



CLOSING THE GAP ON RACIAL AND  
ETHNIC HEALTH CARE DISPARITIES

# Lessons from the 2005-2008 Grantees



# Executive Summary

In 2005, the Blue Cross Blue Shield of Massachusetts Foundation launched the *Closing the Gap on Racial and Ethnic Health Care Disparities* grant program area. Two hospitals and seven community-based providers were funded for three years (\$50,000 for the first year and \$125,000 each in the second and third years) to design and implement strategies aimed at reducing racial and ethnic health care disparities among people of color living with diabetes, asthma, HIV/AIDS, cardiovascular disease, trauma/mental health, and low birth weight/infant mortality. Target populations included African-Americans, African immigrants, Latinos, Chinese-Americans, Cape-Verdeans, Haitians, Jamaicans, Brazilians and Native-Americans.

The Foundation sought to fund strategies for addressing disparities in health care that were replicable, sustainable and had measurable outcomes. It supported a range of interventions included patient-focused solutions, adjustments to provider/clinician processes and behaviors, and systemic and operational changes. The Foundation contracted with the Disparities Solution Center at Massachusetts General Hospital to evaluate the grant program area. The evaluation indicated that although most of the programs achieved some measure of success in improving health outcomes for patients in their target populations, the timeframe, funding levels, and scope of the grant program area were not sufficient to prove medical models for producing consistent improvement in health outcomes. Furthermore, the evaluation documented that the simplicity of the programs often belied the significant changes in infrastructure required in their implementation. The grantees took on a tremendous amount of difficult, behind-the-scenes work in developing and implementing their programs, and those experiences offer great insights for others interested in addressing disparities through system change.

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This report highlights stories of change from policy, organizational, provider and client perspectives, and explains the successes and challenges encountered in the course of implementing the grant-supported programs. Furthermore, it details lessons learned and best practices for providers, policy-makers, and funders to consider when initiating similar efforts.

Finally, the program yielded valuable lessons for the Foundation as it developed the second round of disparities grants to a new cohort of organizations. The grant guidelines were revamped to encourage a focus on collaboration between consumers and providers in the planning and implementation phases. The new grant opportunity also emphasized public awareness, education, and policy change as strategies for addressing health care disparities. Lastly, the Foundation prepared to evaluate the impact of the new programs with a focus on systems change and policy impact, instead of individual behavioral change or health outcomes.

# Background

The existence of racial and ethnic health care disparities has been clearly documented by researchers, state and federal commissions, and perhaps most notably in a 2002 report by the Institute of Medicine, *Unequal Treatment: Confronting Health Care Disparities*.<sup>1</sup> Despite numerous initiatives by foundations, academia, advocacy groups, and municipal, state, and federal government agencies, disparities persist in the United States and can be found in access to health insurance and health care, quality of care, and disease prevalence and outcomes. As documented in the ground breaking seven-part series *Unnatural Causes ... Is Inequality Making Us Sick?*, disparities can be exacerbated by lack of insurance, poor education, unemployment, poverty, racism, inadequate housing, and homelessness.

Beyond the impact of racial and ethnic disparities on a national level, local data further reveal the scope of the problem in Massachusetts:

- From 2000 to 2004, Black Non-Hispanic males had the highest age-adjusted incidence rate of prostate cancer, with 271.8 cases per 100,000 males.<sup>3</sup>
- From 2000 to 2004, Hispanic and Black Non-Hispanic females had larger median tumor sizes at diagnosis of breast cancer (19 and 16 millimeters, respectively) as compared with white Non-Hispanic females (15 millimeters). The median tumor size at diagnosis of uterine cancer for black Non-Hispanic females was statistically significantly larger than the tumor size for white Non-Hispanic females (51 versus 35 millimeters).<sup>3</sup>
- In 2005, Black Non-Hispanic children up to age 14 had the highest rate of emergency department visits for treatment of asthma than any other race or ethnicity group at 2,096 per 100,000.<sup>4</sup>

The lack of culturally competent care that is sensitive to the values, behaviors and needs of a particular community is a widely acknowledged barrier contributing to racial and ethnic health care disparities. Too often, however, “cultural competence” initiatives are seen as the sole response to health disparities. In fact, culturally competent care is one of several critical strategies for alleviating racial and ethnic health disparities. Other interventions to address inequitable care, which should be implemented with leaders from the affected communities, include disease management, workforce diversity, comprehensive patient education, health care system changes, policy changes and changes to the conditions that lead to greater disease prevalence.

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health care disparities among people of color living with diabetes, asthma, HIV/AIDS, cardiovascular disease, trauma/mental health, and low birth weight/infant mortality. Target populations included African-Americans, African immigrants, Latinos, Chinese-Americans, Cape-Verdeans, Haitians, Jamaicans, Brazilians and Native-Americans.

With the grant program, the Foundation sought to fund strategies for addressing disparities in health care that were replicable, sustainable, and that had measurable outcomes. Additionally, the Foundation supported a range of interventions that would address the issue through patient-focused solutions, adjustments to provider/clinician processes and behaviors, and systemic and operational changes.

Grantees operated from distinct perspectives, with different data systems, resources, and levels of sophistication in evaluation methods. Recognizing this diversity, the Foundation contracted with the Disparities Solutions Center at Massachusetts General Hospital to evaluate the grantees' progress. The Disparities Solution Center utilized the Results Based Accountability framework, which could be consistently applied across the array of projects. Under this framework, grantees drafted a clear statement of desired results and developed evaluation measures that answered three simple questions:

- How much are we doing?
- How well are we doing it?
- Is anyone better off?

Grantees used the evaluation measures continuously throughout the grant programs to gauge their progress.

The evaluation process revealed that medical models that produced health outcomes were unlikely given the timeframe and funding levels that were provided to this set of grantee organizations. The programs developed by grantees took a straightforward, common sense approach to the problem: increasing outreach and education to patients in the target populations with culturally competent providers, materials, and venues; and creating programs and support systems to help patients manage their health.

Most of the programs achieved some measure of success in improving health outcomes for patients

in their target populations. The simplicity of the programs, however, often belied the tremendous amount of difficult, behind-the-scenes work in their implementation, that often required significant changes in infrastructure. Grantees, for instance, were continually challenged by: recruiting, training, and maintaining culturally competent staff members; utilizing new technology to capture and manage relevant data; and coordinating new systems across multiple departments and disciplines. In many instances, grantees were unprepared for the amount of planning and organization required to launch their programs. Those initiatives that were most successful were able to adapt program structures and implement solutions to such unforeseen problems.



