

PROJECT TITLE:
**METROWEST HEALTH
DISPARITIES INITIATIVE
(#P139)**
PROJECT PERIOD:
MAY 2, 2005 – DECEMBER 30, 2005

SUBMITTED BY:

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JANUARY 26, 2006

A FINAL REPORT OF THE METROWEST COMMUNITY HEALTH CARE
FOUNDATION'S RACIAL AND ETHNIC DISPARITIES STEERING COMMITTEE

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DEDICATION

The MetroWest Health Disparities Steering Committee dedicates this report to the memory of T. Leon Nicks, Ph.D. a distinguished member of the MetroWest Community Health Care Foundation's Distributions Committee and the Health Disparities Steering Committee. Dr. Nicks formerly served as Director of the Department of Health and Human Services, Region 1 of The Federal Government. He passed away on December 6, 2005.

Dr. Martin Luther King, Jr. once said *“Some of us will have to get scarred up, but we shall overcome. Before the victory of justice is a reality, some may even face physical death. But if physical death is the price that some must pay to free their children and their brothers from a permanent life of psychological death, then nothing could be more moral”*. Dr. Nicks learned many lessons about life as he overcame discrimination and racism to achieve his Ph.D. in clinical psychology in 1960 from Boston University. Throughout his life, he provided outstanding leadership and endless support to help solve issues related to community health, substance abuse, educational attainment, and career advancement, particularly where justice and equal opportunity were in question. Dr. Nicks was an inspiration to many, often offering words of advice or encouragement to help us all find our better selves.

Dr. Nicks' walk in life was about making a difference, one individual, one organization, and one community at a time. As a member of our Committee, his hope was that this report would greatly assist the Foundation in its efforts to establish initiatives and programs that better document and contribute to the alleviation of inequalities in health and health care, experienced by many MetroWest residents of color. May his spirit continue to guide our journey towards healthier residents and communities of MetroWest.

ACKNOWLEDGEMENTS

To the many African American, Brazilian and Hispanic/Latino residents of MetroWest who took time to help organize and participate in community focus groups, we hope this report captures your wisdom, motivation and hope for change. We would also like to acknowledge the Framingham Community Church, Marlborough Library and Milford Library for hosting our community focus groups. We would like to acknowledge Fanny Valencia, Antonio Marin, Libia Gonzales, Ilma Paixao and Janet Velky who served as interpreters during the focus groups, and Jany Finkelstein, Anna Barahona, and Karin Agte for their assistance in the translation of documents into Spanish and Portuguese. We would additionally like to thank Ilton Lisboa, Sidney Peres, and Nancy Nunes for their assistance in recruitment of focus group participants.

Additional collaborators for this report include Naomi Bitow, Research Coordinator, Harvard School of Public Health who organized and collected data on all aspects of this project, Sarah Putney and the Harvard School of Public Health's Human Subjects Committee, American Translation Partners, Patricia Baker of the Connecticut Health Foundation, Chris Kable of the Northwest Health Foundation, Jane Pearson of St. Luke's Health Initiatives, and Vanessa Nelson Hill from the Greater Phoenix Black Nurses Association. We wish to thank Dr. Percy Andreazi, Argentina Arias, Kim Battles, Yvonne Brown, Jerry Desilets, Dr. Michael Gottleib, Diane Gould, Ilton Lisboa, Dr. Richard Marshall, Laura Medrano, Dr. William Muller, Cathy Romeo, Faith Tolson, Ana Velasco, and Dr. Janet Yardley for their contributions as stakeholders in the health of MetroWest communities. We would also like to thank Bruce Cohen, Ph.D., and Brunilda Torres, Massachusetts Department of Public Health, who provided valuable input on Massachusetts's racial and ethnic data collection, reporting protocols, and procedures.

For their support in the writing of this report we'd like to thank Megan Loyd, Paul McEvoy, and Elizabeth Ward. Special thanks to Dr. Deborah Prothrow-Stith for her support and thoughtful guidance over the course of this project.

Finally, we wish to acknowledge the outstanding support and contributions from the MetroWest Health Disparities Steering Committee members who guided us throughout this entire process. Members include: Mrs. Edna Smith, Steering Committee Chairperson, Dr. Percy Andreazi, Robert Awkward, Yvonne Brown, Geri Chimera, Beth Donnolly, Jany Finklestein, Esther Hopkins, Laura Medrano, Dr. T. Leon Nicks, Dr. Christine Robinson, Cathy Romeo, Brenda Thompson Stuckey, Faith Tolson, Dr. Janet Yardley, and Martin Cohen. Your individual enthusiasm and collective efforts to inform this project and final report were invaluable; the best treatment plan for one of our Nation's most difficult health challenges.

Brian K. Gibbs, Ph.D.
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ABOUT THE AUTHORS

Brian K. Gibbs, Ph.D., M.P.A., OTR/L, is the Director of the Program to Eliminate Health Disparities and an Instructor of Public Health Practice in the Department of Health Policy and Management at the Harvard School of Public Health (HSPH). In addition to his role as principal investigator on the MetroWest Disparities Agenda Initiative, Dr. Gibbs serves as principal investigator and researcher on several other private foundation grants including the “Breaking It Down: Community Participation in Cancer Clinical Trails through Community Based Participatory Research”, a three-year grant from the Education Network for the Advancement of Cancer Clinical Trails and “Heart Disease and Racism; Understanding the Relationship and Developing New Strategies”, a one-year partnership between HSPH, Vigorous Interventions in Ongoing Natural Settings, Inc., and The W.K. Kellogg Foundation. Dr. Gibbs is the project director for an NIH-National Center for Minority Health and Health Disparities- Centers of Excellence Project EXPORT initiative titled, Center for Healthy Options and Community Empowerment (CHOICE). CHOICE, a \$6M, four-year partnership involving Florida A&M University, Florida State University, and HSPH, uses research, training, community partnerships, coalition building and social transformation to create models for eliminating health disparities in both rural and urban communities. In 2003, Dr. Gibbs was selected to serve as a member of the Massachusetts Commission on the Elimination of Racial and Ethnic Health Disparities and is a co-author of the Commonwealth Fund’s State Health Disparities Agenda. Also, Dr. Gibbs provides the leadership for Cherishing Our Hearts and Souls, a coalition of over 200 organizations and individuals established to educate communities, providers and policy makers about the intersections of racism, and other social and environmental determinants of health.

Naomi Bitow, MPH, holds the position of Research Coordinator within the Program to Eliminate Health Disparities in the Department of Health Policy and Management, at the Harvard School of Public Health (HSPH). She completed her MPH at the University of Nottingham, England as a Rotary Ambassadorial Scholar in 2002. Ms. Bitow is committed to better understanding the causes of disparate health outcomes and the development of community based solutions to the reduction of health disparities. She will serve as research coordinator for, “Breaking It Down: Community Participation in Cancer Clinical Trails through Community Based Participatory Research”, a three-year grant from the Education Network for the Advancement of Cancer Clinical Trails.

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I. EXECUTIVE SUMMARY

Racial and ethnic disparities in health and health care in the United States are substantial and complex. The reasons are poorly understood, but may reflect socioeconomic differences, differences in health-related risk factors, environmental degradation, and direct and indirect consequences of discrimination (Institute of Medicine, 2003).

Eliminating racial and ethnic disparities in health status and health care, a major focus of *Healthy People 2010* (U.S. DHHS, 2000) requires the involvement of the whole nation, individual states, and community stakeholders. Although the goals of Healthy People 2010 were established at the federal level, development and implementation of a social strategy for health disparities reduction activities requires involvement of state, city, and local stakeholders to improve the health of individuals and communities.

Creating an infrastructure at the state and local community level to address racial and ethnic disparities in health and healthcare requires collaborative partnerships involving policymakers, public health officials, health professionals, health services researchers, private foundations, community organizations and residents. In order to be successful, these collaborative partnerships must be highly responsive to the varied health and healthcare needs of diverse racial and ethnic groups over a sustained period of time.

In December 2004, the MetroWest Community Health Care Foundation (MCHCF) commissioned the Program to Eliminate Health Disparities at the Harvard School of Public Health and a steering committee consisting of community and organizational stakeholders to establish a racial and ethnic health disparities initiative for the MetroWest area of Massachusetts. The purpose of the racial and ethnic health disparities initiative is to enhance the knowledge of and capacity to address health disparities among the MetroWest Community Health Care Foundation's Board of Trustees, grantees, volunteers, community leaders, residents, and other agencies including, but not limited to

health care and affiliated academic institutions. The overall goal for this initiative will be to: 1) assist the MCHCF Board of Trustees in the establishment of an action agenda to address racial and ethnic disparities in health and healthcare; and 2) improve the health status of poor and underserved minority residents in the MetroWest area.

This report was informed by review and assessment of: evidence-based practices addressing racial and ethnic health disparities; relevant MetroWest data involving racial and ethnic health disparities; best and emerging practices of other community foundations; and community capacity to respond to racial and ethnic disparities in health and healthcare including input from steering committee members and community residents, and other community stakeholders.

Following this executive summary, section two of this report features an introduction to the issue of racial and ethnic disparities in health and healthcare, and the project that was undertaken to inform the Foundation's development of a disparities initiative. Results from the five project components are also covered including focus groups, stakeholder interviews, survey of community assets, survey of racial and ethnic data collection methods, and interviews with health foundations addressing racial and ethnic health disparities are included under section three. In section four, a series of five key recommendations, examples of promising initiatives, and an overview of next steps for how the MCHCF can move forward in establishing its racial and ethnic health disparities action agenda are presented.

Project Components

Community Resident Focus Group Discussions: A total of nine focus group discussions were conducted between June and August 2005 with African American, Brazilian, and Hispanic/Latino residents in Framingham, Marlborough, and Milford. The majority of focus group participants did not have an understanding of health disparities. Participants identified the following perceived causes of health disparities and barriers to good health: high cost of healthcare and treatment, the lack of commitment on the part of MetroWest

institutions, the lack of cultural understanding among health providers and staff, limited culturally responsive health care options in the region, racism, and issues related to immigration.

Participants also offered specific community centered solutions to the aforementioned causes and barriers which include, opening area clinics that offer culturally responsive care in MetroWest cities and towns other than Framingham, increasing the dissemination of culturally appropriate health information, and increasing the number of providers and staff of color or those trained to serve communities of color in MetroWest. Additionally, participants offered suggestions of possible areas of focus for the Foundation that fall under the following categories: advocating for and promoting institutional change to improve health experiences (i.e. promoting culturally and socially responsive health care), supporting information dissemination and health promotion activities (i.e. targeted marketing to minority populations with health related messages), and supporting capacity building initiatives (i.e. support the formation of coalitions and partnerships).

Community and Health Stakeholder Interviews: Interviews were conducted with select community, health, and social services stakeholders in the MetroWest region to elicit their insights about possible causes of disparate health outcomes. All stakeholders expressed a familiarity with health disparities and most believed that they existed in MetroWest. Perceived causes and barriers identified by the community and health stakeholders include the following: the lack of recognition and accountability to the health of racial and ethnic minority populations in MetroWest by providers and key decision makers, the entrenched nature of the healthcare system, the lack of commitment on the part of MetroWest institutions, the lack of cultural understanding among health providers and staff, the lack of resources and funding for outreach, lack of advocacy, and inadequate information dissemination, racism, issues related to immigration, and over-utilization of hospital emergency rooms.

Stakeholders offered specific community centered solutions (i.e. community based outreach and education, utilizing community health worker model) and system,

institution, or organization centered solutions (i.e. collect race/ethnicity data and use to identify “high-risk” populations) to the aforementioned causes and barriers. Suggested areas of focus for the Foundation included: promotion of data collection, community wide education around health disparities and the health of racial/minority populations, and that the Foundation should serve as an information clearinghouse for institutions, providers, and community residents.

Survey of Community Assets: An institutional assets questionnaire was disseminated to MetroWest institutions, organizations, and programs to: 1) explore existing involvement with health disparities and 2) determine potential for partnership related to the MCHCF’s Racial and Ethnic Health Disparities Initiative. Organizations in Framingham, Marlborough, and Milford were selected based on listings from the United Way, affiliated or previously funded organizations by the MCHCF, and a select list of institutions such as school districts, health providers, and law enforcement agencies. Twenty-one organizations (60%) out of a total of 35 respondents indicated that their organization has developed programs in response to health disparities. When asked whether they offer informational materials in languages other than English, seventeen (81%), reported that they do. Similarly, seventeen organizations reported that they provide services in languages other than English.

The health and social conditions addressed and services provided by survey respondents are consistent with the areas of concern, suggested interventions, and suggested areas of focus identified by the focus group participants and stakeholder interviewees (promoting culturally and socially responsive health care, supporting information dissemination and health promotion activities and capacity building initiatives, data collection, and community wide education around health disparities, and the Foundation should serve as an information clearinghouse for institutions, providers, and community).

Survey of Health Provider Racial and ethnic Data Collection: Nine health provider surveys (including two hospitals, one community health center, two group practices, two mental health agencies, and two clinics), key informant interviews and on-line searches

were conducted to: 1) better understand the data collection practices of health providers in the region and 2) identify promising practices for: a) addressing the gaps in obtaining health data for the Brazilian population, b) addressing the lack of risk data for the African American population, and c) obtaining school or region specific youth risk data (2005 MetroWest Health Data Book & Atlas).

It was found that the hospitals and the community health center are the only health providers to routinely collect race and ethnicity data. For emergent immigrant populations, the community health center is the only health care provider that routinely collects ethnicity data. Group practices reported not collecting race/ethnicity data. Mental health agencies do collect this information for certain patients based on services accessed and subsidies received. Free and low-cost clinics that independently run outside of the hospital setting, reported that they do not routinely collect race and ethnicity data, but that language information is recorded. Because these clinics are largely utilized by recent immigrants, that may not access services elsewhere, they represent a potential source of insightful health data.

Interviews with Health Foundations Addressing Racial and Ethnic Health Disparities:

Based on their innovative approaches to address racial and ethnic health disparities, the Connecticut Health Foundation (New Britain, Connecticut), St. Luke's Health Initiatives (Phoenix, Arizona), and the Northwest Health Foundation (Portland, Oregon), were interviewed to gain insights around the development and sustainability of such initiatives and programs.

Foundation representatives consistently stressed that working to address racial and ethnic health disparities takes a commitment and passion to understand and eliminate the factors that contribute to disparities in health and health care for racial and ethnic minority populations/populations of color. Representatives consistently echoed that in order to create lasting change to disparate health outcomes and health care experiences, foundations must challenge themselves to move beyond traditional grantmaking and embrace a long-term commitment and vision. Cultural understanding, a willingness to

learn, an understanding of the community landscape, and the promotion of community empowerment and accountability were also indicated as important factors in the development and sustainability of a successful initiative or program in health disparities.

Key Recommendations

Five key recommendations representing a select number of themes and areas of focus that consistently emerged during focus groups, stakeholder interviews, interviews with other health foundations, and ongoing feedback from the Steering Committee are presented. These five key recommendations reflect the range of funding activities currently existing within the MetroWest Community Health Care Foundation (MCHCF).

Recommendation 1: *Cultural and Linguistic Competency.* The MCHCF can assist area health systems and providers develop, implement, and evaluate interpreter services involving data collection, service delivery, financial services and patient satisfaction. The Foundation can support provider-based cultural competency training, develop and evaluate model curricula for cultural competency training, create a cultural competency library or resource bank for local health care providers, promote a regional interpreter bank, and pilot innovative interpreter programs in local hospitals.

Recommendation 2: *Developing Specific Disease Management Protocols & Promote Consumer Advocacy and Capacity Building.* The MCHCF can develop funding programs that: assist in the development and dissemination of culturally appropriate information; support local health education, outreach and screening services targeting minority communities; provide funding to assist in the development of a sustainable infrastructure for community organizing around health and health care advocacy involving faith-based institutions, community based organizations, social groups, and civic organizations; fund outreach worker training programs; and leverage partnerships with provider community to convene meetings between health care system, housing, education and employment sector representatives for training and education on health

related topics such as asthma, indoor air quality improvements, stress reduction, smoking cessation, healthy and affordable food options and physical activity.

In addition, the MCHCF can establish a multi-level disparities reduction action agenda to address longstanding health conditions (diabetes, hypertension, tuberculosis, overweight and obesity) and newly emerging diseases, by partnering with various agencies such as the American Cancer Society, American Diabetes Association, American Heart Association, the National Association for the Advancement of Colored People (NAACP), Brazilian American Association (BRAMAS), MetroWest Latin American Center, local minority faith-based institutions and community organizations. The aim of such partnerships would be to: 1) increase community awareness and knowledge of specific disease management strategies by creating and launching a MetroWest-based multi-year health promotion campaign; 2) increase opportunities for physical activity among minority residents; 3) increase the availability of affordable fresh fruits and vegetables to MetroWest residents and increase their consumption of these foods while decreasing the consumption of unhealthy foods; and 4) enhance existing strategies to decrease smoking among children, youth and adults in the MetroWest area.

Recommendation 3: *Minority Healthcare Professional Recruitment and Retention.* The MCHCF can assist in the racial and ethnic diversification of the health workforce for the MetroWest area by: initiating new and/or supplementing existing after school/weekend junior high and high school math and science programs; co-sponsor tutoring and mentoring programs between MetroWest public school systems, undergraduate, graduate, and professional degree programs, health care, public health and business communities; sponsor MetroWest health career fairs or institutes; and identify new or supplement existing minority health or health disparities fellowship training programs.

