Community Health Network of Connecticut, Inc.™

Assisting Practices to Attain Health Equity with Quality Improvement

Part Two

HUSKY HEALTH CONNECTICUT

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I. Introduction

Introduction

The purpose of this toolkit, “Assisting Practices to Attain Health Equity with Quality Improvement, Part Two,” is to provide our PCMH practices with information on how to collect and analyze their own practice data. This will enable them to identify opportunities to improve the quality of care to their patient populations through the use of the Quality Improvement (QI) process. “Assisting Practices to Attain Health Equity, Part One” provides information on health disparities, the CLAS Standards, and how to integrate those standards into a PCMH practice. It also provides information on how to gather appropriate ethnic and cultural data from patient populations, and understand cultural and health literacy.

The natural next step in the QI process is to use the data collected to assist in attaining health equity. According to The Robert Wood Johnson Foundation’s project, *Finding Answers: Disparities Research for Change,* “Disparities are inevitable among a diverse population. When access is equal, minority patients are known to receive lesser quality care. When outcomes improve, disparities can remain or grow depending on the specific nature of the intervention, and whether or not it reached minority populations served. In other words, an overall improvement in quality does not assure that quality has improved for people of color.”

Practices need to stratify their data by race and ethnicity, linking what is learned from studying the data to possible interventions and resources within the practices. Be realistic and start small. Use the initial data as a baseline and measure change (every six months or so) to see if the intervention is working. Create a timeline for evaluation and measurement. The process is not stagnant; it is cyclical and continuous.

The QI process consists of different tools to measure the practice outcomes. Included in the toolkit, for the practice’s convenience, is a quality improvement worksheet that is designed to address the Plan-Do-Study-Act (PDSA) model. This worksheet shows the practice where to start and explains how the improvement process can help map out goals and achieve better practice outcomes.

Quality measures can come from a variety of data reports that are pulled from current EHR reports, health plan data through the claims process, emergency room utilizations, pharmacy, diabetes, wellness, and CareAnalyzer® reports. All of these measures can help a practice achieve quality performance improvement goals.

If you have any questions or need assistance with the Quality Improvement process, please contact your Community Practice Transformation Specialist (CPTS). You may also call the HUSKY Health program PCMH Administrator at 203.949.4194, or send an email to pcmhapplication@chnct.org.

II. Opportunities to Improve

RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE: OPPORTUNITIES TO IMPROVE IN CONNECTICUT

Do disparities in care exist among racial and ethnic minority populations? Why is this important and relevant to the implementation of person-centered medical homes in Connecticut?

Among the persistent disparities in care documented by the annual 2011 National Healthcare Disparities Reports are:

- African Americans or Blacks received worse care than Whites for 41% of quality measures reviewed.
- For another 30% of quality measures reviewed, Asian Americans, American Indians and Alaska Natives received worse care than Whites.
- For 39% of measures reviewed, Hispanics received worse care than non-Hispanics.
- For 47% of measures reviewed, low-income people had worse outcomes than high-income people.

Source: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *National Healthcare Disparities Report 2011*, AHRQ Publication No. 12-0006 (2012) www.ahrq.gov/qual/qrdr11.htm

Quality improvement is a central focus in health care delivery today and federal, state and local officials, as well as other stakeholders, are all pushing the envelope. Physicians have been key champions of improved health care quality. Other leaders in the efforts to improve quality include the National Committee for Quality Assurance (NCQA), the Institute of Medicine (IOM), and the U.S. Congress. The Affordable Care Act (ACA) as well as state legislation has undeniably pushed the health care industry and stakeholders forward to measure and improve quality of care delivery. Preventable medical errors, reducing avoidable readmissions, continuity, person-centeredness, coordination, and prevention are all among care elements that systems and providers are seeking to improve.

While quality itself is a central focus, an important – but less of a top-of-mind, yet critically important focus that is part and parcel of quality – is disparities in care delivery among persons of color. The Institute of Medicine report *Crossing the Quality Chasm* includes equitable care as one dimension of quality among others. Likewise, the Affordable Care Act has numerous references, initiatives, and funding sources to address inequities in care delivery in the United States.

Most health care providers assume that they offer comparable care with equal outcomes to all patients, regardless of race or ethnicity. Yet, many may be surprised that, based on national and state-specific data, members of minority populations continue to experience worse health care outcomes among a broad set of quality domains than Whites.