# Stories of Change

The elimination of health care disparities will require contributions by policymakers, providers, and individuals and funders. Below are several stories of change and how they influenced the delivery of care with the goal of reducing disparities.

## → **Prevention and Access to Care and Treatment (PACT) Program Goes National**

### **A STORY OF POLICY CHANGE**

The Prevention and Access to Care and Treatment (PACT) Project is a community-based project in inner-city Boston that is committed to improving health outcomes for under-served individuals with HIV disease. It developed a training program for Community Health Workers (CHWs) that utilized a comprehensive home and clinic-based curriculum for patients in health and disease self-management skills. The model has attracted national attention from other health care providers interested in using it in their own communities.

CHWs were trained to engage patients in disease self-management, medication adherence, scheduling appointments and communication with doctors. They also received training in communication and counseling to provide one-on-one guidance to HIV patients with issues of depression, domestic violence, substance abuse, and financial difficulty.

The patient curriculum was designed to educate patients in managing their disease and how to get the most out of their doctor visits. Modules included: *Owning your Antiretroviral (ART) Regimen*, *Handling your ART Medication*, *Adherence to Strengths and Difficulties*, *Identifying Supports and Resources*, and *Medical Appointment Planning*. Four sections of the curriculum were designed to be reviewed by patients with their HIV providers

to improve the quality of their interactions. These included: *Who I Am and What I Want*, *Making the Most of Our Relationship*, *My Current State of Health*, and *My Medications*. CHWs helped patients prepare for these conversations and were available to accompany them on their visits.

In addition to these patient-focused programs, PACT developed an electronic patient tracking system to help clinicians at Brigham and Women's Hospital better monitor poorly performing HIV patients. Because of these innovations, PACT participants consistently slowed or reversed their disease progression and required less frequent hospitalizations.

PACT leveraged its experience and engaged in advocacy efforts around the state, talking with third-party insurers and the Massachusetts Department of Public Health's Community Health Workers Advisory Council to promote a policy change whereby CHW services would be reimbursed by health insurance. If funded by Medicaid, it would mark the first time PACT CHWs would receive direct reimbursement through public payer funds. The funding would also allow the program to provide services on a broader scale and adapt its model for the care of high-risk, high-cost patients living with multiple medical conditions.

PACT's techniques drew attention from providers and advocates around the country. After connecting with the program, the New York City Depart-



ment of Mental Health and Hygiene funded a Bronx hospital to pilot a program largely adapted from PACT's model. A delegation from a Miami hospital visited Boston to observe PACT CHWs at work. Finally, clinics in Virginia and South Carolina have also expressed interest in the program.<sup>5</sup>

### → **DotWell Translates Diabetes Model to HIV Care**

#### **A STORY OF ORGANIZATIONAL CHANGE**

In an effort to help African-American and Afro-Caribbean diabetes patients better manage their disease, DotWell, a consortium of two Dorchester-based community health centers, the Codman Square Health Center and the Dorchester House Multi-Service Center, adopted a more patient-centered model of care. The changes improved the ability of diabetic patients to manage their own care. These organizational improvements are now being utilized to help patients living with HIV take better care of their health.

To establish its diabetes initiative, DotWell moved from the physician-driven model of primary care which emphasizes treating immediate medical needs, to the patient-centered Chronic Care Model. This model uses a clinical team approach with a focus on supporting the patient in disease self-management. It relies on the integration of technology (electronic medical records, patient tracking, and data collection systems) and evidence-based guidelines to better coordinate care. Community resources such as YMCAs and recreational clubs further aid healthy lifestyle changes, and partnerships with community organizations develop programs where gaps in services exist. The most critical piece of the model is empowering patients to manage their health using strategies like assessment, goal setting, action plans, problem-solving, and ongoing follow-up.<sup>2</sup>

Following the Chronic Care Model, DotWell assembled a Care Team that included nurse case managers, registered dietitians and nutritionists, outreach workers, and coordination with specialty services such as podiatry, optometry, nephrology, and neurology. The team developed a new form in DotWell's patient electronic medical record (EMR) system to capture all necessary diabetes data. "Report cards" were created that detailed how each of



the diabetic patients was doing relative to national guidelines set for diabetic health. Nurse case managers helped patients set and achieve self-management goals aimed at controlling their disease and regularly followed up to ensure they kept scheduled health care appointments.

DotWell also implemented educational group programs such as *Diabasics* for diabetes education, and *Eat Green, Save Green*, which trains participants to prepare affordable nutritious meals incorporating the dietary traditions of their cultures. Group visits engaged participants for linguistically appropriate two-hour sessions where they received both educational instruction and hemoglobin A1c

tests to monitor their blood sugar levels. The initiative also introduced fitness groups and collaborated with the HealthWorks Foundation to open a full service gym for women and children at one of its sites.

Despite these successes, implementing such change was not without its challenges. Staff required ongoing training in managing patient records as the electronic medical record was revised and refined over time. Group visits at Codman Square Health Center were not initially well attended, which led to the decision to conduct them in Creole. Financial resources were limited, and staff members needed to convince DotWell administra-



Boston Medical Center



tors to fund the CHW positions. Furthermore, not all of the services provided under the Chronic Care Model are reimbursable by third-party insurers. But due to the improved outcomes they saw in their target populations, DotWell is now treating all of its diabetic patients with the Chronic Care Model.

DotWell's diabetes initiative is now funded by a \$1.45 million grant from the Richard & Susan Smith Foundation, which will last until 2011.

With the Chronic Care Model infrastructure in place, DotWell is now adapting the system for use with other patients living with chronic diseases, with a focus on HIV patients. According to the organization, the health center is now able to continue with this model and use it as the standard way of operating. Given that the utilization of the Chronic Care Model altered the way DotWell treats patients with chronic illness on a systemic level, "we can continue functioning this way," said Kathy Gorman, DotWell's manager of the diabetes initiative, in a report to the Foundation. "It is now our way of doing business," she noted.

