



PRIMER/BRIEF

Using Data to Reduce Disparities and Improve Quality: A Guide for Health Care Organizations

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Unless specifically measured, racial and ethnic disparities in health care can go unnoticed by health care organizations, even as these organizations seek to improve care.¹ Stratifying quality data by patient race, ethnicity, and language is an important tool for uncovering and responding to health care disparities. Using race, ethnicity, and language data strategically allows health care organizations to:

- 1) Discover and prioritize differences in care, outcomes, and/or experience across patient groups;
- 2) Plan equity-focused quality improvement efforts and measure their impact; and
- 3) Tell (and revise) the story of how patients are experiencing health care.

This brief recommends strategies that health care organizations can use to effectively organize and interpret race, ethnicity, and language data to improve equity for their patients. It is intended for health care organizations that already have quality data stratified by race, ethnicity, and language. This document does not discuss collecting or stratifying data, as there are other resources available elsewhere. Organizations who are engaged in quality improvement efforts can use data-driven strategies to identify and reduce disparities in their care delivery.

I. Using Data to Discover and Prioritize Disparities in Care

To reduce disparities in care across patient groups, health care organizations must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their patient population. Examining disparities allows organizations to understand differences in how patients experience care and improve care processes to ensure appropriate care for all patients. Organizations may have pre-existing ideas of how conditions vary in specific patient populations based on observations and anecdotal evidence. However, providers often underestimate the magnitude of disparities in their own

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. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

About the Authors

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS is a technical assistance provider for the Robert Wood Johnson Foundation's *Aligning Forces for Quality* regional collaborative.

Finding Answers: Disparities Research for Change is a national program of the Robert Wood Johnson Foundation with direction and technical assistance provided by the University of Chicago. Since 2005, *Finding Answers* has funded research on innovative interventions to reduce racial and ethnic disparities in health care, performed systematic reviews of disparities research, and provided technical assistance to organizations implementing disparities interventions, including *Aligning Forces for Quality* regional collaboratives.

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patient panel, and staff may not notice barriers patients face during the course of usual care. Disparities also may exist in different groups or conditions than expected. Closely examining performance data stratified by race, ethnicity, or language is the most reliable way to reveal the type and magnitude of a disparity and thus either verify “hunches” or re-direct the organization’s focus.

For example, one practice participating in the [Aligning Forces for Quality \(AF4Q\) Equity Improvement Initiative](#) knew anecdotally that they had a very diverse African American patient population. They were also aware that some of these patients from immigrant communities might need some additional support in navigating care due to their refugee status and low English literacy. However, without a systematic understanding of need, it was difficult to decide where and how to provide additional support. The practice used its R/E/L-stratified quality data to identify subgroups based on language and identified a disparity in diabetes outcomes for their Somali immigrant patients. They created an intervention targeted to these patients, and they plan to revisit their R/E/L-stratified data to monitor progress.

Recommended Variables for Race, Ethnicity, and Language (R/E/L) Data ⁱⁱ		
The Institute of Medicine recommends that organizations collect the following race, ethnicity, and language variables:		
Race	Ethnicity	Language
<ul style="list-style-type: none"> • Black or African American • White • Asian • American Indian or Alaska Native • Native Hawaiian or Other Pacific Islander • Some other race 	<ul style="list-style-type: none"> • Hispanic or Latino • Not Hispanic or Latino • Granular Ethnicity <ul style="list-style-type: none"> ○ Locally relevant choices from a standard list of approximately 540 categories ○ “Other, please specify: _____” response option 	<ul style="list-style-type: none"> • Spoken English Proficiency: Very well/well/not well/not at all • Spoken language preferred for health care <ul style="list-style-type: none"> ○ Locally relevant choices from a national standard list of approximately 600 categories ○ “Other, please specify: _____” response option ○ Including sign language in spoken language need list and Braille when written language is elicited
<p>For information on data collection, view these resources:</p> <ul style="list-style-type: none"> • Standardizing the Collection of Race, Ethnicity, and Language Data • REL Data Training 		

