location; populations and conditions of focus for the initiative; data used to identify or further understand the disparity; interventions developed; and impacts of their efforts.

### Exhibit B

#### Health Care Organizations that Participated in EQull

| Practice (AF4Q Alliance)                           | Type and Location  | Focus Population(s) and/or Condition(s)        | Data Tracking and Information Gathering   | Equity Interventions   | Outcomes and Sustained Efforts   |
|--|--|--|---|--|--|
| Crossroad Health Center (Cincinnati)               | Faith-based Federally-Qualified Health Center in Cincinnati, OH  | Hispanic/Latino patients, Diabetes             | <ul style="list-style-type: none"> <li>Diabetes performance stratified by race/ethnicity</li> <li>Questionnaire to elicit patient satisfaction with diabetes program</li> </ul>   | <ul style="list-style-type: none"> <li>Diabetes education program for all patients with A1c levels &gt;9. Diabetes educator worked closely with volunteer RN to provide culturally tailored education to Hispanic patients</li> <li>Utilization of Pre-Med bilingual students as patient “navigators”</li> </ul> | <ul style="list-style-type: none"> <li>Improved diabetes performance among Hispanic patients, and overall</li> <li>Increase from 40% to 54% in proportion of Hispanic patients with HbA1c &lt; 8 (positive outcome)</li> <li>Reduction from 30% to 18% in proportion with HbA1c &gt; 9 (positive outcome)</li> <li>Increase from 7% to 14% in D5 Optimal Diabetes Care rate across overall patient population</li> </ul>   |
| The HealthCare Connection (Cincinnati)             | Community Health Center in northern Cincinnati, OH (first community health center in Ohio)                                 | African American patients, Cervical Cancer     | <ul style="list-style-type: none"> <li>Cervical cancer screening data stratified by race/ethnicity</li> <li>Survey of African American patients about their perspectives, beliefs, and knowledge regarding cervical cancer screening</li> </ul> | <ul style="list-style-type: none"> <li>Developed strategies to increase preventive education and appointments for cervical cancer screening among African American patients</li> </ul>   | <ul style="list-style-type: none"> <li>Enhanced use of stratified race/ethnicity performance data and population health data management system to identify disparities</li> <li>Better understanding of the drivers of disparity (e.g., perceived economic burden) in cervical cancer screening among African American patients</li> <li>Vision for how to integrate equity efforts into broader practice workflow and staff development, particularly given influx of new patients with Medicaid expansion</li> </ul> |
| UC Health Primary Care at Forest Park (Cincinnati) | Family medicine and residency practices in northern Cincinnati, OH, affiliated with University of Cincinnati Health System | Minority patients, Medicaid patients, Diabetes | <ul style="list-style-type: none"> <li>Diabetes performance data, stratified by Medicaid insurance status</li> <li>Focus group among diabetics with Medicaid insurance status</li> </ul>  | <ul style="list-style-type: none"> <li>Conducted first-ever focus group with patients</li> <li>Created changes in data infrastructure to be able to analyze disparities by diagnoses and insurance status</li> </ul>   | <ul style="list-style-type: none"> <li>Better understanding of the self-management barriers (e.g., access to affordable healthy food and exercise) facing Medicaid patients with diabetes</li> <li>Ability to look at disparities by insurance status, in addition to race/ethnicity</li> <li>Enhanced data management skills and understanding of disparities-focused quality improvement among staff</li> </ul>  |

| Practice (AF4Q Alliance)                                | Type and Location   | Focus Population(s) and/or Condition(s)  | Data Tracking and Information Gathering  | Equity Interventions  | Outcomes and Sustained Efforts  |
|---|---|--|--|---|---|
| Swope Health Services (Kansas City)                     | Primary Care and Community Mental Health Center in Kansas City, MO  | African American patients, Co-morbid diabetes and Serious mental illness (SMI) | <ul style="list-style-type: none"> <li>Health home enrollment data, including patient diagnosis/co-morbidity and race/ethnicity</li> </ul>   | <ul style="list-style-type: none"> <li>Focused on the needs of African American patients served by a health home to coordinate physical and behavioral health care</li> <li>Proposed incorporation of equity in the organizational mission statement</li> </ul> | <ul style="list-style-type: none"> <li>Developed a cultural competency committee to focus on equity-related areas of improvement across the organization</li> </ul>   |
| Elmwood Health Center (Western New York)                | Community based health center in Buffalo, NY, that serves as a general ambulatory center and specialized source of care for individuals with developmental disabilities                 | Minority patients, Low-income patients, Diabetes                               | <ul style="list-style-type: none"> <li>Diabetes performance data, stratified by race/ethnicity</li> <li>Focus groups among patients with diabetes</li> </ul>   | <ul style="list-style-type: none"> <li>Enhanced triage coordination to maximize services of care coordinator, diabetes educator, and nurse care manager</li> <li>Psycho-educational support groups</li> </ul>   | <ul style="list-style-type: none"> <li>Better understanding of the importance of personal staff connections with patients</li> <li>Learned how to “go beyond” data in identifying and understanding disparities</li> <li>Created a conceptual framework for addressing racial/ethnic disparities in ongoing quality improvement</li> </ul>  |
| Jericho Road Community Health Center (Western New York) | Faith-based Community Primary Care Health Center in Niagara area, NY, that merged with Jericho Ministries to provide medical and nonmedical services to provide more comprehensive care | Somali immigrant patients, Diabetes  | <ul style="list-style-type: none"> <li>Focus groups among Somali-speaking community health workers</li> <li>Focus Groups among Somali patients with diabetes</li> <li>Ongoing questionnaires and patient satisfaction surveys to assess appropriateness of physical activity classes</li> <li>Pre- and post-intervention evaluations to measure health outcomes related to diabetes</li> </ul> | <ul style="list-style-type: none"> <li>Exercise class conducted by YMCA staff located at Jericho Road Health Center</li> </ul>  | <ul style="list-style-type: none"> <li>Better engagement with Somali patients and larger community</li> <li>Better utilization of skills of Somali-speaking community health workers/ interpreters in quality improvement efforts</li> <li>Development of community partnership with the local YMCA</li> <li>National connections with other practices focused on Somali populations</li> </ul> |

