

PLENARY SESSION 2: IMPROVING QUALITY. MAKING A DIFFERENCE AT THE INDIVIDUAL, BUSINESS, AND COMMUNITY LEVELS

A. IMPROVING QUALITY OF CARE BY TRANSLATING RESEARCH INTO CULTURALLY COMPETENT PRACTICE

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Improving the quality of health care is an approach that works in overcoming disparities in healthcare delivery. The changes need to occur at multiple levels—involving systems, providers, and patients—and should be scrutinized over a period of time to assess whether patients' health has improved.

Dr. Bigby based these conclusions on published research studies and on findings from a community-based women's health demonstration project being conducted in her hometown of Boston, Massachusetts. The initiative is looking at disparities in breast and cervical cancer mortality between Black and White women. She used the project in her speech as a prototype for actions that others can take to improve health care for minority women.

Five reasons it is important to focus on quality of care in eliminating disparities are:

- **The public thinks racial and ethnic minorities receive lower quality health care than Whites.** A 1999 national survey by the Kaiser Family Foundation of race, ethnicity, and medical care showed that 64% of Blacks and 23% of Whites agreed that Blacks receive lower quality health care. The same held true for Latinos and Whites: 56% of Latinos and 27% of Whites agreed that Latinos receive inferior health services.
- **People from racial and ethnic minority groups are less satisfied with their**

care than others. Patients from five Boston area hospitals who had acute medical conditions such as abdominal pain and chest pain participated in surveys about satisfaction with their health care. Non-English speaking patients reported high rates of dissatisfaction (52% overall) in the areas of courtesy and respect, completeness of care, explanation of care, waiting time, and discharge instructions (*J Gen Intern Med.* 1999;14:82–87). “We conducted a study in Boston to better understand the impact of race and ethnicity on interactions between patients and their doctors,” Dr. Bigby said. “We wanted to identify behaviors that patients perceive as being racial.” To obtain these findings, they talked with White doctors and their women patients of color, conducted focus groups with White doctors and minority women, and developed a survey tool. “We found that both doctors and patients use ‘filters’ such as race, gender, culture, education, and past experiences in the healthcare system in making assumptions and deciding on what they perceive to be true,” Dr. Bigby said. “We also learned that patients and doctors do not experience the same reality. Because they act on different assumptions about health care than their doctors do, the patients withhold important information from their physicians, delay presentation for care, and don't follow their doctors' recommendations.”

- **People from racial and ethnic minority groups are less involved than others in making decisions about their care.** A 2001 survey by the Commonwealth Fund showed that Whites, Blacks, Hispanics, and Asian Americans in large numbers would like to be more involved in their health care. A study of White and African-American patients showed that minority patients felt they had too little say-so

How to treat a woman: the behaviors that build trust in minority patients

- Maintain eye contact.
 - Don't appear rushed.
 - Don't make assumptions.
 - Pay attention to culture beliefs.
 - Respect different perspectives.
 - Treat the patient as an individual.
 - Be responsive.
 - Make the patient feel comfortable.
 - Use understanding language.
 - Display genuine concern.
 - Listen to symptoms in the patient's style of telling.
 - Keep patient information confidential.
 - Ask the patient about her satisfaction with the appointment.
 - Ask if the patient understands what to do.
 - Listen to questions.
 - Apologize when there is a problem.
-

in their physicians' decisions (Cooper-Patrick. *JAMA*. 1999;282:583–589).

- **Blacks receive less information than other patients about managing their conditions.** Black patients and White patients on kidney dialysis were asked about the information they received from a nephrologist about kidney transplants, including the option of receiving a kidney from a family member. In both instances, lower percentages of Black patients (men and women) received such information (Ayanian JZ, et al. *N Engl J Med*. 1999;341:1661–1669).
- **Blacks and other persons of color receive lower quality of care than Whites.** The same study in the *New England Journal of Medicine* (see above) found that smaller percentages of Black women (56% as compared with 75% of White women) who were on chronic kidney dialysis were referred to a transplantation center. The referral rate was also lower for Black men dialysis patients (60% compared with 82% of White men dialysis patients). Another study looked at the healthcare services received by Medicare patients enrolled in managed care plans. "Even in the same setting, Black patients and White patients received different lev-

els of care," Dr. Bigby said. The findings applied to breast screenings, eye exams for diabetics, beta blocker prescriptions for heart attack victims, and follow-up after hospitalization for mental disorders (Schneider EC, et al. *JAMA*. 2002;287:1288–1294).

