Bringing Equity into Quality Improvement:
An Overview and Opportunities Ahead

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ABOUT ACTION

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Visit the website created through ACTION, Advancing Health Equity, at www.advancinghealthequity.org, to find resources and tools to help your organizations improve its efforts to deliver equitable care.

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EXECUTIVE SUMMARY

A decade after the Institute of Medicine focused national attention on quality in health care, robust resources and strategies exist to help organizations strive toward five domains of quality: safe, effective, patient-centered, timely, and efficient care. There has been much less progress in the sixth domain, equity. With changing demographics, persistence of health care disparities, and recent progress in identifying solutions to reduce gaps in care, now is the time to fully integrate equity into quality improvement.

This two-part guide is intended for individuals and organizations, whether new to or experienced in performance improvement, who want to understand the field and are looking for practical approaches to improving equity. Part one sets the context by describing how the field has evolved, what has been learned from regional and national efforts, and what opportunities are on the horizon for advancing health care equity. Part two of the guide focuses on how to improve performance and highlights what infrastructure is needed, how to define metrics and use data, and how to tailor care to reduce disparities.

THE KEY POINTS HIGHLIGHTED IN THIS FIRST GUIDE ARE:

1. Despite recent advances in the field of health equity, disparities remain a common marker of poor health system performance. Persistent and stark inequities in care limit the productivity and economic potential of the U.S. workforce and therefore warrant targeted attention.

2. Improvements in equity cannot be made without high quality race, ethnicity, and language data (REAL) data. Concerted effort must be devoted to making the business case for collecting and using these data.

3. Quality improvement may not benefit all populations equally. Careful measurement and analysis is vital to ensure that these efforts result in improved equity.

4. Interventions to improve health equity must be tailored to overcome barriers and meet the needs of populations experiencing unequal care.

5. All organizations have the ability to start small, identify goals for improvement, and track performance in reducing disparities.

6. Reforms provide opportunities to advance equity through initiatives to achieve meaningful use, accountable care, and patient-centered services. Effort and vigilance are needed to assure their promise is achieved.

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Decades of research has documented that certain populations, particularly racial and ethnic minorities, lag behind whites in health outcomes.[1] These disparities manifest as diminished quality of life due to preventable chronic diseases, decreased productivity, and life spans cut short by premature death. Disparities are a far too common marker of poor health system quality and performance. They warrant targeted attention given their impact on the ability of the workforce to contribute to the U.S. economy and due to growing population diversity. Since the Institute of Medicine focused national attention on quality in health care in 2001,[2] there has been a surge in efforts and resources to help organizations achieve safe, effective, patient centered, timely, and efficient health care. However, there has been less attention to the sixth domain of quality, equity in health care.

To synthesize progress to date in improving equity in health care, we convened a roundtable of experts in March 2011 (see Appendix A for a list of attendees). The discussion focused on strategies for, challenges to, and new opportunities for integrating equity into quality improvement (QI). This guide summarizes the roundtable discussion and includes quotes from participants to exemplify key concepts. The guide begins with a brief overview of three key trends that have shaped the field, discusses the use of QI as a lens for tackling disparities, and summarizes what we have learned from regional and national efforts to achieve equity. We conclude with an outline of the advances needed to improve equity in care. The companion guide focuses on practical strategies for improving performance, beginning with the necessary infrastructure and continuing with practical approaches to collecting and using data and strategies for patient-centered care to meet population needs.

TRENDS SHAPING THE FIELD

A decade after the Institute of Medicine's report, Unequal Treatment, disparities remain central to discussions about quality of health care in the U.S.[1] They will continue to be important into the foreseeable future given the increasing diversity of the population and movement toward a reformed health system that will improve access and motivate quality improvement (QI), but may inadvertently reinforce inequity in care.[3, 4] In recent years, transformation in the field of health care equity has been spurred by three important changes: use of a QI framework, collection of race, ethnicity and language (REAL) data, and advances in language assistance services.

Quality Improvement Framework

The Institute of Medicine's report, Crossing the Quality Chasm, signaled a change in U.S. health care by including equitable care as one of the six components of quality care.[2] However, QI approaches did not shape the field of health care equity until recently when the focus shifted from documenting inequities to implementing changes to reduce gaps in care.