According to the National Healthcare Disparities Reports (NHDR), racial and ethnic minorities and low-income people often face more barriers to care and receive poorer quality of care when they can get it.This National Healthcare Disparities Report (NHDR), produced annually by the U.S. Agency for Healthcare Research and Quality, is based on data from more than three dozen databases, with estimates for different population subgroups and across different years.

The NHDR report further notes that while quality is improving slowly across the country for all groups, few quality-related disparities related to race, ethnicity or income showed significant improvement. The total number of disparities that decreased was fewer than the number of disparities that grew.

Disparities for which the NHDR documented deterioration in outcomes among racial and ethnic minority populations included:

- maternal deaths per 100,000 live births
- breast cancer diagnosed at advanced stage per 100,000 women over age 40
- children for whom a health care provider gave advice about using care safety seats
- adults age 50 and over who ever received a colonoscopy, sigmoidoscopy or proctoscopy
- people with difficulty contacting their usual source of care by phone
- adults who did not have problems seeing a specialist they needed to see in the last year
- people without a usual source of care who indicated a financial or insurance reason for not having regular source of care.

A 2002 report by the Institute of Medicine framed three areas as driving disparities: patient characteristics, processes of care, and the health care system itself. While patient characteristics cannot be influenced by health care providers, there are interventions that can impact improvements in both the processes of care and the contextual health care systems in which individual providers deliver health care.

Some providers and stakeholders believe that quality improvement efforts can result in better care for all consumers of care; however, others have demonstrated that even if "all boats rise" disparities may still persist – and remain at the same magnitude. Other researchers have found that quality can improve for some populations and still not improve for racial and ethnic minority populations.

Quality improvement is an essential component of person-centered medical homes. All person-centered medical home practices should be looking at quality of care and, based on data findings, should make efforts to specifically improve care for racial and ethnic minorities.

Connecticut-specific data from the 2009 Connecticut Health Disparities Report indicated that Hispanic women (23.6%) and Black women (21.8%) received late or no prenatal care as compared to 12.7% of the total population and 7.8% of the White population.

Likewise, from 2001 to 2005, the infant mortality rate for Black Connecticut residents ran three times the rate for Whites (13 vs. 3.9 per 1,000 live births).

Oral health status showed similar trends with people of Hispanic origin showing the worst results for percent with cavities, untreated decay, rampant decay and the percent needing treatment as compared to Whites.

Emergency department visits were significantly higher among Hispanic and Black individuals (169.7 and 151.2 per 10,000 population respectively) as compared to a rate of 32.7 for Whites.

Diabetes prevalence was also significantly higher among Black individuals (12.8 %) and Hispanic individuals (11.4%) as compared to White individuals (5.3%).

A Roadmap for Improving Quality and Reducing Disparities

The Robert Wood Johnson Foundation's project "Finding Answers: Disparities Research for Change" offers a practical roadmap to decrease racial and ethnic disparities. With a focus on the primary care setting, this roadmap suggests an approach with the following steps that can be applied in any primary care or person-centered medical home practice to review, understand and address disparities in care within a patient population.

Step	Approach	What You Can Do
1. Link Quality and Equity	Disparities are inevitable among a diverse population. When access is equal, minority patients are known to receive lesser quality care. When outcomes improve, disparities can remain or grow depending on the specific nature of the intervention and, whether or not it reached minority populations served. In other words, an overall improvement in quality does not assure that quality has improved for people of color.	Be open to the possibility that disparities exist in your practice. Don't assume that your practice does not have any disparities in care delivery.
2. Create a Culture of Equity	It isn't sufficient to know that disparities are a problem in society; owning that they may exist in your practice is an initial step toward improvement.	Encourage your staff to consider whether disparities may in fact exist. Talk to staff, share literature and discuss the possibility that you can do better for patients of color. Let them know that minorities face special challenges in getting care.
3. Diagnose the Issue	Understand what is driving disparities in your patient population so that you can take steps to improve.	Review your data by race, ethnicity and language. Seek out or become an "equity champion" in your practice, in your geographic area or elsewhere who can lead this work. If your practice is relatively small, find another practice that may be willing to form a team to address these issues.
4. Get Buy-in within your Practice	Buy-in means action – not just saying you're on board. Be specific about what you're asking from physicians, other clinical staff, and front-desk staff.	Talk to your providers, front-desk staff and others about what your data shows and, what you're trying to achieve to improve. They are part of the solution.
5. Design the Activity	Link what you learned from studying your data to possible interventions and resources with key stakeholders within your practice.	Once you've identified potential disparities drivers, think creatively and carefully about how to eliminate those drivers with key people from your practice. There's no single right answer – and you need to work with whomever, and whatever resources you have available to you. Identify, in as much detail as you can, the steps required to execute the intervention and how each member of your team is needed to participate.
6. Implement the Change	Be realistic and start small – becoming a person-centered medical home is a lot of work and you can't do everything at once. Use your initial data as a baseline and measure change (every six months or so) to see if your intervention is working. Create a timeline for evaluation and measurement. Be adaptable to maximize results.	Discuss how the intervention is, or is not, working with your team. Make changes as needed. At the outset, buy-in and participation are especially important. Re-measure, based on a timeline, to see if change is truly occurring. As priorities are addressed, re-inspect your data and select a new priority.