Health care organizations should stratify quality measures that reflect their organizational priorities and that would be most sensitive to disparities. These can include measures of access and care delivery (e.g., missed appointments or immunization rates), clinical outcomes, satisfaction, cost, or others. Because managing data can be time and resource intensive, organizations can reduce this burden by choosing measures that overlap with quality improvement work they are already pursuing (e.g., patient-centered medical home certification) or required reporting (e.g., Meaningful Use or health plan reporting). Preferably, data also should be easy to collect or readily available through sources such as registries, electronic health records, medical charts, and health plan/payor data files. Organizations may also want to prioritize domains of care expected to differ the most across racial/ethnic groups. The National Quality Forum offers some principles for identifying these “disparities-sensitive” measures:^{iii,iv}

- **Prevalence:** How prevalent is the disease or condition (targeted by the quality measure) in the disparate population?
- **Impact of the condition:** What is the impact of the condition on the health of the disparate population relative to other conditions (e.g., mortality, quality of life, years of life lost, disability, stigma)?

- **Impact of the quality process:** How strong is the evidence linking improvement in the chosen measure and improvement in outcomes? (See also Appendix A for a table of NQF measures that have been matched to documented disparities.
- **Quality gap:** How large is the gap in quality between the disparate population and the group with the highest quality for that measure?
- **Communication:** Does the process for achieving the outcome depend heavily on patient communication/outreach?

Choosing Strategic Comparisons to Identify Disparities

Correctly identifying disparities requires a two-step process: first, identifying how a chosen quality measure is distributed within each racial/ethnic group (rather than how the measure is distributed across the whole population); and second, comparing the distribution in one group against the distribution in another. (See Appendix B for a step-by-step visual discussion of data comparisons, including how to choose appropriate denominators.) Looking at the distribution within each group answers the question: “What is happening within each racial/ethnic group?” Comparing across groups answers the question: “How is quality within one racial/ethnic group different from quality in another racial/ethnic group?”

Practices should use the group that is doing the best as a point of comparison, since the highest-performing group indicates what is currently possible in that health care organization. Often, the majority population shows the best overall outcomes, which is why practices tend to choose the majority population as a benchmark. Other options for comparison include two minority racial/ethnic groups or the all-patient average. The end goal is to bring all patients up to the same level of good care by identifying meaningful differences.

Meaningful differences are often identified through statistical analysis, but organizations do not need to do rigorous statistical analyses to identify meaningful differences. Instead, organizations can identify measurable differences by benchmarking current data against historical data from within their own organization or against comparison data from other organizations.

- **Historical data:** For example, what was it like a year ago for the same group of patients? Historical data are relatively easy to collect within an organization, though they may be less appropriate for conditions likely to improve over time regardless of intervention.
- **National or local data:** For example, regional quality reports, community needs assessments, and quality data from parent organizations or health plans. External data show the priorities and performance of other peer health care organizations. They also can indicate whether the quality for an organization’s highest-performing patients is on par with the quality that generally occurs outside of that organization.

In addition to using appropriate benchmarks to find meaningful differences, organizations may need to examine multiple measures. Using multiple measures allows organizations to identify disparities and their causes in a way that may not be apparent in a single measure. For example, an outcome measure may show that an increasing number of patients with diabetes are being seen in the emergency room for diabetes-related complications. A process of care measure could reveal that few patients with diabetes are being checked for their blood glucose levels. Using these two measures together would give an organization more information about *why* disparities are occurring than if the organization examined only the single outcome measure.

Recommendation

When possible, stratify measures by demographic data *other than* race, ethnicity, or language to further uncover disparities. Consider insurance status, zip code, income, age, health literacy, gender, sexual orientation, and other determinants of health for identifying disparities.

Additionally, trends in quality among groups can vary across different measures. An organization’s African American population could be receiving higher rates of diabetes care but lag behind other populations for rates of cancer screening. Or within the same condition, an organization’s Asian population may be screened more often but still experience poorer clinical outcomes than other patient groups. Organizations may need to examine an issue from several angles to identify the root causes of disparities and areas for improvement.

Using Data to Identify Causes of Disparities and Intervention Opportunities

After using stratified data to identify disparities in care or outcomes, organizations should then determine the causes of the identified disparities and design appropriate interventions and processes in response. While quantitative data are vital to identifying and eliminating disparities, they do not tell the full story. Focus groups, surveys, and interviews can help organizations collect qualitative insight from patients and staff. Qualitative data lend a personal voice to the trends in quantitative data and help pinpoint causes of disparities that may not be apparent in quantitative data alone.