Recommendation 4: *Promoting Responsive Data Collection and Reporting on Race and Ethnicity.* The MCHCF can establish and support a MetroWest area data collection work group on race and ethnicity comprised of data users, state and local health departments, and collectors of federal data (i.e., funeral directors, hospitals, nursing

homes, Bureau of the Census), local practitioners, health system administrators, academic training institutions, community leaders, and elected officials. More specifically, the MCHCF can encourage and support the collection of race and ethnicity data among its funded programs, maintain annual profile and report on racial and ethnic disparities in health and health care at the individual provider and systems level, and advocate for and support data collection, reporting, and tracking by race and ethnicity across the region and state.

Recommendation 5: *Establishment of Community-wide Disparities Work Group.* The MCHCF can support the development and institutionalization of a special community council/partnership to: 1) assist in the building of a community infrastructure to recruit, retain and grow an academic, professional, and provider community, 2) establish a directory of minority health care providers, and 3) convene and co-sponsor a MetroWest community partnership involving minority health providers, elected officials, professional associations, and local business community and other community stakeholders.

The MetroWest Community Health Care Foundation is strongly positioned to establish, in partnership with local business, health care and community stakeholders, a variety of grants, programs, work groups, and meaningful solutions to support a racial and ethnic health disparities action agenda. We encourage the Foundation to envision the funding of a long-term and sustainable health disparities movement that is multicultural, multi-issue, and based on a set of broader social determinants of health, including education, employment, and housing.

II. INTRODUCTION

Good health is one of the most precious and lasting gifts that you can give to yourself and to others. It will empower you in a way that neither money nor material assets are able to do. This powerful indicator can provide the tools to strengthen families, nurture friendships, and expand opportunities as it circumvents and releases you from needless confinement or isolation. A strong, healthy constitution will enable you to walk among the powerful, stand shoulder to shoulder with the educated, and maximize your contributions to society. Good health is a priceless gem that many aspire to grasp, possess, and retain yet fail to do so. Instead, they acquire inferior or imitation gems that crumble, disintegrate, and decline in value... Do not take good health for granted, for genetics, age and lifestyle affect and alter your body BUT- your quality of life can be enhanced and savored through knowledge, and commitment to diet, exercise, and preventative care.

Yvonne Y. Brown, President, National Association for the Advancement of Colored People, South Middlesex Branch

Eliminating racial and ethnic disparities in health status and health care, a major focus of *Healthy People 2010* (U.S. DHHS, 2000) requires involvement at all levels: nationwide, among the states, and within the community. Although the goals of *Healthy People 2010* were established at the federal level, development and implementation of a social strategy for health disparities reduction activities requires involvement of state, city and local community stakeholders. *Healthy People 2010* states explicitly that “inequalities in income and education underlie many health disparities in the United States,” and that community, state, and national organizations will need to take a multidisciplinary approach “that involves improving health, education, labor, justice, transportation, agriculture, and the environment” if these disparities are to be reduced or eliminated (U.S. DHHS, 2000).

The elimination of racial and ethnic disparities in health status and health care poses a great challenge to the nation as a whole and to states in particular. Certain subsets of the population experience wide disparities in access to health services, outcomes of health care, and higher relative risk of poor health than the population as a whole. At the same time, demographic shifts are occurring in the United States that will result in these populations becoming the majority within the twenty-first century (Parangimalil, 2001).

The sources of many disparities in health status between minorities and non-minorities occur:

- 1) At the level of disease prevalence (with differentials attributable to differences in exposures to hazards, differences in resources for daily living, and the impact of racism on health, including its role in causing differences in socioeconomic and education status, and housing opportunities by “race”).

- 2) At the level of access to health service. Barriers include age or employment eligibility, underemployment, distance, money, language, prejudice, time and legal barriers.
- 3) At the level of treatment within the health care system. Barriers include patient disrespect (as subtle as not giving the patient the full range of treatment options, and as blatant as sterilization abuse), poor communication between the patient and provider, differing resources depending on the site of care, differing levels of physician training with regard to protocol care, subtle biases with regard to treatment recommendations, and subtle biases with regard to assessing whether a patient will find a given treatment acceptable or will be able to afford a given treatment (Jones, 2001).

Addressing factors that endanger the health of minority Americans demands strategies such as general public and health care provider education, prevention, research, policy and environmental changes that facilitate healthy living. To be effective, however, "communities must be involved as partners in the design, implementation, and evaluation of interventions. The best intervention results have been achieved when people who benefit from interventions work closely with researchers and public health practitioners. This phenomenon emphasizes the fact that those in the health community have 'messages,' while individuals in target communities have 'lives.' A partnership between these two groups offers the best chance to bridge the divide" (Livingston, 2004, Smedley & Syme, 2000).

The MetroWest Region

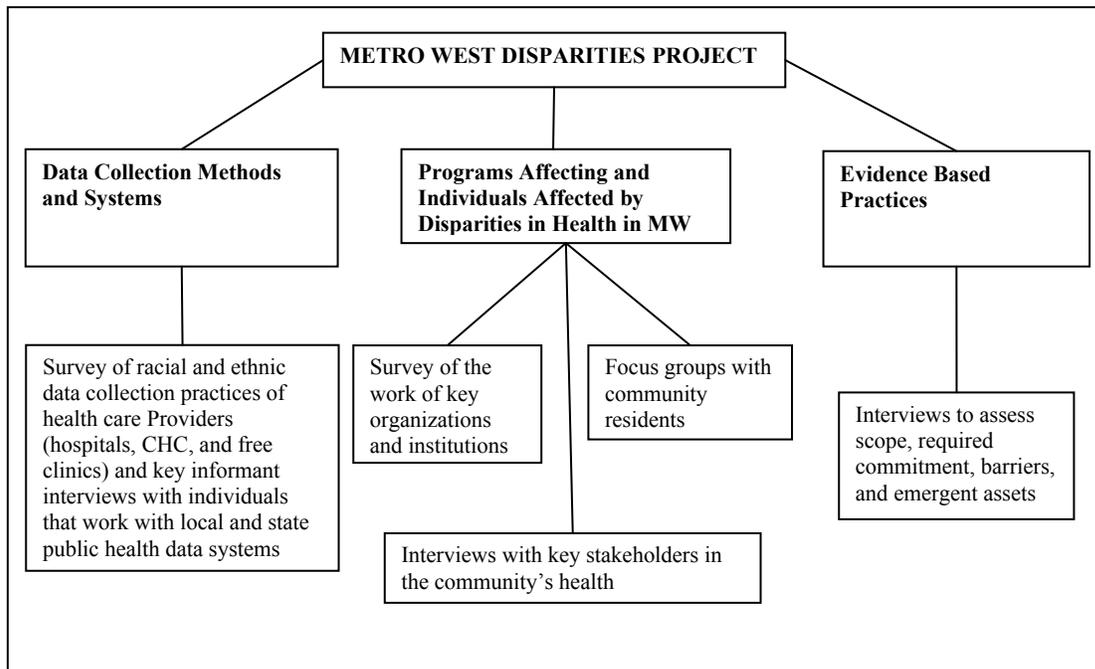
The MetroWest region is a suburban area that is made up of a large racial and ethnic majority in which the overall population has a relatively higher socioeconomic status than other regions of the state. Data on race and ethnicity is not readily available and when it is, the numbers are often too small to draw meaningful or reliable conclusions. "Furthermore, given the small population of persons of color in MetroWest, few valid demonstrations of health disparity are possible even for the entire region". (MetroWest Community Health Care Foundation, 2005)

Despite limited health and hospital outcome data by race and ethnicity, hospital discharge data indicate a pattern of disparate health outcomes among racial and ethnic minority residents. For instance, according to the recently released 2005 MetroWest Health Data Book and Atlas, hospitalization rates for diabetes complications, breast cancer, and prostate cancer for African Americans are significantly higher than for other groups. Similarly, Hispanic residents have higher rates of hospitalization for chronic liver disease and asthma. Both groups have higher HIV/AIDS hospitalization rates.

Given the wide range of factors that contribute to disparities in health and the magnitude of the task of eliminating these disparities, the MetroWest Community Health Care Foundation (MCHCF) in partnership with the Program to Eliminate Health Disparities at the Harvard School of Public Health and a steering committee comprised of community and organizational stakeholders have combined to establish a racial and ethnic health

disparities initiative for the MetroWest area of Massachusetts. The purpose of the initiative is to enhance the knowledge of and capacity to address health disparities among the MetroWest Community Health Care Foundation’s Board of Trustees, grantees, volunteers, community leaders, residents, and other agencies including health care and affiliated academic institutions. The overall goal of this initiative is to assist the MCHCF Board of Trustees to establish an action agenda to address racial and ethnic disparities in health and healthcare for residents in the MetroWest area. The initiative was organized into five project components including: focus groups with community residents, interviews with key community stakeholders, a survey of community assets; a survey of racial and ethnic data collection methods, and a series of interviews with health foundations addressing health disparities. The five project components were divided into three project areas representing: 1) Data Collection Methods and Systems; 2) Programs Affecting and Individuals Affected by Disparities in Health in MetroWest; and Evidence Based Practices: Health Care Foundations with Racial and Ethnic Health Disparities Initiative (See project diagram below).

Project Diagram



Scope of Report

This final report is comprised of four sections. Following this introduction, section three covers five project components (Focus Groups, Stakeholder Interviews, Survey of Institutional Assets, Survey of Racial and ethnic Data Collection Methods, and Health Foundations Addressing Racial and Ethnic Health Disparities). Section four outlines the recommendations presented to the MCHCF Board of Trustees, and highlights examples of promising practices for each recommendation area.

Scope of Project

The Racial and Ethnic Health Disparities Initiative began in January 2005. Dr. Brian K. Gibbs and later research assistant, Ms. Naomi Bitow both from the Harvard School of Public Health, Mrs. Edna Smith from the MCHCF Board of Trustees, and Mr. Martin D. Cohen, President/CEO of MCHCF were responsible for: 1) Establishing a Racial and Ethnic Disparities Steering Committee; 2) Planning and conducting nine focus groups, nine interviews with community and health provider stakeholders, and three health care foundations; and 3) Developing an inventory project consisting of four approaches: evidence-based practices in addressing ethnic and racial disparities in health and healthcare; inventory of clinic/hospital/ community health center/ public health data systems; inventory/analysis of people and programs associated with health and health care disparities; and a review of three health disparities funding initiatives established by health care foundations of a similar size.¹

Racial and Ethnic Disparities Steering Committee:

The Racial and Ethnic Disparities Steering Committee (Table 1) consisting of community and organizational stakeholders was established to help inform and guide all methods involved in identifying institutional, organizational, and individual resources engaged in delivery of health care, social services, and community outreach activities to minority residents in the MetroWest region. The charge to the Steering Committee was to gain an understanding of racial and ethnic disparities in health and health care involving MetroWest residents, and from this understanding, develop recommendations to the Board of Trustees of the Foundation to inform an action agenda that the Foundation may wish to pursue in addressing such disparities².

Table 1 MCHCF Racial and Ethnic Health Disparities Steering Committee

Edna Smith	Esther Hopkins	Faith Tolson
Robert Awkward	Jany Finklestein	Christine Robinson
Yvonne Brown	Laura Medrano	Janet Yardley
Geri Chimera	Leon Nicks	Percy Andreazi
Beth Donnolly	Cathy Romeo	Brenda Thompson Stuckey

¹ All materials and activities related to this project that involved human subjects, focus groups discussions, individual key stakeholder interviews, individual health care foundation interviews, and a survey of community assets were reviewed and approved by the Harvard School of Public Health's, Human Subjects Committee (HSC).

² Steering Committee members were asked to address the following set of questions: do you believe disparities exist in the MetroWest area; where and why do you believe these disparities exist; what can be done to reduce and/or eliminate these disparities in health and health care; are there cities or towns in the MetroWest area that should be given priority attention in the MCHCF's disparities initiative; what should be the determining criteria; should the disparities initiative focus on the entire list of health system factors and/or health conditions that contribute to disparities in health and health care; what is the best way to determine priority area(s); can an initiative to eliminate disparities in health and health care succeed in MetroWest; and what role are you willing to play to ensure success of this initiative?

As a whole, the Steering Committee met on a monthly basis and also in a variety of subcommittees. Initially, three subcommittees, African American, Brazilian, and Hispanic were established to assist in the outreach to minority residents and leaders from our three targeted cities. Each subcommittee identified potential locations for focus groups and language interpreter assistance when required.

Ethnic Groups and Cities/Towns

Demographic data from the 2000 U.S. Census Report was used to narrow the focus of the Racial and Ethnic Health Disparities Initiative. All 25 MetroWest cities and towns were ranked from highest to lowest according to percentages of racial and ethnic groups. Three racial and ethnic groups (African American, Brazilian, and Hispanic) and three local cities with the highest percentages of these groups (Framingham 21.11 %, Marlborough 11.88 %, and Milford 7.43 %) were selected as the primary focus for the MCHCF’s racial and ethnic health disparities initiative. Table 2 highlights the top five cities or towns with the highest percent of documented racial and ethnic groups comprised of African American, Brazilian, and Hispanic residents.

Table 2 Selected Racial and Ethnic Groups by Cities and Towns

City/ Percent Racial & Ethnic Group	African American	Brazilian	Hispanic	Total
Framingham	5.09 %	5.16 %	10.86 %	21.11 %
Marlborough	2.17 %	3.65 %	6.06 %	11.88 %
Milford	1.35%	1.72 %	4.36 %	7.43 %
Hudson	0.91%	2.69 %	3.06 %	6.66 %
Ashland	1.79 %	1.21 %	2.92%	5.91 %

III. PROJECT COMPONENTS AND RESULTS

Because most other people don't have papers, they're not legally [residing in the United States], they're afraid to stand up and talk for themselves. So that's why we're here, because, somebody had to talk; somebody had to say something.

Hispanic/Latino Focus Group Participant (Framingham)

This section provides an overview and highlights from: 1) nine focus groups with African American, Brazilian, and Hispanic residents in Framingham, Marlborough, and Milford; 2) individual interviews with provider and community stakeholders; 3) assessment of data collection and reporting practices among MetroWest area health systems and departments; 4) survey of MetroWest community assets; and 5) interviews with Health Foundations with established funding initiatives to eliminate racial and ethnic health disparities. Each component section begins with a relevant quote from one of our many contributors, a brief discussion of the rationale and research methodology, followed by a discussion of our findings and summary of the results.

a. Focus Groups

I was born and raised in Chicago, lived two years in Nashville, TN and 31 years in California before coming here eight years ago. I think that this is the most racist area that I have ever lived in. African-American youths, past and present, in black communities have the support of the community in coming to grips with racism, a benefit the social environment of suburbia does not provide. The lack of understanding of racism or conscious acceptance of it can lead to profound depression with tragic consequences.

African American Focus Group Participant (Framingham)

Introduction

In keeping with the Foundation's mission to improve the health status of the community, its individuals and families through informed and innovative leadership, it was important that our efforts to establish a racial and ethnic disparities initiative also be guided by input from MetroWest community residents and stakeholders. Focus group discussions with MetroWest residents were identified as one of several essential strategies to obtain input from community members about their perceptions, feelings, and personal stories around health and health care. Focus groups were conducted to: 1) provide insights about the community's awareness of health disparities, 2) identify barriers to health that may lead to disparities in treatment and outcomes, and 3) uncover health concerns and suggestions for how the Foundation should prioritize its health disparities initiative.

Methods

As indicated in Table 2, the 2000 US Census was used to identify three cities and towns with the highest representation of minority residents. Framingham, Marlborough, and Milford were selected for having the highest composite population of African Americans,

Hispanic/Latinos, and Brazilians. Subcommittee participants assisted in recruitment and outreach strategies to identify location sites, prospective focus group participants, community liaisons, and interpreters. Because there is relatively poor public health data available for these groups the Steering Committee agreed that focus group discussions would provide insightful information from the community members' perspective.

Participant Selection and Recruitment

In order to plan the outreach and recruitment of focus group participants, sub-committees were formed for each racial and ethnic grouping. Sub-committees were initially comprised of interested Steering Committee members and evolved to include community leaders. Sub-committee members, outside key informants, and focus group sessions were used to generate additional information about potential contacts and strategies to enhance our outreach and recruitment efforts. There were a few churches that played a significant role in our abilities to outreach to and recruit focus group participants.

A total of nine focus groups were conducted between June and August, 2005 in each of the three selected cities and towns, Framingham, Marlborough, and Milford. Separate focus groups were conducted for African American, Hispanic/Latino, and Brazilian residents within each city and town. The focus groups met weekday evenings and weekends to accommodate the schedules of potential participants. The discussions were also conducted in locations that participants were familiar with or were conveniently located. The first focus group, African American, was conducted in Framingham at the Greater Framingham Community Church. All other focus groups were conducted in public town and city libraries. This venue was chosen because libraries were considered to be neutral, centrally located, and community residents expressed a familiarity with there location. Focus groups sessions were two hours long and consisted of, an overview of the project, overview of focus group session, signed consent, the completion of a questionnaire (Appendix 1, p. 56), and discussion.

Findings

Participant Demographics

[There are] a lot of people here with legal issues...and also the language barrier, everyday living for the immigrant is very stressful.

Brazilian Focus Group Participant (Marlborough)

Seventy-nine individuals that self selected to participate in the focus groups, 60% of which were women (n=47) and 39% of which were men (n=31) (See Appendix 2, Table 5). The average age of all focus group participants was 46 (range 13-80). There was one focus group participant in the Marlborough, Hispanic/Latino focus group that was under the age of 18 (age 13), whose parents requested her attendance and gave their consent prior to the start of the discussion.

The majority, 97% (n=77), of focus group participants reported living in a MetroWest city or town. The average length of residence in MetroWest reported by participants was

14 years. The average number of years of residence in MetroWest was nearly double for African American (20 years) participants than it was for both Hispanic/Latino (11 years) and Brazilian (10 years) participants.