> *"We started out…thinking about racism, bias and discrimination and we've now moved into a world where we are thinking of disparities as a component of quality."*
>
> —Roundtable participant

The adoption of a QI framework has been propelled by guidelines and standards advanced by organizations such as the National Committee for Quality Assurance, National Quality Forum, and The Joint Commission,[5-8] and further spurred by publication of studies that demonstrated the role of QI in improving care and reducing disparities.[9,10] The Centers for Medicare and Medicaid Services (CMS) has also used a QI framework to address disparities.

CMS has required Medicare managed care plans to conduct Medicare Quality Improvement Projects, that address either clinical health care disparities or the provision of culturally and linguistically appropriate services.[11]

NATIONAL QUALITY & SAFETY ORGANIZATIONS
NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) Standards from the Distinction in Multicultural Health Care program[6] were incorporated into the 2011 revision to the NCQA standards for a Patient-Centered Medical Home.[12] Disparities reduction were also included in NCQA's accreditation standards for accountable care organizations[13] and proposed standards for specialty care recognition.[14]
THE JOINT COMMISSION New standards expand requirements to include a specific focus on care for culturally and linguistically diverse populations. The standards were released with a companion report, *Advancing Effective Communication, Cultural Competency, and Patient- and Family-Centered Care: A Roadmap for Hospitals*.[8]
NATIONAL QUALITY FORUM (NQF) Ongoing work to identify best practices in cultural competence and high quality care for diverse populations and endorse tools, strategies and performance measures to reduce disparities.[15] Current effort builds on previous work on disparities-sensitive ambulatory quality measures[16] and its Framework and Preferred Practices for Cultural Competence.[7] In August 2012, NQF endorsed 12 measures designed specifically to help advance quality improvement efforts and eliminate disparities. http://qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx

REAL Data

Despite evidence documenting disparities in virtually all areas of care, health care organizations have been slow to focus on equity. One reason for this is uneven access to race, ethnicity, and language assistance (REAL) data. This is compounded by a lack of confidence in the accuracy and reliability when these data are available.

> *"…it's now part of the meaningful use requirements for health information technology [which] means that we are going to see hospitals and physicians and then everyone that's affiliated with them begin to have [REAL] data and potentially… use it."*
>
> —Roundtable participant

Collecting REAL data requires concerted effort and some resources, neither of which will occur without considerable motivation—either in the form of a "business case" or external requirements to collect this information for contracting, reporting, or initiatives such as "meaningful use" of electronic health records. The "business case" for REAL data can be hard to make in a setting of competing agendas and limited resources. But this is a vital necessity across the nation given the persistence of disparities, the stark reality of their economic impact for employers and employees, and the associated higher cost and lower quality of care.[17] While there is also good evidence that disparities contribute to unnecessary health spending, making the case for an individual organization remains challenging.

> *"We are no longer asking should we collect race, ethnicity, language, etc. data. It's now how and what do we do with it."*
>
> —Roundtable participant

Two key initiatives have led to improved collection of REAL data. First, the National Health Plan Collaborative was a groundbreaking effort bringing together eleven major health insurance companies in partnership with organizations from the public and private sector. The collaborative looked to identify ways to improve the quality of care for racially and ethnically diverse populations. In doing so, it developed recommendations and resources for collecting REAL data to identify and address disparities.[18] The second initiative was the Health Research and Education Trust (HRET) toolkit that was developed to help organizations implement a systematic approach for gathering REAL data from patients/enrollees or their caregivers in an efficient, effective, and respectful manner.[19] Both efforts underscored that collecting accurate REAL data is a fundamental step for identifying populations most at risk for unequal care.[20, 21] This understanding is reflected in the inclusion of requirements for REAL data in regulations that define "meaningful use" of electronic health records.[22]

Health care equity cannot be achieved without high quality race, ethnicity, and language data; without it there is no effective means for identifying best practices that can be spread and lead to improved equity. However, the existence of accurate data does not, in and of itself, guarantee that steps will be taken to identify gaps in quality or unmet health care needs. Nor does the presence of data ensure action to reduce or eliminate inequities that are found. The absence of data, however, essentially guarantees that none of these will occur.