| Practice (AF4Q Alliance)                                       | Type and Location  | Focus Population(s) and/or Condition(s) | Data Tracking and Information Gathering   | Equity Interventions   | Outcomes and Sustained Efforts   |
|--|--|---|---|--|--|
| Mount St. Mary's Neighborhood Health Center (Western New York) | Faith-based Community Primary Care Health Center in Lewiston, NY   | Hispanic/Latino patients, Diabetes      | <ul style="list-style-type: none"> <li>Diabetes performance data, stratified by race/ethnicity</li> <li>Patient interviews with Hispanic patients with diabetes, conducted by Spanish-speaking physician</li> </ul> | <ul style="list-style-type: none"> <li>Forms in Spanish for all Spanish speakers, including those w/o diabetes</li> <li>Medication instructions and patient education materials printed in Spanish</li> <li>Automatic appt. reminder calls in Spanish</li> <li>Customized EHR (E-Clinical Works) to ensure all electronic communications (e.g., outgoing calls) are in Spanish</li> <li>Purchased of educational materials (DVDs) in Spanish, in collaboration with the American Diabetes Association</li> <li>Care coordinator translated/disseminated Spanish materials</li> </ul> | <ul style="list-style-type: none"> <li>Enhanced services, communications, and customization for the needs of Hispanic patients, especially those with diabetes</li> <li>Increase in number of Hispanic patients utilizing practice services, and the support of a community health worker</li> </ul> |
| Monroe Clinic (Wisconsin)                                      | Multi-specialty Clinic and Hospital in Monroe, WI.   | Spanish-speaking patients               | <ul style="list-style-type: none"> <li>Used Community Advisory Councils to collect qualitative data on patient and community needs, revealing obesity and binge drinking as high priority issues</li> </ul>         | <ul style="list-style-type: none"> <li>Standardized processes, including staff training, to ensure accurate and reliable collection of REL data.</li> <li>Made plans to diversify the racial/ethnic makeup of Community Advisory Boards and Board of Directors.</li> <li>Created a language services coordinator position to meet growing needs of non-English speaking patients.</li> </ul>   | <ul style="list-style-type: none"> <li>Developed an understanding of how to address disparities through increased community engagement and use of existing resources in the face of disparities data with small sample sizes</li> </ul>  |
| Wheaton Franciscan (Wisconsin)                                 | Integrated health system based in Glendale, WI (larger Milwaukee area), with 70 primary care sites and 15 hospitals in Wisconsin, Illinois, and Iowa | African American patients, Diabetes     | <ul style="list-style-type: none"> <li>Diagnosis data across local clinic sites, stratified by race and ethnicity</li> <li>Focus groups, African American patients with diabetes</li> </ul>                         | <ul style="list-style-type: none"> <li>Provided community health worker services for patients with diabetes to improve self-management of the condition.</li> <li>Developed a three-year organizational Diversity and Inclusion strategic plan that includes implementing strategies to reduce health and health care disparities across all sites of care</li> </ul>  | <ul style="list-style-type: none"> <li>Improved understanding of the care and behavior change needs of African Americans with diabetes</li> </ul>  |

\*For more information regarding the equity interventions at Jericho Road Community Health Center and Wheaton Franciscan, read the Robert Wood Johnson Foundation's *Quality fields Notes* equity [brief](#).

\*For more information regarding the equity interventions of Crossroad Health Center, read the center's *Quality fields Notes* [profile](#).

### III. Lessons Learned

The following findings are from the experiences of the nine health care organizations that participated in EQuII, and were compiled by Finding Answers and CHCS as technical assistance (TA) providers of the initiative. At the conclusion of the initiative, the TA providers conducted semi-structured interviews with each practice to gather critical implementation lessons, staff feedback on their particular experiences, and to make recommendations for other organizations that wish to carry out similar work. The lessons learned and best practices gathered are organized here by components of Greenhalgh, et al.'s model *Diffusion in Service Organizations*.<sup>4</sup> The model provides a conceptual framework useful for understanding the behaviors and routine ways of working that hinder or enhance the implementation of innovations in health care service delivery organizations. For the purposes of this report, the Roadmap is the “innovation” that EQuII attempted to diffuse throughout the nine participating health care organizations, summarized as identifying a disparity in the patient population, designing an intervention to reduce it, and implementing the intervention.