African American participants reported household incomes higher than Hispanic/Latino and Brazilian participants. According to household incomes reported by participants, (Appendix 2, Table 6), over 90% of the African American participants made more than \$39,999, whereas approximately one third of the Hispanic/Latino and Brazilian respondents reported the same. There was a higher percentage of African Americans that reported having completed a bachelor's level or graduate level education (83%) than both Hispanic/Latino (38%) and Brazilian (29%) participants combined. In terms of health insurance status, fifty-nine of the seventy-one focus group participants had some form of health insurance (African American (96%), Hispanic (71%), and Brazilian (61%)). All African American participants (100%) received their care in a private practice doctor's office or from a primary care physician, compared to Hispanic/Latino (38%) and Brazilian (55%) (Appendix 2, Table 7).

Awareness of Disparities and Existence of Disparities in MetroWest

I think the major problem is the money, we don't have money to pay the doctor, we don't have money to buy the medicine; the major problem is this.

Brazilian Focus Group Participant (Marlborough)

Each focus group discussion started with a question that gauged participant familiarity with health disparities. The majority of focus group participants did not express a familiarity with or understanding of disparities. Focus group participants from the following groups did express a familiarity with or understanding of health disparities: African American (Framingham) and African American (Marlborough). Approximately half of the focus group participants in the Hispanic/Latino (Framingham) expressed a similar understanding. When asked to define disparities in health and health care, they placed emphasis on disparate³ health care and allocation of health related resources. In all other focus groups there was no expressed understanding of the term health disparities.

Causes of Disparities and Barriers to Good Health

There was a Hispanic family [at the hospital] and the woman from the registration was like yelling at them, and I had to tell her "They're not deaf, they just don't speak English; it doesn't mean that they're deaf!"

Hispanic/Latino Focus Group Participant (Framingham)

Salient barriers to good health and possible causes to disparities in health and health care, according to focus group participants are included under Appendix 3 (Table 8). Responses have been categorized into four thematic areas: MetroWest regional factors,

³ Definition: to be markedly distinct in quality or character.

policy and institutional factors, factors related to clinical providers and staff, and those factors that can be related to individual beliefs, norms, and experiences.

MetroWest Regional Factors: There were barriers and causes identified by focus group participants that that can be attributed to generalized characteristics of the MetroWest region.

- African American focus group participants pointed out that racial and ethnic minority populations make up such a small population of most MetroWest cities and towns that it is difficult for them to garner the attention of area institutions and policy makers.
- Those participants also felt that there is little or no dialogue in the region around the issue of disparities in health and health care and the health status of racial and ethnic minority residents.

Systems and Institutional Factors:

- At the *healthcare systems level*, barriers included: the high cost of health care, health insurance, prescription medication, and limited access to oral health care.
- At the *institutional level*, focus group participants identified the following barriers: a lack of commitment on the part of MetroWest institutions, a lack of culturally relevant and pertinent health information, long ER wait times, identification requirements (driver's license, social security card, etc.) of a health institution prior to the delivery of care, and the inadequacy of hospital interpreter services.
- Regarding the *factors related to provider and staff*, participants in all focus groups, regardless of racial and ethnic group, identified differential treatment in clinical settings as a barrier. Some felt this differential treatment was due to their racial and ethnic background, some thought it was due to their immigrant status, and some felt it was due to their insurance status. Brazilian and African American groups in Framingham and Marlborough went further to identify the preconceptions that providers and staff hold about different populations or individuals, which can affect the treatment they receive. Additional barriers attributed to clinical providers and staff includes: a perceived lack of cultural understanding, providers seem to have limited knowledge and interest in the diseases and conditions of concern to patients, and participants do not feel that providers are receptive to their needs and hear their concerns. Participants also shared experiences of late diagnosis or misdiagnosis at the hands of providers resulting from perceived prejudice or lack of understanding.

Focus group participants identified the following causes and barriers relating to *how individuals think, act, and internalize how they are treated*.

- Immigrating to the United States, language barriers, being uninsured or underinsured, and legal residence status may hinder Hispanic/Latinos and Brazilians from adequately accessing health services and information. Racism was an important factor for African American and some Hispanic/Latino residents; feelings of mistrust for area health providers, which are influenced by perceived racism, preconceptions on the part of providers, past negative experiences, and a perceived lack of cultural understanding and interest on the

- part of providers, were also issues. There was an expressed concern over the isolation experienced by residents in the MetroWest region.
- Additional factors contributing to barriers to good health include: late presentation with symptoms for clinical care, self-medication with non-prescribed therapies, and use of the hospital emergency room as primary healthcare setting by community members; poor nutrition and a general lack of health awareness and health related knowledge in the community; and a possible lack of involvement at an institutional and organizational level among MetroWest community members.

Solutions to Address Disparities and Improve Health

You ask what will change the disparities in health care? I think one [thing], is having somebody who looks like me tell me that “you’re messing up”. You know you, you keep eating those Dunkin’ Donuts, you keep doing the take-out every day for lunch, you’re going to get sick.

African American Focus Group Participant (Marlborough)

The following responses are among the most prominent solutions that emerged from focus group discussions regarding *community-centered investment* (a more detailed account of participant responses is included under Appendix 3, Table 9):

- opening area clinics that offer affordable, culturally responsive care especially in cities outside Framingham;
- promoting health education and self-advocacy;
- increasing the dissemination of culturally appropriate health related information;
- investment in systems, institutional and organizational growth to advance change;
- increasing the number of providers and staff of color or those equipped to serve communities of color in the MetroWest;
- provide incentives for the provision of services and the development of programs to meet the diverse needs of communities of color in MetroWest;
- cultural sensitivity training and education for providers and staff;
- culturally responsive patient navigation in various clinical setting; and
- increase opportunities and access to affordable healthcare and insurance.

Foundation’s Focus

[We need people] to advocate, it doesn’t need to be the staff, it could be just another (independent) advocate, where people can go in and work out their problems. [The advocate would] be the liaison between the patients and the hospital.

Hispanic/Latino Focus Group Participant (Framingham)

In developing a program to improve the health and health care of minority residents, focus group participants identified the following areas of *focus for the MetroWest Community Health Care Foundation* (a more detailed account of participant responses is included under Appendix 3, Table 10):

- *The Foundation should advocate for and promote institutional change to improve health experiences by:*
 - Involvement in policy and institutional change
 - Advocacy
 - Patient rights education
 - Promoting culturally and socially responsive health care
 - Quality in health care
 - Promote accessible recreation options

- *The Foundation should support information dissemination and health promotion activities by making available or supporting:*
 - Health awareness raising activities
 - Health education
 - Targeted marketing to minority populations with health related messages
 - Health promotion and prevention activities/programs
 - Information dissemination
 - Men's health
 - Focus on youth health
 - Parent education

- *The Foundation should support capacity building initiatives that:*
 - Promote social inclusion
 - Support the formation of coalitions and partnerships

Community Involvement

When you think about health you think hospital, emergency room, or the clinic, but if there is a space where people can gather...it could be a space where people can dance or they can play bingo where people can get together socially; prevention without thinking about health in that negative way.

Brazilian Focus Group Participant (Framingham)

Institutions and Organizations to Involve: There were a number of organizations and institutions identified by focus group participants as entities that they feel should be involved in future programs developed or efforts made to improve the health of their communities (see Appendix 3, Table 15). These organizations included community organizations, faith based organizations, schools, law enforcement agencies, and various media outlets that resonate with specific communities.

Individual Involvement: Participants in focus groups across the different racial and ethnic groups expressed a willingness and interest to increase their own involvement with various institutions. They mentioned involvement in institutional boards and decision-making processes as an option. Similarly, there was an expressed willingness to take part in information dissemination activities if called upon by the Foundation. Brazilian and African American participants expressed a willingness to take part in outreach efforts as

well. Brazilian participants also indicated a willingness to translate documents or serve as interpreters.

Health and Social Concerns

It's like we don't exist, they don't want to know why [rates of certain diseases are] higher for us, they think that we're fine, we're not complaining, you know, we'll continue to die at a higher rate from diabetes, and cancer, and things like that, because we're not the majority population here, we're a minority population in numbers, and so we're not skewing the data, if you know what I mean, because we're only a few people who are dying at a higher rate [from] those particular diseases.

African American Focus Group Participant (Marlborough)

During the course of discussions, focus group participants provided information in additional areas outside those presented above. Given that regional public health data for minority populations is limited, especially for Brazilians, of particular interest is the information provided regarding perceived health and social concerns for their communities (See Appendix 3, Table 11). Respondents across ethnic groups identified cardiovascular health as being a major concern for their community.

Summary

Focus group participants offered important solutions to the problems associated with poor health and health disparities. Their suggestions included two primary strategies: invest resources in the area of health education and training that leads to community empowerment; and create opportunities for community members from racial and ethnic groups to get involved in institutional and organizational capacity building activities that result in more culturally competent treatment settings where minority residents are better served. Participants identified a number of organizations for potential partnership around a MCHCF agenda on health disparities. Focus group participants consistently expressed an interest in individual involvement and volunteerism. These findings suggest that the MCHCF and its numerous community partners, organizations, and residents are prepared to begin a focused initiative, that aims to improve disparate health outcomes and health related experiences in involving racial and ethnic minority residents.

b. Stakeholder Interviews

I think there are huge disparities in who has access to what we call in public health the social determinants of health, who has access to either good nutrition, the ability to exercise, even scheduling time of appointments. People who are on the tougher end of the economic scale may be working two jobs and may have great difficulty getting to clinic hours that fit in with their schedule, or not have enough infrastructure to support their getting to health care, like not having child care options, not having transportation.

Interviewed Stakeholder, MetroWest Public Health Practitioner

Introduction

Just as we conducted focus group discussions with residents to elicit community input, we also saw the significance of informative discussions with community leaders and leaders in health and social services in the region. As service professionals on the frontline, community health and mental health professionals were approached to provide important insights into the possible causes of disparate health outcomes, including differences in treatment, and access to services experienced by minority residents in MetroWest. Similarly, community leaders, many who work in service professions, were able to provide insights into the expressed and experiential concerns of the communities that they serve and are members of.

Methods

The Steering Committee was instrumental in nominating and selecting participants in the informant interviews. From feedback provided by the Committee, an initial list of MetroWest-based stakeholders was drafted. The list included the chief medical officers and executive staff from the largest hospitals in the region, the Framingham Community Health Center, leading group practices, heads of mental health and social service agencies, and community based organizations that serve the African American, Hispanic/Latino, and Brazilian populations. This list was presented to the Steering Committee, leading to a series of discussions to finalize the list of possible interviewees (See Final List of Community Stakeholders in Appendix 3, p. 69).

The Steering Committee established a series of interview questions designed to explore potential causes of disparities in the region, possible solutions, and to identify organizations that should be involved in the development of a disparities initiative by the Foundation. Interviewees were contacted and scheduled for a one-hour tape-recorded phone or face-to-face interview at the Foundation. The audio recording were then transcribed and prepared for analysis.

Findings

Causes of Disparities and Barriers to Good Health

I feel that the MetroWest area has become much more culturally diverse than people in positions of power, authority, and [involved in the] provision of health services are either aware of or willing to acknowledge.

Interviewed Stakeholder, MetroWest Physician

MetroWest Regional Factors: Stakeholders identified characteristics and factors that can be attributed to barriers to good health and health care in the MetroWest region.

- Stakeholders identified the lack of recognition and sense of accountability to the health of the growing immigrant and racial and ethnic minority populations in MetroWest, by providers and key decision makers in the region. This is compounded by the lack of cultural and linguistic diversity among the pool of health providers in MetroWest.

- Poor public transportation was also cited by stakeholders as being a barrier to receiving care for area residents; especially when residents live in areas where their healthcare needs are not being met and they are required to travel outside the MetroWest region.

Systems and Institutional Factors:

- At the *healthcare systems level*, the entrenched nature of the healthcare system that places emphasis on the illness rather than wellness and focuses on treatment of the individual rather than looking at the social determinants of health and illness was implicated by stakeholders as being a crucial factor to disparate health outcomes experienced by racial and ethnic minority populations. Stakeholders also identified the limited access to affordable healthcare as being a significant barrier to the health of various communities.
- At the *institutional level*, stakeholders highlighted the mandatory identification requirements and inadequate interpreter services as being barriers to individuals that have immigrated to this country and have limited English proficiency and concerns regarding their legal residence status. A lack of culturally relevant health information serves to isolate communities and prevent them from accessing available resources. According to the stakeholders, this is partly due to the lack of resources and funding for outreach, advocacy, and information dissemination. There is also an acknowledged lack of partnership and collaboration between organizations, institutions, and community groups.
- Regarding *provider and staff factors*, Stakeholders identified the limited cultural understanding and sensitivity among providers as being a key barrier to positive healthcare experiences and good treatment. Preconceptions and prejudices held by healthcare providers and staff around patient compliance to treatment were also identified as impeding the receipt of quality care. According to stakeholders, these factors fuel the mistrust that area residents have of providers.

Individual Beliefs, Norms, Experiences, and Behaviors:

- Most stakeholders noted that it is the intersection of racism with other factors such as immigrant status, socioeconomic status, insurance status, perceptions of healthcare providers, education/literacy levels, and poor nutritional options, and other social determinants of health that lead to disparate health outcomes.
- Stakeholders working with social services and mental health agencies also introduced the challenging case of those that are homeless; they are most in need of services and are among the hardest to reach.
- Specific to recent immigrant populations, namely Hispanic/Latinos and Brazilians, language barriers, legal residence status, and loss of socioeconomic or professional status via immigration were identified as factors that contribute to poor health or expose individuals to a reduction in health status.
- Also mentioned as being germane to immigrant groups (especially among Brazilian residents) is the use of non-prescription therapies and utilization of hospital emergency rooms as primary healthcare setting.

Solutions to Reduce Disparities and Improve Health

I think also, if we can involve the business community. For instance, there are fresh fruits and vegetables in certain neighborhoods, and I think if we can encourage the residents to take advantage of them and not just pick up the junk food because its so convenient. So if we can continue to reach out, then perhaps some of the stores might have[educational] sessions [where people are approached] to try new foods that might be healthier for them. [Help people] realize that there are different ways to prepare food.

Interviewed Stakeholder, Community Advocate

Community Centered Investment:

- Community based outreach and education, utilizing community health worker model
- Promoting health education and self-advocacy
- Increase the dissemination of culturally appropriate health related information through the use of popular media outlets and gathering places
- Increased patient advocacy and access
- Opening area clinics that offer affordable, culturally responsive care
- Promote prevention and screening in community

System, Institution, and Organization Centered Investment:

- Promote the collection of data on health outcome measures by grantees
- Support cultural competency training
- Collect and use race/ethnicity data to identify “high-risk” populations
- Increase availability of interpreters
- Shift the institutional focus from illness to wellness
- Provide accessible preventative care
- Increase allocation of resources for advocacy, education, and outreach
- Provide access to provider networks that match patient demographics and health needs
- Promote synergistic work between providers

Foundation’s Focus

I think disease management protocols are things that not only are important in this particular perspective, but across the board. I mean, health care in general has basically been focused on illness, not on wellness in the past, and clearly we need to [focus] much more heavily on wellness. And so disease management protocols, in terms of having people take their medications properly, understanding how to take their medications, understanding how to self-manage their disease, is extraordinarily important in maintaining the health and welfare of the community. But there has not been the appropriate resources brought to bear in order to do that. The Foundation is in a unique position to help with that, and the amount of money that is available, relative to the number of people served, is extraordinary.

Interviewed Stakeholder, MetroWest Physician

Advocacy and Institutional Change to Improve Healthcare Experiences:

- Involvement in patient advocacy

- Increase the number of culturally and linguistically competent staff through recruitment of providers of color, multilingual staff, and cultural competency training
- Promote culturally and linguistically appropriate mental health services
- Promote data collection

Information Dissemination and Promoting Health Awareness:

- Community wide education around health disparities and the health of racial/minority populations
- Serve as information clearinghouse for institutions, providers, and community at large
- Community centered outreach efforts
- Information dissemination
- Targeted health education
- Promote screening and prevention
- Support school based health programs

Capacity Building:

- Promote social inclusion
- Support the formation of community coalitions and partnerships

Projecting Community Involvement

And I think that its important to develop or cater to folks on the health care front who are from the communities themselves, who represent those communities, who speak to those communities, and who are trusted by those communities, in terms of [improving] peoples health status? Lets get their attention. How do we get their attention? You get their attention through folks who understand who they are and where they come from, and what their traditions, and cultures, and languages are all about. I think that's a critical part of this, and the folks who work in health care, whether its a hospital, or health center, or even the social service agencies in communities, should all be trained as well, I think, in cultural competence.

Interviewed Stakeholder, MetroWest Public Health Practitioner

Institutions and Organizations to Involve: There were a number of organizations and institutions identified by stakeholders as entities that they believe should be involved in programs developed or efforts made to improve the health of racial and ethnic minority populations in MetroWest. Interestingly this list of organizations was much longer and included health care providers, social service agencies, and mental health agencies that were not identified by focus group participants when asked the same question.