Patients have important insight into why disparities exist and therefore what might be the best way to address them. For example, stratified data may show low rates of HbA1C screening among Hispanic patients but say little about how to respond. Patient input could illuminate transportation difficulties, a need for additional patient education, or other barriers that the organization can help address. One practice in the AF4Q Equity Improvement Initiative learned that their diabetic patients felt they needed more emotional coping support rather than simply additional education on their diabetes.

Staff members have practical experience in how care is delivered. For example, staff could report trouble using an automated call system to make Spanish-language appointment reminders as another reason for low screening rates among Hispanic patients. Such insight from either patients or staff is not “quantifiable” but is necessary for organizations to address disparities.

Qualitative data are especially useful for organizations where minority populations are small or for organizations with substantial diversity across several racial, ethnic, or language groups resulting in small sample sizes for a given measure. These organizations may find it more difficult to identify quantitative trends but can use qualitative data to respond meaningfully to all populations.

Organizations also can look to qualitative data sources outside the organization to find further contextual clues about the causes of disparities. For example, community data can reveal local disease prevalence, common patient behaviors in the community (e.g., substance use, smoking), and environmental risk factors in geographic locations where there is a high concentration of minority groups (e.g., food deserts, availability of safe walking spaces).

Sources of Community Data	Primary Value
Regional newspapers, neighborhood newsletters, public bulletin boards (in libraries, community centers) and culturally-specific news media	Identify local priorities and current events among minority communities
Digital storytelling archives or photovoice projects (often run by community-based organizations or public health campaigns)	Hear first-hand accounts of community needs (potential causes of disparities), particularly among more vulnerable populations
Meetings with local business leaders, cultural or religious figures, social services directors, school superintendents, consumer advocacy groups, and neighborhood coalition members	Promote equity efforts among diverse stakeholders, gain buy-in for future interventions, and access resources such as additional data or other kinds of data
Community needs assessments and health improvement plans, developed by local authorities for public health accreditation or regional planning efforts	Identify community priority issues that could affect your clinical data (e.g., the prevalence of disease, environmental hazards, and behavioral risk factors like smoking rates) Collaborate with public health entities that can help support and spread effective interventions
<p><i>For information on designing interventions to reduce disparities, view these Finding Answers resources:</i></p> <ul style="list-style-type: none"> • Diagnosing the Disparity • Designing the Activity 	

Thus, using both qualitative and quantitative data helps organizations choose interventions or process improvements that will make the best use of their resources to meaningfully impact disparities in care.

II. Planning Quality Improvement Efforts and Measuring Their Impact

As organizations are choosing a course for reducing disparities, they should establish a cohesive evaluation plan so that using data is an integral part of implementation rather than an afterthought. Such an approach ensures that organizations have the data they need to support claims about the intervention's impact and track implementation progress and challenges. As an organization develops its strategic plan, there are two key steps that it should begin early:

- 1) Define goals for improvement and identify appropriate measures; and
- 2) Develop a process for reviewing data over the course of the intervention.

Defining Goals for Improvement and Tracking Appropriate Measures

As with any other quality improvement effort, organizations should define the degree of change they hope to see over time and define measures to track that improvement. Organizations should start with the measures they used to identify disparities in the first place but also should choose other measures that will reflect the intervention's impact and the care patients are receiving. Three types of measures are useful for successfully evaluating data: process, outcome, and intervention tracking measures. Process and outcome measures show an impact on patients (positive or negative) and are usually the measures organizations stratify to find disparities in the first place.

- **Process measures** refer to what is done to a patient. Ideally, organizations will use evidence-based process measures that have been demonstrated to improve patient outcomes (e.g., administering a flu shot, using an angiotensin-converting enzyme inhibitor medication for a patient with systolic heart failure, or eye screening for patients with diabetes). Process measures tend to improve faster than outcome measures since they focus on one part of care rather than on the constellation of factors that influence clinical indicators.
- **Outcome measures** refer to the actual results for the patient. These include clinical indicators such as blood pressure control in a patient with hypertension or hemoglobin A1C as a marker of glucose control in a patient with diabetes. Other outcome measures include results like the number of emergency department visits or hospitalizations and survey measures of patient experience. Outcome measures can be disease specific or general.
- **Intervention tracking measures** evaluate whether the intervention was successfully implemented as planned. These are new measures specific to the intervention efforts and help organizations avoid wasting time or resources as they adopt new intervention approaches, with implications for staffing, cost, and future sustainability. For example, an organization may track no-show rates or the number of calls it takes to reach a patient in order to show the effort required for "successful" patient contact. These data are usually specific to the quality improvement effort and generally come from workplans, staff assignment logs, or other project management tools. Intervention tracking measures can be measured as absolute numbers as well as rates. For example, an organization that is instituting a new referral program might track the *number* of people referred (25 people) for resource allocation but also the *rates* of people referred (80 percent of eligible patients) to show improvement over time. *See below for a more detailed example.*