### → **Boston Medical Center Streamlines Electronic Medical Record and Communications Systems with Partner Community Health Centers**

#### **A STORY OF PROVIDER CHANGE**

Boston Medical Center (BMC) struggled to launch its perinatal health network, which aimed to improve maternal health and reduce infant mortality among African-American women in Dorchester and Mattapan. A challenge was that BMC and its two partner sites, Mattapan Community Health Center and Codman Square Health Center, used different patient case management systems. Therefore, it was difficult to develop and implement a uniform set of guidelines to assess a patient's risk for pregnancy or post-partum problems. An overall lack of communication between the sites compounded the problem. In the end, a relatively simple solution was implemented to solve the communications problems. But it took a while to figure out what they needed to do.

In a report to the BCBSMA Foundation mid-way through the grant cycle, BMC detailed three challenges they encountered when launching the network: 1) Extreme disconnect between the clinics

which served as ambulatory sites, and the hospital which oversaw labor and delivery; 2) Identifying common strategies and goals across groups with differing organizational structures and priorities; and 3) Obtaining consensus among participating health centers on common language so as to simplify and coordinate efforts. This severely delayed the implementation of the grant activities.

BMC mitigated these challenges by gathering staff members from each of the partner organizations and having them review each of the electronic medical record systems and identify commonalities and differences. This process led to a shift in attitude by the collaborators and ultimately an agreement as to the importance of a standardized documentation and case management tool. The group also identified the need for training in use of the problem list.

"Exploring these together allowed the group to highlight problems inherent in their different templates and different locations of information," BMC's Dr. Larry Culpepper stated in a report to the Foundation. "This led to a rapid attitude shift following understanding of the importance of a common mode of documenting and agreement on use of the problem list as our case management tool. The group further identified the need for training in use of the problem list as a case management tool."

Ultimately, BMC and its partners succeeded in developing a comprehensive case management electronic medical record template for use in the community health centers and in BMC's Obstetric and Family Medicine Clinics, Labor and Delivery, and the Antenatal Testing Units. They also developed a perinatal case management training tool to educate colleagues on a standard approach to coordinating prenatal care.

### → **Patient Helps Spread the Word On Asthma Self-Management at Greater Lawrence Family Health Center**

#### **A STORY OF CLIENT CHANGE**

Gladys Cabral, a woman in her fifties, has had asthma since she was a child growing up in the Dominican Republic. After it flared up three years ago, she sought help at the Greater Lawrence Family Health Center (GLFHC), enrolling in the four-part Asthma Self-Management Education (ASME)

Program, coordinated by nurse Evelin Viera. The program worked. Cabral used it to get her asthma under control. “Now I feel much better,” she said in an interview.

ASME was part of GLFHC’s effort to reduce the burden of the disease for its Latino patients in Lawrence. The city has a large Latino population that experiences hospitalization rates for asthma far higher than the state average. The program educates patients about asthma and empowers them to better manage their illness and live more comfortable, healthy lives.

Cabral, who owns rental property in Lawrence, mentioned her success to Socorro Marte, a woman of similar age who also has asthma and rents an apartment from her. Marte got in touch with Viera, who helped her devise a plan to minimize exposure to asthma triggers. This included abandoning chemical cleaners in favor of water and a damp cloth and ensuring that Marte got new pillowcases and mattress covers. And to prevent grass dust from infiltrating the apartment and triggering Marte’s asthma, Evelin reminded her patient to close the windows, especially when the lawn was being cut. She also advised Marte to switch to more effective medication. “I am in control,” said Marte, with satisfaction, during an interview.

Like Cabral, Marte will probably spread the word as well.

Greater Lawrence  
Family Health Center





# Lessons Learned

Grantees' experiences in this program area offer many lessons for providers, policymakers and funders invested in creating a more equitable health care system.

## KEY FINDINGS FOR PROVIDERS

### → Hire or assign a dedicated manager to the project.

A day-to-day manager is needed to ensure the project's continued progress and to champion its successes while solving problems as they arise. In some cases, it may be particularly important to ensure that this individual resembles the target population both culturally and experientially; in all cases, the individual should have close familiarity with the population being served. One of the more successful strategies, regardless of population or disease, seems to be the use of culturally competent community health workers who work with patients in their homes, schools, or communities. They work to minimize disparities in access and treatment by helping patients and providers better communicate. They also assist with enrollment and re-enrollment in public health insurance programs, and identify for providers factors that may impact health, such as housing conditions, limited access to healthy foods, etc.

### → Involve the community you seek to treat in your planning.

Stakeholders representing the target population should be involved in the conceptualization and implementation of the project. Individuals may be from cultural organizations or vocal patients who are members of that population. Not only

will this best inform the process, it will also make the services relevant to the population and improve patient outcomes.

### → Sharpen your focus with community and organizational goal setting.

Though it was not required in the planning year, the majority of the grantees conducted community assessments in order to better understand the target population. Such assessments revealed cultural attitudes toward medicine; actual and perceived barriers to care; epidemiological patterns of health outcomes; and frequent treatment regimens. Many grantees also conducted organizational assessments by speaking with health professionals and other staff to gauge their experiences with members of the target population. These assessments were critical to building successful interventions. Too often, providers design programs based on their perceptions of barriers to care and in doing so miss critical elements that could lead to better health outcomes.

With this information, organizations must specifically define the problem they seek to address. It is likely that other providers have defined the problem similarly and they may have data available on their findings. A brief literature review is helpful in understanding more about potential interventions, barriers and evidence-based solutions. Using this information, programmatic goals can be developed.



## DotWell

### EATING GREEN, EATING RIGHT, AND KEEPING BLOOD SUGAR IN LINE

The dialogue was intense at a recent educational meeting for people with diabetes at the Codman Square Health Center. Rose Estimable, RN, explained that members of the group must eat healthy foods and keep their weight down. The participants were not shy about asking questions. “Can we eat cheese?” some of them asked. By gathering together, getting expert advice, and exchanging information, they were taking control of a chronic disease and prolonging their lives.