Advances in Language Assistance Services

In 2000, the U.S. Department of Health and Human Services' Office of Minority Health published National Standards for Culturally and Linguistically Appropriate Services in Health Care (known as the CLAS standards). These standards provide guidance on how organizations can best serve increasingly diverse communities and fulfill the Federal mandates for language assistance.[23, 24] To date, language services, and the infrastructure to systematically implement them, are the most robust interventions for improving equity.[25, 26] The adoption and spread of services such as medical interpretation and translation has been promulgated by national dissemination of the CLAS standards, development of trainings for health professionals, use of technology to increase access to language services, and the establishment of certification processes to ensure the quality of medical interpretation.

The delivery of language services was framed as a QI effort in Speaking Together: National Language Services Network, which was a learning collaborative to improve interpretation services across 10 hospitals. This framing helped forge relationships between interpreters, clinicians, quality managers, and patient registration and information technology staff within health care organizations.[27] Established QI techniques were applied to improve the delivery of language services and newly developed performance

> *"You are seeing the maturation of the healthcare interpreting field… [with] certification… technology being used, especially video technology… developing standards and quality measures around language services… people are moving from …should we do this to how do we do it [to] how do we do it well?"*
>
> —Roundtable participant

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measures were used to assess screening for patients' preferred language, receipt of services, and timeliness of care. Hospitals participating in the collaborative demonstrated improvement in at least one of the performance measures.[28] These measures have since been successfully used in multi-hospital collaboratives, and are available for use by organizations desiring to set goals and measure processes to improve language services.[29]

USING A DISPARITIES LENS FOR QUALITY IMPROVEMENT

The field of health equity has evolved from asking if disparities exist to asking why they exist. Now, the focus is on what works to reduce gaps in care.[30] This evolution, combined with evidence that improvement methods may indeed help achieve equity in care,[10, 31-36] has led to the notion that QI could result in a "rising tide lifts all boats" phenomenon where interventions to improve care for all populations would also improve care for those who experience disparities.[37]

There are two distinct approaches in using QI to address disparities, both of which emphasize the tailoring of interventions to meet the cultural and linguistic needs of the populations of focus. The difference lies in the use of data in the identification of disparities and monitoring of improvement. One approach, commonly used in research and practice, is to focus on improving care for a population that has historically experienced disparities in care or is an underserved population. With this approach, the use of REAL data to monitor differences among and between groups is not emphasized. Improved equity is determined by assessing if interventions lead to improvements in baseline measures.

The second and ideal approach is to use REAL data to demonstrate gaps in care by comparing a quality measure among two (or more) groups. For example, colon cancer screening rates for English speaking patients are compared with screening rates for non-English speakers. Improved equity is evaluated by looking for better quality of care and a decrease in the gap between groups. This approach is impossible to do without high quality REAL data. Using this approach, QI can result in three possible effects on equity. First, it can improve care for both groups but have no effect on the gap. Or, QI can improve quality of care and reduce the gap. Lastly, improvement efforts can widen the gap by improving care for one group while worsening it for the second group. Stratifying quality measures improves accuracy and quality of data and therefore allows more efficient and cost effective use of QI resources. This approach also provides a way to demonstrate which practices result in improved equity and can be spread to other systems and settings.

The promise of QI has spurred experimentation and led to development of tools and strategies for tailoring and improving care for vulnerable populations. These early efforts underscore the need to carefully define, measure, and monitor changes in equity to identify which interventions are effective.[7, 8, 38-40] Although progress has been made in defining how to measure disparities in care,[39] some important questions remain. For example, what types of interventions can improve equity for chronic conditions prevalent today? What strategies can support and spread QI efforts to achieve equity and what are the key infrastructure needs to do so? In the remaining sections of this guide, we highlight efforts that have tackled these important questions.

National and Regional QI Efforts to Improve Equity

While efforts to improve equity of health care have varied in their impact, they have all contributed knowledge that has moved the field. We summarize key national and regional programs across a broad array of sectors in health care. These examples, while not exhaustive, reflect a robust array of efforts that range in size, scope, and clinical focus. Together they represent an impressive range of endeavors in the U.S. We categorize the efforts by the health care sector they targeted and provide an overview of their intent and results.