REFERENCES

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academies (2001)
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www.ahrq.gov/qual/qrdr11.htm

National Committee for Quality Assurance and Eli Lilly Company, *Toolkit for Multicultural Health Care: A Quality Improvement Guide* (2007)
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http://www.iom.edu/reports/2002/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care.aspx

Robert Wood Johnson Foundation, Finding Answers: Disparities Research for Change, *The Roadmap to Reduce Disparities*
http://www.solvingdisparities.org/tools/roadmap

Weinick, RM, Hasnain-Wynia, R. Quality improvement efforts under health reform: How to ensure that they help reduce disparities – not increase them. *Health Aff,* (2011);30(10):1837-1843

http://www.ncbi.nlm.nih.gov/pubmed/21976324

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

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III. Finding Answers Roadmap

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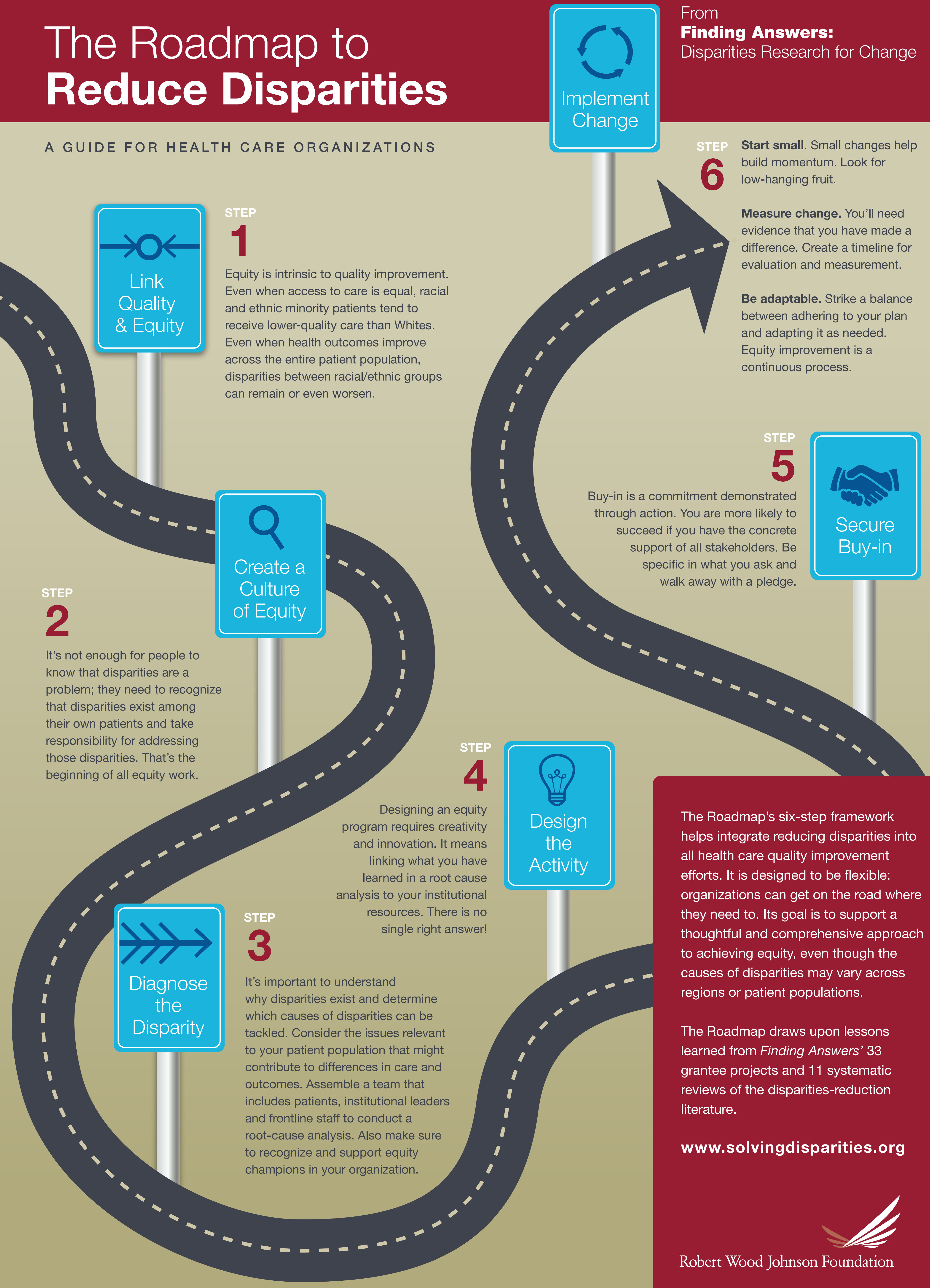
The Roadmap to **Reduce Disparities**