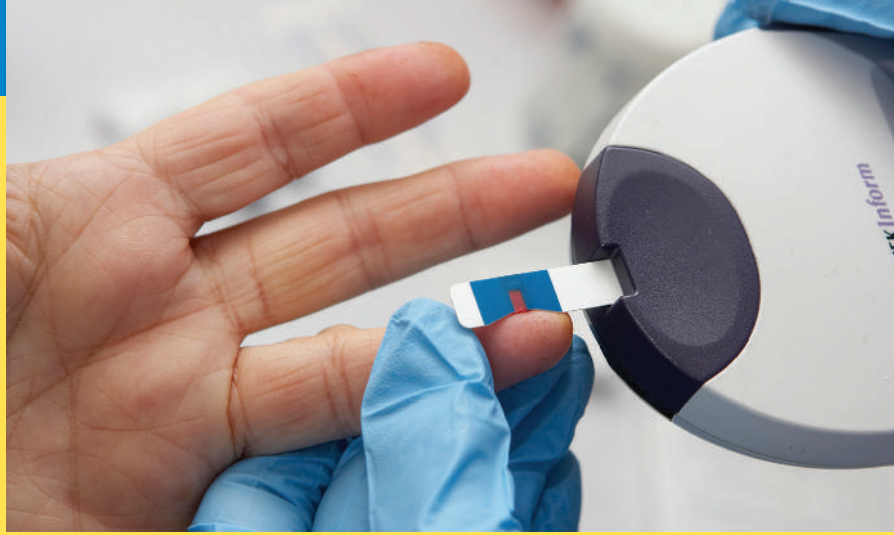
The impetus for this meeting comes from a campaign initiated three years ago by DotWell, a public health consortium of the Codman Square Health Center and the Dorchester House Multi-Service Center. The two centers are responsible for medical care for 40,000 people in Dorchester, including 2,500 diabetics.

Leaders of the two centers enlisted the help of the Blue Cross Blue Shield of Massachusetts Foundation for a three-year grant to pay for the initial outreach. Workers educated Dorchester residents about diabetes via booths at health fairs, the DotWell health van, and a display table at a supermarket. They also worked with health center staff to start the group meetings.

“I think of the Blue Cross grant as seed money,” said Kathy Gorman, coordinator of the diabetes initiative. “It got us to think about how we can get people engaged.” Even though the grant expired last year, the program continues because of a \$1.45 million grant from the Richard & Susan Smith Foundation, which will last until 2011.

Thanks to the initiative, health center patients can enroll in Diabasics, a two-hour course about understanding the disease. They learn how to prepare nutritious and affordable meals by attending the Save Green, Eat Green classes. If they are women, they can work out at a fitness club near Codman Square at no charge for three months (fees are income-based thereafter). And their physicians and nurses receive a monthly “report card” indicating how well each of their diabetes patients is doing on 16 key clinical indicators.

And if patients have difficulty managing the disease, or would benefit from social interaction, they can take part in a series of eight group meetings, either at Dorchester House or Codman Square. Estimable conducted the one in Codman Square in Creole, as many Haitian immigrants rely on the health center for medical care.



The 14 participants at the Codman Square group meeting got a snack of orange and apple slices, crackers and low-fat cheddar, which provoked the cheese questions. “It’s okay to eat a little bit of everything,” Estimable told them. She also offered more specific advice. “When you fill your plate, don’t put on so much rice,” she said to groans from people who regard rice as a staple. “It should only fill a quarter of the plate. Put on more vegetables.”

John Feliciano, a representative from the supply company Neighborhood Diabetes, dropped by to give them tips about self-testing for blood sugar level, and subsequently how to adjust insulin intake according to test results. “Don’t test on the tip of your fingers,” he advised. Plentiful nerve endings there can cause intense pain.

Participants in the program also get regular hemoglobin A1c tests, a more precise indication of the progress of the disease than self-testing. Every few minutes one of them leaves the room to learn the results of the test from a previous session. If the reading is too high, participants receive counseling from Dr. Unique Michaud, a physician with a special interest in diabetes.

As the two-hour meeting ended, one of the participants, Marie Blanc, gave this appraisal: “I eat better. I know what to eat — more vegetables.” Michaud explained that when patients first learn that they have diabetes, they are scared. They need to learn how to improve their diet, control their weight, test their blood sugar, and use medication to manage the disease. Once participants complete the course, they get a diploma and Michaud adds, “they are not afraid.”

→ **Build coalitions and include community voices.**

It is important to identify and engage stakeholders that would be interested or useful to the project. Stakeholders may include local government (such as departments of health and education), local businesses (such as grocery stores and pharmacies), community agencies (such as YMCAs) and cultural organizations. Many grantees learned that coordinating efforts across multiple individuals and organizations is required for success. This includes work in the areas of communication, resource sharing, obtaining agreement on program goals from all partners, and clarifying roles and responsibilities. Many partnerships can be successfully formed by building off of existing relationships.

→ **Establish infrastructure with staff, technology, and alternative care delivery models.**

Grantees spend considerable time and energy hiring and filling vacant positions, limiting their own capacity to work on the projects at hand. Some grantees had great success with retention when they hired from within the organization.

At the beginning of the grant cycle, few of the grantees had the ability to collect race/ethnicity data on desired indicators, or sort data with their electronic medical record technology. By the end of the implementation period, each had successfully manipulated the technology to collect relevant information. After they accomplished this task, they discovered that some providers were not using the electronic medical records properly. Thus, some grantees found it useful to implement a series of workshops to encourage better documentation of data.

Many resources were useful for grantees seeking to best utilize their technology. Software company tutorials and staff visits or calls with the organizations helped guide them through the process. Also, networks of health professionals were very informative, such as the Massachusetts Health Disparities Collaborative, a group effort of the state and community health centers begun in 2006 to improve outcomes for diabetic patients.

There was considerable discussion around the use of alternative care delivery models, including the use of community health workers, group visits, case managers, and disease program “champions.” These strategies were usually more culturally sensitive to the needs of the population and quite effective in improving outreach to and care for high-risk patients.

→ **Program optimization: adapt, integrate, and evaluate.**

Time and energy can be saved by using existing evidence-based care models. Programs that already focus on the target population and disease area can be adopted with a few provisions for a different community. Several grantees had success with adapting programming and protocols from other clinical areas to meet their needs, keeping in mind the specific culture of the organization and target population. Those projects that took place at multiple sites had to be mindful of competing priorities, and staff members had to be flexible.

Several of the grantees also noted challenges with integrating grant-related activities into the everyday functioning of their organizations, which they feel is important for long-term sustainability. The manner in which programs are integrated affects both workflow and organizational financing. Though many grantees experienced hesitance from providers, their cooperation was key to successful integration. In one instance, a grantee experienced resistance to cultural competence trainings from providers at its clinical partner. Feedback revealed that the doctors were hesitant to receive trainings from non-MDs; a sense that the information presented was “too basic”; and discomfort with the training because it implied they were not already providing good care. As a result, grantees worked closely with the Disparities Solutions Center at Massachusetts General Hospital to shorten trainings and integrate them with doctor expectations and practice. Measuring change in cultural competence among medical staff remained challenging, however.