While the *Diffusion in Service Organizations* model consists of several conceptual categories, this paper highlights four that were most salient to the experiences of the EQuII organizations:

1. **Attributes of the Innovation:** Innovation-system fit, compatibility, and complexity
2. **System Antecedents for Innovation:** Slack (available) resources and technical capacity
3. **Adoption by Individuals:** Stakeholder concerns
4. **Implementation of the Innovation:** Internal communication

#### 1. Attributes of the Innovation

***Innovation-System Fit:*** *The more relevant the innovation is to the performance of the intended user's work, the more likely it is to be successfully adopted and implemented, particularly if it improves task performance.*

The majority of the practices made a deliberate decision to look for disparities in health conditions that they had already prioritized for quality improvement intervention. Crossroad Health Center further noted that participation in EQuII would help the practice comply with upcoming modifications of the Health Resources and Services Administration's (HRSA's) Uniform Data System reporting requirements to implement more nuanced health outcome and disparities measures. EQuII also aligned with their need to meet data-driven quality requirements to gain certification as a patient-centered medical home (PCMH) and further its goal of enhanced patient engagement given the recent addition of a certified diabetes educator and bilingual patient navigator. Practices that were Federally Qualified Health Centers (FQHCs) had similar rationales, as they were already required to submit race/ethnicity-stratified performance data to HRSA but in most cases had rarely analyzed and incorporated these data into quality improvement activities.

Many practices also cited the capacity building they experienced to achieve PCMH Level III status as a helpful precursor to data-driven disparities work. Thus, practices without experience implementing a PCMH model might feel less skilled in implementing some Roadmap activities. The Roadmap strongly recommends actively engaging patients to elicit their understanding of the identified disparity and engage their input in designing appropriate interventions. The PCMH model's focus on population management, patient experience of care, data-informed quality improvement activities, and shared decision-making aligns with Roadmap recommendations. Thus, practices felt their PCMH implementation experiences facilitated their EQuII work.

***Compatibility and Complexity:*** *Practices are more likely to adopt an innovation when they believe it is compatible with their values, norms, and perceived needs (high compatibility) and when they believe that adopting the innovation will be simple (low complexity).*

**Compatibility.** All of the practices began participation in EQuII with an existing commitment to disadvantaged populations. Several practices had terms such as “justice,” “access,” “discrimination,” and “racial equity” in their mission and vision statements. As many were publicly financed (e.g., FQHCs) or religiously affiliated, they also had more of a community, or service, orientation; FQHCs are required to have governing boards that include a majority (at least 51 percent) of users of the health center who are representative of the populations served. The practices self-identified as holding specialized knowledge in understanding and serving their specific patient populations and surrounding communities with some track record for providing customized programs. However, their motivations to participate in

EQuII also stemmed from the recognition that the status quo was not sufficient to take them to their highest operating potential. Organizations were also driven by the following business and efficiency rationales in addition to their mission: 1) regulatory and payer-led incentives to improve quality and cost measures; 2) high, often unmanageable patient flow; and 3) a preponderance of racially and ethnically diverse patients, particularly among safety-net practices serving majority-Medicaid, under-insured, or uninsured populations.

**(Misconceptions of) Complexity.** A common challenge among the practices was accurately anticipating the level of effort, resources, and new skills that would be required to implement disparities-focused work. Practices discovered that identifying and reducing specific disparities, while related and beneficial to their existing programming, required substantially different skills, quality improvement activities, and ways of applying organizational resources compared to other initiatives. The hurdles were varied, but common ones included: 1) gaining broader staff buy-in beyond the existing champions leading the work; 2) making the right kinds of demographic and performance data queries and waiting for these data to be extracted or analyzed appropriately; 3) knowing where to turn when patterns in the disparities data did not point to easy next steps; 4) engaging patients and community members; and 5) staff turnover. Practices came to realize by the end of the EQuII that simply “knowing” from a conceptual standpoint or having the right philosophical frame was not enough to successfully pursue their equity activities. One practice representative stated, “We think about it [disparities], but did not have the [correct] processes in place. We thought we were already doing everything we could. We were wrong.” Another practice representative noted, “It’s so much more involved than I would have thought. I’m not so naïve anymore.”

## 2. System Antecedents for Innovation

***Slack (Available) Resources:*** Organizations with resources beyond the minimum required to maintain current operations (i.e., slack resources) are more likely to adopt and implement innovations.

Nearly every practice that participated in EQuII struggled with adequately resourcing its disparities reduction efforts, particularly in terms of personnel. Approximately half of the participating organizations experienced significant turnover and staff transitions in key leadership and implementation positions over the course of the initiative, which led to significant interruptions and periods of inactivity. Several factors likely played a role, including an overall weak economy (the Great Recession), and multiple changes in the health care policy and finance environment that led to staffing disruptions and organizational facelifts (e.g., mergers, ACO transformation, and electronic medical record [EMR] implementation). Further, the vast majority of the practices’ resources, particularly in the case of safety net practices, were already being used for other activities, with the organizations operating on thin financial margins.

While staff transitions can seem inevitable, practices identified some long-term solutions that could strengthen personnel capacity and institutional knowledge to sustain equity efforts in the face of staff discontinuity. These solutions include identifying and empowering multiple staff members to implement equity activities; automating recurring tasks whenever possible (e.g., using population health management software to routinely produce REL-stratified performance reports); and regularly communicating about disparities issues and activities with all staff. The Roadmap also suggests cross-training staff; documenting institutional knowledge; incorporating intervention training into staff orientation and refresher courses, including program responsibilities in job descriptions; and assessing job candidates’ interest in current and future disparities reduction activities. The latter is especially important for job candidates seeking leadership positions.