Dr. Bigby recommended the following actions to improve the quality of health care and to decrease disparities:

- Document that disparities exist in care and satisfaction.
- Develop strategies to intervene on multiple levels. "This involves agreeing upon standards of care that are appropriate for all patients; developing strategies to intervene at the system, provider, and patient levels; and creating ways to collect data and monitor outcomes by race and/or ethnicity," Dr. Bigby said. "We are developing a process to have all hospitals and healthcare institutions in the Boston area to collect the same racial/ethnic data," she continued. "This is no small task, given the disagreement about what should be collected and how it should be collected."

BREAST AND CERVICAL CANCER MORTALITY DISPARITIES IN BOSTON

Dr. Bigby used data gathered by the Massachusetts Department of Public Health to illustrate the disparities in health care for breast and cervical cancer. The study showed that the death rate per 100,000 population from cervical cancer declined to 2.2 for White patients in the years between 1995 and 1997 while the mortality for Black patients almost doubled to 6.4 per 100,000. "This didn't occur because Black women failed to get Pap smears," Dr. Bigby said. In fact, 82% of Black women, compared with 77% of White women, said in 1994–1997 that they had received a Pap smear in the last two years (Boston Behavioral Risk Factor Surveillance Survey, Massachusetts De-

partment of Public Health). The Boston Public Health Commission found that Black women had a higher age-adjusted death rate from breast cancer (24 per 100,000) than Whites, Hispanics, or Asians. "There had been a slight decline in breast cancer deaths among Black women, but the disparities still existed," Dr. Bigby said. The breast cancer death rate was significantly higher (more than twice as much) among Black women aged 85 and older than among White women in that same age group. "Here again, we can't blame the differences on lack of mammography screening," Dr. Bigby said. Slightly more Black women than White women in the years between 1994 and 1997 had undergone a mammogram breast examination in the last two years (Boston Behavioral Risk Factor Surveillance Survey, Massachusetts Department of Public Health).

"We worked with the community to determine general attitudes about health, doctors, and health facilities," Dr. Bigby said. The community said:

- Medical providers need to change their approach to improve communication and demonstrate more caring with patients.
- Language and culture are barriers to health care.
- Screening and prevention are not high priorities for minority populations.
- The concept of prevention is not universal. Many believe in "predetermined destiny" and "fatalism."
- Logistical barriers include limited hours of operation for mammography units and gynecological or surgical clinics.
- Women want to learn more about health in general, not just breast and cervical cancer.

The general views about breast cancer and mammography were very revealing. "We learned that breast cancer is not discussed in the Black community, that breast cancer screening is not a high priority, and that breast cancer is not seen as an important disease among

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Black women, who see it as a 'White woman's disease,' "Dr. Bigby said.

In terms of risk factors, minority women tend to believe that breast cancer is caused by factors such as breast feeding, wearing bras, diet, genetics, smoking, hormones, or fate (It just happens.). "Many women believe breast cancer results from trauma to the breast," Dr. Bigby said.

Minority women believe breast examination and mammography are important strategies in screening for breast cancer, but they have concerns about "touching themselves" and not knowing how to do an examination. "Immigrant women are uncomfortable with mammography, fearing pain, having to show their breasts, and being exposed to radiation," Dr. Bigby said. Another impediment to screening is that some providers do not offer breast examination or mammography.

"Most minority women know about surgery as a treatment for breast cancer, but they are very concerned about disfigurement," Dr. Bigby said.

Although Black and White women have about the same rates of screening for breast and cervical cancer, the Black women are more likely never to have had a mammogram, and immigrant women are more likely never to have had a Pap smear. "We found that poor women have low rates of follow-up for abnormal Pap smears and mammograms or for abnormal breast exams," Dr. Bigby said.