Community Health Centers

The Health Resources and Services Administration (HRSA) **Health Disparities Collaboratives,** was the largest multi-site quality improvement effort with a specific focus on underserved populations. The collaboratives combined rapid cycle QI with a chronic care model developed by Ed Wagner and colleagues from the MacColl Institute for Healthcare Innovation.[41] The effort was implemented in more than 900 community health centers across the country over the past decade. Participating centers took part in learning networks and received technical assistance from a network of experts managed by HRSA and others, including the Institute for Healthcare Improvement. The initiative showed improvements in clinical processes of care and outcomes for underserved populations, with many centers experiencing dramatic improvements for patients with heart disease, diabetes, asthma, HIV/AIDS, and other conditions.[32]

Small Physician Practices

NCQA Technical Assistance Project: Caring for Diverse Populations was launched in 2006 and provided demonstration grants to 20 small physician practices in California and New Jersey to initiate new efforts to reduce health care disparities. Through this collaborative learning project, the practices implemented a QI project to improve care for their patients, most of whom represented traditionally underserved, minority communities. The results highlighted the infrastructure, trainings, resources, and leadership needed to enhance the ability of small physician practices to successfully undertake equity focused QI.[42] This project paralleled similar work to build the capacity of small practices to improve the quality and equality of care for their patients.[42, 43]

Hospitals and Affiliated Clinics

Robert Wood Johnson Foundation's (RWJF) **Expecting Success** program was designed to improve the care of patients with heart disease in hospital and ambulatory settings. Ten hospitals were selected through a competitive application process to participate in a 32-month learning collaborative to improve care for patients with acute myocardial infarction[36] and heart failure.[36, 44, 45] Hospitals were chosen in part because of their large African-American and/or Latino populations, willingness to track and share data on nationally recognized quality measures for AMI and heart failure, and two composite quality measures, stratified by patient race, ethnicity and language. Participants were trained in uniform collection of REAL data. The results of the collaborative were extremely encouraging with seven of 10 hospitals demonstrating significant improvement on composite quality measures, which require a higher standard of improvement across multiple quality domains. Four of the 10 hospitals were able to eliminate documented racial or ethnic cardiac care disparities. Overall, care for African-

Americans and Latinos improved, with care for all patients improving at rates exceeding those observed nationally for all hospitals.

Private Health Plans

As mentioned earlier in this document, eleven national health plans, in partnership with the Agency for Healthcare Research and Quality (AHRQ) and Robert Wood Johnson Foundation (RWJF) formed the **National Health Plan Collaborative** to identify ways to improve the quality of care for racially and ethnically diverse populations. During the collaborative, health plans made great strides collecting and using race, ethnicity, and language data and implemented systems to sustain these processes. The plans also tested interventions at provider, member, and community levels and developed and implemented recommendations for improving language services. While clinical outcomes were not reported in this collaborative, participating health plans began to institutionalize disparities reduction activities, which have since continued under the direction of America's Health Insurance Plans.[46, 47]

Public Health Plans

RWJF and the Commonwealth Fund supported the Center for Health Care Strategies (CHCS) to lead the program, **Improving Health Care Quality for Racially and Ethnically Diverse Populations.** CHCS worked with 11 Medicaid health plans and one state case management program to develop strategies for identifying and addressing disparities. The teams worked together to develop methods to identify members of racial and ethnic subgroups, to measure gaps in their care, and to test interventions to reduce disparities and improve overall quality of care. All teams focused on one of three targeted clinical areas: birth outcomes and immunizations, asthma care, or diabetes care. The program demonstrated improved quality of care and reduction of disparities for all three clinical areas. This effort also provided valuable information about the challenges and opportunities Medicaid plans face in their efforts to reduce disparities, particularly around the collection and use of data, tailoring care, and engagement with key stakeholders.[48]

RWJF also supported CHCS's effort with the **Practice Site Exploratory Project** (PSEP) to examine the quality of care that Medicaid managed care beneficiaries receive in different-sized practices in Arkansas; Michigan; Erie County, and Bronx, New York; and Southwest Pennsylvania. One goal was to explore whether practice size was related to variations in quality of care. The study confirmed pervasive disparities in these populations and found that high access to care and quality of care did not necessarily go hand-in-hand. This effort underscored that the Medicaid program, with its long history of collecting REAL data, is an excellent launching point for efforts to improve equity.[49]

These findings informed the CHCS's **Reducing Disparities at the Practice Site** initiative, funded by RWJF in 2008, to support quality improvement in small practices serving a high volume of racially and ethnically diverse patients. The three-year project helped Medicaid agencies and health plans in Michigan, North Carolina, Oklahoma and Pennsylvania to build the quality infrastructure and care management capacity of these "high-opportunity" primary care practices.[50] The evaluation for this effort is currently underway, but early information underscores the challenge of creating a "business case" to focus organizational attention and effort to improving care for minority populations.