***Technical Capacity:*** Innovations perceived by key players as simpler to use are more easily adopted.

**EMR data extraction.** All of the practices used EMRs and collected patient-level race and ethnicity data before their participation in EQuII; some also collected patient’s preferred language. However, many of the organizations began EQuII with the misperception that their EMR would allow them to somewhat easily generate reports on key health care process and outcome measures, stratified by patient demographics. When they attempted to generate the desired reports, they experienced many unanticipated EMR-related challenges. Despite the complexity, which posed the danger at times of “stalling” progress, practices were able to develop alternative means of accessing some of the desired information to maintain momentum, such as: manual extraction for a smaller sample set of data; data manipulation

outside of the EMR system; having IT staff develop software workarounds; and collecting qualitative data from patients on their perceived disparities as an alternative to quantitative data.

**Quality of demographic data.** Some of the practices that did succeed in generating stratified quality reports discovered new concerns about the quality of the data, such as large percentages of the patient population with “unknown” or “refused” race, combinations of “race” and “ethnicity” that suggested patient misunderstanding of the categories, and unexpectedly large percentages of missing data. These were attributed to inadequate data collection and recording procedures, such as lack of consistency across staff regarding where specific quality data should be entered into the EMR, lack of clarity on the order and definitions of the race and ethnicity categories, and hesitation about how to coach patients on the data intake process. During the course of the initiative, at least three practices implemented, or made plans to implement, refresher training on best practices for collecting and entering patient-level race, ethnicity, and preferred language data for frontline reception staff.

**Data analysis and interpretation.** A related challenge was lack of staff with the expertise in data management and statistical analysis to interpret data reports. Staff were not always familiar with how to query their EMRs effectively to produce the right reports, nor how to use analytic software (e.g., Excel, SPSS, and in-built features of EMRs) to calculate appropriate rates. Common issues included the inability to display the demographically stratified data in a meaningful way (e.g., charts or graphs), identify the appropriate numerators and denominators to construct measure rates, compare rates appropriately within and across groups, and decide if a difference in rates was meaningful. EQuII TA providers helped conduct specific analyses and provided data templates as necessary to address these gaps in staff knowledge. TA providers also consulted with AF4Q Alliances to see what kinds of local resources (e.g., university partners or data workgroups) might assist staff with building that capacity. Having identified the need for this capacity, some practices, such as HealthCare Connection, decided to include these competencies in future job descriptions for staff members.

Practices that could not access stratified data, or did not identify disparities in their available data, relied upon qualitative and population-level data to inform their decisions about which disparity to target. Both Elmwood Health Center and UC Forest Park used income data (e.g., insurance status) to identify gaps in care and outcomes, as their race/ethnicity stratifications did not show compelling differences in quality or outcomes. This was a key learning point, as it required them to go beyond the technical shortcomings of the data-driven project and stay committed to the spirit of the disparities reduction effort by identifying other disparities that affected their patient populations.

**Qualitative data.** Practices also collected qualitative data from providers, staff, and patients to inform their interpretation of the stratified performance measures and intervention design. TA providers emphasized the importance of gaining patients’ perspectives about the identified disparity, their beliefs about why it exists in their community, and potential interventions to reduce or eliminate the inequity as a fundamental component of the Roadmap. Practices valued external guidance on the optimal methods for acquiring these data. TA providers were often involved in developing effective questionnaires and designing focus groups (see Exhibit C). Practices also relied on outside individuals to serve as neutral moderators of focus groups. Regardless of their experience level, the patient survey or focus group component of the EQuII was among the most cherished by the practices—engaging directly with patients gave staff highly valuable primary feedback, empowered them to take action, and lent a sense of accountability for their work. The staff of Jericho Road Health Center particularly noted that patient input drastically altered the nature of the intervention they had anticipated implementing with their prioritized population, Somali patients with diabetes.

To provide assistance with the various data challenges experienced by the practices, the EQuII TA providers created a [resource](#) (also communicated via webinars) to support their needs across the continuum of disparities identification, intervention implementation, and evaluation.<sup>5</sup>

EQuII practices utilized focus groups, questionnaires, and surveys to elicit patient input on root causes of disparity and suggestions for improved care delivery. The practices commonly relied on TA providers to develop these tools and ensure the appropriateness for their equity efforts. The following is an example of guidance provided by the TA providers around focus group development:

## Exhibit C

| Key Considerations in Developing Focus Groups for Equity-Focused Quality Improvement |  |   |
|--|--|---|
| Function   | Key Considerations   | Recommendations   |
| Identify the Type of Focus Group(s) and the Intent                                   | <ul style="list-style-type: none"> <li>• What is the ideal number of patients?</li> <li>• What type of feedback do you need?</li> <li>• If you are doing more than one focus group (e.g. patients successfully managing their diabetes v. patients struggling to manage their diabetes), consider how your recruitment strategy and focus group questions should differ.</li> </ul>  | <ul style="list-style-type: none"> <li>• Generally, the ideal number of participants per group is 5-10: less than that and you may not have enough voices for discussion while, more may make it difficult for the moderator to keep the group focused on task, and everyone fully participating.</li> </ul>  |
| Devise Focus Group Questions   | <ul style="list-style-type: none"> <li>• How many questions are ideal for the timeframe?</li> <li>• How do you strike a balance between open-ended and close-ended questions?</li> <li>• What kinds of language will ensure a respectful, non-judgmental dialogue?</li> <li>• Are the questions ordered so that earlier questions will not unduly bias participants' responses to later questions?</li> <li>• Who should review the questions before finalizing?</li> </ul>  | <ul style="list-style-type: none"> <li>• Think hard about the types of answers you might get for each question. Imagine people sitting in the group and answering each one.</li> <li>• Is the question worded in a way to prompt for the information that you desire? For example, "Do you know how HIV is transmitted?" will not tell you if people know the answer. They might honestly answer, "Yes" but be misinformed.</li> <li>• Have multiple people review the questions before the first focus group; ask people who are familiar with the purpose of the group and others who are not. People who are not familiar with the purpose of the group can often provide a good estimation of how the participants will interpret the questions.</li> </ul> |
| Recruit patients for the focus group   | <ul style="list-style-type: none"> <li>• How will you ensure that patients hear about the focus group in a timely fashion?</li> <li>• What kinds of outreach materials will entice patients to participate?</li> <li>• In which locations should outreach materials be placed to maximize awareness?</li> <li>• Based on experience with other projects, how much lead time will be needed to recruit a minimum number of participants?</li> <li>• Who should be the "figurehead" of the project or the lead contact? How might this impact patient commitment?</li> </ul> | <ul style="list-style-type: none"> <li>• Patients are more likely to participate if someone they know and trust invites them.</li> <li>• Patients may need to be exposed to the idea of the focus group 3-4 times before deciding to participate (e.g. read about it on a flyer at patient registration, hear about it from a staff member, and see a poster in the hallway).</li> </ul>  |
| Ensure patient participation   | <ul style="list-style-type: none"> <li>• What will make it easy for patients to participate?</li> <li>• How can peer networks be optimized to motivate participation?</li> <li>• What kinds of incentives (e.g., financial or otherwise) can be used?</li> <li>• Has something like this been done before, and how can that experience be leveraged?</li> </ul>  | <ul style="list-style-type: none"> <li>• Think about the following factors that may affect patient involvement: <ul style="list-style-type: none"> <li>• Location (e.g., at the clinic, near patient neighborhood, familiar location)</li> <li>• Timing (e.g., after work hours)</li> <li>• Transportation assistance</li> <li>• Childcare</li> <li>• Food or snacks</li> </ul> </li> </ul>   |

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|---|--|---|
| <p><b>Identify a moderator</b></p>      | <ul style="list-style-type: none"> <li>• Who would be considered objective?</li> <li>• Who would instill patient comfort and trust?</li> <li>• Would the moderator need to speak a non-English language?</li> <li>• Do the patients know the moderator in some way? Is this a benefit or detriment to comfort and neutrality?</li> <li>• Is there some kind of training that would benefit the chosen moderator?</li> </ul>  | <ul style="list-style-type: none"> <li>• Ideally, the moderator is trained and has experience conducting focus groups.</li> <li>• You may want a moderator who is from a similar community or cultural background as the participants to enhance comfort. Depending on the topic and associated cultural stigma, a moderator from a similar community may not be the ideal choice.</li> <li>• Refrain from choosing moderators who may have a conflict of interest (e.g., the patients' own provider, or a nurse or staff member with whom they work regularly).</li> <li>• Experienced moderators might be found at affiliated organizations not directly involved in patient care (e.g., practice coaches, regional health care associations), community-based organizations, students from local universities, and clinic volunteers may be options.</li> </ul>  |
| <p><b>Focus group logistics</b></p>     | <ul style="list-style-type: none"> <li>• What kind of seating arrangement will be used?</li> <li>• What mix of patients will maximize patient comfort and direct, transparent communication?</li> <li>• What kinds of language (or literacy levels) should be used?</li> <li>• How will the focus group protocol ensure an open, private, and respectful environment for patients?</li> <li>• How long will the focus group last, including preparation time?</li> </ul> | <ul style="list-style-type: none"> <li>• Generally, the ideal seating arrangement is around a large table or in a circle. Think about whether there are cultural expectations or norms that would dictate a different seating arrangement.</li> <li>• Allowing patients to use a fake name on name tags or giving everyone a name tag with a number instead of a name may help participants feel safe when discussing personal or sensitive topics.</li> <li>• Typically, 30 minutes is needed to accommodate late arrivals, distribute and eat food or snacks if provided, and get participants registered, settled, and ready to go. Ideally, the focus group discussion (after the preparation period) will be approximately 60 minutes.</li> <li>• With an effective moderator some groups can go as long as 90 minutes. However, the ability to gather reliable information will drop exponentially after 90 minutes.</li> </ul> |
| <p><b>Tracking focus group data</b></p> | <ul style="list-style-type: none"> <li>• How will information from the focus group be recorded/notated?</li> </ul>   | <ul style="list-style-type: none"> <li>• Ideally, the focus group will be audio recorded on two recorders. A second recording device serves as a back-up and might also be necessary in larger rooms. There should also be a note taker in addition to the moderator. This person will take notes about important points and which participant is making them. The latter is important since the transcriber may not always be able to tell who is talking when listening to the recording.</li> <li>• To help them feel comfortable, participants should be informed about the roles of each staff member in the room.</li> </ul>  |
| <p><b>Post-focus group analysis</b></p> | <ul style="list-style-type: none"> <li>• Which staff will be involved in the analysis of focus group data? Think about how this might affect interpretation of the findings.</li> <li>• Remember to thank the patients for participation and create a vehicle for their continued informal input.</li> <li>• How will you relay to participants the next steps you are taking based on the focus group data?</li> </ul>  | <ul style="list-style-type: none"> <li>• As part of any follow-up communication, thank the patients for sharing their time and thoughts.</li> <li>• Ideally, the findings and next steps will be presented to the participants or other groups of patients. This can be accomplished via presentations, flyers/handouts, or existing venues to communicate with patients (e.g., newsletters). This can serve to validate the conclusions and appropriateness of next steps (via additional feedback). It also creates a sense of community and shared ownership in the organization, and enhances trust.</li> </ul>   |