Summary

Although there was a resounding recognition of disparities in MetroWest, we learned from stakeholders that there may be a lack of recognition and/or disinterest around this issue by providers and decision makers that impact the health of individuals in the region. Stakeholders consistently identified the lack of cultural competence among health care institutions and providers as a significant barrier in health care settings along with language barriers and racism. Community based outreach and education utilizing

community health workers, popular media outlets and gathering places to disseminate culturally appropriate health related information were highly recommended as mechanisms to reduce the barriers to good health and health care. Also, these stakeholders identified numerous organizations and strategies to support the MCHCF’s racial and ethnic health disparities agenda including the promotion of data collection on health outcome measures by grantees, increasing the allocation of resources for advocacy, education, and outreach, and the support increased availability of trained interpreters, multilingual, and culturally competent providers and staff.

c. Survey of Community Assets

Introduction and Methods

To explore the response to health disparities by institutions, organizations, and programs in MetroWest we distributed an institutional assets questionnaire. Organizations in Framingham, Marlborough, and Milford were selected based on listings from the United Way, affiliated or previously funded organizations by the MCHCF, and referrals from the Racial and Ethnic Disparities Steering Committee.

The questionnaire (See Appendix 1, pp. 59-62) collected information on: general organizational information, populations served, along with the health conditions, social factors that the organizations addresses and health-related services provided. Seventy-two institutions, organizations, and groups representing a wide array of service areas were sent the questionnaire electronically or via fax.

Findings

Thirty-five completed questionnaires were returned, yielding a 49% response rate. The total number of respondents from each city/town is included in Table 11 below.

Organizational Classifications

Respondent organizations included eleven (30%) social service agencies, six (17%) educational institutions, two (6%) hospitals, two (6%) mental health agencies, two (6%) health clinics, one (3%) local health department, one (3%) public safety institution, and ten (29%) other. The majority type of respondent was eighteen (51%) private, seven (20%) public, seven (20%) local, two (6%) was regional, and one (3%) was a state agency. Additional charts and tables summarizing the respondents’ background and information are provided in Appendix 4.

Table 3 The total number of respondents from each city/town

City/Town	Number of Respondents
Framingham	26
Marlborough	10
Milford	4

* The total number of respondents for this table does not equal 35 because some respondents indicated that they have multiple operational sites

Twenty-one (60%) out of the 35 respondents indicated that their organization has developed programs in response to health disparities⁴. These 21 respondents also reported that there is at least one dominant language other than English that is spoken by their service population. Languages identified as often used included: Spanish, Portuguese, Haitian Creole, Russian and Khmer/Cambodian. When asked whether they offer informational materials in languages other than English, seventeen (81%) reported that they do. Informational materials were reported as being provided in were Spanish, Portuguese, Haitian Creole, French, Russian, Khmer/Cambodian, Vietnamese, Japanese, and Chinese. Respondents were also asked about the provision of services in languages other than English. Seventeen (81%) also reported that they provide services in languages other than English, such as Spanish, Portuguese and Russian. Two of the organizations, one a hospital and the other a clinic, reported that services are provided in various languages outside of those listed, via interpreter services and bilingual or multilingual staff.

Health Conditions and Social Factors

Based on respondent feedback, the five most frequent health conditions and social factors addressed in the general population include other mental health conditions, substance abuse, depression, domestic violence, and obesity, respectively. The five most frequent health conditions and social factors addressed among African Americans include diabetes, heart disease, obesity, domestic violence, and other mental health disorders, respectively. Among Brazilian residents, the most frequently addressed health conditions and social factors include substance abuse, domestic violence, with post-traumatic stress disorder, youth violence, obesity, and other mental disorders all ranking the same. For Hispanic/Latino residents, the most frequently addressed health conditions and social factors include substance abuse, domestic violence, with youth violence, post traumatic stress disorder, other mental disorders, and obesity all ranking the same. African Americans were more often indicated as population served, followed by Hispanic/Latino and Brazilian (see Appendix 4, Table 16).

Health Related Services

Among the general population, the five most frequently indicated health related services include health education, mental health services, referral services, health promotion and screening services. For African Americans, the five most frequently indicated health related services include health education, mental health services, health promotion, referral services and screening respectively. For Brazilians, health education, screening, mental health services, referral services, with support groups and health promotion each ranked the same. For Hispanic/Latino residents, the most frequently indicated health related services include health education, mental health services, screening, with referral services, health promotion, and support groups each ranking the same (see Appendix 4, Table 17).

⁴ For the purposes of discussion, we considered the 21 programs that indicated that their organization has developed programs in response to health disparities.

Summary

Over half of the organizations/institutions surveyed reported having developed programs in response to health disparities. Eighty one percent of those organizations provide informational materials or services in languages other than English. Although the number of organizations/institutions selected to take part in the project was limited, these results illustrate that there are opportunities for partnership and collaboration in the region, among entities that already have a relationship with the Foundation. Most importantly those organizations represent various sectors: social services, healthcare, education, mental healthcare, and public health, the collaboration of which will be essential to the success of the Foundation's initiative.

d. Survey of Racial and Ethnic Data Collection Methods

Introduction and Background

One of the principal challenges to eliminating disparities in health and health care lies within our abilities to collect and appropriately use racial and ethnic data at the neighborhood, community, regional, state, and national levels. Data are essential for state policymakers, agencies, and private health systems to identify health disparities, plan and justify special initiatives targeted for minority communities, measure progress in eliminating disparities, and make regional or cross-state comparisons (McDonough et al, 2004). Without legislation and enforcement, routine monitoring, and adequate training and infrastructure, health departments, health systems, hospitals, health centers, mental health programs, social services, school systems, and other small and large city and state agencies are less likely to expand collection and use of racial and ethnic data, particularly where sub-populations are concerned.⁵

For MetroWest the reliance on race and limited ethnicity data results in an incomplete picture of health status for the region, in that the health of growing immigrant subpopulations, such as Brazilians, is portrayed accurately. According to the MetroWest Health Data Book & Atlas (2005) approximately half of the Brazilian population identifies as "Some other race alone" or "Two/more major race groups" and an overwhelming number does not identify as being ethnically Hispanic/Latino.

For this project we sought to better understand how data on race and ethnicity are collected and reported by various health providers in the MetroWest region and what can be done to remedy the gaps in data for racial and ethnic groups in the region.

⁵ Efforts have been made to enforce and standardize data collection by federal, state, and private agencies and organizations. In 2003, the Office of Management and Budget (OMB) announced its decision concerning the revision of Race and Ethnic Standards for Federal Statistics and Administrative Reporting. The revised standards called for five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The new standards also included two categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino (Office of Management and Budget). These standards have improved our ability to investigate the health outcomes and health care of racial populations. Yet, there is still an emphasis on the collection of race data as opposed to increasing the options for ethnicity beyond Hispanic/Latino ethnicity.

Methods

MetroWest Health Providers Race/Ethnicity Data Collection Practices

Data collection practices of health providers were assessed through a questionnaire and informational interviews. We started by identifying different types of health providers and provider institutions in MetroWest. The selection of categories for types of providers was informed by discussions with the Steering Committee, and led to the selection of hospitals, the community health center, group practices, and clinics. Facilities were chosen based on their size, their role in serving the racial and ethnic populations, and their geographic placement. A total of ten health care settings were surveyed, three hospitals, one community health center, two group practices, two mental health agencies, and two clinics. All but one of the ten health care settings chosen agreed to participate in the project (See below).

Health care settings that were surveyed regarding their race/ethnicity data collection practices include the following:

- MetroWest Medical Center
- UMASS Memorial Marlborough Hospital
- Framingham Community Health Center
- Southboro Medical Group
- Harvard Vanguard Medical Associates
- Open Door Medical Program
- MetroWest Free Medical Program
- Wayside Youth and Family Support Network
- Advocates, Inc.

Addressing Gaps in Data: Promising Practices

In order to examine plausible solutions to addressing the gaps in data collection, we conducted key informant interviews. We also conducted research to identify other local and regional activities in the state to address similar gaps in data. From the MetroWest Health Data Book & Atlas (2005) we were able to identify three clear challenges and gaps in data for racial and ethnic minority populations in MetroWest:

1. Obtaining data about the Brazilian population
2. Lack of risk data for African American population
3. Obtaining school or region specific youth risk data

Findings

MetroWest Health Providers Race/Ethnicity Data Collection Practices

Results of our survey of racial and ethnic data collection practices among area health providers are summarized in Appendix 5 (Table 18). We found that most health providers collect this data in order to adhere to funder or regulatory guidelines and that

there is an emphasis placed on the collection of data along broad racial categories, where Hispanic/Latino is the only ethnicity option provided. Among health providers that routinely reported this data for patients, only the community health center collects this data for smaller emerging ethnic groups, such as Brazilians. Group practices reported that they did not routinely collect race/ethnicity or language data, although one provider did state that they are in the process of developing a data collection protocol that will allow for the collection of this information about patients. Independent (free/low-cost) clinics, which serve immigrant residents and those that have barriers to accessing care elsewhere, reported that they do not collect race/ethnicity information for patients.

Obtaining Data on Emerging Populations and Sub-populations

The Brazilian population is often subject to misclassification. Through both the survey of data collection practices and institutional assets questionnaire we found that the Brazilian population is sometimes categorized racially as White or ethnically as Hispanic. To avoid such misclassification the Framingham Community Health Center has been collecting data on the Brazilian population and other groups since its inception in 2004. This broader selection of racial and ethnic categories allows the Health Center to get a more accurate health profile of the patients and any disparate health outcomes that may arise.

Great Brook Valley Health Center in Worcester has had an extensive history of responsive data collection by increasing the number of racial and ethnic categories that patients have to select from and building capacity among their staff around changing data collection practices. According to Zoila Torres Feldman, Executive Director of Great Brook Valley Health Center, *“each data point is a client, and if you don’t appropriately record that point you cannot administer appropriate treatment and develop appropriate programs.”* It is with this understanding that the Health Center started collecting information on subpopulations in the early 1980s, before they had electronic medical records.

Obtaining Risk Data for Small Populations

Community Health Network Areas (CHNAs) were established in 1992 out of the Office of Health Communities within the Massachusetts Department of Public Health. The CHNAs are coalitions of public, non-profit, and private sectors groups and individuals whose aim is to track and improve upon the health of the population in their regional area. In response to the lack of risk data for small populations in their area, CHNA 11, the Greater Lawrence Community Health Network, contracted to conduct oversampling in Lawrence and Lowell. This was done to obtain specific data on communities for which specific data was or was not available through the state Behavioral Risk Factor Surveillance System (BRFSS).

Obtaining Local and Regional Youth Risk Data

Many schools in the MetroWest region are or have been involved in providing youth risk data through participation in the Youth Risk Behavior Survey (YRBS), conducted by the Massachusetts Department of Education and the Centers for Disease Control and Prevention. Unfortunately, this data is not provided for at the local or school-specific level. MCHCF has already taken the initiative to obtain local and regional youth risk data through administration of the YRBS in several communities. In November 2005, the foundation approved an initiative that will provide funding to all high school in the service area of 25 cities/towns to conduct the survey biannually over a ten-year period. This effort will allow the Foundation to aggregate regional data and develop specific initiatives and interventions based on identified needs and trends.

Summary

Through the survey of data collection practices of area health providers and key informant interviews, we have identified some of the sources of gaps in health outcome data and gained insights into solutions that can be put in place to close those gaps in the MetroWest region. All health providers do not routinely collect race and ethnicity data, and those that do collect this information do so to adhere to funding or regulatory guidelines. Addressing the gaps in health outcome data for racial and ethnic minority populations requires the development of innovative strategies that meet local and regional needs such as oversampling of specific racial and ethnic populations in geographic areas (i.e. census tracts) where their populations are relatively high. Key informants also suggested working with area health providers, boards of health, schools nurses, mental health and social service agencies to obtain, collect, aggregate, and disseminate health information as strategies to overcome the complex and varied challenges involving data collection on race and ethnicity.

e. Health Foundations Addressing Disparities

Introduction

Health related funding is the second largest area of funding by larger foundations in this country.⁶ Since the *Healthy People 2010* (U.S. DHHS, 2000) and the 2002 Institute of Medicine report, *Unequal Treatment*, the number of philanthropic organizations establishing innovative grant making initiatives to address the issue of disparate health outcomes and to improve health care experiences of racial and ethnic minority populations has increased. Specifically, larger foundations such as the Kaiser Foundation, the Robert Wood Johnson Foundation, the California Endowment, and the Commonwealth Fund have made notable strides in the area of health disparities. They've focused on areas of policy making at national and state levels, the development and

⁶ Foundation Center, Foundation Giving Trends, December 2005

promotion of quality standards at the institutional level, and increasing health provider and community capacity to improve upon health outcomes and health care experiences.

For this project we sought to gain insights by conducting investigative interviews with three mid-size health foundations with an asset size similar to MCHCF and that are currently involved in racial and ethnic health disparity programs or initiatives, and to assist us in gaining a better understanding of the scope, commitment, and challenges involved in developing and sustaining programming to tackle racial and ethnic health disparities.

Methods

A search using the Grantmakers In Health website was conducted to identify Foundations in the United States that have a regional focus, have assets in the range of \$50-\$100 million, grantmaking in the range of \$500,000 to \$2.5 million, and serve the following populations: communities, immigrants, minorities. An additional search was conducted based on grant programs or initiatives for foundations with assets in the range of \$50-\$100 million with programming targeting communities, minorities, and immigrants. From these two searches we compiled an initial list of 16 foundations.

Internet, literature, and publication searches were used to make a preliminary determination of the racial and ethnic health disparities programming at each foundation. This information was presented to the Steering Committee during two separate monthly meetings, at which time additional foundations were also suggested. From these searches and meetings our initial list was narrowed down to a list of 7 foundations.

Connecticut Health Foundation, St. Luke’s Health Initiatives, and the Northwest Health Foundation were selected to participate in interviews based on their health disparities programming and willingness to participate in an interview about a specific racial and ethnic health disparities program or initiative developed by their foundation. The assets, regional focus, and regional populations for each foundation in comparison to MetroWest are presented in Table 7.

Table 4 Comparison of each Foundation’s Regional Focus, and Populations Served, and Assets

Foundation	Regional Focus	Regional Population	Assets*
MetroWest Community Health Care Foundation	MetroWest, Massachusetts	457,232	\$95,857,544
Connecticut Health Foundation	State of Connecticut	3,503,604	\$132,808,187
St. Luke’ Health Initiatives	Maricopa County, Arizona	3,501,001	\$98,287,858
Northwest Health Foundation	Oregon, and six counties in Southwestern Washington	4,179,718 (2,609,288)	\$86,682,149

*Assets are based on foundation’s reported assets reported in 2004 annual reports. Regional population is based on 2000 U.S. Census data for regional focus, as specified by each foundation.

With input from the Steering Committee, a set of interview questions were developed to ascertain information about the scope of each foundation’s program or initiative, the impetus for the foundation’s work in the area of disparities, data utilization in planning,

barriers to programming, community assets that have emerged, and the time table for the disparities program or initiative (See Appendix 1, p. 63). The interviews were conducted via telephone, tape recorded, and structured to last approximately one-hour.

Results

Each foundation has developed a program or initiative that represents a unique way of addressing disparities in health and health care. Information presented about each program or initiative was informed by literature, the foundation's website and interviews with foundation executives. The information below includes our key findings from foundation interviews and is organized to highlight the scope, timetable, impetus, data utilization, barriers, and emergent community assets for each program or initiative. Also included below are foundation accounts of the barriers faced in establishing their program or initiative and the community assets that emerged along the way.

Connecticut Health Foundation

The Connecticut Health Foundation (CHF), established in 1999, was the youngest of the health foundations we interviewed. With a statewide emphasis, this mid-size foundation has made great strides in incorporating the reduction and elimination of racial and ethnic disparities in health and health care into their foundation and affecting change throughout Connecticut. In 2001, reducing racial and ethnic health disparities was adopted as a priority area for the foundation.

The impetus for the Foundation's focus on racial and ethnic health disparities was a combination of a belief that health care conversion foundations are instruments of change, a recognition by foundation leadership that health disparities is a fundamental issue in health, and the tremendous passion that the Foundation's leadership has around this issue. The CHF has a strong foundation in data driven decision-making. In order to establish priority areas, the Foundation accessed the following data and resources: a commissioned needs assessment, state health outcome data, a series of white papers, the IOM *Unequal Treatment* report, a state multicultural health report, along with other literature. To plan and develop programming areas, the foundation conducted a series of focus groups to determine successful communication and information dissemination around the topic of disparities, stakeholder interviews, sponsored two large conferences to facilitate networking and identify "best practices", and convened discussions with physicians and various community leaders.

The goals of the racial and ethnic health disparities priority area are to address disparities through increasing minority health providers, promote and fund community owned and community driven associations, and translate policy recommendations into action. The first of these goals involves partnering with academic institutions and organizations to increase enrollment, recruitment and retention at the baccalaureate, graduate, and post-graduate levels. The foundation also shared an interest in targeting minority high school students to foster academic pathways that lead to careers in the biomedical and healthcare industries. The Foundation has launched the Community Leadership Fellows Program to

foster community owned and community driven programs, build leadership capacity within communities, and distribute community guided health education grants that serve to educate community around health related issues of concern.

In relation to translating policy into action, the Foundation has distributed advocacy grants that funded the health report card by the NAACP and a report by the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Health Disparities. The policy panel was an independent group of individuals and state leaders from various fields which convened at the end of 2003. After approximately one year of data collection the Panel presented the Foundation with a set of recommendations in March 2005.

When asked about the barriers to developing the Foundation's priority on racial and ethnic health disparities, Foundation President, Patricia Baker listed the following:

- Figuring out how to take a limited pool of resources and exact real change;
- Eliciting board open-mindedness around the level of complexity of racial and ethnic disparities in health/healthcare;
- Figuring out the right language and means by which to make disparities work resonate and incite passion in others;
- Addressing racism and people's unwillingness to openly address the issue;
- Lack of data;
- Lack of clarity around cultural competency (what does it look like and how do we get there?)