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Multi-stakeholder efforts

In 2005, RWJF launched **Finding Answers: Disparities Research for Change**, a national initiative focused on discovering and evaluating innovative interventions to reduce racial and ethnic disparities in health care.[51] This program focuses on reducing disparities in the quality of care for cardiovascular disease, diabetes, and depression. Finding Answers has funded evaluations in 33 health care organizations across the country. These projects evaluate a variety of intervention strategies in different settings to find out what works— and what does not—to improve care. The settings include rural and urban primary care practices, health services companies (e.g., payers), safety-net clinics, federally qualified health centers, community health centers, hospital-based clinics, academic medical centers and Veterans Administration medical centers. Finding Answers also conducts systematic reviews of the scientific literature. The goal is to disseminate information so that health care organizations have a place to start, options to consider and directions about how and where to deploy interventions to improve equity in care.

In 2008, The California Endowment funded the Center for the Health Professions at University of California, San Francisco to launch the **ACTION** program, a four year initiative to build the capacity of health care organizations in California to improve equity using the Model for Improvement, the framework used by the Institute for Healthcare Improvement to guide improvement work.[52] Twenty health care organizations, identified through a competitive process, received funding to catalyze improvement work in a clinical area of their choosing (e.g., diabetes, childhood obesity, preventive care, prenatal care). The program also provided comprehensive technical assistance to help organizations identify quality metrics, refine small tests of change, and interpret data. The program developed resources to enhance access to knowledge and practical tools in health equity that can be viewed at www.advancinghealthequity.org.

The majority of funded organizations were community clinics, with the rest consisting of county Medicaid plans, hospital-based clinics, and one staff model medical group. The improvement results in these real world settings were mixed. Overall, ACTION demonstrated that quality of care can improve for all populations when QI efforts focus on improving equity. The majority of organizations had significant improvement in overall quality, but little or no change in disparities. A few organizations improved both the quality and equity of care. This effort provided valuable insight in how to tailor QI methods to address equity and identified skills needs to measure and look at gaps in care. This program also underscored the ongoing need to help organizations improve methods for obtaining accurate REAL data. (See part two of this guide for more information.)

Taken together, these initiatives demonstrate that health care equity is relevant across every sector of the U.S. health care system. They have also contributed to the development of knowledge and tools that can be used by organizations seeking to improve care for the diverse populations they serve. These initiatives also underscore the critical role of technical assistance to ensure that organizations can successfully undertake improvement processes, data collection and develop interventions tailored to meet the needs of the populations being served. Finally, they point to key policy and practice changes at the national, state, health system, provider, and patient level that have the potential to significantly enhance efforts to deliver equitable care.

ONGOING ADVANCES TO ACHIEVE HEALTH EQUITY

At the national level, there have been dramatic changes in health care policy and practice in the past few years that have the potential to advance efforts to improve health care equity. These efforts focus on changing access, delivery systems, and payment. Vigilance and effort will be needed to assure their promise for improving equity in health care is achieved.

The Health Information Technology for Economic and Clinical Health (HITECH) Act

Health information technology can improve the quality of care by making more accurate and timely information available to health care providers, patients, families and caregivers.[53] The increased accessibility of information can lead to better coordinated care, enhanced communication, and systematic monitoring of quality outcomes at a population health level.[54]

As part of the 2009 American Recovery and Reinvestment Act (ARRA), billions of stimulus dollars were invested to support the rapid adoption and use of health information technology. Included in the ARRA are funds for the Health Information Technology for Economic and Clinical Health (HITECH) Act, which include incentive payments for demonstrating "meaningful use of certified electronic health records (EHRs)".[55] The guidelines for "meaningful use" payment incentives include requirements to collect and use REAL data to monitor and improve the quality of health care. While the requirements do not explicitly require any disparities reduction activities, the availability of stratified data will greatly facilitate the identification of disparities, the essential first step towards health equity.[56, 57]