From
Finding Answers:
Disparities Research for Change

A GUIDE FOR HEALTH CARE ORGANIZATIONS



STEP
1

Equity is intrinsic to quality improvement. Even when access to care is equal, racial and ethnic minority patients tend to receive lower-quality care than Whites. Even when health outcomes improve across the entire patient population, disparities between racial/ethnic groups can remain or even worsen.

STEP
2

It's not enough for people to know that disparities are a problem; they need to recognize that disparities exist among their own patients and take responsibility for addressing those disparities. That's the beginning of all equity work.

STEP
3

It's important to understand why disparities exist and determine which causes of disparities can be tackled. Consider the issues relevant to your patient population that might contribute to differences in care and outcomes. Assemble a team that includes patients, institutional leaders and frontline staff to conduct a root-cause analysis. Also make sure to recognize and support equity champions in your organization.

STEP
4

Designing an equity program requires creativity and innovation. It means linking what you have learned in a root cause analysis to your institutional resources. There is no single right answer!

STEP
5

Buy-in is a commitment demonstrated through action. You are more likely to succeed if you have the concrete support of all stakeholders. Be specific in what you ask and walk away with a pledge.

STEP
6

Start small. Small changes help build momentum. Look for low-hanging fruit.

Measure change. You'll need evidence that you have made a difference. Create a timeline for evaluation and measurement.

Be adaptable. Strike a balance between adhering to your plan and adapting it as needed. Equity improvement is a continuous process.

The Roadmap's six-step framework helps integrate reducing disparities into all health care quality improvement efforts. It is designed to be flexible: organizations can get on the road where they need to. Its goal is to support a thoughtful and comprehensive approach to achieving equity, even though the causes of disparities may vary across regions or patient populations.

The Roadmap draws upon lessons learned from *Finding Answers'* 33 grantee projects and 11 systematic reviews of the disparities-reduction literature.

www.solvingdisparities.org

Robert Wood Johnson Foundation

LINK CREATE DIAGNOSE DESIGN SECURE IMPLEMENT

IV. PCMH Health Measures Defined

P.O. Box 5005, Wallingford, CT 06492 | 1.800.859.9889 | www.ct.gov/husky

PCMH Quality Health Measures

A defined set of Quality Health Measures was approved for use for Person-Centered Medical Homes by the Department of Social Services (the Department/DSS). The defined set of measures is from the Healthcare Effectiveness Data and Information Set (HEDIS®), Children's Health Insurance Program Reauthorization Act (CHIPRA), and custom measures approved by DSS. Many of the health measures are related to preventive care, treatment of chronic diseases, and member utilization. Improving results of health measures means improved clinical outcomes and better health for HUSKY members. Sharing the results of these measures with our providers fosters collaboration in achieving the highest standards of care by identifying and defining opportunities to improve quality of care delivery by evaluating and constantly improving the HUSKY Health program.

The National Committee for Quality Assurance (NCQA) annually publishes Health Effectiveness Data and Information Set (HEDIS), which is used to measure program performance. Measures are calculated with claims data only, or by a hybrid method based on both claims and medical record data. Data collection and reporting is governed by NCQA.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 provides renewed focus and momentum for the use of standardized performance reporting in Medicaid and CHIP. With the national interest in transparency and accountability, we are presented with an unprecedented opportunity to use the tools of measurement to inform and encourage improvement efforts and make performance information available for public comparisons.