Ms. Baker also stressed the importance of long-term commitment. With no concrete time limits set by her Foundation, she recommended that foundation's make about a 10-20 year commitment. She also mentioned the significance of benchmarks to track the progress and marked reduction in health disparities or improved health outcomes.

Through the development and implementation of the Foundation's priority on racial and ethnic health disparities, the community has taken a more active role in identifying their needs, and new partnerships have been formed between organizations, institutions, and community. Overall, the Foundation has been relatively successful to date but remains challenged to sustain and improve upon their progress in eliminating racial and ethnic health disparities.

Northwest Health Foundation

The Northwest Health Foundation (NHF) is a conversion foundation that has been in the business of health philanthropy since 1997. At the end of 2004, NHF partnered with the group practice healthcare organization, Kaiser Permanente (Northwest Region) to establish the Kaiser Permanente Community Fund (KPCF). This partnership allowed for a shift in the geographic focus of the Foundation and created an opportunity to focus a greater amount of resources on the issue of disparities of health and healthcare.

Kaiser Permanente selected the following three areas of concentration for the fund:

1. Increasing the capacity of community safety net clinics

2. Promoting health equity
3. Promoting culturally competent care

All three aspects address racial and ethnic disparities in health and healthcare. Priority two speaks to the approach by KPCF advisory committee and NHF staff to address such disparities. Chris Kable, program officer explained, *“What we’re trying to get at is a little more upstream rather than try to correct let’s say the fact that Latinos in Oregon have diabetes mortality more than 60% higher than the rest of the population and trying to redress that clinical condition after its already manifested itself. [We’re] trying to get a little more upstream to the social determinants that cause those disparities.”* In deciding to focus on disparities in health and health care and selecting these priority areas they were guided by such publications as the Surgeon General’s Office, IOM *Unequal Treatment* Report, Grantmakers In Health, and state health outcome data along with the passion and commitment of leaders at Kaiser Permanente around this issue.

Kaiser Permanente committed all of the initial \$28.5 million dollars to the KPCF; these funds were a result of a surplus from their clinical operations. In late 2005, the Foundation announced and distributed the first round of grants to 11 organizations, totaling \$1,981,994. The KPCF intends to distribute approximately \$3 million per year over approximately 10 years. At the end of the 10 years the goal is to have made a substantial impact on the health profile for the region.

A group of individuals were selected by Kaiser Permanente to serve on an advisory committee, which works with NHF staff to administer, manage, and grow the Fund’s capacity to disperse grants annually that will translate into lasting change. The advisory committee consists of up to 10 individuals, 5 that represent different constituencies within Kaiser Permanente and 5 that represent various constituencies in the community.

The following emerging barriers were identified from the Fund:

- Assessing and raising racial/cultural sensitivity levels among staff that view themselves as being generally open-minded and accepting;
- Staffing- there was a great deal of work to be done by a handful of people at the start of the Fund.

Community based groups, agencies or organizations were not involved in the planning and decision making of the KPCF, outside of receiving requests for proposals, which was largely due to time constraints. But the advisory committee and NHF staff does intend to engage community stakeholders in the future to elicit information about the health concerns and priority areas of their communities.

St. Luke’s Health Initiatives

The St. Luke’s Health Initiative is a health conversion foundation that has operated in Maricopa County and throughout the state of Arizona for over 10 years. Formerly known as the St. Luke’s Charitable Health Trust, the St. Luke’s Health Initiatives has been the beacon for socially responsive public health over the course of the last decade. In 2003,

the Foundation took a step in relatively uncharted territory with the creation of the *Heart and Soul Program (HSP)*. Through the initiatives of members and leaders of faith based organizations and community mobilization, the *HSP* was developed to address the high rates of cardio-vascular disease among African Americans in Arizona. The Foundation was moved to action by state level health outcome data that indicated that African Americans in Arizona were disproportionately affected by cardiovascular disease, their inherent interest in disparate health outcomes, the availability of restricted funds from the conversion process that were meant to fund work in the area of cardiovascular and respiratory health, and an interest in innovative grant making.

Although the *HSP* is funded by the foundation, it is organized and led by a coalition comprised of the following partners, the Black Nurses Association of Greater Phoenix (BNA-GP), the African American Faith Partnership, and Tanner Community Development Corporation. The Foundation is quick to credit the focus on the faith-based community and coalition members. With a sense of ownership, coalition members identified the existing networks of faith-based groups and harnessed the pastor's influence to enhance information dissemination and outreach activities early in the developmental stages of the *HSP*.

The *HSP* emphasizes exercise, health conscious nutrition and dietary habits, screening, health education, and awareness raising activities. The health education piece is carried out by the BNA-GP for the most part. According to Vanessa Hill, president of the BNA-GP, through the *HSP*, community members and congregants of various churches have received blood pressure screenings, cholesterol screenings, diabetes screenings, and actively participate in walking clubs. As incentives for participation in walking clubs, pedometers and t-shirts are distributed along with milestone prizes when participants reach their personal goals. Associated with the screenings is a referral system that has been established to refer individuals based on their scores/levels for free or low-cost care.

The barriers involved with the *HSP* include those affecting the foundation and those affecting the coalition members.

- Foundation Barriers:
 - o Preconceptions about what an effective intervention or program looks like;
 - o Forging meaningful connections with community;
 - o Understanding what segments of community are represented by community organizations; and
 - o Understanding the extent to which organizations represent the populations or segments of community they say they do.
- Coalition Barriers:
 - o Receiving assistance as-needed rather than adhering to traditional guidelines from funding organization
 - o Staffing

Both the foundation and coalition members identified the following community assets that have emerged during the course of the *HSP*:

- Community members/congregants actively request health education or information in specific areas that concern them;
- The growth in the coalition as it begins to set its own goals, as it becomes a conduit for the community's interests and concerns;
- Community networks emerge as networks for information dissemination; and
- Feelings of ownership and accountability.

When asked about the timeline for the *Heart and Soul Program*, we were informed that there is no concrete timeline. This is due to St. Luke's and their board having undergone "an evolving process" in recent years to think beyond the traditional 3-5 year granting cycles. With the experiences of a successful infant hearing program, funded from restricted funds, which, in a ten-year period, led to the establishment of state-wide guidelines and a system for infant screening and follow-up treatment, the foundation was primed to make the shift towards another long-term investment.

According to Jane Pearson, Associate Director of Programs, "*While we don't promote it (the Heart and Soul Program) as a disparity initiative, it really is trying to address disparities. But it is flipping it on its side and saying what is it that communities have that they can bring to the table to address issues in their own communities. That isn't to say that they have to address them all by themselves. It becomes their initiative rather than our initiative.*"

Summary

Foundations interviewed for this project highlighted the importance of a commitment and passion to understand and tackle the factors that contribute to disparities in health and health care for racial and ethnic minority populations/populations of color. There was a shared understanding that in order to create and bare witness to lasting change in health outcomes there needs to be long term commitment and vision beyond traditional grant-making initiatives. Foundation representatives also felt that health disparities work requires cultural understanding, a willingness to learn, the facilitation and support for community ownership and community-centered leadership, and an understanding of the evolving community landscape, customs and norms.

CONCLUSION

I think education, outreach, and advocacy are functions that are very vital to improving the health status of folks in our community. There are things which are not being done now, except on an ad-hoc and/or volunteer basis, and I think that's a place that the Foundation -- might look as a place to do something very concrete, very real.

Interviewed Stakeholder, MetroWest Public Health Practitioner

Section three presented our research findings from the five project components including focus groups, stakeholder interviews, survey of community assets, survey of racial and ethnic data collection methods, and interviews with health foundations addressing racial and ethnic health disparities. The overall goal of this research was to identify information and resources that would improve the MetroWest Community Health Care Foundation's Board of Trustees understanding about and willingness to establish a health disparities action agenda for minority residents in the MetroWest area.

To improve the health status of poor and underserved minority residents in the MetroWest area, MCHCF and its board must be responsive to system, institutional, interpersonal, and individual factors that contribute to health disparities including but not limited to: the lack of recognition and accountability to the health of racial and ethnic minority populations in MetroWest by providers and key decision makers; the lack of commitment on the part of MetroWest institutions; the lack of cultural understanding among health providers and staff; the lack of resources and funding for outreach; the inadequacy of hospital interpreter services; poorly addressed issues related to immigration; over-utilization of hospital emergency rooms; the high cost of health care, health insurance, prescription medication; limited access to oral health care; differential treatment, racism, and feelings of mistrust in clinical settings; a lack of culturally appropriate health information and dissemination strategies; and identification requirements (driver's license, social security card, etc.) of a health institution prior to the delivery of care.

Based on our findings, community assets in MetroWest are numerous and provide the fertile ground for mutually beneficial partnerships in the implementation of a MCHCF health disparities action agenda. In partnership with its many MetroWest constituents and community stakeholders, we strongly support the Foundation's commitment to establishing a clear and sustainable health disparities action agenda that should include at a minimum: a sustainable, long-term, multicultural, multi-ethnic, multi-lingual, community owned and community-driven program development; requirements for data collection measures on race and ethnicity by grantees; increased allocation of resources for advocacy, education, outreach, and information dissemination; and support for the promotion of synergistic work between MCHCF, academic institutions, health department, local businesses, health care systems and providers. Community partners, organizations, and residents must be identified and proactively engaged and a strong sense of trust and commitment must be allowed to develop where the opportunities for change translates into an empowered community of change agents.

IV. RECOMMENDATIONS

Even in a setting where an individual physician or provider with an individual patient has an open, respectful, nondiscriminatory relationship, without any appreciation of the epidemiological facts of differences in morbidity and mortality, you're not going to make a difference—you barely make a difference in that individual person's health. There is no possibility to have any impact on the health of the community.

Interviewed Community Stakeholder, MetroWest Physician

The MetroWest Community Health Care Foundation is strongly positioned to establish, in partnership with local business, health care and community stakeholders, a variety of grants, programs, work groups, and meaningful solutions to support each of the recommendations listed below. The recommendations are broken up into four categories: **Cultural and Linguistic Competency, Disease Management Protocols & Consumer Advocacy and Capacity Building Initiatives, Minority Healthcare Professional Recruitment and Retention, and Develop Uniform Standards for Data Collection and Reporting on Race and Ethnicity.** Also included under each of the five recommendation areas is a description, a quote from focus group participants, community stakeholders or foundation interviews, specific suggestions for the MCHCF, and a set of examples from other foundations, state entities, and academic institutions. This section concludes with suggestions for how the Foundation can take the next step(s) towards establishing its Racial and Ethnic Health and Health Care Disparities Initiative.

The following key recommendations do not include the total list of recommendations that surfaced during this project. Instead, we identified a select number of themes and areas of focus that consistently came forth from focus group participants, stakeholder interviews, interviews with other health foundations, and ongoing feedback from the Steering Committee. In addition, we strongly considered the Foundation's mission and capacity as we further refined the themes and areas of focus into the five key recommendation areas.

1. Cultural and Linguistic Competency.

Culturally and linguistically appropriate services (CLAS) are health services that are respectful of and responsive to cultural and linguistic needs. Cultural sensitivity is the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups that have shared a common and distinctive racial, national, religious, linguistic, or cultural heritage (McDonough 2004). The quality of communication between patients and clinicians can have a major impact on health outcomes. Limited English proficiency (LEP) can interfere with effective communication as well. Compared with proficient English speakers, people with LEP are less likely to seek care and receive needed services (*Health Affairs*, March/April 2005, p. 424-425).

I found that there's a lack of diversity among health providers. We had trouble reaching out and establishing that connection. I found that sometimes people have delayed seeking medical treatment because there wasn't that connection that was out there. So we have to be more creative and not just take for face value, the information that's given to us. We have to realize that there are differences in cultural needs, and that African Americans, Hispanics and other minorities cannot take some of the same medicines. Some of the treatments will be different, and we may try to hold back as far as reaching out. And, we don't have as many people that we can connect to, so we have to work a little bit harder.

Interviewed Stakeholder, MetroWest Community Advocate

The MetroWest Community Health Care Foundation can assist area health systems and providers develop, implement, and evaluate interpreter services involving data collection, service delivery, financial services and patient satisfaction. The Foundation can support provider-based cultural competency training, develop and evaluate model curricula for cultural competency training, create a cultural competency library or resource bank for local health care providers, promote a regional interpreter bank, and pilot innovative interpreter programs in local hospitals, etc.

Examples for developing or enhancing existing cultural competency initiatives or programs include:

Harvard Pilgrim Foundation, The Institute for Linguistic and Cultural Skills⁷: The Institute offers three distinct programs that provide training for physical (medical and nursing programs) and behavioral health providers, two medical interpretation programs, and one that trains interpreters and another that trains interpretation program trainers.

State Department of Health Initiatives⁸: Los Angeles County is one of the first counties in the State of California to develop cultural and linguistic competency standards. Standards include creating performance measures, promoting incentives for culturally competent practices, empowering staff with necessary skills, obtaining knowledge and tools to support culturally competent practices, promoting recruitment and retention of qualified bilingual staff and staff with diverse backgrounds, and requesting facilities and programs to record a patient's language preference and ensure an interpreter is available if requested (McDonough 2004).

2. Develop Specific Disease Management Protocols & Consumer Advocacy and Capacity Building Initiatives.

The purpose of **Disease Management Protocols** is to present specific treatment strategies based on scientific data that has been reviewed and determined to represent "standard care", "optimal care" or "best practice" standards by expert consensus panels. Disease Management Protocols can help educate consumers and health care providers by providing the most updated information on the range of treatment options based upon a medical diagnosis. By making this information accessible to all consumers in a culturally

⁷ www.harvardpilgrim.org

⁸ <http://www.dhs.co.la.ca.us>

competent and linguistically appropriate manner, all social groups are more likely to benefit in comparable ways. Also, many efforts aimed at populations rather than individuals provide opportunities to promote health in cost-effective ways while decreasing the likelihood of disparities resulting from status advantages (*Health Affairs*, March/April 2005, p. 337).

I think disease management protocols are things that not only are important in this particular perspective, but across the board. I mean, health care in general has basically been focused on illness, not on wellness, in the past, and clearly we need to function much more heavily on wellness. And so disease management protocols, in terms of having people take their medications properly, understanding how to take their medications, understanding how to self manage their disease, is extraordinarily important in maintaining the health and welfare of the community. But there has not been the appropriate resources brought to bear in order to do that.

Interviewed Stakeholder, MetroWest Physician

[Consumer] **Advocacy** is defined as involving ‘the use of tools and activities that can draw attention to an issue, gain support for it, build consensus about it, and provide arguments that will sway decision makers and public opinion to back it’ (Rice 1999*). Addressing factors that endanger the health of minority groups demands strategies such as public and provider education, prevention, research, policy, and environmental changes that facilitate healthy living. To be effective, however, “communities must be involved as partners in the design, implementation, and evaluation of interventions. The best intervention results have been achieved when people who benefit from interventions work closely with researchers and public health practitioners” (Gibbs 2004).

“They need to provide better education regarding health and nutrition and everything, and it should be made available in Spanish.”

Hispanic/Latino Focus Group Participant

Capacity Building involves the recognition that the social whole is more than the sum of its individual components. The quality of the social processes and relationships within which learning interactions take place is especially influential on the quality of the learning outcomes in collaborative approaches. Taken one step further, this suggests that social capital plays an important role in fostering the social networks and information exchange needed to achieve collective action - and sustaining a social and institutional environment which is ready to adapt and change⁹.

I say that it is due to money; many times it is due to money because they (the hospitals) don't have the budget to pay interpreters [that are] present in every shift, such as doctors and nurses. And in addition to it being due to money, I also believe that it is because they don't care.

Hispanic/Latino Focus Group Participant (Marlborough)

The MetroWest Community Health Care Foundation can develop or fund programs that assist in the development and dissemination of culturally appropriate information,

⁹ <http://nrm-changelinks.net/capacity.html>

support local health education, outreach and screening services targeting minority communities, provide funding to assist in the development of a sustainable infrastructure for community organizing around health and health care advocacy involving faith-based institutions, community based organizations, social groups, and civic organizations, fund outreach worker training programs, and leverage partnerships with provider community to convene meetings between health care system, housing, education and employment sector representatives for training and education on health related topics such as asthma, indoor air quality improvements, stress reduction, smoking cessation, healthy and affordable food options and physical activity.

In addition, the MetroWest Community Health Care Foundation can establish a multi-level disparities reduction agenda to address longstanding and newly emerging diseases and health conditions (diabetes, hypertension, tuberculosis, overweight and obesity). Also, they can partner with various agencies such as the American Cancer Society, American Diabetes Association, American Heart Association, the National Association for the Advancement of Colored People (NAACP), Brazilian American Association (BRAMAS), MetroWest Latin American Center, local minority faith-based institutions and community organizations to: 1) increase community awareness and knowledge of specific disease management strategies by launching a MetroWest-based multi-year health promotion campaign; 2) increase options for participation in physical activity and minority residents' utilization of those options; 3) increase the availability of affordable fresh fruits and vegetables to MetroWest residents and increase their consumption of these foods while decreasing the consumption of unhealthy foods; and 4) enhance existing strategies to decrease smoking among children, youth and adults in the MetroWest area.

Examples of developing specific disease management protocols & consumer advocacy and capacity building initiatives include:

San Francisco Foundation, Community Health Programs¹⁰: Grants contributing to the improvement of the health of communities, particularly underserved populations, by expanding access to services, promoting prevention to reduce illness and advancing health policy reform. Program objectives are to: foster efforts to prevent poor health status, disease, and disability through investments in health promotion and health education; ensure access to health services safety net; support local efforts designed to reduce and/or eliminate disparities in health status due to poverty, disproportionate exposure to environmental agents/hazards, and/or race; and advance policy reform efforts that improve access to health services. Program funding includes:

NICOS Chinese Health Coalition, San Francisco, \$25,000, 12 mos.