Disparity	Intervention	Example Intervention Tracking Measures
<p>Spanish-speaking Hispanic patients have worse glycemic control rates than other racial/ethnic groups</p> <p>(Disparity identified using clinical quality data in the electronic health record; intervention designed based on focus groups)</p>	<p>An after-hours diabetes education class, in Spanish, for Hispanic patients</p> <p><i>Strategies:</i></p> <ul style="list-style-type: none"> • Culturally relevant nutrition and cooking techniques • Tips and stories from peers who have improved their physical fitness • Techniques for stress management • Provide incentive gift card • Pre- and post-intervention questionnaire on health behaviors 	<ul style="list-style-type: none"> • Number of patients invited via phone; number of calls, per patient, required for successful contact • Number of patients who accept/ decline invitation to the class • Percentage of patients who attend at least two classes • Percent of patients who receive gift card (vs. number of gift cards sent) • Percent of patients who complete pre- and post-intervention questionnaire • Total cost of the intervention; cost per patient

For each type of measure, organizations can define goals in terms of: 1) the same population before and after the intervention (e.g., 10 percent increase in LDL screening rates), 2) a comparison to another group (e.g., equal rates between Hispanic/Latino patients and Asian-American patients), or 3) a comparison to a benchmark outside of the organization (e.g., 80 percent of the national rate for this measure). A control group can demonstrate change in a compelling way, but a control group may not be feasible or acceptable. (For example, organizations may not wish to exclude patients or have them wait to receive the “intervention” care.) In these cases, organizations often choose pre- and post-measurement to show improvement.

Developing a Process for Reviewing Data Over the Course of the Equity Intervention

Organizations should determine how often they will review data over the course of the intervention to monitor outcomes and adjust intervention processes as they learn what works and what does not. For example, organizations may measure baseline and then review every six months, quarterly, or monthly. By regularly reviewing data, organizations can break goals into manageable pieces, ensure accountability among involved staff, and address feasibility challenges before they compromise the intervention.

Regularly reviewing data ensures that an organization’s efforts are not creating or worsening disparities. Organizations can use several tools for regular data review, including standard quality improvement methodology (such as Plan-Do-Study-Act (PDSA) cycles^v) as well as project management tools (such as workplans, staff assignments, and timelines).

All organizations should regularly review data to adjust their intervention processes, and some organizations also may find it helpful to conduct “pilot testing” before the intervention begins. Pilot testing involves implementing change on a smaller scale before expanding the intervention in order to collect data that can suggest future changes. Future changes may include: 1) the scale of the intervention (e.g., more patients or more practices), 2) the population or condition of focus, 3) the intervention itself, and 4) stakeholder involvement (who and how to engage). Organizations that lack the staff time or institutional resources to perform dedicated pilot testing should look for ways to improve their intervention efforts within the data they regularly review.

III. Telling the Story of How Patients Experience Health Care

Organizations should not simply collect and monitor disparities data. As organizations work to reduce disparities, they can improve their success by also sharing the results of the intervention. Sharing the results of equity efforts can encourage further action and highlight opportunities for improving implementation. By sharing results within and outside of the organization, organizations can:

- Receive feedback and ideas for ways to improve equity efforts;

- Celebrate progress (including “quick wins”) in order to maintain momentum;
- Understand why results came out as they did;
- Empower the people and communities who received the intervention by highlighting their improved outcomes;
- Lay the groundwork for future partnerships and encourage action from people not previously involved (e.g., partnerships with additional health plans or community-based organizations); and
- Maintain equity as a top priority by linking clear, compelling results to other high-priority programs in the organization (e.g., patient safety or care management).

Organizations can best share their intervention results by developing concise results statements targeted to the interests of their specific audiences. Visual tools such as charts or infographics also can be compelling ways to share results. For each audience, organizations should highlight a few data points and give context to make the results most pertinent to the audience’s priorities and concerns. Organizations might relate the data to national or local trends, to organizational goals, or to possible action.

