Goal: To help the health care field take action by developing and disseminating models for identifying and addressing racial and ethnic disparities in health care.

Demonstrable outcome:

*Standardized collection of race/ethnicity and aligned data measurement, analysis, and reporting with Massachusetts General Hospital's quality improvement goals.

*Ongoing programs have improved colorectal cancer screenings among Latinos and helped Latinos better manage their diabetes.

*Easy-to-use, publicly available resources help other health organizations tackle disparities.

Contact: Joseph Betancourt, MD, MPH
            Director
            Disparities Solution Center
            jbentancourt@partners.org

Organization: The Disparities Solutions Center at Massachusetts General Hospital

Location: Boston, MA

Summary:
Through new research, education and leadership training, and customized policy and practice solutions, the Disparities Solutions Center strives to eliminate racial and ethnic disparities in health care locally and nationally.

Created in 2005, the Center is an outgrowth of Massachusetts General Hospital's (MGH) own efforts to address disparities and the city of Boston's citywide efforts to comprehensively eliminate disparities in health and health care.

The Center brings together health policy experts, health service researchers and physicians. It is housed within MGH's Institute for Health Policy, which is affiliated with Harvard Medical School's Department of Medicine and Health Care Policy and the MGH Division of General Medicine.

Q&A:

1. **How did the organization's leadership know there were disparities in care, i.e., clinical data outcomes, HCAHPS survey, some other mechanism?**

   After the Institute of Medicine's *Unequal Treatment*, which documented health disparities nationally, MGH created a committee to focus internal attention on ways to improve collection of race / ethnicity data and implement quality improvement programs that would reduce disparities. The desire was to make progress immediately, assuming disparities existed until data proved otherwise. The organization simultaneously built an effective data measurement process while, at the same time, developed interventions to address disparities outlined by the IOM and the city of Boston.

2. **How did the MGH identify and measure disparities?**

   Recognizing that standardized collection of race and ethnicity data is key to identifying and addressing disparities, MGH revisited how it collected race data. Partners Healthcare System and MGH developed a revised format for collection, which allows for broader race and ethnicity categories including input of race or ethnicity not covered by existing categories.

   Traditionally, there are concerns about the legal restrictions of collecting race/ethnicity data, patient comfort about being asked, uncertainty about which categories to use, and costs of tweaking existing collection methods. To alleviate some of these concerns, all staff receives training as to why the data is collected and how it will be used and different patient scenarios that may come up.

   To consistently analyze and monitor for disparities, the leaders of MGH's Center for Quality and Safety and the Disparities Solutions Center created a Disparities Dashboard. Key to the dashboard's development was a new medical policy that all quality improvement data collection and initiatives be stratified by race and ethnicity. In 2008, the a component of the dashboard became publicly available in an electronic, web-based format.

   The Disparities Dashboard includes the following components:
   - Welcome: describes what a disparity is, how data is collected, the purpose of the dashboard (with strengths, limitations, methods for interpretation) and process for distribution;

- Snapshot of patient diversity at MGH: Provides data from the past year on race/ethnicity breakdown of inpatients and outpatients (compared to the city of Boston and the state of MA), race/ethnicity breakdown of patients in health centers versus hospital, and race ethnicity breakdown of patients by clinical service;

  Quality measures: stratified race/ethnicity breakdown for:

  - National hospital core measures
  - HEDIS preventive services and diabetes measures
  - Patient satisfaction
  - Quality and safety rounds
  - Number of interpreter visits

- Summary
- Action

3. How did the organization plan interventions and implement programs?

The Center worked with MGH and community health centers to develop two programs that improve quality and reduce disparities. Both are based on existing models that use "navigators" and "coaches". One addresses colorectal cancer screening among Latinos; the other addresses diabetes management, originally among Latinos at one health center, but the program has now expanded to include the local Cambodian population at another health center.

COLORECTAL CANCER SCREENINGS
Studies showed that fewer Latinos were being screened for colon cancer and after researching why, the reasons were: problems scheduling; financial and transportation impediments; fear and misperceptions based on others' experiences; lack of knowledge and provider recommendations; and lack of motivation/personal desire. The solution was connecting patients with bilingual, culturally competent patient navigators to help them overcome these barriers.

Navigators identify patients who are overdue for screenings and provide:

- one-on-one education
- counseling
- scheduling help
- transportation if needed
- follow-up

Over a nine-month period, there was a marked increase in Latino patients being screened. The program is still successfully used. To date, 470 patients have been screened through this program.

DIABETES MANAGEMENT
Nearly twice as many Spanish-speaking Latinos demonstrated poor diabetes control compared to English-speaking whites. The Center developed a culturally competent, individualized management program that includes:

- telephone outreach using an electronic diabetes registry
- group education sessions offered in both Spanish and English
- a bilingual, culturally competent diabetes coach who works closely with patients to help them identify and deal with barriers to care

To date, patients using the coach have significantly improved their glycemic control. 373 patients have enrolled in the personalized coaching session and an additional 107 have participated in the group education sessions.

4. What was the time frame, from conception to full implementation?

Both programs took about a year with time built in that allowed understanding of various challenges unique to populations (one Spanish and one Cambodian). While everything is based on a model, alterations must be made so the program effectively addresses the desired population.

5. What were the results?

Improved colon cancer screening rates among Latinos and improved glycemic control as well as more self-involvement in managing their diabetes for both Latino and Cambodian patients living with diabetes.

Preliminary analyses show a decrease in mean HbA1c values by 1.4 points for Latinos and White patients in the program with baseline HbA1c > 8.0. The percentage of diabetic patients (Latino and White) with HbA1c tests within the past 9 months also increased from 69% and 74% respectively to above 80% for all patients. Further, new results show the gap in disparities between Whites and Latinos closing at MGH Chelsea with a decrease in the percentage of Latino patients with uncontrolled diabetes from 2005 - 2007 (37% vs. 29%) and for White patients (24% vs 20%).

6. What challenges or obstacles were overcome?

When working on challenging collaborative projects, it is important that all partners share funding and credit. Transparency can play a big role in this. Everyone should feel equally informed, involved and responsible for addressing disparities among a particular population.

7. What is the cost of the programs and how are they funded (grant, etc.)?

The Center received $3 million in seed money from MGH and PartnersHealth to establish an operational entity that could pursue funding for programs. External funding, secured through private philanthropy, is what keeps the programs running.

8. How are programs aligned with quality improvement efforts?

From the beginning, addressing disparities has been directly tied to quality improvement. From leadership commitment to data collection, one cannot be achieved without the other.

9. What advice would you give other organizations wanting to improve care in similar ways?

Models exist that can be easily replicated. Tailor the idea and approach to address the root causes of disparities and allow time to change the model so the focus population is truly helped.

Quality measurement is the foundation of any work. Collecting data is very helpful in effectively understanding and addressing disparities, but don't wait to have organizationally specific data. National data can provide enough detail to begin addressing disparities. Assume disparities exist until you have the data to prove otherwise.