Frequent evaluation of process, impact, and outcomes helps to further refine programming. Patient satisfaction surveys, provider feedback

## Boston Medical Center

### DELIVERING HEALTHY PREGNANCIES AND HEALTHY BABIES

The Centering Pregnancy group was holding its last meeting. And there were new little distractions—seven healthy babies, born several weeks before. Some of the births had been difficult, but all the mothers were ready for their birthing experience because of the seven-month educational program sponsored by Boston Medical Center (BMC) and Codman Square Health Center.

“We listened to our babies’ heartbeats, compared weights, we gossiped, we laughed,” said Senai Clark of Hyde Park. “They [the medical staff] made sure we’re okay and the baby’s okay,” said Ursula Allston of Dorchester.

This particular meeting was the culmination of a program that was part of an initiative supported by the BCBSMA Foundation to improve the health — before, during, and after childbirth — of both mothers and babies in the Dorchester area. Research has established that African-American infants are at greater risk for low birth weights and other health disparities. The perinatal network led by BMC aims to get these families off to a healthier, safer start.

To date, 33 women have taken part in the program. Like many low-income women, they often feel isolated and depressed, overwhelmed by the responsibilities of parenting and struggling with the need to find stable housing and deal with other economic problems.

“Centering Pregnancy [based on a national program] was one of our interventions to address these issues,” says Beth Monahan, a nurse-midwife and director of the perinatal network. “Instead of the typically rushed 15-minute visit with a prenatal care provider, with the Centering Pregnancy model, mothers-to-be get group visits for two hours that include an individual medical assessment, health and parenting education, and psychosocial support. The group provides opportunities to discuss and figure out solutions to common worries, and staff make referrals to needed services such as housing assistance or the WIC program.”

According to Monahan, another major goal of the network was greater staff collaboration, so that when women gave birth at BMC, staff were electronically linked to the records of the community health center where the women received prenatal care. As a result, medical staff can quickly obtain information about the patients and coordinate care more efficiently and responsively. This exchange of social and medical information, Monahan says, ensures that patients get the highest quality of care during



pregnancy, childbirth, and the postpartum period, as well as peer support, parenting education, and links to needed services.

“In the group the women create the emphasis and learn from each other,” Monahan said. “The care becomes relevant to them. We’ve noticed an increase from 60 percent attendance in traditional care to 93 percent attendance in Centering Pregnancy groups.”

The Mattapan Health Center is in the early stages of setting up its own Centering Pregnancy Program in conjunction with Boston Medical Center. Dr. Larry Culpepper, Chief of the Department of Family Medicine at the hospital, thinks that it will become a model for other health centers in Boston. The sharing of data between Codman Square and the main hospital will be especially important as an example of how electronic medical records can be coordinated to improve care.

Besides helping the mothers, the program is intended to promote the babies’ health in their first year of life. According to Culpepper, one of the biggest obstacles to good health for both mothers and babies is pre- and post-partum depression. The mother is too burdened by her new role to give proper care to the newborn.

But there were no signs of depression at this meeting. The mothers described their childbirth experiences, some of them which were not so easy. “They had to do a C-Section,” said Allston, describing a long labor, but “it was well worth the wait.” Teresa Thompson of Dorchester remembered, “We had the best nurse. I felt really confident in my preparations.”

The group then feasted on lasagna and fruit salad and exchanged information about breast-feeding and day care. Several of the first-time mothers were understandably anxious about putting their babies in unfamiliar hands. Thompson, who had given birth to her second child, offered this advice: “What you want is somebody like a really good grandma... a nice aunt.” Although the birthing group officially ended with this session, the new mothers all had each other’s phone numbers. They promised to get together again.



and EMR data were useful ways in which to gauge effective methods and those that would benefit from improvement.

→ **Think long-term: cost effectiveness, attacking root causes and educating skilled workers.**

Planning for sustainability should be a priority in both planning and implementation. An inability to preserve the model beyond grant funding undermines the project's success. It is critical that project managers investigate how to best use the funds to build organizational infrastructure and establish a proactive strategy to recruit necessary funds following the conclusion of the grant cycle. This can be accomplished if the organization can prove the cost-effectiveness of maintaining the program and staff after the grant has concluded.

Future program sustainability beyond the life of the grant proved challenging for many grantees. Those that were more successful either leveraged their progress to acquire additional funding from other funders, or worked to align their work with current legislative initiatives or judicial events that would potentially utilize their intervention model.

Projects that modify the standard of care can significantly improve the quality of care for patients, and as a result, amend disparities in care. Other providers may seek to address the root causes of disparities — the conditions which perpetuate health inequities overall. Interventions within the home, school, or outdoor environments can significantly improve the quality of life for patients and improve health outcomes.

Some grantees also sought to address shortages among skilled professionals. For example, in an effort to better assist its Somali families, Alliance for Inclusion and Prevention partnered with Children's Hospital and Boston University to recruit Somali individuals to train as social workers. Scholarships were provided by the university, and graduates received a Masters of Social Work degree. This program achieved not only filling the vacancies in the program, but also established a model to target the shortage of professionals in the field.

## KEY FINDINGS FOR POLICYMAKERS

→ **The importance of reimbursement for alternative care models.**

Obtaining funding for alternative care delivery models is a significant issue. Many grantees developed creative programming including group nutrition or weight loss classes, group medical care visits, and community health worker models. However, they found that public and private insurers would not pay for their costs, even if there was preliminary evidence demonstrating their impact on better health outcomes. As a result, several grantees including the Holyoke Health Center began advocacy campaigns to address these policy barriers. Using the evidence from their interventions, health centers were able to prove the efficacy of alternative care models to third-party payers and policymakers. Tufts Medical Center's Asthma Prevention and Management Initiative supported pending state legislation that would mandate health insurance coverage for asthma self-management programs. Policymakers may find data and anecdotes on alternative care models to be largely informative on the role they can plan in enhancing health care services and delivery.

→ **Electronic medical records play a critical role.**

Electronic medical records can be utilized to enhance data collection, track discrepancies or disparities between providers or different groups of patients, and promote best practices for office visits. With increased federal attention and financing towards electronic medical records, ways in which to leverage this technology to eliminate disparities can be explored.