Data Messaging for Different Stakeholder Groups		
Stakeholder	Likely Concern	Building the Case
Leadership	Return on investment	Present data on potential positive financial impact
Providers	Office visit efficiency	Describe patients’ cultural background as information that, like family history, helps determine the best course of action with the patient. Give examples of how culturally tailored approaches enhance patient engagement and satisfaction, reducing redundancy or disconnect in visits and outreach.
Front-line staff	Clinic flow	Be honest about potential temporary impact but note how changes will ultimately improve flow (for example, reduce patient confusion). Solicit input for improvement.
Patients	How the clinic will use race/ethnicity/ language data (privacy) Health status	Discuss that data are private and help the organization make sure that discrimination and stereotyping do not exist and that everyone gets the good care they need
Community	Access to health care services and general wellness in the community	Emphasize project outcomes that benefit the community and include community partners in developing strategies to reduce disparities
Everyone	Patient outcomes	Explain equity efforts and how activity should affect outcomes

Not all interventions will successfully reduce disparities. Organizations may hesitate to share negative results, but even negative results can carry lessons for success. Where projects fail to have an effect, organizations can learn important lessons that they can incorporate into future implementation efforts.

Using Data to Support Future Sustainability

Equity data can help “prove” the value of a project and make the case for allocating resources to the project. Data also show which aspects of a program are essential for continued impact and which can be altered or minimized to make it easier to maintain efforts. As with other quality improvement efforts, having data allows organizations to best identify opportunities to improve care. Leadership, especially, may expect such data when evaluating their commitment to future disparities efforts.

Equity data support sustainability in several ways. First, using race, ethnicity, and language data to track disparities helps organizations maintain a focus on the importance of reducing disparities and providing equitable care among competing priorities. Second, using equity data helps organizations identify how factors that drive disparities (e.g., race, ethnicity, and language) also drive quality; thus, reducing disparities offers insight into improving other areas of quality. For example, an organization seeking to reduce emergency room use might find that utilization is being driven by one or a few racial/ethnic groups, suggesting that interventions targeted for these groups may be most effective. Finally, equity data can help organizations demonstrate their success to external entities, such as payors and foundations. These entities may have programs, partnerships, or grant opportunities that can support organizations’ efforts—financially or otherwise—to reduce racial and ethnic disparities and thus improve quality.

Recommendation

Use a variety of methods to share equity data internally and externally.

Sharing data internally: Waiting room posters, staff meetings, provider “report cards,” regular update emails.

Sharing data externally: Research publications, newsletters, conferences, blogs and social media, radio, television, and live talks. Where possible, partner with community-specific sources (e.g., a culturally specific newsletter).

IV. Conclusion

Race, ethnicity, and language data allow organizations to systematically improve care for all patients and reduce gaps in the quality of care between groups. Stratified R/E/L data best support quality improvement when organizations include analyzing and responding to data in the earliest stages of planning and continue throughout intervention implementation. Actively reviewing and responding to data allows organizations to reduce disparities and engage patients and the community in ways not possible without data. When used in this way, equity data tell a compelling story that motivates health care stakeholders—patients, providers, payors, community members, and others—to participate in achieving high-quality health care for all.

Appendix A: NQF Measures Matched to Documented Disparitiesⁱⁱⁱ

As discussed earlier, some measures are more sensitive to disparities than others, including those that have previously identified disparities successfully. This table lists quality measures from the National Quality Forum that have demonstrated disparities in the literature. Certainly, they are not the only measures that organizations could successfully use to measure disparities; but organizations may have the most success tracking and improving disparities with measures that have this level of evidence behind them.

Sample NQF-Endorsed™ National Performance Measures to Address Health Care Disparities	
Priority Area	Measure Description
Asthma	Use of appropriate medications
Diabetes	Percentage of patients with most recent A1c level >9.0% (poor control)
Heart disease	Coronary artery disease: beta blocker treatment after a heart attack
Screening	Breast cancer screening Colorectal cancer screening
Prenatal care	Prenatal screening for HIV Prenatal anti-D immune globulin
Mental health	Antidepressant medication management
Immunization	Childhood immunization status Flu shots for adults aged 50 to 64
Prevention	Tobacco use assessment and cessation intervention
Patient experience	Ambulatory Consumer Assessment of Health Care Providers and Systems (ACAHPs)

Appendix B: Choosing the Right Denominator

This document outlines key considerations for organizing, interpreting, and acting on performance data stratified by race, ethnicity, language, or other demographics.

