Meaningful Disparities Reduction Through Research and Translation Programs

Marshall H. Chin, MD, MPH
Don Goldmann, MD

Health care disparities are unacceptable, but progress toward reducing them has been painfully slow. Each year the Agency for Healthcare Research and Quality’s (AHRQ’s) National Healthcare Disparities Report documents persistent differences in care by factors such as race, ethnicity, and insurance status. Public awareness of these disparities is growing, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 will hasten transparency by encouraging collection of race, ethnicity, and language data. However, recognizing the existence of disparities is not sufficient to catalyze meaningful action. Even the most motivated clinicians and health care organizations may not know how to proceed because information on which interventions work in specific contexts or at scale is limited.

There is broad agreement that meaningful efforts to reduce disparities are linked inextricably to quality improvement. In its 2001 report Crossing the Quality Chasm, the Institute of Medicine (IOM) called out equity as 1 of 6 pillars of quality care. The IOM’s 2010 report advising AHRQ on Future Directions for the National Healthcare Quality and Disparities Reports (NHQDR) highlights equity as a crosscutting dimension that spans all components of quality and types of care (preventive care, acute care, and chronic condition management). The IOM singles out value and equity as the most important factors to use in choosing measures for the NHQDR.

Despite this drumbeat, governmental and private agencies fall short in their efforts to fund the research needed to discover, develop, implement, evaluate, and scale up effective strategies and interventions to address disparities. Typically, an agency will include language in a request for applications encouraging proposals that include specific vulnerable populations, but this general statement does not require investigators to demonstrate that they have a conceptual theory, logic model, and plan to reduce disparities that they observe. For example, in 2003 AHRQ released its policy on the inclusion of priority populations in research, noting the importance of including inner-city, rural, low-income, elderly, special health care needs, and minority populations, the need for recruitment outreach plans, and the value of subgroup analyses. While helpful for raising the profile of equity issues, the policy does not offer guidance on ways to translate the inclusion of priority populations into research that develops new knowledge on how to reduce disparities.

We describe an approach for making equity an integral component and explicit requirement of funding announcements aimed at improving quality of care and outcomes. The approach makes disparities reduction a key goal in the development and rollout of a grant initiative and requires applicants to provide a detailed description of how they will address equity in their conceptual, intervention, and analytical models.

Meaningfully Incorporating Equity Into Research Agency Efforts to Improve Quality

Research funding agencies should state that equity is a fundamental dimension of care quality that must be considered explicitly and addressed from the beginning in all efforts to improve processes of care and outcomes. The practical reason for this requirement is that quality improvement efforts must be tailored to specific populations and settings to be most effective. The “rising tide lifts all boats” argument of quality improvement is suboptimal and often ineffective. An axiom of implementation science, exemplified by the SQUIRE publication guidelines for quality improvement articles, is that context is critical. For interventions to be most successful, they must be individualized for the specific organizational, historical, cultural, and geographic contexts and patient populations. Similarly, literature on reducing disparities notes the importance of culturally tailoring interventions. Agencies should move beyond merely asking applicants to include priority populations in their research plans. Without being overly restrictive, agencies need to ask research applicants how they will address disparities; measurement plans should stratify data appropriately; and the overall portfolio of grantees in an initiative must provide solutions for improving outcomes in a variety of populations and settings. Applicants who address equity issues well should be rewarded in the grant review process. Some funding announcements could require a principal focus on disparities, some could give extra points to such proposals, and others could set aside awards solely for investigators who meet criteria for studying interventions to reduce disparities.

Author Affiliations: Department of Medicine, Diabetes Research and Training Center, University of Chicago; Robert Wood Johnson Foundation Finding Answers: Disparities Research for Change National Program Office, Chicago, Illinois (Dr Chin); Institute for Healthcare Improvement, Cambridge, Massachusetts, and Children’s Hospital Boston and Department of Pediatrics, Harvard Medical School, Boston, Massachusetts (Dr Goldmann).

Corresponding Author: Marshall H. Chin, MD, MPH, University of Chicago, Section of General Internal Medicine, 5841 S Maryland Ave, MC 2007, Chicago, IL 60637 (mchin@medicine.bsd.uchicago.edu).
Box. Examples of Research Questions for Reducing Disparities by Level of Influence and AHRQ Priority Population

Chronic Care Coordination
Policy (low income): How can accountable care organizations and integrated payment policies increase chronic care coordination for low-income populations?

Health care delivery entity (racial/ethnic minorities, low income, inner city): What are the best ways to implement the patient-centered medical home model across community health centers and public hospitals to improve chronic care coordination in racial/ethnic minority populations?

Microsystem (rural): What innovative uses of health information technology can improve communication, data exchange, and chronic care coordination among rural patients and their office-based team of physicians, nurses, and health educators?

Clinician (elderly): How can generalist physicians integrate most effectively and efficiently with specialists to improve chronic care coordination of elderly patients?

Patient/family (special health care needs): How can patients with disabilities and their families be empowered to promote and catalyze chronic care coordination among multiple health care providers?

Community (children with special health care needs): How can schools and community-based organizations interact most effectively with the health care system to improve the chronic care coordination of children with special health care needs?

Pediatric Asthma
Policy (pediatric): How can policy and resource allocation promote clean air, reduced exposure to secondhand smoke, and a nonallergenic housing environment for children?

Health care delivery entity (low income, racial/ethnic minorities): How can emergency department visits and readmissions be reduced by enhanced primary care access (extended hours, open access)?

Microsystem (rural): How can office-based care teams collaborate with community health workers to support home-based asthma management?

Clinician (racial/ethnic minorities): How can clinicians perform culturally appropriate motivational interviewing to promote self-management?

Patient/family (pediatric): How can parents safely use e-mail or text messaging to receive real-time advice on handling severe asthma exacerbations?

Community (pediatric): How can school-based programs and community organizations promote early recognition and management of asthma in student athletes?

A Conceptual Model for Specifically Addressing Disparities
A variety of models outline approaches to reducing disparities. What they share is a realization that the causes of disparities are multifactorial and that interventions to reduce disparities must address the different levels that influence health care delivery and health outcomes. This emphasis on multifactorial, multilevel strategies represents a significant change in intervention approach and research priorities. We highlight 6 key levels of influence: policy, health care delivery entities, microsystems, clinicians, patients/families, and community. Grant applicants should identify which levels they will focus on and which specific approaches and interventions they will employ. Agencies such as AHRQ could require or encourage applicants to use the conceptual model to organize and integrate intervention proposals. The Box provides examples of disparity reduction questions for each level of influence for chronic care coordination and pediatric asthma.

Conclusion
There is a need to move beyond the general recognition that unacceptable disparities exist to the creation of structures and mechanisms to maximize the chance that equity issues will be addressed meaningfully in quality initiatives. It should be mandatory to explain how equity will be examined in all quality improvement efforts, with details on the approaches that will be taken within different levels of the health care system that influence disparities. This Commentary highlights the integral nature of equity in efforts to improve quality of care while providing sufficient detail to make such initiatives practically useful for policy makers, organizations, microsystems, individual clinicians, patients and families, and communities trying to make a difference.

REFERENCES