→ **More champions are needed to educate the public and providers about disparities.**

Raising awareness and educating stakeholders is critical to reducing health care disparities. A key component of such education and awareness raising is the availability of data and research findings that can be widely disseminated to further emphasize the need to address disparities in ways that will motivate the public and providers to support successful innovations.

## Greater Lawrence Family Health Center

### SPREADING THE WORD ABOUT MANAGING ASTHMA

Wanda Gonzalez, like many other people in Lawrence, needed medical help because of her asthma, a chronic disease that flared up when she was in her forties. “I went to the doctor,” she said. “He referred me to Evelin. She taught me how to use medications and how to avoid pollen and perfumes.” Gonzalez breathes better because of the work of nurse Evelin Viera, Coordinator of the Asthma Self-Management Education Program at the Greater Lawrence Family Health Center.

“We focused on being able to provide linguistically and culturally appropriate asthma care,” said Viera. Lawrence was in need of the project’s work. A city with a large Latino population, it has a far higher average rate of hospitalization for asthma than the state.

The causes of the disease are unknown, although environmental factors are suspected. The National Institutes of Health has devised treatment guidelines that should keep admissions to a minimum if health care providers teach patients to follow them rigorously. But without special help, it’s hard to get the word out in a community struggling with poverty, and where many residents do not speak English as their first language.

The asthma self-management team had to go to where the people were. Workers at the health center spread the word at health fairs and during local radio programs and community meetings that asthma could be controlled without hospitalization. Project support was especially helpful to Dr. Marcelo Campos, a physician at the South Lawrence branch of the health center, whose practice was the initial focus of the program’s outreach.

“As a family doctor, it is hard to keep track of the latest asthma guidelines,” he said. But because of the grant, he was able to attend a conference in Dallas. “The grant provided me with an education necessary to impart knowledge to other providers,” he added. Viera supplemented Campos’s work with a four-part asthma education course that enrolled 68 patients, Gonzalez among them.

Allergies often are associated with asthma. Viera arranged the purchase and distribution of hypoallergenic mattresses and pillow covers to minimize patients’ exposure to dust mites, a trigger for asthma in many people.

After patients completed the course, Viera and Campos tracked their progress, and Viera did follow-up consultation every few months. During the



two-year span of the grant, only one of Campos’s patients had to go to a hospital emergency room for an asthma attack. The asthma-control project has been expanded to other patients at the South Lawrence center, and will later be offered at the other three sites in the Greater Lawrence network.

And as a result of the grant, the health center was able to offer its asthmatic patients an asthma control test based on the NIH guidelines. Among Campos’ patients, 89.8 percent have taken the test. He and Viera are able to offer treatment tailored to a patient’s symptoms.

Gladys Cabral, who is in her 50s, has had asthma since she was a child in the Dominican Republic. It flared up three years ago. She sought help at the health center, took and course, and the asthma control test. “Now I feel much better,” she said. Cabral, who owns rental property in Lawrence, mentioned her success to Socorro Marte, a woman of similar age and one of her tenants. Dust, household cleaners, grass cuttings and other features of daily life trigger Marte’s asthma.

Nurse Viera helped Marte devise a plan to minimize exposure. This included abandoning chemical cleaners in favor of water and a damp cloth. Viera made sure that Marte got new pillowcases and mattress covers. And to keep the grass dust out the house, she reminded Marte to make sure the windows are closed when the lawn is being cut and encouraged her to switch to better medication. “I am in control,” Marte said with satisfaction.

Management of a disease isn’t a cure, but thanks to Viera and Campos, medical knowledge about asthma is transformed into workable advice that makes sense to their patients in Lawrence.

→ **Community voice, collaboration and upstream responses are effective.**

Consumer input can ensure that planning and interventions are more targeted towards their needs and are ultimately successful. The funded projects demonstrated that it is often necessary to collaborate among a diverse range of stakeholders, and that involvement of the affected population leads to better outcomes. Finally, responses that focus on upstream factors that affect health outcomes will have a great impact on the populations that grantees serve.

## **KEY FINDINGS FOR FUNDERS**

→ **Facilitate peer-to-peer assistance among grantees.**

At numerous points throughout the three-year grant cycle, grantees expressed the desire to collaborate with their peers working with similar target populations, medical conditions, and organizational challenges.

The Foundation held three in-person technical assistance sessions over the course of the grant program cycle. During these sessions, grantees assisted each other with organizational, outreach, and systems challenges, and shared experiences over the conceptual development of programs. These sessions also helped to clarify communications between grantees and the Foundation in regards to the development of goals and measurable outcomes. Finally, such sessions addressed the underestimation by many grantees of their need for technical assistance and further support in data collection and development, as well as systems development.

→ **Ensure that grantees develop sustainability plans from the project's inception.**

Providing examples of other grantees that were successful in sustaining their programs can be helpful, especially information around the various approaches grantees took to integrate their programs into their organizations. Funders should also consider leveraging their connections and networks in philanthropy to make grantees aware of other funding opportunities.

→ **Rigorously assess grantees' experience with project management, provide a checklist of activities to be completed during the planning year, and evaluate progress.**

There was significant variation in project planning, management, and implementation skills among grantees. Nearly all grantees would have benefited from a clearly defined checklist of activities to be completed during the planning year. Categories that could have been further outlined included: marketing and outreach initiatives; assessment and adoption of training and clinical tools; organizational readiness; and development of a tracking plan and measurement of outcomes. The absence of specific deliverables during the planning year can inhibit a project's progress throughout the grant period, whereas requiring grantees to report on these activities at the midpoint or at regular intervals can allow for corrective action prior to the start of program implementation.

→ **Support program and funding models that promote alternative care models.**

Many grantees experienced difficulty integrating new care models with traditional primary care, and furthermore had limited capacity to treat all the patients that were newly identified by outreach strategies. As a result, some programs reported delays of up to eight weeks when scheduling an appointment. Funding that allows for flexibility around the implementation of strategies can ensure the successful launch of these alternative care models.