INTERVENTIONS TO ELIMINATE BREAST AND CERVICAL CANCER DISPARITIES

These findings about breast and cervical cancer gave rise to an intervention by the REACH Boston 2010 Breast and Cervical Cancer Coalition, which decided to implement the Women's Health Demonstration Project (WHDP). REACH is funded by the US Centers

for Disease Control and Prevention (CDC) with a grant to the Boston Public Health Commission. The project consists of:

- A questionnaire to assess the medical and social risk of Black women at high risk for not following through with medical care. The questionnaires go into a computer that generates a report for the patient and her doctor on risk factors and health concerns.
- Case managers at six clinical sites to partner with primary care providers in helping patients address their risks.
- Changes in the system to enable tracking of women to ensure regular screening and follow-up of abnormal results.
- Agreed-upon standards for breast and cervical cancer screening.
- Training for providers in how to be more culturally competent.
- Community outreach and education programs. Women's health ambassadors conduct the programs.

In terms of outcomes, the project is looking at the regularity of Pap smear and mammogram screening in this group of women and the adequacy of follow-up treatment. It is observing changes being made in the system to track Pap smear and mammogram screening and results, and is finding out if the cultural competency of providers at the six clinical sites improves after training.

A total of 905 women have enrolled in the project at this point, all of them self-identified as Black. "We often hear how difficult it is to enroll Black women in clinical trials or research," Dr. Bigby said. "We are very proud of our effort. It has helped a lot that we use staff who are very much like the women they are recruiting."

Early analysis of the data has revealed the following facts: Twenty-seven percent of the participants were born outside the United States. Eighty-two percent are uninsured or eligible for free care or are signed up for Medicaid.

One-fourth of the women have less than a high school education. More than one-third (38%) rate their health as fair or poor.

The following data have been collected from women participating in the Women's Health Demonstration Project:

Follow-up care. Baseline data showed that improvement is needed in follow-up of abnormal Pap smears and mammograms. "Only 47% of the women had received follow-up after abnormal Pap smears and only 58% had received follow-up after abnormal mammograms," Dr. Bigby said. "We are looking at how system changes can improve follow-up rates."

Differences were evident in the follow-up patterns of patients with abnormal Pap smears and those with abnormal mammograms. For example, women who had no follow-up for abnormal Pap smears tended to be younger (a mean age of 28.7) and had more active medical problems. Women who received follow-up after an abnormal mammogram were older (a mean age of 50.8) and had a significant number of medical problems. "This may be an indication of how well some women are tied into the health system," Dr. Bigby said.

Quality of care. Participants rated the care they received before and after their providers were trained in cultural competency. The pre- and post-assessments showed that larger percentages of women said they were "comfortable with their providers" and that their providers were "interested" and "asked the right questions" after training, compared with before training.

Effectiveness of communication. The women completed pre- and post-tests on the quality of communication with their providers. In the pre-test, the percentages of women rating their providers as "excellent" totaled only 53% in the area of effective communication, only 21% in effective communication when the provider was a different race,

only 37% in understanding the provider's explanations about abnormal Pap smears, and only 42% in understanding the provider's explanations about abnormal mammograms. The percentages of women rating their providers as "excellent" have increased somewhat in the areas of effective communication (62% in the most recent assessment), effective communication when the provider is a different race (32%) and understanding Pap smear explanations (40%). The percentage of women saying their providers rated "excellent" in giving understandable mammogram explanations dropped to 31%. Tracking of all four of these factors is continuing.

B. IMPROVING THE QUALITY OF PUBLIC HEALTH SERVICES

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It's "code orange" time in the nation's public health system, Dr. Caine declared. The population is aging, the demographics are shifting, and health disparities are preventing many people from getting the care they need. On the other hand, these hurdles represent tremendous opportunities for public health to achieve its goal of healthy people and healthy communities.

"My vision for public health—as so eloquently expressed by Dr. G. E. Alan Dever, author of *Improving Outcomes in Public Health Practice*—is that we will be the preferred provider of disease prevention and health promotion activities, that we will do surveillance of health trends, assess the status of public health, and develop health policies to satisfy the

needs of our customers," Dr. Caine said.

From her perspective on the front lines of America's health services, Dr. Caine traced changes that have taken place in public health, major victories that the system has chalked up, and offered recommendations for meeting future challenges. Her unique vantage point is based on her qualifications as a practicing physician, an educator, and president of the 60,000-member American Public Health Association, the nation's oldest and largest organization for public health professionals.