National Health Care Reform

The landmark Patient Protection and Affordable Care Act (ACA) will fundamentally change health care in the U.S. The legislation expands health insurance coverage, primarily through expansions of Medicaid, insurance reforms, the establishment of state health insurance exchanges, and the availability of subsidies to enable low-income individuals to purchase private health insurance. With the June 2012 decision of the U.S. Supreme Court upholding the constitutionality of both the minimum coverage requirement, or individual mandate, as well as the expansion of Medicaid (to be optional for states, without jeopardizing loss of existing Medicaid funding to states which decline to implement the expansion), full implementation of the ACA now moves forward.[58] These expansions are particularly important for health equity since racial, ethnic, and linguistic minorities are disproportionately represented among the nation's uninsured and are estimated to comprise up to half of the newly insured in some states.[59]

There are other significant components of the legislation that support quality improvement and payment reform and provide opportunities to advance equity. For example, the U.S. Department of Health and Human Services (HHS) issued the first ever National Strategy for Quality Improvement in Health Care with three goals: 1) improving overall quality, by making health care more patient-centered, reliable, accessible, and safe, 2) improving the health of the U.S. population by supporting interventions to address behavioral, social, and environmental determinants of health, and 3) reducing the cost of quality health care for individuals, families, employers, and government.[60]

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While there are some clear directions established in the National Strategy for Quality Improvement in Health Care, much of what will be achieved through health care delivery system redesign is yet to be shaped. Congress created the Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services to invest in health system redesign, quality improvement, and payment reform.[2] An independent Patient-Centered Outcomes Research Institute (PCORI) was established to conduct comparative effectiveness research with a strong focus on incorporating input from patients, community representatives, researchers, providers, insurers and other stakeholders. PCORI's priorities and research agenda explicitly include disparities reduction.[61]

Even with the opportunities for better care that these activities promise, it is important to make certain that QI does not result in the unintended consequence of worsening disparate care.[37] Therefore, QI projects should have a specific and explicit focus on disparities reduction. HHS has issued an Action Plan to Reduce Racial and Ethnic Health Disparities, which explicitly addresses the need to focus on disparities reduction as part of health care quality improvement activities.[62] This plan underscores the need to assess and monitor policies and activities so that overall change, even in the spirit of advancing overall health care, does not result in diminished quality for individuals who already bear a disproportionate burden when it comes to health disparities.

Medical Homes

A key concept being integrated into health care delivery system redesign efforts is the patient-centered medical home.[63] While the essential principles of the patient-centered medical home are improved coordination of care by a primary care provider, there is also a potential for advancing health equity by focusing on the needs of underserved patients.[64, 65]

Two notable examples in the development and spread of the medical home model that are particularly relevant to improvements in health equity are:

1. The Safety Net Medical Home Initiative: The Commonwealth Fund and other partners are supporting the five-year initiative to help 65 primary care safety net sites become high-performing medical homes. These sites provide services to many underserved patients, including low-income individuals, racial and ethnic minorities, individuals with limited English proficiency, and individuals with lower health literacy.[66] The initiative has produced guides, assessments, training and technical assistance materials.

2. Advanced Primary Care Practice Demonstration: CMS and HRSA are supporting 500 federally qualified health centers (FQHCs) to implement patient-centered medical homes.[67] The initiative will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for Medicare patients. The centers will receive technical assistance and waivers of application fees to become recognized as patient-centered medical homes by NCQA. These FQHCs serve many racial and ethnic minorities and other underserved patients.

While the medical home model holds enormous potential for patient care in general and for more equitable and higher quality care for racial, ethnic and linguistic minorities,[65,68] it remains an open question whether it will deliver on its many promises. Preliminary

evaluations show promising results and this is an exciting development in the evolution of strategies to provide high quality care to all individuals.[69-70] Appendix B lists ways in which health equity can be advanced through the implementation of the medical home model of care delivery.

Accountable Care Organizations

The concept of "accountable care organizations" (ACOs) that are responsible for improving quality and reducing costs has also received significant attention.[71-76] ACOs require shared responsibility between hospitals and physicians in a geographic service area for a defined population of patients. With shared "accountability", providers use patient safety, disease management, and population health improvement techniques to avoid readmissions, hospitalizations, and emergency department use to bring down overall costs. The savings from those reduced costs would then be "shared" among the hospitals and physicians.