→ **Identify and publicize the evaluation methodology to grantees as they are applying for funding.**

Grantmakers should select an evaluation methodology that is functional and useful for both grantees and the funder. During this grant cycle, the Foundation adopted the Results-Based Accountability framework by the Disparities Solution Center. However, many grantees found this methodology intimidating even after several trainings, and could not produce effective results using it. Stating both the desired results and performance measures for the program as a whole prior to receiving proposals, as well as providing



extensive training in evaluation methodology before the start of the grant cycle can alleviate confusion during this initial ramp-up period.

→ **Ensure thorough but useful progress reports.**

Regular submission of data and progress reports are important while being cognizant of the burden it may place on grantees. It is important to consider what information would be useful for the grantmaker and use reports as mechanisms to promote deeper thought on a particular issue of concern. Funders should also provide acknowledgement and feedback on the reports, as well as technical assistance on how to address the issues raised, so as to enhance a grantee's experience. Grantmakers should use these progress reports to analyze internal processes and make necessary adjustments.

→ **Share what you learn.**

Too often grantmakers close a grant cycle without analyzing the impact of grantees individually and collectively. Reports and other internal records can be used to understand that impact, and share it back with the grantees, other funders and stakeholders. If the results and findings from a grant area are not viewed within the context of the larger field, a tremendous disservice is done to grantees and the affected community.



# Changes for the 2008-11 Closing the Gap on Health Care Disparities Program

The lessons learned from the 2005-08 class greatly informed the development of the second three-year grant cycle of *Closing the Gap on Health Care Disparities*. For the 2008-2011 grant program area, the possible target populations were broadened, allowing grantees to define target populations beyond race or ethnicity. Additional changes were designed to help grantees more directly address the root causes of health care disparities by engaging consumers and promoting systemic changes in their organizations as well as in their surrounding communities. Grantees in the current grant cycle demonstrated a significant level of engagement by members of their target population in the planning and implementation of their programs. The Foundation believes that consumer collaboration is essential to effectively identify a disparity and implement a plan for its reduction or elimination.

The Foundation also required grantees to look beyond the walls of their organizations and to integrate public awareness and education along with systemic and policy changes. As a result, the Foundation funded programs that sought to create change in organizational systems and policies that impact health care delivery and contribute to health care disparities.

To analyze the impact of community engagement and learning among the grantees, the Foundation developed a grantee Learning Community that meets quarterly each funding year, and provides space for the funded organizations and Foundation staff to learn alongside one another as the efforts progress. The framework, vision, and agendas for the Learning Community are largely designed and facilitated by staff members of the grantee organizations with Foundation staff support.

The Foundation recognizes that eliminating, or even reducing, health care disparities is a long-term prospect that requires systemic change inside and outside the clinical setting. Therefore the Foundation has shifted its evaluation focus from a results-based approach to one that is process-based. The evaluation of the 2008-2011 grants measures the system change and policy impact that funded organizations can have on health care disparities issues, including increased public awareness, enhanced collaboration among consumers and providers, and the capacity to develop strategic change agendas with their peers and coalition partners.

As the current cohort of grantees continues to progress in their implementation efforts, the Foundation will continue to use the lessons from both funding cycles to inform efforts towards eliminating health care disparities in the Commonwealth.



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# Appendix

## A

The following nine programs received *Closing the Gap on Health Care Disparities* funds between 2005 and 2008:

→ **Alliance for Inclusion and Prevention:  
Connecting With Care**

**TARGET POPULATION:**

African-American, Latino and Somali youth and families at five schools in the Grove Hall section of Boston

**TARGET HEALTH CONDITION:**

Mental/behavioral health diagnoses and disorders

**CONTACT INFORMATION:**

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**WEBSITE:**

[http://www.aipinc.org/cwc\\_overview.htm](http://www.aipinc.org/cwc_overview.htm)

The Alliance for Inclusion and Prevention is a non-profit children's mental health and special education organization which seeks to improve the performance of youth attending schools in a community heavily impacted by crime and violence and where utilization rates of mental health services are extremely low. Through its Connecting With Care program, AIP partnered with other child welfare agencies including the Home for Little Wanderers, the Massachusetts Society for the Prevention of Cruelty to Children, Family Service of Greater Boston, Lilla G. Frederick Pilot Middle School and Children's Hospital Boston to place mental health clinicians in five elementary and middle schools. The clinicians provided individual, group and family therapy and were available during the day and after school hours, including evening clinics that also provided children and families with access to a psychiatrist. The program provided transportation

and child care as a means of further encouraging utilization. Children identified as suffering from traumatic stress were treated through the multi-disciplinary team approach of Trauma Systems Therapy, which included psychopharmacology, psychotherapy, family stabilization/home visits and legal advocacy.

→ **Boston Medical Center**

**TARGET POPULATION:**

African-American pregnant and postpartum women, their infants and families in the Dorchester and Roxbury communities

**TARGET HEALTH CONDITION:**

Infant mortality and morbidity

**CONTACT INFORMATION:**

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Boston Medical Center (BMC) seeks to ensure that women have healthy newborns with a safe and nurturing environment in their first year of life and beyond. Collaborating with the hospital's Division of Family Medicine and Obstetrics, BMC Midwifery Service, Codman Square Health Center, Mattapan Community Health Center and Harvard Street Community Health Center, it created the Boston Health-Net perinatal committee. The committee moved to standardize case management and improve coordination of care between BMC and the health centers, with the goal of better identifying and intervening with women at risk for pregnancy and/or

post-partum problems. Based on the committee's work during the grant cycle, BMC received a federal one-year technology grant to implement increased coordination of care with its partner health centers.

Additionally, BMC expanded the use of its *Birth Sisters* program, which provides women with a trained companion for support during prenatal care and labor and delivery. Companion women are generally from the same community and background as the patients with whom they work. Finally, BMC implemented the national model program *Centering Pregnancy*, which is a structured group visit program that encourages peer-to-peer support and provides parenting education, social support, self-care and empowerment through individual goal setting.

### → Cape and Islands Diabetes Disparities Collaborative

#### TARGET POPULATION:

Brazilian, Wampanoag, Black (African-Americans, Cape Verdeans, Haitians and Jamaicans) and Latino individuals

#### TARGET HEALTH CONDITION:

Diabetes

#### CONTACT INFORMATION:

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The Cape and Islands Diabetes Disparities Collaborative (CIDDC), a coalition of health centers and community agencies, sought to improve the health of diabetics in their region by developing a continuum of services to identify and coordinate their care. CIDDC integrated community health workers (CHWs) trained in diabetes care and standards at five area health centers. The CHWs were able to conduct a significant amount of outreach to the target populations through clinic days and screenings in the community, such as at Brazilian grocery stores. The health centers also notified CHWs when diabetes patients had medical appointments so that they could offer support, monitor and evaluate self-management progress, and arrange for further

follow-up. CIDDC also implemented day and evening diabetes support groups, thus bringing social reinforcement to the population.