"The environment for public health has changed," Dr. Caine said. The system became much more "visible" after the September 11 terrorist attacks and is now expected to deliver "immediate" results. She used as an example the aftermath of the anthrax deaths of two US Postal Service workers in Washington, DC.

Public health professionals in Indianapolis, Indiana, where Dr. Caine heads the Marion County Health Department, had their work cut out for them during the anthrax scare. "A thousand postal service workers were threatening to walk off the job," she said, and the local postal service needed to assess all of its employees within 48 hours. The health department rose to the challenge by organizing a community-wide team of public health doctors and nurses, private physicians, and faculty and fellows from Indiana University School of Medicine. The medical professionals met with postal workers at the jobsite around the clock, even if the workers' shifts were in the middle of the night. They educated them about anthrax and assessed which ones might need to be placed on the antibiotic Ciprofloxacin for prophylaxis.

Dr. Caine explored other changes in public health. She said the system is now based on "evolving" rather than "static" science and that it is confronted by "information overload." The result is a need to "decipher and prioritize" all of the phone calls, e-mails, and other mes-

sages that public health professionals receive daily.

America's involvement in health issues is now global as well as national, Dr. Caine continued. "What happens across the waters can have a huge impact on what happens here in the United States," she said.

Public health has produced favorable outcomes in four areas: containing the 2003 SARS (severe acute respiratory syndrome) disease outbreak, immunizing children, waging the tobacco wars, and safeguarding the environment from mercury emissions.

PUBLIC HEALTH'S FOUR MAJOR CHALLENGES

Public health professionals need to be alert to the four major challenges facing public health today. Dr. Caine identified them as: 1) an aging population and other demographic patterns; 2) health disparities; 3) new disease threats; and 4) revitalization of environmental health. She chose to focus her remarks on the first two challenges:

- **An aging population and other shifting demographic patterns**—Dr. Caine used figures from the US Census Bureau to show the percentage distribution of the US population by race and ethnicity in the year 2000 and projections for the year 2050. (She believes the changes will occur by 2040.) The percentage of Whites is expected to decrease from 72% currently to 53% in four more decades. The Hispanic/Latino population will more than double, from 11% now to 25% at mid-century. "In 2002, Hispanics outnumbered African Americans for the first time in the history of the United States," Dr. Caine said. The percentage of Blacks/African Americans will rise from 12% now to 14% in 2050. The percentages of Asians/Pacific Islanders and American Indians/Alaska Natives will increase some-

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what. Within 50 years, 48% of the nation's population will be non-White.

"If the gap in health disparities is huge right now and we do nothing to address it aggressively, imagine what the disparity will be by the year 2040," Dr. Caine warned.

- **Health disparities**—"Minorities face greater difficulties in communicating with physicians," Dr. Caine said. The Commonwealth Fund's 2001 Health Care Quality Survey revealed that among adult patients, 33% of Hispanics, 27% of Asian Americans, and 23% of African Americans said they had one or more communication problems in receiving care from their doctors. Only 16% of White adult patients reported that they had one or more communication problems. "Doctors need to understand their patients' cultural backgrounds in order to know why they don't comply," Dr. Caine said.

Literacy Problems that Interfere with Health Care

"Health literacy is a huge challenge for public health professionals," Dr. Caine said. She gave statistics for three groups of patients who seek care from public health facilities.

Minority Patients

- Up to 20% of Spanish-speaking Latinos do not seek medical advice due to language barriers.
- Asians and Hispanics often report difficulties understanding written information from doctors' offices and instructions on prescription bottles.
- Up to 40% of African Americans have problems reading.

Older Patients

- Two-thirds of adults ages 60 and over have inadequate or marginal literacy skills. For example, 81% of patients ages 60 and over at a public hospital could not read or understand basic materials, such as prescription labels.

Low-income Patients

- Approximately half of welfare recipients read below the fifth grade level.

"We must have more research on diverse populations in terms of their attitudes, beliefs, and feelings about the healthcare system," Dr. Caine said. "A pregnant Hispanic woman with diabetes may not want to take insulin for fear that it will harm her baby. We need to be able to understand her culture to know why she is not complying and to tell her that the treatment will be good for her baby."

Focusing on the importance of clear communication in health care, Dr. Caine reminded the audience that patients with limited English proficiency "may be looking at you and nodding their heads when in actuality they don't understand what you are saying."