Title IV of CHIPRA 2009 encourages voluntary, standardized reporting of a core set of child health quality measures for children enrolled in Medicaid and CHIP.

Enhanced Fee-for-Service Payments

The Department shall make enhanced fee-for-service payments to a practice as enhancements to the current Medicaid fee schedule, visit rate, or other fee applicable to the practice. The enhanced fee-for-service will be limited to primary care practices. The Department shall post the primary care codes for which enhanced fee-for-service payments are available on its website or by other means accessible to providers.

Performance-Based Supplemental Payments

The Department may distribute performance-based supplemental payments to each practice with approved PCMH status. Each PCMH practice's performance is evaluated during the measurement year, which includes one full year of program participation from January through December, using the quality measures. The Department will make payments in an annual lump sum no later than six months after the close of the measurement year. Payments are calculated by multiplying the monthly payment rate by the number of months members are attributed to a practice by the Department. The two types of performance-based supplemental payments to eligible PCMH practices or providers are:

- *Performance Incentive Supplemental Payment*. Each year, the Department shall calculate each practice's performance incentive supplemental payment rate on the payment schedule based on the practice's performance during the measurement year compared to all practices with PCMH status.

- *Performance Improvement Supplemental Payment*. Each year, the Department shall calculate each practice's performance improvement supplemental payment rate on the payment schedule based on the practice's or provider's performance during the measurement year compared to the calendar year prior to the measurement year. After each measurement year, the Department shall develop performance improvement targets necessary for practices or providers to be eligible to receive performance improvement supplemental payments. A practice or, if applicable, PCMH-accredited provider, that performs in the ninety-first (91st) to one-hundredth (100th) percentiles, inclusive, during the measurement year may be eligible for a performance improvement supplemental payment even if the practice's or provider's performance did not improve compared to the calendar year prior to the measurement year. The Department may distribute a performance improvement supplemental payment only to a practice or, if applicable, PCMH-accredited provider that continuously maintained PCMH status in good standing for all twelve (12) months of the measurement year and the calendar year prior to the measurement year.

Review of Performance-Based Supplemental Payments

If a practice with PCMH status or Glide Path status, or a PCMH-accredited provider, if applicable, did not qualify for a performance-based supplemental payment, or for the full amount of such payment, the practice or provider may request a review from the Department.

V. 2011 PCMH Performance Measures NCQA Resources

Crosswalk of DSS PCMH Performance Measures and 2011 NCQA PCMH Standards

This comparison focuses on the 2011 NCQA standard *PCMH 6: Measure and Improve Performance*, and is provided in its entirety below.

PCMH 6: Measure and Improve Performance

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.

Element A: Measure Performance

1. At least three preventive care measures
2. At least three chronic or acute care measures
3. At least two utilization measures affecting healthcare costs
4. Performance data stratified for vulnerable populations (To assess disparities in care, stratify data by indicators of vulnerable groups for one or more measures from factors 1-3)

Element B: Measure Patient/Family Experience

1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: access, communication, coordination, whole-person care/self-management support
2. The practice uses the CAHPS Patient-Centered Medical Home (PCMH) Survey Tool
3. The practice obtains feedback on the experiences of vulnerable patient groups
4. The practice obtains feedback from patients/families through qualitative means

Element C: Implement Continuous Quality Improvement *(Must Pass)*

1. Set goals and act to improve performance on at least three measures from Element A
2. Set goals and act to improve performance on at least one measure from Element B
3. Set goals and address at least one identified disparity in care or service for vulnerable populations (May stratify data by indicators of vulnerable groups for at least one measure from factors 1-2)
4. Involve patients/families in quality improvement teams or on the practice's advisory council

Element D: Demonstrate Continuous Quality Improvement

1. Track results over time
2. Assess the effect of its actions
3. Achieve improved performance on one measure
4. Achieve improved performance on a second measure

Element E: Report Performance **(Share performance data from 6A and 6B)**
1. Within the practice, results by individual clinician
2. Within the practice, results across the practice
3. Practice provides an example of its reporting to patients or to the public

Element F: Report Data Externally
1. Ambulatory clinical quality measures to CMS or states
2. Ambulatory clinical quality measures to other external entities
3. Data to immunization registries or systems
4. Syndromic surveillance data to public health agencies

Element G: Use Certified EHR Technology
1. The practice uses an EHR system (or modules) that have been certified and issued a Certified HIT Product List (CHPL) Number(s) under the Office of the National Coordinator for Health Information Technology (ONC HIT) certification program
2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules), implementing security updates as necessary, and correcting identified security deficiencies

