CLOSING THE GAP ON HEALTH CARE DISPARITIES

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DECEMBER 2012

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BACKGROUND

In October 2008, the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation launched the Closing the Gap on Health Care Disparities Initiative that supported 11 community-based coalitions across Massachusetts in addressing disparities in health care and outcomes. The projects selected a variety of health problems (e.g., diabetes, obesity, HIV/AIDS, and adolescent pregnancy) that differentially affect people with various demographic characteristics (e.g. race, ethnicity, economic status, and sexual orientation). Grantees received one-year planning awards to develop their ideas, assess needs, hone their approaches, and strengthen their coalitions. They then received two-year implementation grants. The Foundation also established a learning community where grantees shared their experiences and gained a stronger understanding of successful techniques for reducing health disparities.

Extensive prior research had shown that multiple factors influence the health of individuals and communities. While medical coverage and care are important, other issues contribute, such as social class, housing stability, racism, stress, and availability of community resources (Cooper, Hill, & Powe, 2002; Collie-Akers, Fawcett, Schultz, Carson, Cyprus, & Pierle, 2007). This ecological approach "allows for holistic considerations of health and disease outcomes, emphasizes the multiple types of interacting factors that operate at individual and community levels — including but not limited to health programs and health services — and also highlights the fact that all of these factors and health determinants are embedded in an ecology that includes the natural environment as well as the cultural and political contexts that are relevant at a given place and time" (Kumanyika & Morssink, 2006).

Given this approach, changes in community, societal, and individual behavior are needed if health disparities are to be reduced, and actors from numerous spheres of influence must collaborate in order to achieve meaningful change. The public health field uses this framework, and has long relied on community coalitions to further community health and prevention efforts and health disparities work (Giachello, 2003; Roussos & Fawcett, 2000).

Based on this theoretical view, the Foundation established five goals for the Initiative: 1) develop coalitions that include multiple constituencies (e.g., consumers, health care providers, and community organizations) committed to reducing health disparities; 2) achieve system change, especially within health care provider institutions; 3) improve public awareness and understanding of health disparities and the factors that contribute to them; 4) track and use data to inform project development and implementation; and 5) set the stage for long-term community-wide efforts that will reduce health disparities.

This report summarizes findings and important lessons from the Initiative that may be helpful to foundations, community organizations, and health care institutions working on similar projects. The evaluation addressed four major research questions:[1]

- How well did the projects achieve the goals of the Initiative in the areas of coalition development, system change, public awareness, use of data to monitor progress, and sustainability of action after the Initiative ended?
- What strategies worked well, and what challenges emerged?
- What factors explain the variations in results across the 11 projects?
- How well did the learning community achieve its goals?

CLOSING THE GAP ON HEALTH CARE DISPARITIES — GRANTEES AND PROJECTS

LEAD AGENCY	GEOGRAPHY	TOPIC AREA	POPULATION
AIDS Action Committee of Massachusetts, Inc. – *Project LEAP*	Boston	HIV	Women of color
Cambridge Cares About AIDS, Inc./ AIDS Action Committee – *We're Still Here*	Greater Boston	HIV	Men of color who have sex with men
Casa Latina – *Bridges to Latino Health*	Western MA	Access to care	Latinos
Central MA Area Health Education Center, Inc. – *Mental Health and Substance Abuse Services for Latinos and Brazilians*	Metro West – Framingham	Behavioral Health	Latinos and Brazilians
Community Health Center of Cape Cod – *Healthy Immigrant Families*	Cape	Diabetes / Obesity	Immigrants
Lowell Community Health Center – *Gateways to Care*	Lowell	Behavioral Health	Immigrants
Mount Auburn Hospital – *Listen and Learn*	Greater Boston	Diabetes / Obesity	Latinos
Partners for a Healthier Community, Inc. – *FIT+*	Western MA	Diabetes / Obesity	Latinos and African Americans
ServiceNet, Inc. – *Your WAY (Wellness and You)*	Western MA	Diabetes / Obesity	People with severe mental illness
Tapestry Health and the Youth Empowerment Adolescent Health (YEAH!) Network	Western MA	Adolescent Births	Latino adolescents
YWCA of Central MA – *Peso Sano Ahora Coalition*	Central MA	Diabetes / Obesity	Latinos