To strengthen the organization's ability to engage in planning and advocacy in order to enhance the health and well-being of the Chinese community.

¹⁰ <http://www.sff.org/grantmaking/community.html>

Oakland Acorn, Oakland, \$25,000, 7 mos.

To develop a research study that will determine whether the community organizing and leadership development approach used by the organization can result in improved health outcomes among low-income residents.

Senior Services Coalition of Alameda County, Oakland, \$44,000, 24 mos.

To strengthen the capacity of this coalition of organizations to provide leadership and advocacy to improve community-based systems of care for senior citizens.

Latina Center, Inc., Richmond, \$40,000, 24 mos.

To support the Latina Community Women's Health Leadership Program, which provides leadership and personal development opportunities for women who are grassroots health leaders in Alameda and Contra Costa Counties.

California Pan-Ethnic Health Network, Oakland, \$12,500, 16 mos.

To develop a strategic plan for the organization to increase capacity to improve access and eliminate health status disparities in California's communities of color.

The Horizon Foundation, Horizon Community Councils¹¹: The Horizon Foundation supports councils that are made up of individuals that work or live in the Foundation's service area. Council members inform the Foundation's priority areas and guide the work that takes place in smaller geographic areas.

3. Minority Healthcare Professional Recruitment and Retention.

There is compelling evidence for the need to increase diversity within the physician workforce to ensure high-quality medical education, access to health care for the underserved, advances in research, and improved business performance. In order to address the future health care needs of the general public, as well as of minority citizens, we must recruit and retain students from diverse populations who are interested in health care careers. The demand for physicians, particularly under-represented minorities, will continue to grow. Addressing shortages requires inventive efforts to counter obstacles created by the anti-affirmative action movement, as well as strategies to encourage institutions to become more engaged in diversity efforts (Reed 2003).

I think we need more professionals in the area to work with mental health. We have some agencies that have a few professionals in this area, but it's not enough. It's a problem that's hard to solve. And they need to be bilingual, bicultural to be competent to work with the children and adults. I don't know how to bring more people here to work as mental health professionals, but we need to make it attractable to professionals to come or [those] that are [already] in the area. Like, I know that we have been losing people in this area to go to Boston, to go to Cambridge, because they pay better there than they are typically paying here. So we need to have incentives to have more people working and helping the community.

Interviewed Stakeholder, MetroWest Educator

¹¹ <http://www.thehorizonfoundation.org/initiatives/councils.html>

The MetroWest Community Health Care Foundation can assist in the racial and ethnic diversification of the health workforce for the MetroWest area by: initiating new or supplementing existing after school or weekend junior high and high school math and science programs serving minority youth; co-sponsor tutoring and mentoring program linkages between MetroWest public school systems, undergraduate, graduate, and professional degree programs, health care, public health and business communities; sponsor MetroWest health career fairs or institutes; and identify new or supplement existing minority health or health disparities fellowship training programs. The goals and strategies for the partnership would be to: 1) identify recruitment and retention initiatives; 2) developing linkages with state-based and minority serving institutions, medical schools, and foundation-sponsored fellowship training programs in health disparities (W.K. Kellogg Foundation, Robert Wood Johnson, and California Endowment Foundation); 3) foster concrete training and practice opportunities in primary care and specialty services; and 4) engage in routine monitoring, evaluation, and feedback activities to ensure retention and ongoing program improvement.

Examples of foundation-based or government sponsored health careers and mentoring programs include:

Buncombe County Medical Society Foundation, Minority Physician Mentoring Program¹²: A program that pairs local African American high school students with an interest in medicine with minority physicians in Buncombe County, North Carolina. The program started off with African American students and will be expanded to include Latino high school students in Spring 2005.

Community Based Pipeline Programs Pipeline, Profession & Practice: Community-Based Dental Education¹³: The Boston University Goldman School of Dental Medicine has a long tradition of improving oral health by building community partnerships, conducting oral health disparities research, and advocating changes in health policies. The School has numerous service learning programs that provide needed care to the community while educating dental students. These programs include a 30-week mentoring series where freshman and sophomore students work in dental teams in practitioner's offices and a 35-day senior externship in general and pediatric dentistry.

The W.K. Kellogg Foundation, Scholars In Health Disparities Program¹⁴: The Kellogg Scholars in Health Disparities Program is preparing a new generation of minority scientists for careers and leadership roles in health disparities research, health policy research and health policy and practice. The program is supporting a cadre of creative thinkers - largely from minority groups and with a passion for health equity and social justice - trained in behavioral and social science disciplines, epidemiology and related biomedical sciences and public policy. Minority groups to date have been under-

¹² http://bcmsonline.org/foundation2/pp/health_parity.php

¹³ http://www.dentalpipeline.org/home/572/dental_pipeline_projects

¹⁴ http://www.cfah.org/programs/kellogg_scholars.cfm

represented in leadership roles in academic health-related careers and in national health and public policy development.

University of Massachusetts Medical School NIH Summer Research Fellowship

Program¹⁵: The University of Massachusetts Medical School NIH Summer Research Fellowship Program is a non-credit, ten-week, structured research experience, consists of "hands-on" laboratory research experience with an investigator serving as a mentor, role model and advisor. The curriculum is designed to provide participants in-depth exposure to the actual practice of scientific research in the hopes that the excitement, challenge and creativity of the enterprise will convince them to consider basic research in the sciences as a viable career choice. The goal of the NIH Research Fellowship Program for Minority College Students is to: 1) attract minority students into biomedical and behavioral research careers in the area of heart, lung and blood disorders; 2) increase the number of minority investigators; and 3) increase the number of minority applicants to the Graduate Schools of Biomedical Science at the University of Massachusetts Medical School.

4. Develop Uniform Standards for Data Collection and Reporting on Race and Ethnicity.

Traditionally, data are collected on race and ethnicity to accomplish several overlapping purposes in public health: to describe vital and health statistics; as a risk indicator for health outcomes; to improve the delivery of health services; as a marker of unmeasured biological differences; and as a proxy for unmeasured social factors (Mays et al., 2003). In order to eliminate racial and ethnic disparities in health and health care, such disparities must first be identified (Livingston 2004). Without data on the health conditions of minority groups in the state, it is difficult to measure the progress of state initiatives. It is also frequently difficult to produce meaningful data for small population groups (McDonough 2004). Health care organizations – health plans, hospitals, community health centers, clinics and group practices – can play an important role in the elimination of racial and ethnic disparities in health care (*Health Affairs*, March/April 2005, p. 409).

...[There are] somewhat invisible populations within the community itself, in that [their] numbers don't jump out at you, and so I think that getting -- in some communities, getting attention they need to their issues is harder than it might be in other places where there's strength in numbers, which I think people don't see here.

Interviewed Stakeholder, MetroWest Public Health Practitioner

The MetroWest Community Health Care Foundation can establish and support a MetroWest area data collection work group on race and ethnicity comprised of data users, state and local health departments, and collectors of federal data (i.e., funeral directors, hospitals, nursing homes, Bureau of the Census), local practitioners, health system administrators, academic training institutions, community leaders, and elected officials. More specifically, the MetroWest Community Health Care Foundation can encourage

¹⁵ <https://www.umassmed.edu/outreach/apply/srfpapp.cfm>

and support the collection of race and ethnicity data among funded programs, maintain annual profile and report on racial and ethnic disparities in health and health care at the individual provider and systems level, and advocate for and support data collection, reporting, and tracking by race and ethnicity.

Examples of policies, initiatives, or work groups involving the development of uniform standards for data collection and reporting on race and ethnicity include:

The National Health Law Program (NHeLP) of California: On behalf of the Office of Minority Health – recently completed the first phase of a major study regarding collection and reporting of racial and ethnic data by health insurers and managed care plans (McDonough 2004).

The California HealthCare Foundation¹⁶: The California HealthCare Foundation took a *no* position on Proposition 54 but developed this issue brief to examine the potential impact of Proposition 54 on health-related research that uses ethnic and racial data. The brief includes examples of specific research activities and projects, the data used in these activities, and the effects the initiative might have had on the research methodology and resources.

St. Luke's Health Initiatives, Arizona Health Query (AzHQ)¹⁷: A voluntary project to develop an integrated community health data system that houses essential health information for all Arizona residents with complete confidentiality and privacy. It is designed to be a comprehensive community resource for assessing the health care needs of the state and informing solutions to a wide range of population health and health system issues. St. Luke's Health Initiatives is the principal convener and funder of AzHQ.

The Commonwealth Fund, Equity Measures and Systems Reform as Tools for Reducing Racial and Ethnic Disparities in Health Care¹⁸: Health care quality regulators, such as the Centers for Medicare and Medicaid Services (CMS) and other agencies, have embraced systems reform, largely through mandates that require health care providers to implement Quality Assessment and Performance Improvement (QAPI) initiatives. In these two-part programs, "quality assessment" involves the use of scientifically validated indicators of care, such as vaccination rates, preventive screenings, and medication rates, to measure quality of care. "Performance improvement" refers to the programs' data-driven interventions that aim to quantifiably adjust those indicators for the better.

5. Establish a Community-Wide Disparities Work Group.

Historically, when public health professionals consider changes at any level, except the individual level, the approach taken is more often narrow and haphazard. Efforts to

¹⁶ <http://www.chcf.org/documents/policy/RacialAndEthnicDataCollection.pdf>

¹⁷ http://www.slhi.org/ahf_projects/mhip.shtml

¹⁸ http://www.emwf.org/usr_doc/776_Watson_equity_measures_systems_reform.pdf

change institutions often focus only on individual knowledge with little attention to organizational infrastructure and institutional practices. Whether working with communities, schools, hospitals, professional training academic programs and institutions, professional associations, or government agencies, the intentional connection of strategies to change individuals (micro) with efforts to change institutions and society at large (macro) is critical (Gibbs and Prothrow-Stith, 2004).

Education is important but it's also, I need community support around that. Community support is not just the people I'm seeing day to day, that's also my health care providers. They're part of my community support.

African American Focus Group Participant (Marlborough)

The MCHCF can support the development and institutionalization of a special community council/partnership to assist in the building of a community infrastructure to recruit, retain and grow an academic, professional, and provider community, establish a directory of minority health care providers, convene and co-sponsor a MetroWest community partnership involving minority health providers, elected officials, professional associations, and local business community and other community stakeholders. Specifically, MCHCF can engage the public health and business community to: 1) facilitate a highly collaborative and integrated initiative involving local practitioners, health system administrators, academic training institutions, community leaders, and elected officials; 2) promote the enhancement of existing community and institutional assets; 3) establish a multi-disciplinary multi-year recruitment and retention initiative; 4) ensure the viability of strategies involving retention and program sustainability; and 5) engage in routine monitoring, evaluation, and feedback on measurable short- and long-term benefits.

Examples of developing community driven work groups or coalitions involving the elimination of racial and ethnic disparities in health and health care include:

The Mayor's Hospital Working Group and The Task Force on Disparities¹⁹: In 2003, Boston Mayor Thomas Menino, in partnership with the Boston Public Health Commission, formed a Blue Ribbon Task Force to Eliminate Racial and Ethnic Disparities in Health and a Hospital Working Group, comprised of leaders from the health care industry, health center directors, academic institutions, community coalitions, and representatives of the insurance and business sectors. The two-year process that included input from hundreds of experts led to three different reports: Mayor's Task Force Blueprint: A plan to eliminate racial and ethnic disparities in health; Hospital Working Group Report: Action steps and recommendations for Boston hospitals; and Data Report: A presentation and analysis of disparities in Boston. The Mayor also committed \$1 million in funding for implementation of recommendations found in two of the three reports.

¹⁹ http://www.bphc.org/director/dispatch_hwg.asp

Massachusetts Commission on the Elimination of racial and Ethnic Health

Disparities: The Commission is charged with: 1) reviewing national and state racial and ethnic disparities in health data; 2) developing a policy framework across multiple sectors to eliminate racial disparities in health that would include recommendations for policy, legislation and budget initiatives; 3) identifying short and long term goals; and 4) developing a process to assess progress after the Commission's work concludes. Commission members include city and state health department representatives, leaders from the health foundations and health care industry, health center directors, academic institutions, professional associations, community advocacy groups, and representatives of the insurance and business sectors. The Commission is divided into four subcommittees to address a broad set of health-related factors including but not limited to: workforce development and diversity, quality of care and services, data collection, cultural competency, access to care, racism and discrimination in care, and social and environmental determinants of health. At the time of this report, the Commission is in its final phases of completing a comprehensive list of recommendations that will guide the implementation of a state-wide plan to eliminate disparities.

The California Asthma Public Health Initiative²⁰: An initiative funded by the California Department of Health Services' Chronic Disease Branch, to eliminate disparities in asthma practices and outcomes through coordinated approaches and partnerships with communities, state and local organizations, health care providers, health departments, foundations and academic institutions.

Buncombe County Medical Society Foundation, Asheville-Buncombe Institute of Parity Achievement²¹: A coalition of health providers that work to enhance the health of individuals by integrating services and fostering partnerships between various agencies and service providers (housing, mental health, etc.).

Conclusion

“Success in eliminating racial and ethnic health disparities will not be achieved by government agencies acting alone. There must be collaborations and innovative partnerships between governmental bodies, community agencies, health-care organizations, insurance companies, and professional bodies at the local, state, and national levels” (Livingston, 2004 p. 853).

The MetroWest Community Health Care Foundation has many tools in its toolbox (i.e., grants, scholarships, conferences and meetings, policy briefs, and special projects). Application of these tools in the design, implementation, evaluation, and sustainability of a MetroWest-based health disparities initiative is the next important step towards the elimination of racial and ethnic disparities in health and health care.

²⁰ <http://arcc.ucsf.edu/caasa/>

²¹ <http://bcmsonline.org/foundation/healthparity.html>

Applying the tools to expand existing programs and initiatives (i.e., the Mental Health Task Force, Nurse Power Initiative, Health Professions Scholarship Programs, and Community Health Awards), the Foundation can establish immediate and seamless integration of focused solutions and resources to address racial and ethnic disparities in health and health care in MetroWest communities. Additionally, the Foundation can add to its grant guidelines, language that requests all applicants address how their proposed initiatives or programs will address racial and ethnic disparities in health and/or health care.

However, beyond the traditional design, implementation, and evaluation of new or existing programs, the Foundation should strongly consider funding a long-term and sustainable health disparities initiative. Rather than employing the standard random funding mechanism, the MetroWest Health Disparities Initiative must be envisioned as a movement, involving deliberate strategies and tactics to connect diverse people, communities, and programs, making them feel they can actively participate rather than function as spectators when it comes to their health and health care experiences. This movement must be multicultural, multi-issue, and based on a set of broader social determinants of health, including education, employment, and housing.

We applaud MCHCF for their efforts to eliminate racial and ethnic health disparities thus far. With the recommendations presented in this report we envision the Foundation making substantial impact on the future health of minority residents in MetroWest.

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APPENDIX 1: Data Collection Tools

- 1- Focus Group Questionnaire**
- 2- Focus Group Discussion Questions**
- 3- Stakeholder Interview Questions**
- 4- Institutional Assets Survey**
- 5- Foundation Questionnaire**

Community Resident Focus Group Discussion Questions:

- 1.) Are you familiar with health disparities?
- 2.) Do you believe that disparities exist in health exist in the MetroWest area?
- 3.) If so, why do you believe these disparities exist?
- 4.) Do you believe that disparities exist in health care exist in the MetroWest area?
- 5.) If so, why do you believe these disparities exist?
- 6.) What are some of the barriers to receiving health care or reasons for relatively poor treatment?
- 7.) What should be done to reduce and/or eliminate barriers to good health?
- 8.) What are some of the things that are currently being done in MetroWest to improve the health of minorities in MetroWest?
- 9.) In developing a program to improve the health and health care of minority residents in MetroWest what are some of the issues that the Foundation should focus on?
- 10.) If so, what community groups or organizations should be involved in such programs to ensure their success?
- 11.) Furthermore how can individual community members be involved in such programs?
- 12.) What role are you willing to play to ensure the success of these potential programs?

Community and Healthcare Stakeholders Interview Questions:

- 1.) Do you believe that disparities exist in health exist in the MetroWest area?
- 2.) If so, why do you believe these disparities exist?
- 3.) Do you believe that disparities exist in health care exist in the MetroWest area?
- 4.) If so, why do you believe these disparities exist?
- 5.) What are some of the barriers to receiving health care or reasons for relatively poor treatment?
- 6.) What should be done to reduce and/or eliminate barriers to good health?
- 7.) What are some of the things that are currently being done in MetroWest to improve the health of minorities in MetroWest?
- 8.) In developing a program to improve the health and health care of minority residents in MetroWest what are some of the issues that the Foundation should focus on?
- 9.) If so, what institutions, community groups, or organizations should be involved in such programs to ensure their success?

*MetroWest Health Disparities Initiative:
Institutional Assets Questionnaire*

Section 1: Institutional Information

Name of Institution/Organization/Agency/Group _____

Address _____

Phone _____ E-mail address _____

* Please circle the answer that best describes your organization for questions 1-3 below.