There is some concern that ACOs will not address the needs of underserved populations, many of whom have the most acute and chronic health conditions, as well as the most inconsistent access to regular health care. In focusing on improving overall quality and reducing costs, ACOs may have the unintended consequence of perpetuating, or worse, increasing disparities.[3] It is far too early to estimate ACOs' impact on equity or even the extent to which groups who are at high-risk for disparate care will be included in local ACOs.

As the descriptions above demonstrate, ACA offers promise and opportunity for improving health care equity. However, demonstrated progress in collecting REAL data and improving care and reducing disparities is not guaranteed and could easily be relegated to a lower order of priority unless there is a compelling business case and or concerted effort and vigilance to assure that the promise these opportunities offer are actually realized.

RECOMMENDATIONS FOR FUTURE RESEARCH

Over the past decade, contributions to the field of disparities and practice improvement research have helped create an evidence base for how to advance equity. Nevertheless, too little is known about what interventions actually work to improve care for diverse populations. A recent discussion in Health Affairs suggests several challenges to advancing research in the field. Among them is the fact that too few improvement initiatives include a disparities focus and lack important fundamentals such as meaningful performance measurement that provides data necessary to make informed judgments about how care is differentially delivered or received by different populations.[37]

Other barriers include assuring proper incentives, addressing factors that concern patients and providers, and focusing equity efforts in sites that serve critical numbers of minority populations. This last point is particularly important because evidence suggests one reason for disparities may be that minority patients are more likely to receive care from lower quality providers who are already stressed by the challenges of caring for patients with complex needs who bring fewer resources into the health care organization.[77] With greater expectations on such organizations to monitor and improve quality, better research is needed on how to engage in meaningful QI in a way that is cost-effective and has the greatest likelihood of success for a given population or setting.

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Evaluations of equity focused improvement indicate that there may be benefits associated with a team-based care and use of lay health workers and patient navigators.[78] Yet many promising interventions do not produce results that meet rigorous evaluation standards. In addition to identifying better ways of measuring promising interventions, there is a need to more effectively disseminate the lessons and strategies of what has worked and how these promising improvements can best be implemented and studied in busy health care settings. Promising strategies for this include the use of comparative research, as articulated by PCORI.[61] PCORI will incorporate vigorous patient and stakeholder engagement to inform and guide the research it supports; emphasis will be placed on developing new research methods for better understanding of what works and what does not for individual patients.

The National Institutes of Health, AHRQ, and many other research enterprises recognize the need to develop better ways to transform scientific knowledge about high quality health care into routine clinical and community practice. This approach is embodied in the field of dissemination and implementation research which seeks to build a knowledge base to "get the best return on decades of investment" in biomedical and behavioral research. In the context of health equity, the notion of "translating" science into meaningful protocols and practices takes on added meaning when the populations of interest speak languages other than English or have cultural preferences that are not well integrated into standard health care practice.

Although it is too early to speculate on the impact of health reform efforts, it is safe to say that the traditional models of QI or research being conducted without input from the individuals or groups most affected, and without sufficient data to measure disparate impacts, should be considered obsolete. Better research is needed on what interventions work, and under what circumstances, for specific populations.

SUMMARY AND RECOMMENDATIONS

The lessons of previous QI work to improve equity can help guide the many activities that are likely to spread as the federal government, states, industry, health professionals, communities and patients increasingly expect higher quality care for all. We offer the following recommendations for future efforts in this critically important area.

1. Health care disparities remain a far too common marker of poor health system performance and warrant targeted attention. Given that disparities could continue to increase in significance as the U.S. population becomes more diverse, this issue warrants targeted attention.

2. High quality REAL data is critical for demonstrating equity in care. It will take resources to assure that they are widely or reliably available. It will take concerted effort to help organizational leaders understand the benefits the data can yield in improving patient care, and cost and risks of not having them. Resources are available to help organizations uniformly and accurately collect REAL data. Research demonstrates that health plans, hospitals, clinics, and physicians' offices can efficiently collect these data.

3. Quality improvement may not benefit all populations equally. Careful measurement is vital to improving equity. Focused analysis of data can help uncover disparities between and within populations. These data should be monitored as improvements

are made to confirm that the changes resulting in the intended goal of diminishing gaps in the quality of care.

4. Interventions to improve overall equality of care need to be tailored to overcome barriers and meet the needs of populations, especially those that have historically experienced disparities. The information learned from these efforts—what works and what does not work—needs to be widely disseminated.