### 3. Adoption by Individuals

**Stakeholder concerns.** *The culture of the health care organization must undergo a change process whereby key stakeholders must become motivated and able to adopt the innovation. This change process involves the specific needs, motivations, values, goals, skills, and learning style of each key stakeholder as they relate to the innovation.*

Over the course of their projects, organizations had to contend with cultural and political issues among staff and leadership. Initiating disparities-focused efforts raised fears in some key stakeholders that existing resources would be removed from, or never allocated to, other highly valued activities. For example, before participating in EQuII, one of the practices was taking steps to increase the number of patients with private insurance in order to strengthen its overall financial status. This would enable them to maintain their fundamental mission of serving disenfranchised, under-, and uninsured patients. When a higher-level administrator learned about his organization's interest in participating in EQuII to address a disparity in diabetes health outcomes, he expressed concern about becoming "too good" at serving this portion of their patient population and that the innovation's success might draw new patients from a demographic who were likely uninsured or underinsured. He feared this would potentially undermine the organization's goal of altering its payer mix to improve reimbursements. His concerns were eventually addressed by emphasizing the potential for improved health outcomes for these patients and anticipated reduced levels of complications and costs in the future.

In another practice, both the staff and patient populations were composed primarily of three different racial-ethnic groups. Pre-existing tensions between staff members of one of the racial-ethnic groups and management were exacerbated when the staff members learned that another racial-ethnic group had been identified and prioritized for intervention. They communicated that they did not want to participate in training or implementation of the disparities project because they felt their needs, and those of their patient-peers, were being overlooked or inadequately addressed. Management let the concerned staff members know that the project would not be a single and isolated disparities reduction activity and that other disparities would be identified and addressed in the future.

Every practice experienced some level of resistance from one or more key stakeholders during the culture change process. Overcoming resistance to implementing the Roadmap innovation was even more challenging in resource-constrained settings where practices often required more time to gain buy-in than originally anticipated. However, at the end of EQuII, every practice reported that the final outcome was an improved culture that highly prioritized identifying and eliminating disparities. They also noted that achieving this culture change was worth the effort, largely due to the fact that it allowed them to better meet their mission of improved health for their patient population. For example, Swope Health Center revised its mission statement to explicitly address equity and convened a cross-departmental cultural competency committee charged with developing mechanisms to promote equity throughout the health system. Monroe Clinic committed to diversifying its Board of Directors with representatives from racial and ethnic minority populations as board positions became available.

### 4. Implementation of the Innovation

**Internal Communication:** *Strong communication within the organization enhances the success of implementation and the chances of routinization. A narrative approach to communication ("purposeful construction of a shared and emergent organizational story about the innovation") can serve as a robust motivator.*

At the end of EQuII, several practices strongly recommended instituting staff-wide communications activities at all levels of the organization to educate, motivate, and obtain ideas for the disparities efforts. Some of them secured regular agenda time at various all-staff and department meetings while others used protected and recurring space such as monthly newsletters or hallway posters to communicate the organization's equity goals and activities. Alliances also offered to help practices disseminate their achievements and stories of their experience. Crossroad Health Center applied for a grant to create a video of its disparities reduction story to communicate its efforts to internal and external stakeholders. Toward the end of EQuII, many practices also brainstormed opportunities to record staff and patient testimonials (e.g., stories and video) and use social media to disseminate successes of their equity work and continue to build a culture of inclusion.

## IV. Recommendations

Using *The Roadmap to Reduce Disparities* to identify and reduce disparities in patient care and outcomes is a complex innovation that requires a significant culture change for most organizations. Greenhalgh et al. note that one high-quality study in their literature review revealed a stepwise or stage-like process of innovation adoption comprising “knowledge-awareness,” “evaluation,” and “adoption-implementation.” Otherwise, the rest of the empirical evidence was “more consistent with an organic and often rather messy model of assimilation in which the organization moved back and forth between initiation, development, and implementation, variously punctuated by shocks, setbacks, and surprises.” The latter description more closely matches the overall experience of the EQUII practices. While each practice had its share of strengths and challenges, different timelines, and a unique project journey, a common sentiment among practices was a sense of optimism about how the knowledge gained through EQUII could lead to a salient change in their organizational culture. The practices also learned about concrete activities for addressing equity that they could carry forth into their ongoing care delivery transformation activities (see Exhibit D for a compilation of best practices for addressing disparities through the Roadmap). Compiled from these practices’ experiences, the following recommendations will help health care organizations that are looking to pursue efforts similar to those in EQUII.