1. Which of the organizational types listed below best describes your organization?
 - a. Private
 - b. Public
 - c. Federal
 - d. State
 - e. Regional
 - f. Local

2. What is the for-profit status of your organization?
 - a. For-profit
 - b. Non-profit, 501(c)(3)

3. How best can your organization be classified?
 - a. Local Health Department
 - b. Hospital
 - c. Community Health Center
 - d. Clinic
 - e. Social Service Agency
 - f. Mental Health Agency
 - g. Public Safety Institution
 - h. Educational Institution
 - i. Other (Please Specify) _____

Section 2: Populations Served

* In this section we are asking that you provide us with information about the populations served by your organization. For questions 4-7 please provide percentages of individuals that are served by your organizations according to various demographic categories. The total of percentages of each category should equal 100% for these questions.

4. What is the percentage of individuals served by your organization according to gender?

Female _____%

Male _____%

MetroWest Health Disparities Initiative:
Institutional Assets Questionnaire

5. What is the percentage of individuals served by your organization that fall into the following age groups?

0-4..... _____ %
5-17..... _____ %
18-24..... _____ %
25-64..... _____ %
65 and over _____ %

6. What is the percentage of individuals served by your organization that fall into the following racial/ethnic categories?

African American or Black _____ %
Asian..... _____ %
Brazilian..... _____ %
Hispanic/Latino..... _____ %
White..... _____ %
Other (Please Specify)..... _____ %

7. What is the breakdown of individuals served by your organization according to economic status (total should equal 100%)?

Below the poverty line _____ %
Low income, above the poverty line... _____ %
Middle income..... _____ %
Higher income..... _____ %

8. Please identify the top three languages spoken by individuals that access services with your organization?

1. _____
2. _____
3. _____

9. Are materials offered in languages other than English by your organization (circle answer)?

- a. Yes
- b. No

10. If so, specify those languages in the space provided below.

11. Are services offered in languages other than English by your organization (circle answer)?

- a. Yes
- b. No

12. If so, specify those languages in the space provided below.

*MetroWest Health Disparities Initiative:
Institutional Assets Questionnaire*

Section 3: Targeted Programming

The following questions will allow us to better understand the current range of programming in the areas of health and health care to address racial and ethnic health disparities. More specifically we would like to know whether existing health and health care services are meeting the needs of African American, Hispanic/Latino, and Brazilian residents in the MetroWest region. Please fill out the tables included in questions 13 and 14, providing information about the health conditions, social factors, and those health-related services provided by your organization.

13. In the following table we have compiled a list of health related areas, specific health conditions (i.e. diabetes) and social factors (i.e. teen pregnancy). To the right of this list please indicate the racial/ethnic population(s) served by your organization for each category. You may also include up to two additional areas of focus. Please complete the entire table below.

Follow this key when completing the table:

General Population=GP
African American=AA
Hispanic/Latino=HL
Brazilian=BR
Other Specific Population=Other
Not Addressed=None

Health Conditions and Social Factors	Populations Served
<i>Diabetes (Example)</i>	<i>GP, HL, BR</i>
<i>Heart Disease (Example)</i>	<i>GP, AA</i>
<i>Breast Cancer (Example)</i>	<i>None</i>
Diabetes	
Heart Disease	
Breast Cancer	
Colorectal Cancer	
Prostate Cancer	
Other Cancers	
Asthma	
Obesity	
HIV/AIDS	
Tuberculosis	
Substance Abuse	
Depression	
Post-traumatic Stress Disorder	
Other Mental Health Conditions	
Domestic Violence	
Youth Violence	
Teen Pregnancy	
Other (Please Specify)	
Other (Please Specify)	

MetroWest Health Disparities Initiative:
Institutional Assets Questionnaire

14. In the table below we have compiled a list of **health-related services**. To the right of this list please indicate the racial/ethnic populations served by your organization for each of the listed services. You may include up to four additional health-related services that your organization offers. Please complete the entire table below.

Follow this key when completing the table:

General Population=GP
African American=AA
Hispanic/Latino=HL
Brazilian=BR
Other Specific Population=Other
Not Provided=None

Health-related Services	Populations Served
<i>Emergency Care (Example)</i>	<i>None</i>
<i>Diagnostic Services (Example)</i>	<i>GP</i>
<i>Outpatient Care (Example)</i>	<i>GP, HL, BR</i>
Emergency Care	
Diagnostic Services	
Outpatient Care	
Inpatient Care	
Disease Management	
Referral Services	
Screening	
Immunization	
Oral Health Services	
Health Education	
Health Promotion	
Mental Health Services	
Support Groups	
Patient Navigation	
Violence Prevention	
Other (Please Specify)	

15. Does your organization have existing programs that were developed in response to the presence of health disparities (circle answer)?
- a. Yes
b. No

Thank you!

Should you have any questions regarding this questionnaire, please contact Naomi Bitow via phone or e-mail at (617) 384-8523 or nbitow@hsph.harvard.edu

For more information about the MetroWest Community Health Care Foundation you can visit their website at <http://www.mchcf.org/>

Community and Healthcare Stakeholders Interview Questions:

- 1) Please describe your Foundation's funding/programming initiative in the area of racial/ethnic disparities in health and health care.
- 2) What was the impetus for your Foundation's interest in this targeted funding, and programming around racial/ethnic disparities in health and health care?
- 3) What are the specific areas of focus for the Foundation's work in this area? How were these areas of focus chosen?
- 4) What data did your Foundation utilize to inform the development of the initiative(s) or program(s)?
- 5) What institutions, organizations, agencies, or community groups have been involved in the development or monitoring of your initiative or program? To what extent have these entities been involved?
- 6) What were some of the internal and external barriers to the development of your Foundation's initiative or program?
- 7) What were some of the preexisting community assets that have enhanced or helped to ensure the success of the Foundation's work?
- 8) What is the time table for the Foundations work in the areas of racial/ethnic disparities in health and health care? How was this time table determined?
- 9) What is the impact of your racial/ethnic disparities in health and health care initiative? How are you measuring short term and long term success?

APPENDIX 2: Focus Group Participant Profile

- 1- Focus group participant demographics**
- 2- Health insurance status of focus group participants according to ethnic group**
- 3- Primary healthcare settings utilization by focus group participants according to ethnic group**

Table 5 Demographic description of focus group participants according to city/town, gender, and ethnic group

City	African American	Hispanic/Latino	Brazilian*	Total
Milford	2 (2 Women)	5 (3 Women, 2 Men)	12* (6 Women, 5 Men)	19 (11 Women, 7 Men)
Marlborough	4 (4 Women)	11 (7 Women, 4 Men)	13 (8 Women, 5 Men)	28 (19 Women, 9 Men)
Framingham	18 (7 Women, 11 Men)	8 (6 Women, 2 Men)	6 (4 Women, 2 Men)	32 (17 Women, 15 Men)
Total	24 (13 Women, 11 Men)	24 (16 Women, 8 Men)	31* (18 Women, 12 Men)	79* (47 Women, 31 Men)

* One of the Brazilian Participants in the Milford Focus Group did not identify their gender and therefore the numbers for the totals for the focus group in question and for all participants and the additive number of men and women that participated are not equal.

Table 6 Reported household income of participants according to ethnic group

Household Income Range	African American	Hispanic/Latino	Brazilian
Less than \$10,000 - \$19,999	2 (8%)	7 (29%)	12 (39%)
\$20,000 - \$39,999	0 (0%)	6 (25%)	10 (32%)
\$40,000 - \$69,999	6 (25%)	5 (21%)	4 (13%)
\$70,000 and above	16 (67%)	3 (13%)	2 (17%)
Total	24 (100%)	21* (88%)	28* (90%)

* Three of the Brazilian Participants and three of the Hispanic/Latino did not identify the household income to which they belong.

Table 7 Reported Health Insurance Status and Primary Healthcare Setting of Focus Group Participants according to ethnic group

	African American	Hispanic/Latino	Brazilian
Health Insurance			
Yes	23 (96%)	17 (71%)	19 (61%)
No	1 (4%)	6 (25%)	12 (39%)
Non respondents	0	1 (4%)	0
Total	24 (100%)	24 (100%)	31 (100%)
Primary Health Care Setting			
Private Practice Doctor's Office/ Primary Care Physician	24 (100%)	9 (38%)	17 (55%)
Hospital Emergency Room	0	2 (8%)	8 (26%)
Community Health Center	0	2 (8%)	5 (16%)
Other Clinic	0	9 (38%)	1 (3%)
Non respondents	0	2 (8%)	0
Total	24 (100%)	24 (100%)	31 (100%)

Figure 1 Health insurance status of focus group participants according to ethnic group

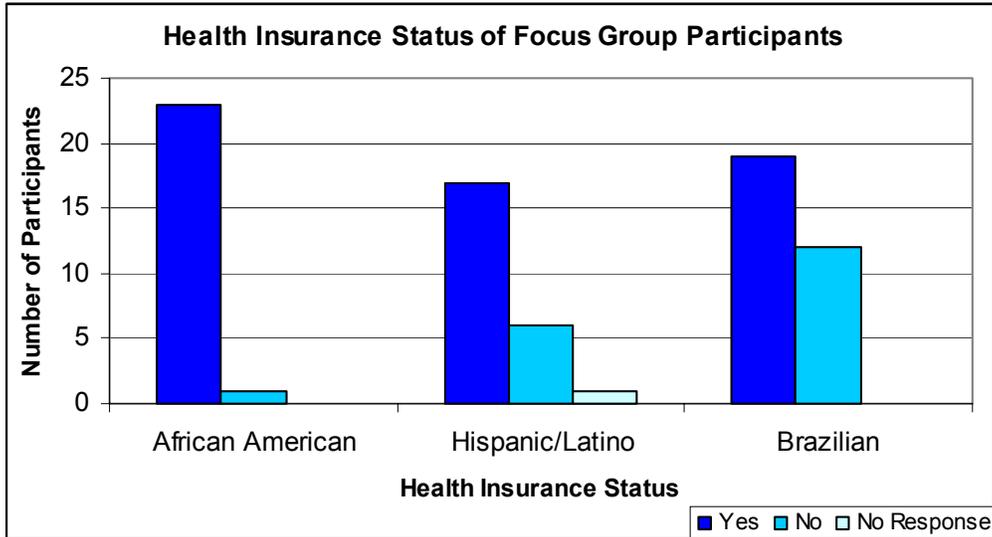
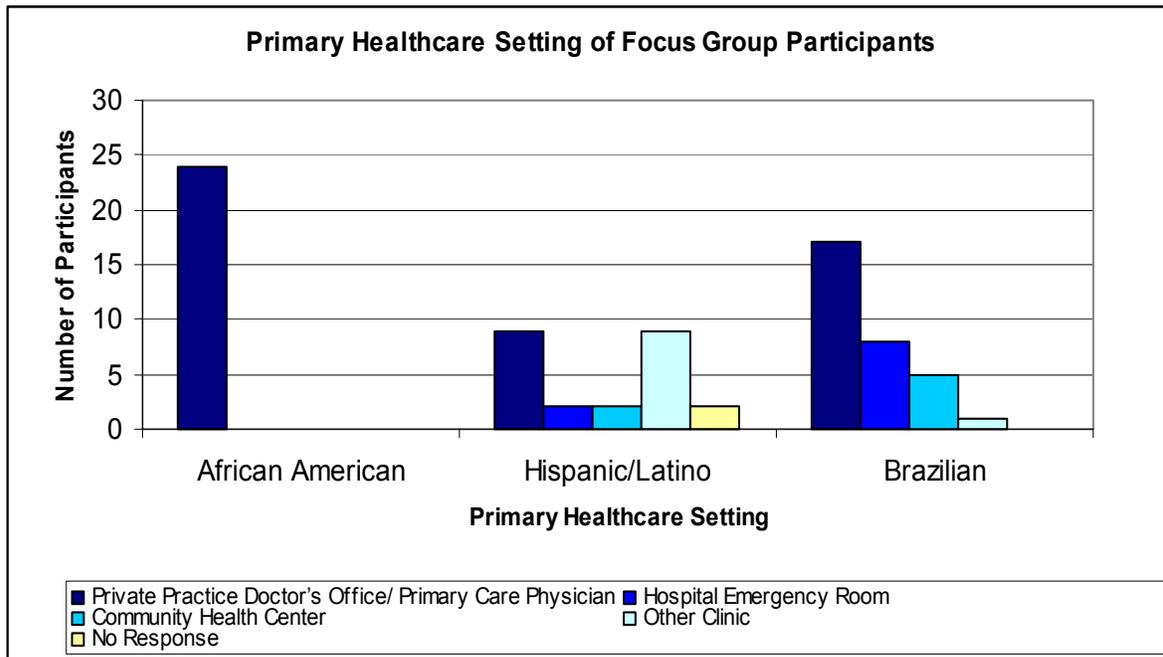


Figure 2 Primary healthcare setting utilized by focus group participants according to ethnic group



APPENDIX 3: Key Responses from Focus Group Discussions and Stakeholder Interviews

- 1- Focus group participant perceptions of the causes of health disparities and barriers to good health according to ethnic group**
- 2- Solutions to address health disparities and improve the health racial and ethnic minority communities, according to focus group participants**
- 3- Areas of focus for the Foundation's Racial and ethnic Health Disparities Initiative, according to focus group participants**
- 4- Health and social concerns that focus groups participants felt were of special concern with regards to their ethnic populations**
- 5- List of interviewed stakeholders**
- 6- Stakeholder perceptions of the causes of health disparities and barriers to good health**
- 7- Solutions to address health disparities and improve the health racial and ethnic minority communities, according to interviewed stakeholders**
- 8- Areas of focus for the Foundation's Racial and ethnic Health Disparities Initiative, according to interviewed stakeholders**
- 9- Comparative table of organizations and institutions that the Foundation should involve in programs or initiatives that address health disparities according to focus group discussions and stakeholders interviews**

Table 8 Focus group participant perceptions of the causes of disparities in health and health care and barriers to good health according to ethnic group

African American	Brazilian	Hispanic/Latino
<i>Differential treatment (All)</i>	Being un-insured or under insured (Marlborough and Milford)	<i>Being un-insured or under insured (All)</i>
Ethnic minority population is significantly small percentage of total population (Marlborough and Milford)	<i>Differential Treatment (All)</i>	<i>Differential treatment (All)</i>
Experience of ethnic and cultural tensions in the MW region (Framingham and Marlborough)	High cost of health care (Marlborough and Milford)	Fear of litigation on the part of health providers (Framingham and Marlborough)
Feeling that needs are not heard by providers (Marlborough and Milford)	Identification requirements of clinical settings (Marlborough and Milford)	Feelings of invisibility (Framingham and Marlborough)
<i>Feelings of invisibility (All)</i>	Immigrant status (Framingham and Marlborough)	<i>High cost of health care (All)</i>
Feelings of isolation (Marlborough and Milford)	Lack of culturally relevant and pertinent health information (Framingham and Marlborough)	<i>Immigrant status (All)</i>
<i>Lack of commitment on the part of MetroWest institutions (All)</i>	Lack of health related knowledge in community (Framingham and Marlborough)	<i>Inadequacy of interpreter services (All)</i>
<i>Lack of cultural understanding on the part of providers and staff (All)</i>	Language barriers (Marlborough and Milford)	Lack of commitment on the part of MetroWest institutions (Framingham and Marlborough)
Lack of culturally relevant and pertinent health information (Marlborough and Milford)	<i>Late Presentation (All)</i>	Lack of cultural understanding on the part of providers and staff (Framingham and Marlborough)
Lack of disparities dialogue in the MetroWest region (Marlborough and Milford)	Legal residence status (Marlborough and Milford)	Language barriers (Framingham and Milford)
Lack of involvement in various sectors in their city or region by community members (Marlborough and Milford)	Limited access to oral health care (Framingham and Milford)	<i>Late diagnosis or misdiagnosis (All)</i>
Late diagnosis or misdiagnosis (All)	Long emergency room wait times (Marlborough and Milford)	<i>Legal residence status (All)</i>
Limited knowledge around the health concerns of specific ethnic communities on the part of providers (Marlborough and Milford)	Poor nutrition (Framingham and Marlborough)	Long emergency room wait times (Framingham and Marlborough)
Mistrust of providers (Marlborough and Milford)	Preconceptions and stereotypes held by providers and staff (Framingham and Marlborough)	Racism (Framingham and Marlborough)
Preconceptions and stereotypes held by providers and staff (Framingham and Marlborough)	<i>Self medication (All)</i>	Short-staffed hospitals (Framingham and Marlborough)
<i>Racism (All)</i>	<i>Use of hospital emergency room as primary health care setting (All)</i>	

Table 9 Suggested solutions to address health disparities and improve the health racial and ethnic minority communities by focus group participants, according to ethnic group

Brazilian	Hispanic/Latino	African American
Increase access to affordable health care (Framingham and Marlborough)	Cultural sensitivity among providers and staff (Framingham and Marlborough)	<i>Increase the number of providers and staff of color or those equipped to serve communities of color (All)</i>
Increase access to affordable insurance (Framingham and Marlborough)	Increase the number of providers and staff of color or those equipped to serve communities of color (Framingham and Marlborough)	Incentivize the provision of services and development of programs to meet the needs of racial and ethnic minority populations (Marlborough and Milford)
<i>Increase the distribution of culturally appropriate health information (All)</i>	<i>Open area clinics that offer affordable, culturally responsive care (All)</i>	Promote health education (Framingham and Marlborough)
<i>Open area clinics that offer affordable, culturally responsive care (All)</i>	Provide patient navigation in various clinical settings (Framingham and Marlborough)	Promote Self-advocacy on the part of community (Framingham and Milford)

Table 10 Areas of focus for the Foundation’s Racial and ethnic Health Disparities Initiative, according to focus group participants