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

Child/Adolescent PCMH Measures	Measure Resource	2011 NCQA CrossWalk	Resources	CHNCT Available Reports
Well-child visits in the first 15 months of life[1]	HEDIS® Measure W15	6A1,4* 6C1,3** 6D1-4~	https://brightfutures.aap.org/Pages/default.aspx http://www.aafp.org/fpm/2006/0900/p63.html http://childtrends.org	**CareAnalyzer®**: Provider Effectiveness Report and Provider Detail Report
Well-child visits in the third, fourth, fifth and sixth years of life[1]	HEDIS Measure W34	6A1,4* 6C1,3** 6D1-4~	https://brightfutures.aap.org/Pages/default.aspx http://www.uspreventiveservicestaskforce.org/ http://www.aafp.org/fpm/2006/0900/p63.html http://childtrends.org	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report
Adolescent well-care visits[1]	HEDIS Measure AWC	6A1,4* 6C1,3** 6D1-4~	http://www.aafp.org/fpm/2006/0900/p63.html https://brightfutures.aap.org/Pages/default.aspx http://www.uspreventiveservicestaskforce.org/ http://childtrends.org	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report
Percentage of members 2-21 years old who had at least one dental visit during the measurement year	HEDIS	6A1,4* 6C1,3** 6D1-4~	http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://www.uspreventiveservicestaskforce.org/ http://childtrends.org	**CareAnalyzer**: HEDIS Module - Summary Report and Detail Report
Annual percentage of asthma patients 2-20 years old with one or more asthma related emergency room visits[1]	CHIPRA Measure (#20)	6A3,4* 6C1,3** 6D1-4~	http://www.ncqa.org/HEDISQualityMeasurement/OtherMeasurementActivities/CHIPRAInitialCoreSet.aspx http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://childtrends.org	**Online Secure Provider Portal**: ED Utilization Report
Rate of ED visits per 1,000 members per month, ages 0-19	CHIPRA ED Measure (#18)	6A3,4* 6C1,3** 6D1-4~	http://www.ncqa.org/HEDISQualityMeasurement/OtherMeasurementActivities/CHIPRAInitialCoreSet.aspx http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://childtrends.org	**CareAnalyzer**: HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal**: ED Utilization Report

Child/Adolescent PCMH Measures	Measure Resource	2011 NCQA CrossWalk	Resources	CHNCT Available Reports
The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months, preceding their first, second, or third birthdays[1]		**6A1,4*** **6C1,3****	http://www.childtrends.org http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://childtrends.org	**CareAnalyzer**: HEDIS Module - Summary Report and Detail Report
Use of appropriate medications for people with asthma, ages 5-18[1]	HEDIS Measure ASM	**6A2-4*** **6C1,3**** **6D1-4~**	http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://www.ncqa.org/Portals/0/Education/NCQA%20Asthma%20webinar%20Oct%202011.pdf http://childtrends.org http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer:** HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal:** Pharmacy Claims Report
PCMH CAHPS Survey		**6B2** **6C2** **6D1-4~**	https://www.cahps.ahrq.gov	**2012 Annual Provider Profile Reports**

[1] Health Equity Measure selected by DSS.

* A measure may be used only once for Element 6A. If your practice decides to use the measure for one of the categories it fits in 6A Factors 1-3, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

** A measure may be used only once for Element 6C. This measure could fit the category 6C3 because your practice’s population with Medicaid insurance could be considered a vulnerable population. If your practice decides to use the measure for one of the categories it fits in 6C Factors 1-2, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

~ May select this measure to demonstrate that your practice tracks results over time, assesses the effects of its actions, and achieves improved performance if used for 6A or 6B.

Adult PCMH Measures	Measures	2011 NCQA CrossWalk	Resources	CHNCT Available Reports
Adults ages 18-75 with a diagnosis of Type I or Type II diabetes who had at least one LDL-C screening during the measurement period[1]	HEDIS Measure CDC Component	**6A2,4*** **6C1,3**** **6D1-4~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.hrsa.gov/quality/toolbox/measures/diabetes/index.html http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/diabetes/index.html http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report
Adults ages 18-75 with a diagnosis of Type I or Type II diabetes who received at least one eye screening for diabetic retinal disease[1]	HEDIS Measure CDC Component	**6A2,4*** **6C1,3**** **6D1-4~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.hrsa.gov/quality/toolbox/measures/diabetes/index.html http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/diabetes/index.html http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report
Adults ages 18-75 who were discharged alive for AMI, coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) the year prior to the measurement period or who had a diagnosis of ischemic vascular disease (IVD) during the measurement period and the year prior to the measurement period who had an LDL-C test performed during the measurement period. This is a component of the "CMC" HEDIS measure	HEDIS Measure CMC Component	**6A2,4*** **6C1,3**** **6D1-4~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/heart/index.html http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report