### → Caring Health Center

#### TARGET POPULATION:

African-Americans and Latinos

#### TARGET HEALTH CONDITION:

Diabetes

#### CONTACT INFORMATION:

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Caring Health Center (CHC) in Springfield sought to reduce the incidence of and complications from diabetes among its African-American and Latino patients. The center implemented the Patient Electronic Case System, a customized patient registry tool, to help identify their target population. In addition to encouraging provider referrals, CHC also utilized marketing and advertisement campaigns within the health center and to the general public to enroll the target population. Enrollees joined an individualized system of care that included medical treatment, nurse case management, chronic disease self-management workshops, nutrition education and referrals to specialists as needed. Individual care plans for enrollees assessed their knowledge of diabetes, diabetes-related health status, patient instruction in the pathophysiology of diabetes, treatment through healthy eating, exercise, medications and the Diabetes Standards of Care. CHC also instituted group sessions on nutrition, glucose testing, exercise and the Chronic Disease Self Management Program.



### → DotWell

#### TARGET POPULATION:

Diabetic patients in Dorchester/Mattapan, especially African-Americans and Afro-Caribbeans

#### TARGET HEALTH CONDITION:

Diabetes

#### CONTACT INFORMATION:

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With its diabetes initiative, DotWell, a non-profit organization in Dorchester that collaborates with two neighborhood health centers, sought to decrease the burden of diabetes in the community by empowering diabetics to self-manage their condition and lead healthier lives. The organization integrated the Chronic Care Model into its clinical practice, moving from a primary care physician-focused model of care to a patient-centered model where nurse case managers, nutritionists, specialists and the use of exercise programs and cooking classes supported patients in their self-management efforts.

DotWell employed two outreach workers to promote diabetes awareness at local venues and events, encouraging patients to seek care at the health centers and educating those who were at-risk to develop the disease. Additionally, outreach workers contacted diabetic patients that had been lost to care via phone calls and home visits to encourage them to return to the centers for follow-up care.

### → Tufts Medical Center

#### TARGET POPULATION:

Asian-American children attending school or seeking medical care in the Chinatown neighborhood

#### TARGET HEALTH CONDITION:

Pediatric Asthma

#### CONTACT INFORMATION:

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#### WEBSITE:

www.tuftsmedicalcenter.org/commhealth

Tufts Medical Center's Asthma Prevention and Management Initiative (APMI) sought to improve the quality of life of their pediatric asthma patients by improving systems of care coordination, developing accessible bilingual educational materials and implementing self-management programs.

APMI developed, produced and incorporated comprehensive multimedia bilingual educational materials into an asthma education curriculum. Written materials were published in English and Chinese, and a DVD was produced in English, Cantonese, Mandarin and Vietnamese. In addition, the initiative did extensive outreach and collaboration with community agencies, schools, and neighborhood health centers to disseminate the materials. The program also decreased the variation in asthma care among clinic pediatricians and clinicians.

### → Greater Lawrence Family Health Center

#### TARGET POPULATION: Latinos

#### TARGET HEALTH CONDITION: Asthma

#### CONTACT INFORMATION:

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#### WEBSITE:

www.glfhc.org

Greater Lawrence Family Health Center (GLFHC) sought to reduce the burden of asthma for Latino patients. Beginning with one provider and his panel of asthma patients, GLFHC tested and implemented a number of innovations at the center, including the use of the Asthma Control Test in both English and Spanish and the implementation of a Plan-Do-

Study-Act cycle approach. Over the course of their project, GLFHC developed and began implementing a new asthma care process, incorporating a new local asthma practice guideline based on materials from the National Heart, Lung and Blood Institute. Additionally, they developed a method for electronic capture of data for emergency department utilization for their asthma patients. They have begun to implement the successful elements with other providers and hope to expand to utilize these practices with all asthmatics under care at the health center.

#### → **Holyoke Health Center**

##### TARGET POPULATION:

Adult Latino patients

##### TARGET HEALTH CONDITION:

Cardiovascular disease

##### CONTACT INFORMATION:

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Holyoke Health Center's (HHC) *Proyecto Corazon Saludable (Healthy Heart Project)* sought to affect positive behavior changes and health outcomes through programmatic interventions tailored to the psychosocial and cultural needs of Latinos in Holyoke who are at high risk of developing cardiovascular disease. Clinical staff worked collaboratively with patients to develop self-management goals and subsequently referred them to relevant support programs. HHC developed a variety of services including smoking cessation, exercise classes, lifestyle counseling, nutrition classes and Chronic Disease Self Management groups.

In order to better meet the needs of its target population, the program utilized *Promotoras*, or lay health workers from the Latino community who exemplify a healthy lifestyle and were able to assist patients with developing strategies to overcome barriers. Additionally, patients benefited from bilingual, and in many cases bicultural, case managers and group facilitators. Low-literacy educational materials were published in Spanish.

#### → **Prevention and Access to Care and Treatment (PACT) Project**

##### TARGET POPULATION:

HIV-positive African Americans,  
Latinos and Haitians

##### TARGET HEALTH CONDITION:

HIV/AIDS

##### CONTACT INFORMATION:

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The Prevention and Access to Care and Treatment (PACT) Project, a collaboration between Brigham and Women's Hospital and Partners In Health sought to help patients at Codman Square Health Center and Dorchester House Multi-Service Center adhere to their treatment regimens and lower their risk of developing AIDS. Their program, known as IMPACT, provided a comprehensive home- and clinic-based curriculum to educate patients in health and disease self-management skills. BWH staff provided case management services and weekly PACT Health Promotion Services, and program participants were given assistance in negotiating the health care system.

The PACT Disease Management Curriculum and Patient Workbook was used by health promoters or community health workers to engage patients in disease self-management. It was used in individual sessions between patients and health promoters during the first nine months of their relationship. The curriculum modules were developed with the assistance of PACT patients, health promoters and behavioral change experts. The Patient Workbook included four sessions to be reviewed with physicians at patient visits and exercises for the patient related to each module.



**FOUNDATION**  
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