1 The research design included both process and outcomes evaluation methods. The process evaluation considered how the coalitions developed, how they selected their objectives, and how the learning community evolved. The outcomes evaluation focused on the results and impact of the coalitions' work, and compared those results with expectations of the individual coalitions and the Foundation.

Data sources included: 1) a literature review; 2) a survey of individual coalition members; 3) a survey of learning community members; 4) focus groups with foundation staff; 5) proposals and annual reports from individual coalitions; 6) scoring sheets for coalition proposals; 7) telephone interviews with key informants including staff, consumers, and other coalition representatives; 8) observations at learning community meetings; and 9) minutes of selected meetings.

MAJOR FINDINGS

COMMUNITY COALITIONS

Based on the literature and previous grantmaking experience, the Foundation defined an effective coalition as one that had members from multiple constituencies who were all committed to the objectives of the group and who participated in meaningful ways. Members were expected to make collaborative decisions and make substantial progress toward their objectives (Butterfoss & Kegler, 2002; Granner & Sharpe, 2004; Crozier Kegler, Steckler, Mcleroy, & Herndon Malek, 1998). By the end of the Initiative, seven of the 11 coalitions met these criteria and reported substantial accomplishments in the areas of system change and public awareness. The results of those seven coalitions were more robust than those of the four coalitions that did not function as well.

Gaining the participation of people from different interest groups was not always easy. Many coalitions, especially those led by health care institutions, struggled to consistently engage consumers, so they hired community health workers or worked with community advisors to overcome those challenges. On the other hand, some coalitions sponsored by community-based organizations had difficulty engaging leaders from health care institutions. They succeeded when champions from provider communities joined the projects. In other cases, health care providers became aware of successes with small pilot projects, which spurred their willingness to engage or participate.

Coalitions led by health care institutions (e.g., hospitals and community health centers) had advantages when the focus of change was within those organizations. Since those coalitions' leaders were embedded in the medical system, they understood how it operated and were able to leverage change. Sometimes the Initiative's grant funds provided extra incentive and support to move ongoing efforts forward.

The factors associated with developing effective coalitions included:

- Engaging people who were outside the normal circles of influence and comfort zones of the sponsoring organization.
- Building on members' common interests, especially those linked to their work responsibilities.
- Recognizing the value of members' time by compensating consumers or sharing grant funds with institutional partners.
- Encouraging creative solutions and shared ownership of decisions.
- Respecting the unique contributions and roles of all members.
- Allowing adequate time for coalitions to develop.
- Demonstrating tangible progress toward clear action plans and results.

Over time, the coalitions concluded that compensation for members helped foster consistent participation. Some hired consumers to be "navigators" or "*promotoras*" to help patients secure adequate care, help medical providers understand patient concerns, and to represent these interests in coalition meetings. Other groups compensated consumers for their advice and participation in the coalitions. Support for institutional partners occurred through subcontracts or competitive bids (mini-grants) from prospective community partners that wished to join the groups.

FUTURE OF THE COALITIONS

The Foundation hoped that the three-year grants would help to foster community coalitions that would continue their work even after philanthropic support ended. The Foundation also recognized that major changes in health disparity indicators for individuals and populations were unlikely to take place during the time frame of the program. At the end of the Initiative, five of the 11 groups reported that they had specific plans for continuing, and one other thought that some of its activities might continue even though the coalition would no longer formally exist. These six had strong support from their sponsoring organizations, staff dedicated to support the work, and/or new sources of funding.