Brazilian	Hispanic/Latino	African American
<i>Culturally and socially responsive health care (All)</i>	Advocacy (Framingham)	Advocacy (Framingham and Marlborough)
Health education (Marlborough)	<i>Culturally and socially responsive health care (All)</i>	Awareness raising activities (Framingham and Marlborough)
<i>Information dissemination (All)</i>	Focus on youth health (Marlborough)	<i>Culturally and socially responsive health care (All)</i>
Involvement in policy and institutional change (Framingham and Marlborough)	Health education (Marlborough and Milford)	Focus on youth health (Framingham and Marlborough)
Men’s health (Marlborough and Milford)	Information dissemination (Milford)	Health education (Framingham and Marlborough)
Patient rights education (Marlborough)	Involvement in policy and institutional change (Framingham)	Involvement in policy and institutional change (Framingham and Marlborough)
Promote prevention (Framingham)	Parent education (Marlborough)	Promote social inclusion (Framingham and Marlborough)
Support the formation of coalitions and partnerships (Framingham and Milford)	Promote accessible recreation options (Milford)	Support the formation of coalitions and partnerships (Framingham and Marlborough)
Targeted marketing to minority populations with health related messages (Milford)	Promote prevention (Framingham)	Targeted marketing to minority populations with health related messages (Marlborough)
	Quality in health care (Framingham and Marlborough)	

Table 11 Health and social concerns that focus groups participants felt were of special concern with regards to their ethnic populations

Brazilian	Hispanic/Latino	African American
Back Problems (Marlborough and Milford)	Cardiovascular Health (Milford)	Cardiovascular Health (Marlborough)
Cardiovascular Health (Marlborough and Milford)	Gastrointestinal Health (Milford)	Diabetes (Marlborough and Milford)
Domestic Violence (Framingham)	Mental Health (All)	Mental Health (Framingham)
Gastrointestinal Health (Marlborough and Milford)	Cancer (Milford)	
Genitourinary Health (Marlborough and Milford)	Tuberculosis (Framingham)	
Mental Health (Marlborough and Milford)		
Urinary Tract Infections (Marlborough)		

Interviewed Healthcare and Community Stakeholders

Yvonne Brown
 Kim Battles
 Argentina Arias
 Jerry Desilets
 Diane Gould
 Ana Velasco
 Ilton Lisboa
 Laura Medrano
 Dr. Janet Yardley
 Cathy Romeo
 Dr. Percy Andreazi
 Rev. Faith Tolson
 Dr. Richard Marshall
 Dr. William Muller
 Dr. Michael Gottlieb

Table 12 Stakeholder perceptions of the causes of health disparities and barriers to good health

MetroWest Regional Factors
The lack of recognition or responsiveness to the increasing diversity in MetroWest among providers and decision makers
Lack of providers/staff of color or those that are culturally competent in the region
Transportation, highlighting the lack of adequate public transportation in MetroWest)
Systems and Institutional Factors
Limited access to affordable healthcare
Lack of partnerships and collaborations between area organizations and institutions
Lack of culturally relevant and pertinent health information
Identification requirements of a healthcare institutions
Availability of resources for outreach, advocacy, and information dissemination
Entrenched nature of healthcare system, emphasis on the individual and illness as opposed to the community and wellness
Inadequacy of hospital interpreter services
Provider and Staff Factors
Limited cultural understanding and sensitivity among providers
Mistrust of providers by community
Preconceptions that providers and staff hold about different populations around the issue of compliance
Individual Beliefs, Norms, Experiences, and Behaviors
Being uninsured or underinsured
Education and literacy level
Homelessness
Lack of community organization and infrastructure
Language barriers
Legal residence status
Loss of socioeconomic/professional via immigration
Low socioeconomic status
Mistrust of area health providers
Poor Nutrition and nutritional options
Racism and discrimination
Self medication with non-prescribed therapies

Table 13 Solutions to address health disparities and improve the health racial and ethnic minority communities, according to interviewed stakeholders

Community Centered Investment
Community based outreach and education, utilizing community health worker model
Increase the dissemination of culturally appropriate health related information through the use of popular media outlets and gathering places
Increased patient advocacy and access
Opening area clinics that offer affordable, culturally responsive care
Promote prevention and screening in community
Promoting health education and self-advocacy
Systems, Institutional, Organizational, and Provider Investment
Collect race/ethnicity data and use to identify “high-risk” populations
Increase availability of interpreters
Increased allocation of resources for advocacy, education, and outreach
Promote the collection of data on health outcome measures by health providers grantees
Promoting synergistic work between providers
Providing access to provider networks that match patient demographics and health needs
Providing accessible preventative care
Shift the institutional focus from illness to wellness
Support cultural competency training

Table 14 Areas of focus for the Foundation’s Racial and ethnic Health Disparities Initiative, according to interviewed stakeholders

Advocacy and Institutional Change to Improve Healthcare Experiences
Involvement in patient advocacy
Promote data collection
Increasing the number of culturally and linguistically competent staff through recruitment of providers of color, multilingual staff, and cultural competency training
Promote culturally and linguistically appropriate mental health
Information Dissemination and Promoting Health Awareness
Community wide education around health disparities and the health of racial/minority populations
Community centered outreach efforts
Information dissemination
Targeted health education
Serve as information clearinghouse for institutions, providers, and community
Promote screening and prevention
Support school based health programs
Capacity Building
Involving community in institutional decision making
Support and facilitate the formation of coalitions and partnerships

Table 15 Organizations and institutions that the Foundation should involve in programs or initiatives that address health disparities according to focus group discussions and stakeholders interviews

Focus Group Participant Response	Stakeholder Response
Institutions and Organizations to Involve	
<p>Brazilian American Association (BRAMAS)</p> <p>Brazilian Media Outlets</p> <p>Catholic churches that serve Hispanic/Latino and Brazilian populations (i.e. St. Tarcisius)</p> <p>Greater Framingham Community Church (GFCC)</p> <p>MetroWest Latin American Center</p> <p>National Association for the Advancement of Colored People (NAACP), South Middlesex Branch</p> <p>Police Departments</p> <p>Schools</p> <p>School Nurses</p>	<p>Advocates, Inc.</p> <p>African American Sororities</p> <p>Area social service agencies</p> <p>Community based organizations that with technical assistance and assistance to strengthen their infrastructure can support future education and advocacy activities</p> <p>Faith Based Organizations</p> <p>Framingham community health center</p> <p>Harvard Vanguard Medical Associates</p> <p>Local boards of health</p> <p>MetroWest Community Health Care Coalition</p> <p>MetroWest Medical Center, Milford Regional Hospital, Marlborough Hospital, and other area hospitals</p> <p>National Association for the Advancement of Colored People (NAACP), South Middlesex Chapter</p> <p>Private practices and Individual providers who are interested in or active in service racial and ethnic minority populations in the region</p> <p>Schools</p> <p>South Middlesex Opportunity Council (SMOC)</p> <p>Southborough Medical Group</p> <p>State and National level organizations that are working on disparities, or specific health conditions for which we know there are disparities</p> <p>Visiting Nurses Associations (VNA)</p> <p>Wayside Youth and Family Services</p>

APPENDIX 4: Institutional Assets

- 1- Respondent Demographics Charts and Tables**
- 2- Health Conditions and Social Factors**
- 3- Health Related Services**

Figure 3 The reported organizational classification of all respondents

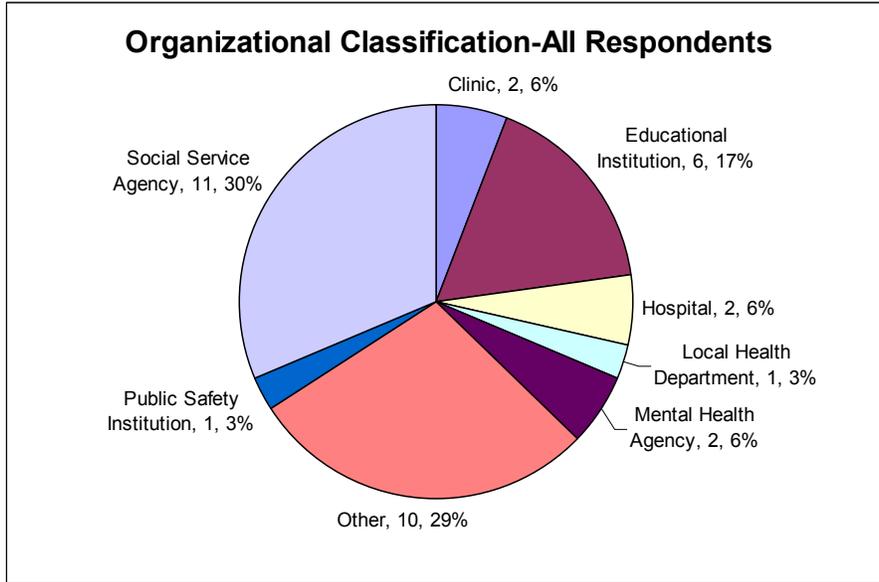


Figure 4 Organizational type as reported by all respondents

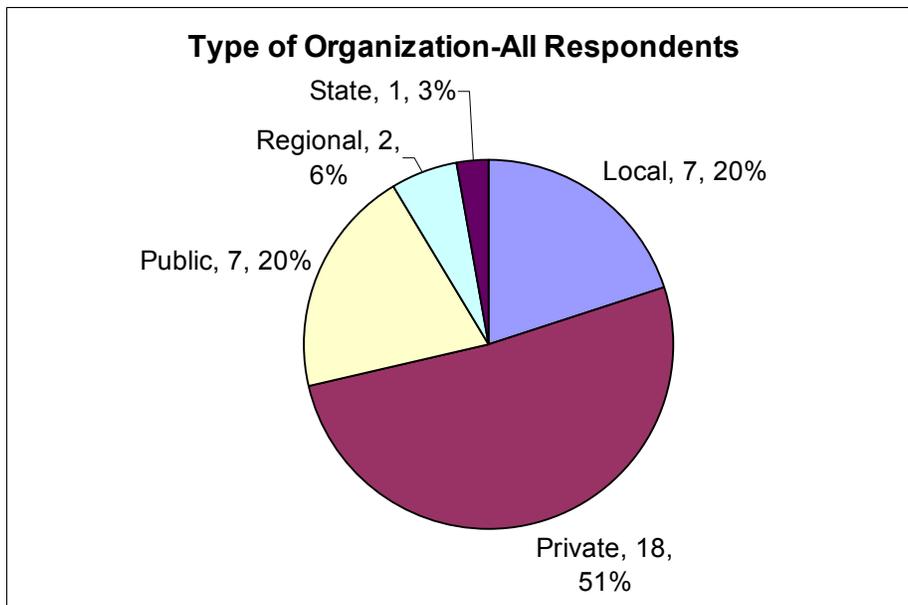


Figure 5 Organizational classification as reported by organizations that indicated they have developed programs in response to health disparities

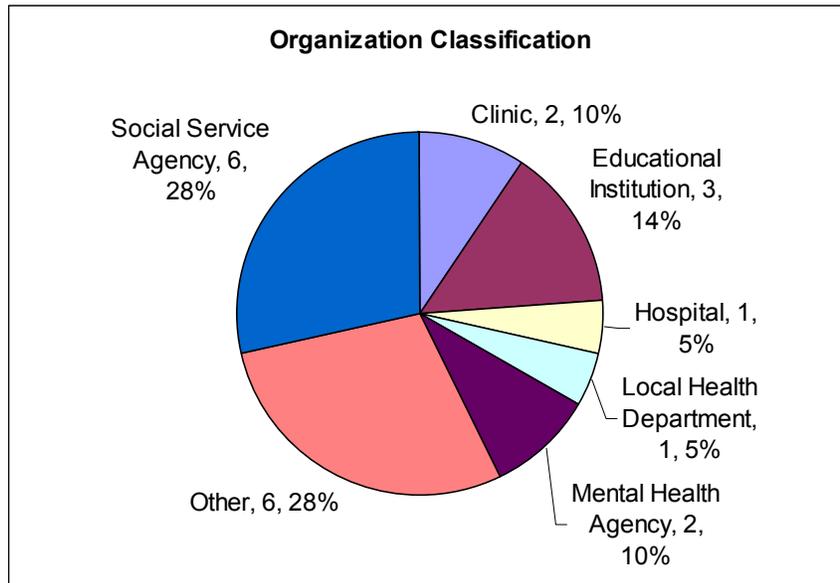


Figure 6 Types of organizations that indicated they have developed programs in response to health disparities

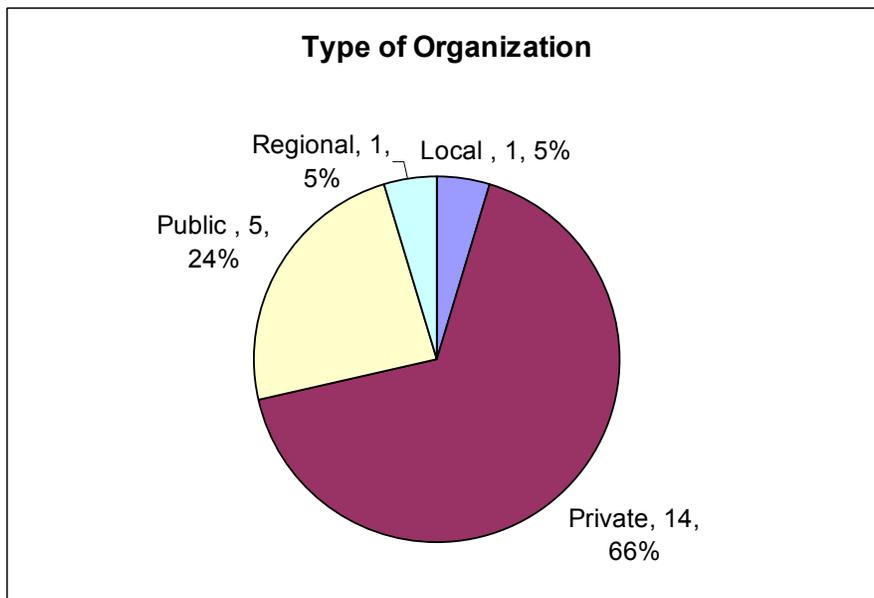


Table 16 Health conditions and social factors that institutions/organizations (that reported developing programs in response to health disparities) address according to ethnic group

	General Population	African American	Hispanic/Latino	Brazilian	Other
Diabetes	9	8	5	4	1
Heart Disease	7	8	5	4	1
Breast Cancer	7	5	4	2	1
Colorectal Cancer	5	5	4	2	1
Prostate Cancer	5	5	4	2	1
Other Cancers	6	3	4	2	1
Asthma	8	5	4	3	1
Obesity	10	7	6	5	1
HIV/AIDS	7	4	4	4	0
Tuberculosis	4	3	3	3	2
Substance Abuse	11	6	7	6	0
Depression	10	6	6	5	2
Post-traumatic Stress Disorder	9	6	6	5	2
Other Mental Health Conditions	12	7	6	5	2
Domestic Violence	10	7	6	6	2
Youth Violence	7	5	5	5	1
Teen Pregnancy	8	3	4	4	0
Other	4	2	2	2	2

Table 17 Health Services that in institutions/organizations (that reported developing programs in response to health disparities) address according to ethnic group

	General Population	African American	Hispanic/Latino	Brazilian	Other
Emergency Care	4	2	2	2	0
Diagnostic Services	8	4	3	3	0
Outpatient	6	3	3	2	0
Inpatient Care	1	1	1	1	0
Disease Management	4	4	3	2	1
Referral Services	13	7	4	5	2
Screening	10	6	5	6	1
Immunization	5	2	2	3	1
Oral Health Services	2	1	1	1	1
Health Education	16	10	7	7	4
Health Promotion	12	7	4	4	3
Mental Health Services	13	8	6	6	4
Support Groups	8	3	4	4	1
Patient Navigation	5	2	2	2	0
Violence Prevention	9	4	2	2	0
Other	8	2	2	1	2

APPENDIX 5: Data Collection Practices

1- MetroWest Health Providers Race/Ethnicity Data Collection Practices

Table 18 Reported data collection practices by surveyed area health providers

	Healthcare Provider	Race/Ethnicity Data Routinely Collected	Categories	Language Data Collected	Income Data Collected	Residence Information Collected
Hospitals	MetroWest Medical Center	Yes	Asian, Black, Caucasian, Hispanic, Native American, Other, Unknown	Yes. English entered as default language unless patient requires interpreter.	No	Yes, mandatory.
	UMASS Memorial Marlborough Hospital	Yes	White, Black, Hispanic, American Indian/Eskimo, Asian, Hispanic/Black, Hispanic/White, American Indian/White, Native Hawaiian/Pacific Islander, Asian/Black, Asian/White, African American/White, Refuse to answer	Yes. English entered as default language unless patient requires interpreter.	No	Yes, mandatory.
Community Health Center	Framingham Community Health Center	Yes	White, Asian/Pacific Island, Unknown, Hispanic, Middle Eastern, Brazilian, Black, Native American	Yes	No	Yes
Private Group Practices	Southboro Medical Group	No. Except for mammogram recipients, as required by state.	Hispanic, White/Non-Hispanic, Black/Non-Hispanic, Asian/Pacific Islander/Non-Hispanic, American Indian/Non-Hispanic, Multiracial/Non-Hispanic, Unknown, Refuse to answer	No	No	Yes
	Harvard Vanguard Medical Associates	No. Currently developing a data collection system through which this information can be collected.	n/a	No, unless interpreter services required	No	Yes
Clinics	Open Door Medical Program	No	n/a	Yes	No	Yes
	MetroWest Free Medical Program	No	n/a	Yes	No	Yes
Mental Health Service Providers	Wayside Youth and Family Support Network	No	n/a	Yes, if interpreter or treatment in non-English language is necessary.	No	Yes
	Advocates	Yes	Vary according to division.	Yes	Yes	Yes