PUBLIC HEALTH'S BASIC RESPONSIBILITIES

"The basic framework of public health still applies," Dr. Caine said. "We need to continue to do assessment, policy development, and assurance." *Assessment* means monitoring health and diagnosing and investigating disease outbreaks. *Policy development* means informing, educating, and empowering communities and mobilizing partnerships to make a difference in health care. "Many communities have enacted smoking bans to cut down on the adverse effects of cigarette smoking," Dr. Caine said. *Assurance* means enforcing laws "so that people can feel safe enjoying a meal without fearing they will get a food-related illness," she explained.

The core functions of public health, according to Dr. Caine, are to: 1) link people to health care; 2) provide training and professional development to health professionals to meet the demands of the 21st century; and 3) measure the effectiveness of health services. "You can't do things just because they are popular and have always been done

that way," she said. "You have to know if they are effective."

Dr. Caine based some goals for public health on a model provided by the Washington State Department of Health. "Anyone can adapt these goals," she said. The components are: 1) have a plan and measure it annually; 2) focus resources effectively; 3) monitor the outcomes; and 4) emphasize evidence-based strategies. "We have to learn the tools of analysis to do public health well," Dr. Caine said. "Can we analyze and do the surveillance for an outbreak? Do we have an accountability system?"

Public health professionals should ask themselves the following questions about the quality of health care: Do we have information technology to understand what's going on? Do we have a workforce that is well trained to meet the current challenges, and does it have access to continuous professional development? Can we facilitate discussions about healthcare access and delivery from the perspective of the community—from the experiences of patients, providers, purchasers, and payers, discussing and communicating together? "We must have effective communication strategies," Dr. Caine said. "Can I reach the homeless population? Can I impact them? Can I foster greater public involvement in achieving public health goals?" Fifty percent of what happens in public health is related to changes in lifestyle, Dr. Caine pointed out.

What are the ideals of public health? "We need to be versatile and flexible," Dr. Caine said. "We need an agenda to address and eliminate health disparities. And we need technology to make it happen." When Indianapolis was ranked number one in the nation in syphilis cases, the health department used a Geographic Information Systems (GIS) map to pinpoint the affected area, which consisted of three zip codes. "I didn't have to divide my resources among the entire community," Dr. Caine said.

WHAT CAN PUBLIC HEALTH PROFESSIONALS DO TO IMPROVE THE QUALITY OF HEALTH CARE?

Dr. Caine recommended a “work plan” for improving the quality of public health care from the Washington State Department of Health model:

- Create a health report card on the status of health care issues in the community. “We did one on minority health and were shocked to find that AIDS is the number one killer of Black males between the ages of 25 and 44 in our community,” Dr. Caine said.
- Set clear performance standards for health practice. “How can you measure progress if you don’t set standards?” she asked.
- Address the costs associated with different models of public health services. “We need to talk with our business partners about the costs of basic ser-

vices we are offering and look for ways to subsidize our programs,” she said.

- Use an electronic disease report that is standardized across agencies and across state lines to address any epidemics that may be taking place.
- Look at the menu of critical health services to see what else is needed in your community.
- Develop a “tool kit” for effective communication. “We must educate the public about public health, what it is, and how it protects them,” she said.

HOW CAN PUBLIC HEALTH CONNECT WITH THE COMMUNITY?

“We must make a number of connections with the community to achieve the vision of healthy people in healthy communities,” Dr. Caine said. She believes public health needs to:

- Partner with the private sector to address unemployment, the working

poor, poverty, and education in the community.

- Work more closely with minorities in a non-paternalistic fashion.
- Recognize grassroots leaders and key laypersons as assets in building community coalitions.
- Invest in public health research.
- Develop mechanisms—such as focus groups, surveys, and advisory groups—to collect community input.
- Strengthen public health communications.
- Be accountable. Results count.

C. IMPROVING THE QUALITY OF WOMEN’S HEALTH BY ADDRESSING A PROMINENT CONCERN— IS HORMONE REPLACEMENT THERAPY DEAD?

Valerie Montgomery Rice, MD

Please see complete article, *Post Menopausal Hormone Therapy Today*, published under Original Reports: Women’s Health in this supplement.