Organizations interested in implementing the Roadmap, or other innovations to address racial/ethnic disparities in health and health care, should:

1. *Feel confident and proud of their history serving minority and disenfranchised patient populations, but avoid assuming that this history will make it easy to adopt and implement the Roadmap innovation.* Identifying specific disparities within a patient population, understanding their etiology, and designing effective interventions to address them will require new skills and different ways of conceptualizing and implementing quality improvement activities. It will take longer than expected, but patience and sensitivity to the complexity of the process are key.
2. *Conduct a thorough assessment of existing data resources and systems* with an emphasis on paper or electronic medical records, the quality of the data within them (particularly self-reported patient-level demographics such as race, ethnicity, preferred language, sexual orientation, and gender identity), the personnel available and skills needed to generate high-quality and reliable data reports stratified by key patient demographics, and any needs to improve the quality of the desired data.
3. *Be ready to adapt and tailor their approach and confront obstacles with creativity and flexibility.* All practices recommended to keep moving forward despite the challenges, even if this means setting aside one or more tasks that they would come back to later when the necessary resources become available or solutions are discovered. Challenges extracting and analyzing stratified performance data are common. Move forward on other steps of the Roadmap innovation, and collect and use qualitative data while waiting for reliable quantitative data to become available.
4. *Start small.* The Roadmap is a complex, multi-faceted, ongoing process. Set small goals that can be achieved while simultaneously working on longer-term activities. This might include altering mission statements, training staff on data collection, sharing early data with staff and providers, surveying patients, and having staff discussions about race and other sensitive issues.
5. *Consistently communicate with all staff at all levels of the organization.* Ongoing communication facilitates the necessary culture change and can help identify potential program champions for the Roadmap innovation. Spread the importance of reducing disparities in the patient population, and ask staff members to share their perspectives on why the disparities exist and recommendations for eliminating them. Remember that an open, non-discriminating, and safe staff environment is a key precursor to achieving equitable patient outcomes. Keeping leadership in the loop about developments through success stories and data is key to building the case for sustainable resources.
6. *Involve patients in equity efforts through focus groups, surveys, and informal communications.* This is one of the most important aspects of efforts to reduce disparities. Understanding patient perspectives on gaps in care or quality and how to design effective solutions can be enlightening and useful, especially because their perspectives can differ significantly from those of staff members. Additionally, seeking their input reinforces their perceived value to the organization, builds important trust and loyalty, and ensures cultural appropriateness and effectiveness of disparities efforts.

7. *Build external partnerships to pursue short-term funding or personnel resources.* Philanthropic grants or public health programs may provide needed dollars or open doors to longer-term sustainability. Check with local universities and colleges to see if human resources (e.g., student volunteers, medical residents, and data analysts) or expertise (e.g., state university extension office consultants or medical center community-based programming) might be available to support efforts. For example, Jericho Road Health Center partnered with a local YMCA to design and staff culturally competent onsite exercise classes for its Somali patient population experiencing disparities in diabetes control. Crossroad Health Center used a volunteer nurse to provide culturally competent patient education and care management services to Spanish-speaking patients with diabetes. Mount St. Mary's partnered with the local American Diabetes Association office to obtain Spanish-language diabetes education DVDs. Crossroad staff are planning to present quantitative (health care process and outcome measures) and qualitative data (patient satisfaction ratings) from their improvement efforts, in concert with other FQHCs, to solicit additional reimbursement and financial resources from regional payers. To provide assistance in this area, CHCS staff members created a [resource](#) that provides suggestions for how providers can create community partnerships.<sup>6</sup>

8. *Convene stakeholders with an explicit mission to support equity.* A cultural competence committee or community advisory board can serve as a sounding board for key decisions and help develop ties with community-based organizations. External entities have unique and valuable perspectives on non-medical factors driving patient outcomes—e.g., housing, availability of healthy food, environmental triggers, and transportation—that practices can incorporate into the supports and services available to patients. This may be especially important for minority populations experiencing structural and cultural barriers to health and health care. Stakeholders with expertise in language and literacy or behavior change may be especially important partners for interventions such as enhanced interpreter and translation services or motivational interviewing.