5. Organizations may have limited capacity to make all the changes needed to deliver equitable care, but all have the ability to start small, define a population, identify goals for improvement, and to track performance.

6. Opportunities exist to advance equity through common goals across current policy initiatives such as efforts to achieve meaningful use, accountable care, and patient-centered care. Effort and vigilance is needed to assure their promise is achieved.

7. Consumer engagement in quality improvement and disparities reduction is an understudied area but one that has the potential to yield substantial benefits. Identifying, training, and engaging patients and consumers – including those from diverse and disparate populations - as advisors in quality improvement and research activities should be considered an integral component of an effective strategy.

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APPENDIX A: MARCH 2011 ROUNDTABLE CONVENING

Over the past few years, the Center for the Health Professions has been focusing on the intersection between quality improvement and disparities reduction. This work was primarily manifested in the ACTION program. The program, funded by The California Endowment, used several strategies (grant funding and technical assistance, training, and new online resource, www.advancinghealthequity.org) to achieve its goals.

With the dramatic changes occurring in the health care environment, a group of experts was convened to define the issues, opportunities, and efforts that would help move health care organizations toward the delivery of equitable, patient-centered care. The hope was that the meeting would both contribute to planning for future work at the Center for the Health Professions, as well as stimulate ideas about potential projects and collaborations among the group and in the field broadly.

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APPENDIX B: OPPORTUNITIES TO HIGHLIGHT AND ADVANCE HEALTH EQUITY THROUGH THE IMPLEMENTATION OF MEDICAL HOMES

- Providing patients an explanation of the medical home that addresses literacy, language access, and cultural barriers

- Engaging the patient's family and caregivers in the medical home in a way that addresses literacy, language access, and cultural barriers

- Recruiting and retaining diverse, culturally and linguistically appropriate members of the medical home team (that reflect patient demographics)

- Collecting and using granular data on patient ethnicity and language assistance needs and collecting and using data on other demographic characteristics such as literacy, income, disability, sexual orientation, gender identity, etc.

- Ensuring that language assistance needs are communicated and considered in electronic prescribing, all referrals to labs/imaging/tests, all referrals to hospitals, in all electronic summary of care and care coordination documents that are exchanged with other providers and made available to the patient

- Expanding access through language assistance services and through multiple communications formats (internet website, mobile/smartphone access, phone, email, text, mail, etc.) to make appointments, refill prescriptions, etc.

- Using language assistance services and multiple communications formats to communicate reminders and health information to patients, and their families and caregivers

- Providing tailored/customized patient education materials with translations, large print, etc. and through multiple communications formats.

- Ensuring language assistance needs are addressed in electronic prescription medication instructions/labels and medication counseling; language assistance needs also are addressed during any medication reconciliation

- Sharing information such as electronic office visit summaries, electronic medication lists, and other electronic health information with translations, large print, etc. and through multiple communications formats (internet website, mobile/smartphone access, phone, email, text, mail, etc.)

- Receiving timely information from patients from personal health records and from home monitoring and self-monitoring devices

- Having a patient-facing portal that provides access to health information with language assistance services and through multiple channels (internet website, mobile/smartphone access, etc.)

- Using electronic health record clinical decision support tools that include epidemiological and clinical information specific/relevant to local health care disparities, i.e. screenings for Hepatitis B

- Integrating access to mental and behavioral health services with medical care

- Supporting shared decision making with the patient and family by providing tools that address literacy, language access, and cultural barriers

- Strengthening linkages to community health, social, and other services such as health education, child care, school-centered health, home health, adult day health, rehabilitation, and long term care and ensuring that such services are culturally and linguistically appropriate, and address disparities

- Supporting linkages to prevention, community health, and public health resources that helps address the social determinants of health through referrals, tracking, and follow-up, and ensuring such services are culturally and linguistically appropriate and address disparities

- Measuring patient engagement and patient-centeredness including measures that specifically address literacy, language access, and cultural barriers

- Reporting and acting on quality data by stratifying all quality by patient race, ethnicity, language, and other demographic data; identifying and specifically addressing disparities in any quality improvement plans and objectives

- Working with state health insurance exchanges and state health information exchanges to maximize connectivity and seamlessness between enrollment into health care coverage, enrollment into a medical home, and coordination across the entire continuum of care

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