Key Consideration 1

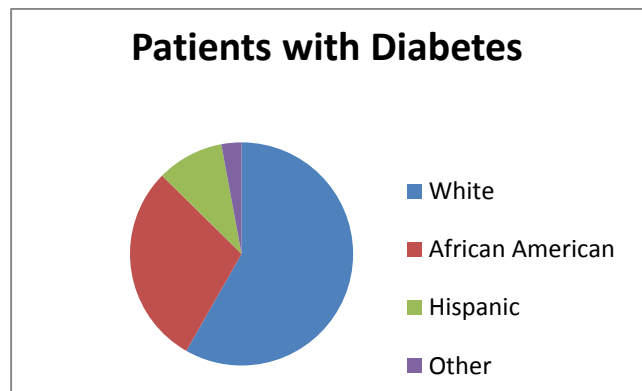
Compare the distributions of disease within each racial/ethnic group, not just across the total population. This affects whether or not you can identify disparities because it allows you to compare the burden of disease among groups with different sample sizes.

The first example below does not allow you to compare the burden of disease among groups. It shows what your data would look like if you looked across the total population instead of within each racial/ethnic group. This answers the question:

Among our diabetic patients, how many are White? How many are African American (etc.)?

- Denominator = all patients with diabetes
- Numerator = number of patients with diabetes in each racial group

Patients With Diabetes, by Racial/Ethnic Group			
	Diabetic patients in all racial/ethnic groups	Diabetic patients within each racial/ethnic group	Percent of total population
White	515	300	58.3
African American	515	150	29.1
Hispanic	515	50	9.7
Other	515	15	2.9



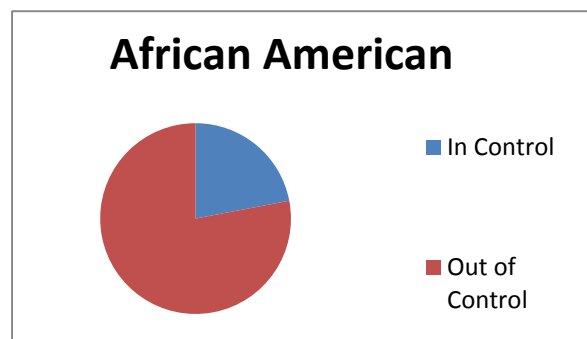
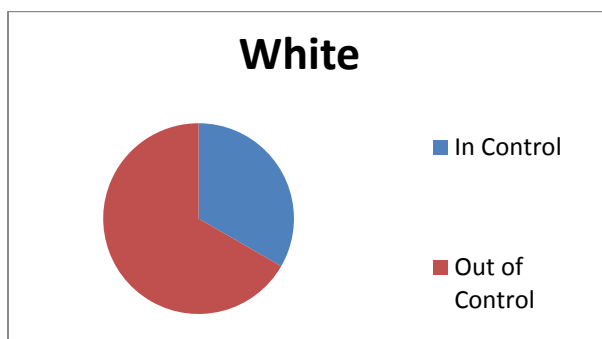
Because this analysis compares racial/ethnic groups to the total population of diabetic patients in the clinic, the White population appears to have the biggest burden of diabetes; this is not surprising because there are more White individuals in this example. This does not tell us where disparities exist or if they exist at all. In other words, we still do not know which group is most impacted by diabetes.

Instead, look at the distribution of uncontrolled diabetes *within* each racial group. This answers the question:

Among diabetic White patients, how many have HbA_{1c}>7? Among diabetic African American patients, how many have HbA_{1c}>7?