SYSTEM CHANGE AND PUBLIC AWARENESS

Given its relatively short-term nature, the Initiative could not accomplish significant reductions in health disparities for individuals and populations. Therefore, the evaluation assessed coalition accomplishments in system change and public awareness, areas identified by the Foundation as precursors to long-term improvements for target groups. The coalitions selected strategies in those arenas based on the major purposes of their projects, their local contexts, their unique opportunities and barriers, and their own expertise.

System Change. In this Initiative, the term "system change" covered a variety of possibilities, including:

- **Changes in practices or policies of health care institutions.** For example, some providers collaborated with community organizations to train clinicians about economic and cultural barriers to health care. Others examined their service models to assess whether structural barriers contributed to disparities in health care utilization and then modified factors such as their hours of service in order to better meet the needs of those they hoped to serve.
- **Improvements in patient interaction with health providers.** Some coalitions hired bilingual, bicultural peer navigators to help patients understand how to obtain the medical care they needed and to help providers understand cultural interpretations of health and illness. Health facilities developed techniques to: 1) enhance patient education and system navigation; 2) translate and explain patient concerns and assumptions to health care providers; 3) advocate for patients; and/or 4) encourage patients to follow provider recommendations.
- **Strengthening consumer participation in health care advocacy.** A few grantees focused on fostering consumer self-sufficiency and leadership. They trained peer leaders to become publicly visible advocates about the problems associated with health disparities and to highlight specific ways to address them that tapped consumer expertise. Others trained

consumers so that they could take on the role of educators either about the health care system or the health issue.

- **Changes in practices of organizations other than health care institutions.** The coalitions recognized that schools, churches, social service organizations, and local businesses such as supermarkets and hair salons could be instrumental in multi-pronged community-wide efforts to address health disparities. For example, programs to improve healthy eating and physical activity included modifications in food offerings at schools and churches, as well as the availability of new food options at local markets.

All of the groups addressed challenges such as confusion about the definition of system change, uncertainty about what would be viewed by the Foundation as "adequate" progress, and resistance from institutions targeted for change.

In addition, some groups had problems building bridges to the influential people who could implement change. System change usually requires the cooperation and participation of many actors who have varying roles and responsibilities within relevant institutions and communities. In this Initiative, the Foundation highlighted this idea by fostering coalitions with representation from multiple constituencies. Each coalition had a unique set of "strong" relationships or partnerships that served as the core for coalition development. These relationships included people who knew one another well. "Weak ties" or partnerships were tangential relationships, in which professional acquaintances occasionally shared information and had common as well as dissimilar interests and objectives.

One key to system change lay in developing both types of ties and using them to further broad interorganizational strategies for change (Granovetter, 1983). Some of the collations successfully fostered both types of relationships in order to pursue their objectives — they deliberately considered where they had influence and where they did not, and then forged alliances with new partners. Others had difficulty moving beyond the comfort zone of working exclusively within well-established relationships in order to consciously engage new, and sometimes unlikely, partners.

Overall, the results were promising by the end of the three years, with nine of the 11 groups making moderate to strong progress on their objectives. System change succeeded when coalitions met the criteria for effective coalition functioning, influenced key power brokers to make changes, identified clear objectives, and followed through with coordinated action.

Public Awareness. The coalitions employed diverse strategies to explain the multiple determinants of health and to highlight the specific health disparities targeted by their groups. Key categories included:

- **Education for the public** including radio and TV programs, public discussions, photo-voice projects (narratives by and photos of individuals affected by health disparities), movies (e.g., Unnatural Causes), press conferences, and presentations.
- **Education for service providers** through workshops and training sessions.
- **Education for members of the target community affected by health disparities** to help them understand the multiple factors contributing to a particular health issue. Examples

included flyers, a photo-voice project, theater of the oppressed, community workshops, outreach to churches and local businesses, and community dinners.