# Best Practices to Reduce Disparities

Finding Answers: Disparities Research for Change

**Finding Answers:**  
Disparities Research for Change



Robert Wood Johnson Foundation

| Practice  | Rationale   | Possible Strategies   | Outcome  |
|---|---|---|--|
| Collect and stratify race, ethnicity, and language (REL) data in tandem with other equity efforts   | REL data is an important part of reducing disparities, but it is not necessary to put all equity efforts on hold until REL data is available.   | Use qualitative methods (e.g., surveys, interviews) to identify disparities if quantitative data isn't available.<br><br>Continue to foster a culture of equity across the organization while REL data collection is in progress.   | Disparities efforts are not stalled.<br><br>The organization is primed to address disparities once REL-stratified data is available.   |
| Foster a culture of equity  | Success is more likely if staff recognize that disparities exist within the organization and view inequality as an injustice that must be redressed.<br><br> | Share feedback with providers and incentivize disparities reduction.<br><br>Include equitable health care as a goal in mission statements.<br><br>Build a work force that reflects the diversity of the patient population.<br><br>Institute a Community Advisory Board and develop ties with community-based organizations.    | Staff, patients, and community members share a definition of equitable care and value equity in health care delivery.<br><br> |
| Appoint staff and protect their time for equity programs and hold them accountable for results  | Without staff time and effort, equity programs are unlikely to reach their full potential.  | Include equity goals in job descriptions and performance reviews.<br><br>Prepare for leadership and staff turn over by cross-training staff and documenting institutional knowledge.<br><br>Identify equity champions to lead the effort.  | Staff is not overtaxed and remains committed to the program over time.   |
| Target multiple levels and players across the care delivery system<br><br> | The causes of disparities are complex; solutions need to address multiple factors.  | Avoid focusing exclusively on patients - design programs that intervene with providers, organizations, community groups, and policies, as well as patients.   | Programs effectively address the multiple causes of disparities.<br><br>Improvements are systematic and comprehensive.   |

# Best Practices to Reduce Disparities

Finding Answers: Disparities Research for Change

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| Practice  | Rationale   | Possible Strategies   | Outcome   |
|---|---|---|---|
| Identify and appeal to the equity rationale that is most important to your audience | <p>Staff members are motivated for a variety of reasons:</p> <p>Providers are often concerned with maximizing efficiency during the office visit.</p> <p>Front-line staff may be wary of impacting patient flow and room availability.</p> <p>Leadership may respond well to programs that guarantee a positive return on investment and leverage existing resources.</p> | <p>Leverage staff motivation to support a project:</p> <ul style="list-style-type: none"> <li>Enhance the care team and promote care management outside of the clinic.</li> <li>Minimize burden and show respect for staff time.</li> <li>Present data that demonstrate potential for positive financial impact.</li> </ul> | <p>Buy-in across the organization is secured.</p> <p>The intervention is consistently and accurately implemented by all staff.</p>                                    |
| Involve members of the target population during program planning                    | <p>Programs that are not culturally targeted risk rejection by patients.</p> <p>Input by minority health workers is not a proxy for patient involvement.</p>  | <p>Involve the target population in program design in a manner that is meaningful and inclusive.</p> <p>Engage patients, not just minority health workers.</p>  | <p>Community engagement is advanced.</p> <p>Programs are adaptive and effective.</p>  |
| Strike a balance between adherence and adaptability                                 | <p>While adherence to protocol ensures consistency, flexibility is key when working with diverse patients.</p>  | <p>Regularly collect process measures, identify opportunities for improvement, and adapt the intervention accordingly.</p> <p>Use standardized checklists to monitor adherence.</p>   | <p>Programs are consistent, yet flexible.</p>   |
| Be realistic about the time necessary to move the dial on disparities               | <p>Improvements in minority health take time because of multiple challenges inside and outside the clinic.</p>  | <p>Plan long-term follow-up to demonstrate statistically significant improvements in health outcomes.</p>   | <p>A realistic timeline manages expectations and maintains ongoing support.</p>  |

## V. Conclusion

In the rapidly evolving field of health care, there are a growing number of reasons and opportunities for practices to actively address equity. The lessons from EQuII offer a framework, *The Roadmap to Reduce Disparities*, to guide organizations in using a quality improvement approach to reduce inequities in care and outcomes. The Roadmap is designed to minimize the burden and cost of equity efforts by incorporating them into existing quality improvement infrastructure and flexibly supporting the growing and multiple obligations of health care organizations, such as meeting quality measures, bearing financial risk, transforming into new models of care, and performing data-driven population management. This report's lessons and best practice findings will hopefully support more health organizations in their efforts to align both their quality and equity aspirations.

## References

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<sup>1</sup> Two initiative rounds were conducted, with three and six practices, respectively, each for 18 months. This report reflects a total of 36 months of time spent with the practices and Alliances collectively.

<sup>2</sup> Based upon observations of 33 health care organizations' efforts to reduce racial and ethnic disparities in their patient populations and the results of outcome and process implementation evaluation funded by Finding Answers: Disparities Research for Change. See [www.solvingdisparities.org](http://www.solvingdisparities.org) for more information.

<sup>3</sup> Chin, M. H., A. R. Clarke, R. S. Nocon, et al. 2012. "A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care." *J Gen Intern Med* 27:992-1000.

<sup>4</sup> Greenhalgh, T., G. Robert, F. Macfarlane, P. Bate, and O. Kyriakidou, O. 2004. "Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations." *Milbank Quarterly* 82:581-629. doi:10.1111/j.0887-378X.2004.00325.x.

<sup>5</sup> R. DeMeester and R. Mahadevan. *Using Data to Reduce Disparities and Improve Quality: A Guide for Health Care Organizations*. Robert Wood Johnson Foundation. April 2014. Available at: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/04/using-data-to-reduce-disparities-and-improve-quality--a-guide-fo.html>

<sup>6</sup> R. Mahadevan and T. McGinnis. *Improving Health Care Quality and Equity: Considerations for Building Partnerships Between Provider Practices and Community Organizations*. Robert Wood Johnson Foundation. April 2013. Available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf405459](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf405459)

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