- Denominator = number of diabetic White patients
- Numerator = number of White patients “out of control”

Patients with HbA1C>7, by Race/Ethnicity				
	Diabetic patients in each racial/ethnic group	Diabetic patients with HbA1C>7 by racial/ethnic group	Percent of racial/ethnic group	Percent of total population (N=515)
White	300	200	66.7	58.3
African American	150	117	78.0	29.1
Hispanic	50	43	86.0	9.7
Native American	15	9	60.0	2.9



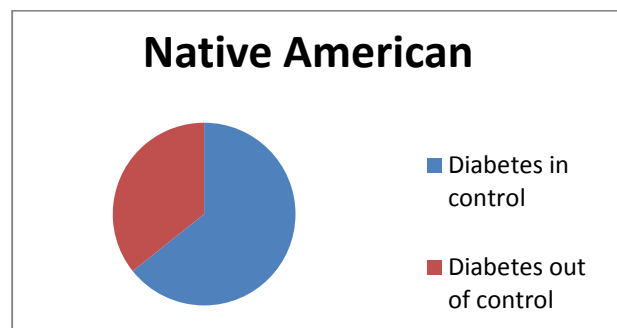
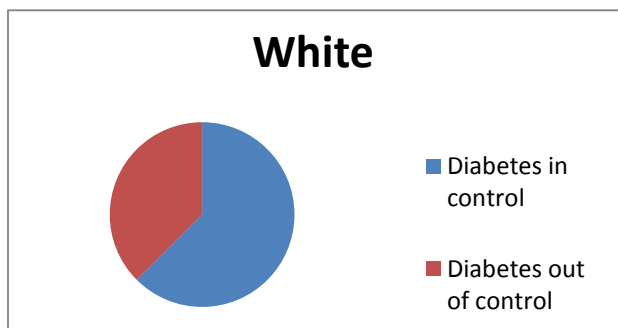
Here it is clear that some groups are more impacted by diabetes than others. Looking at rates relative to each population allows you to compare between groups and know whether a disparity exists or not, and where.

Sample Results Statements

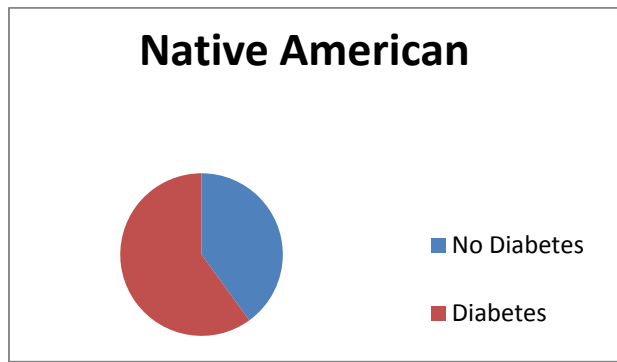
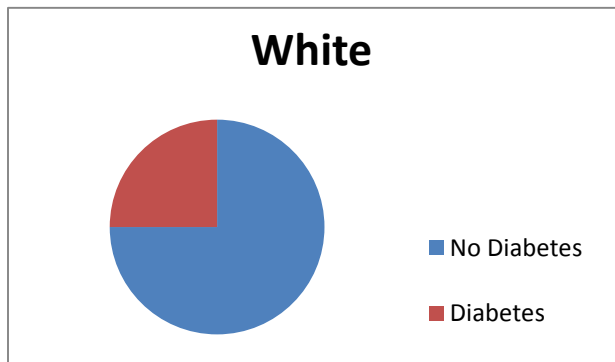
There are 150 diabetic African American patients and **78 percent** of them are out of control, whereas there are 300 diabetic White patients—but only **67 percent** are out of control. As a group, our African American patients are bearing a greater disease burden than our White patients.

Key Consideration 2

Equal Rates of Diabetic Control



Unequal Rates of Diabetic Control



Sample results statement

White patients and Native American patients have about the same proportion of patients with uncontrolled diabetes (about **60 percent in each**). That is, there does not appear to be a disparity in HbA_{1c} levels between the groups. However, a much greater proportion of Native Americans *have* diabetes (controlled or uncontrolled) compared to White patients—**60 percent** of Native American patients vs. only **25 percent** of White patients. Given the prevalence of diabetes among our Native American patients, we may want to intervene with them, despite their small number.

Key Consideration 3

Monitor the impact on different racial/ethnic groups throughout the project to avoid creating disparities as you intervene. If you choose an intervention that spans multiple groups, it may impact groups differently.

While interventions that are tailored to a population (even if it is a smaller group) are generally most effective, some practices choose to pursue broader interventions to:

- Raise the level of care for all patients or multiple groups.
- Impact a larger population, particularly when the sample size of the population not meeting clinical targets is rather small.