- **Collaboration with other groups, coalitions, and task forces that address health care disparities.**

In this area, nine of the 11 coalitions achieved moderately to highly positive results in terms of the scope and impact of their public awareness campaigns. Here, the keys to success were past experience in the area, clear project plans, and concerted action. Common challenges included confusion about the meaning of public awareness and the Foundation's expectations; stigma related to health disparities (e.g. people living with HIV and people with severe mental illness) that limited the focus and extent of publicity; gaps in knowledge about health disparities and affected populations, especially on the part of health care providers; and difficulty reaching and engaging individuals in the target communities.

ORGANIZATIONAL FACTORS ASSOCIATED WITH SUCCESS

The evaluation identified five organizational dimensions that were theoretically correlated with accomplishments in system change and public awareness. Using a three-point scale where 1 = weak, 2 = moderate, and 3 = strong, the evaluation rated each project in terms of access to power and decision-making in institutions deemed important to addressing health disparities, presence of persistent and consistent project leadership, organizational and financial stability of the lead agency, clarity of the project focus and expected outcomes, and presence of a feedback loop to assess project progress and make adjustments.

Eight projects received strong or moderate overall ratings on their organizational capabilities. Seven of them also had strong or moderate ratings on their accomplishments. However, the three coalitions with "weak" overall organizational ratings also received "weak" ratings for their overall accomplishments.

MONITORING PROGRESS OF PROJECTS

Coalitions reported mixed results related to tracking and using data to plan and manage their projects. Several groups had access to sophisticated data systems prior to the onset of the Initiative and were able to develop data collection and analysis plans. Others had limited capacity to monitor and use data on a regular basis. The coalitions tracked some or all of the following types of information:

- **Individuals affected by health disparities.** Seven coalitions planned to collect data on changes in outcomes, such as changes in body weight, smoking, physical activity, nutrition, and receipt of treatment. By the end of the Initiative, some had systems in place to monitor this information and others were making progress toward such systems.
- **Effectiveness of selected strategies.** Seven groups tracked inputs that were expected to lead to changes in outcomes for individuals (e.g., participants' gains in knowledge from attending programs, numbers of people served, consumer satisfaction with services received, and provider behavior toward consumers).

- **Neighborhoods or population groups affected by disparities.** Some coalitions focused on data about the prevalence of health disparities within geographic neighborhoods or within population groups. They were able to use existing data for baseline purposes, but none were able to report changes by the end of the Initiative, which is not surprising given the short time frame.

LEARNING COMMUNITY

A key feature of the Initiative was the learning community. The Foundation sponsored quarterly daylong meetings so that grantees could share their experiences, learn about factors that contribute to health care disparities, and obtain tools and resources to further their work. The Foundation also used these gatherings to recognize the dedication of the coalitions and to strengthen its own relationships with people in the field.

Foundation and grantee staff members planned the agendas together, selecting topics of emerging interest and concern to participants. Foundation staff handled logistics and brought in content experts to discuss issues such as prevalence of health disparities, the intersection of racism and disparities, evaluation techniques, and methods for increasing public awareness. Resources such as videos and published reports were available. The Foundation also sponsored an online forum (Collective X) where grantees could share ideas outside the regularly scheduled meetings and post resource materials. However, given other demands on the coalitions' project managers, only a few used this tool consistently. Collective X was used primarily for meeting updates and posting resource materials.

By the end of the third year, most grantees were very positive about the learning community, even though it required them to devote four full days to it each year. Most respondents to key informant interviews strongly recommended that the Foundation use the model in the future. Coalition members thought that the most important features of the learning community were:

- **Learning with and from peers.** They valued the opportunities to learn about the techniques used in other projects and to obtain peer feedback about their own successes and challenges. These conversations occurred primarily during the quarterly sessions, rather than by telephone or e-mail outside the scheduled sessions.
- **Resource materials.** The learning community provided resources that could be used by the local projects, such as videos and research on health disparities, data gathering techniques (e.g., photo-voice), evaluation tools, public awareness messaging, and tools for supporting groups to formulate and ask appropriate questions (e.g., materials from The Right Question Institute).
- **Guidance about project development.** At the onset of the Initiative, grantees had a wide range of experience, knowledge, skills, and capacities. The Initiative design included an important planning phase to enable groups to address their own needs and pursue their own ideas. However, the grantees wanted more information, clarification, and technical assistance about

the major theories and components of the Initiative (i.e., the multiple determinants of disparities in health care and health outcomes, the rationale for developing coalitions, the language used to discuss health disparities, definitions of and techniques for system change and public awareness, and methods for monitoring progress). By the end of three years, they thought that the Foundation had provided good support, but they wanted more guidance and detailed information upfront and perhaps through a formal curriculum.

- **Framework for understanding health disparities.** The learning community offered many opportunities to explore the nuances of the ecological approach to health disparities and social determinants of health, including the advantages and challenges of using the framework to address the problem. Participants valued these sessions, especially those that drew on the views of consumers.
- **Communication with Foundation staff.** The learning community created an environment that encouraged honest dialogue among coalition members and Foundation staff about the progress of the Initiative, its success, and challenges.

RECOMMENDATIONS FOR GRANTMAKERS

Some lessons emerged that may provide useful insights for future initiatives as well for future grantmaking. Concrete suggestions include:

- **Support project development.** Grantees wanted more guidance about: 1) building coalitions and promoting the participation of different types of members; 2) defining "system" and "system change;" 3) planning for and conducting public awareness campaigns; and 4) choosing and developing advocacy campaigns. Grantmakers might also consider developing curriculums for learning communities that would include open-ended discussions. The format would provide both semi-structured time for sharing ideas and structured time for dealing with project development.
- **Provide guidance about project planning and modification.** The Foundation provided latitude to grantees so that they could change their program designs and models as their projects matured. Since many of the projects were complex, with a large number of actors and perspectives, change was expected. This approach allowed coalitions to remain flexible and agile. Funders might also consider leading group discussions about techniques for updating program models and redefining expected outcomes.
- **Help coalitions nurture and expand their "weak" ties.** As was noted earlier, one key to system change was the ability of a coalition to develop both "strong" and "weak" ties to further broad interorganizational change. A learning community could support coalitions to assess their relationships and develop plans for strengthening coalition participation and outreach to people with whom they have weak ties.
- **Identify factors correlated with coalition development and impact.** The evaluators identified a set of factors related to coalition and project successes based on the findings

from this study and literature in the field. Further exploration of these and other factors could form the basis of a framework that would provide valuable guidance to other coalitions as they develop and monitor their projects.

- **Provide financial and technical support for data tracking and analysis.** Coalitions had varying levels of ability, in terms of both knowledge and financial capacity, to collect and analyze data and measure system change and/or project impact. Foundations may want to consider offering specialized support to grantees that are less experienced in evaluation methods.
- **Further project sustainability.** Planning for project sustainability should begin at the onset of the grant period. Grantmakers might consider providing technical assistance to grantees to help further the long-term viability of projects.
- **Extend the funding period.** At the end of three years, seven of the 11 coalitions showed promising results, and five of them were likely to continue their work. However, system change and meaningful change in health disparities typically require more time than three years to implement. Future initiatives might include a longer grant period for all grantees or investment in the most promising coalitions at the end of a multi-year period.
- **Consider the advantages and costs of a learning community.** In this project, the learning community successfully promoted collaborative learning and discussion. It created an environment that allowed honest dialogue about project progress and challenges. However, it also required significant staff time from the Foundation and grantee participants. The costs and benefits of this model should be weighed based on the goals of a specific initiative. It may be best suited to projects seeking to raise awareness about a particular topic, projects promoting collaborative action among grantees, programs that test exploratory or novel responses to especially vexing issues, or statewide or national advocacy campaigns.

For a complete bibliography, please contact the Blue Cross Blue Shield of Massachusetts Foundation at (617) 246-3744 or info@bcbsmafoundation.org.