This approach may generally work, but it is important to make sure the intervention works well for all groups. If organizations choose not to tailor, they are unlikely to know ahead of time how specific racial/ethnic minority groups will react to the intervention. Monitoring individual groups throughout the intervention will allow organizations to adjust their intervention approaches as needed to avoid creating further disparities.

Key Consideration 4

Assess disparities in processes of care, not just clinical outcomes.

Assessing disparities in processes of care can:

- Help you identify an area to improve if disparities in clinical outcomes aren't readily apparent.
- Allow you to see progress more quickly after beginning interventions, since processes of care generally change more quickly than clinical outcomes. This progress helps maintain momentum. Support funding proposals, and continue leadership and staff buy-in.
- Give you a greater sample size to work with (a larger population to impact). For example, perhaps you have only five patients whose diabetes is out of control, but you have 20 patients who aren't getting tested. This could justify an intervention focusing on increasing testing rates.
- Even if you do see disparities in clinical outcomes, reviewing care processes can help you narrow down your intervention approach. For example, if two groups are receiving LDL screening tests at the same rate, but one

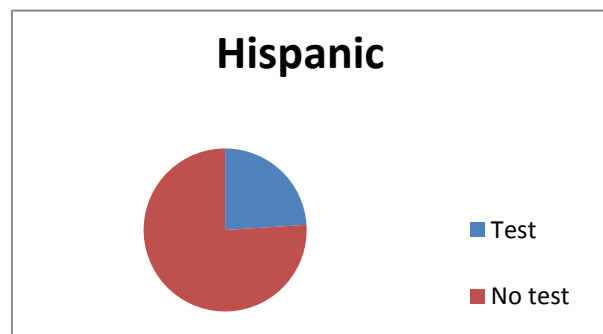
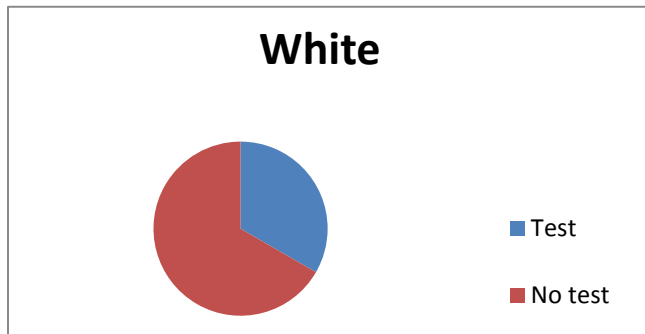
group has higher cholesterol levels, you will know to rule out access to LDL tests as a source of disparities and consider other possible causes of the disparity.

In looking at care processes, you can look at between-group differences (for example, who is getting tested?) in the same way that we compare clinical outcomes by racial/ethnic group.

Among White patients, how many completed an HbA1C test? Among Hispanic patients, how many completed an HbA1C test?

- Denominator = number of diabetic White patients
- Numerator = number of White patients who completed a test

Patients With Completed HbA1C Tests, by Race/Ethnicity			
	Diabetic patients in each racial/ethnic group	Diabetic patients in each racial/ethnic group with completed test	%
White	300	100	33.3
Hispanic	50	12	24.0



Sample results statement

Only **24 percent of Hispanic patients** have completed requested HbA1C tests, whereas **30 percent of White patients** have completed tests. Though every individual has different barriers, we would like to identify barriers that may affect a large portion of our Hispanic patients, causing them to miss needed tests more often than our White patients.

ⁱ Sequist TD, Fitzmaurice GM, Marshall R, et al. "Cultural Competency Training and Performance Reports to Improve Diabetes Care for Black Patients: A Cluster Randomized, Controlled Trial." *Annals of Internal Medicine*, 152(1): 40-46, 2010.

ⁱⁱ *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: Institute of Medicine, 2009, <http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx> (accessed March 2014).

ⁱⁱⁱ Weissman JS, Betancourt JR, Green AR, et al. "Commissioned Paper: Healthcare Disparities Measurement." Washington, DC: National Quality Forum, 2012, http://www.qualityforum.org/Publications/2012/02/Commissioned_Paper_Healthcare_Disparities_Measurement.aspx (accessed March 2014).

^{iv} *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities: A Consensus Report*. Washington, DC: National Quality Forum, 2008, http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx (accessed March 2014).

^v *The Model for Improvement*. Cambridge, MA: Institute for Healthcare Improvement, 2014, <http://www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx> (accessed March 2014).

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