Adult PCMH Measures	Measures	2011 NCQA CrossWalk	Resources	CHNCT Available Reports
Post-Admission follow-up Percentage of adults ages 21-75 with inpatient "medicine" admissions with a claim for post-admission follow up with a physician, PA, or APRN within seven days of the inpatient discharge[1]	The "medicine" definition is a HEDIS concept from the "IPU" measure	**6A4** **6C1,3**** **6D1-4~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx	**Online Secure Provider Portal**: Inpatient Claims Report; Inpatient Daily Census Report
ED Usage	HEDIS	**6A3,4*** **6C1,3**** **6D1-4~**	http://pso.ahrq.gov/	**CareAnalyzer:** HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal:** ED Utilization Report
Use of appropriate medications for people with asthma, ages 19-64	HEDIS Measure ASM	**6A2-4*** **6C1,3**** **6D1-4~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer:** HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal:** Pharmacy Claims Report
The percentage of adults who were given a new psych diagnoses, and medication, by a PCP who received a follow-up visit within 30 days[1]	DSS Specs.	**6A2,4*** **6C1,3**** **6D1-4~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.ctbhp.com/ www.ctbhp.com/providers/pdfs/CT_BHP_Provider_FAQ.pdf	**2012 Annual Provider Profile Report**
PCMH CAHPS Survey		**6B2** **6C2** **6D1-4~**	https://www.cahps.ahrq.gov	**2012 Annual Provider Profile Report**

Adult PCMH Measures	**Measures**	**2011 NCQA CrossWalk**	**Resources**	**CHNCT Available Reports**
Readmission Rate - 30 days	DSS Specs.	**6A3,4*** **6B3** **6C1,3****	http://pso.ahrq.gov/ http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf Page 30, Measure #7	**2012 Annual Provider Profile Report**: Inpatient Claims Report; Inpatient Daily Census Report

[1] Health Equity Measure selected by DSS.

* A measure may be used only once for Element 6A. If your practice decides to use the measure for one of the categories it fits in 6A Factors 1-3, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

** A measure may be used only once for Element 6C. This measure could fit the category 6C3 because your practice's population with Medicaid insurance could be considered a vulnerable population. If your practice decides to use the measure for one of the categories it fits in 6C Factors 1-2, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

~ May select this measure to demonstrate that your practice tracks results over time, assesses the effects of its actions, and achieves improved performance if used for 6A or 6B.

The Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used. AHRQ located in Rockville, Maryland.

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

VI. 2014 PCMH Performance Measures NCQA Resources

Crosswalk of DSS PCMH Performance Measures and 2014 NCQA PCMH Standards

This comparison focuses on the 2014 NCQA standard *PCMH 6: Measure and Improve Performance*, and is provided in its entirety below.

PCMH 6: Performance Measurement and Quality Improvement

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency, and patient experience.

Element A: Measure Performance
1. At least two immunization measures
2. At least two other preventive care measures
3. At least three utilization chronic or acute care clinical measures
4. Performance data stratified for vulnerable populations (To assess disparities in care, stratify data by indicators of vulnerable groups for one or more measures from Factors 1-3)

Element B: Measure Resource Use and Care Coordination
1. At least two measures related to care coordination
2. At least two utilization measures affecting healthcare costs

Element C: Measure Patient/Family Experience
1. The practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least three of the following categories: access, communications, coordination, and whole-person care/self-management support
2. The practice uses the PCMH version of the CAHPS Clinician & Group Survey Tool
3. The practice obtains feedback on experiences of vulnerable patient groups
4. The practice obtains feedback from patients/families through qualitative means

Element D: Implement Continuous Quality Improvement ***(Must Pass)***
1. Set goals and analyze at least three clinical quality measures from Element A
2. Act to improve at least three clinical quality measures from Element A
3. Set goals and analyze at least one measure from Element B
4. Act to improve at least one measure from Element B

5. Set goals and analyze at least one patient experience measure from Element C
6. Act to improve at least one patient experience measure from Element C
7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations

Element E: Demonstrate Continuous Quality Improvement

1. Measure the effectiveness of the actions it takes to improve the measures selected in Element D
2. Achieving improved performance on at least two clinical quality measures
3. Achieving improved performance on one utilization of care coordination measure
4. Achieving improved performance on at least one patient experience measure

Element F: Report Performance (Share performance data reports using measures from Elements 6A, 6B, and 6C)

1. Individual clinician performance results with the practice
2. Practice-level performance results with the practice
3. Individual clinician or practice-level performance results are available to the public
4. Individual clinician or practice-level performance results with patients

Element G: Use Certified EHR Technology

1. The practice uses an EHR system (or modules) that have been certified and issued a Certified HIT Products List (CHPL) Number(s) under the Office of the National Coordinator for Health Information Technology (ONC HIT) certification program
2. The practice attests to conducting a security risk analysis of its electronic health record (EHR) system (or modules), implementing security updates as necessary, and correcting identified security deficiencies

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

Child/Adolescent PCMH Measures	Measures	2014 NCQA Crosswalk	Resources	CHNCT Available Reports
Well-child visits in the first 15 months of life[1]	HEDIS® Measure W15	6A1,2,4* 6D1,2** 6E1,2~	https://brightfutures.aap.org/Pages/default.aspx http://www.uspreventiveservicestaskforce.org/ http://www.aafp.org/fpm/2006/0900/p63.html http://childtrends.org	**CareAnalyzer®**: Provider Effectiveness Report and Provider Detail Report **Online Secure Provider Portal**: Child Well-Care Visits-Gaps in Care
Well-child visits in the third, fourth, fifth and sixth years of life[1]	HEDIS Measure W34	6A1,2,4* 6D1,2** 6E1,2~	https://brightfutures.aap.org/Pages/default.aspx http://www.uspreventiveservicestaskforce.org/ http://www.aafp.org/fpm/2006/0900/p63.html http://childtrends.org	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report **Online Secure Provider Portal**: Child Well-Care Visits-Gaps in Care
Adolescent well-care visits[1]	HEDIS Measure AWC	6A1,2,4* 6D1,2** 6E1,2~	http://www.aafp.org/fpm/2006/0900/p63.html http://www.uspreventiveservicestaskforce.org/ http://childtrends.org	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report **Online Secure Provider Portal**: Child Well-Care Visits-Gaps in Care
Percentage of members 2-21 years old who had at least one dental visit during the measurement year	HEDIS Measure	6A2,4* 6D1,2,7** 6E1,2~	http://www.qualitymeasures.ahrq.gov/content.aspx?id=48682 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html http://www.uspreventiveservicestaskforce.org/ http://childtrends.org	**CareAnalyzer**: HEDIS Module - Summary Report and Detail Report
Annual percentage of asthma patients 2-20 years old with one or more asthma-related emergency room visits[1]	Based on retired 2013 CHIPRA Measure (#20)	6A3,4* 6B2 6D3,4,7** 6E1,3~	http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://www.uspreventiveservicestaskforce.org/ http://childtrends.org	**Online Secure Provider Portal**: ED Utilization Report

Child/Adolescent PCMH Measures	**Measures**	**2014 NCQA Crosswalk**	**Resources**	**CHNCT Available Reports**
Rate of ED visits per 1,000 members per month, ages 0-19	CHIPRA ED Measure (#18/AMB-CH)	**6B1,2** **6D3,4** **6E3~**	http://www.ncqa.org/HEDISQualityMeasurement/OtherMeasurementActivities/CHIPRAInitialCoreSet.aspx http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://childtrends.org	**CareAnalyzer**: HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal**: ED Utilization Report
The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthdays[1]	CHIPRA Measure (#8/DEV-CH)	**6A2,4*** **6D1,2**** **6E1,2~**	http://www.childtrends.org http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://childtrends.org	**CareAnalyzer**: HEDIS Module - Summary Report and Detail Report **Online Secure Provider Portal**: Child Well-Care Visits-Gaps in Care
The percentage of members ages 5-18 during the measurement year who were identified as having persistent asthma, and who were appropriately prescribed medication during the measurement year[1]	HEDIS Measure ASM	**6A3,4*** **6B2** **6D1-4,7**** **6E1-3~**	http://www.childtrends.org/databank/indicators-by-topic-area/health/ http://www.ncqa.org/Portals/0/Education/NCQA%20Asthma%20webinar%20Oct%202011.pdf http://childtrends.org http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer:** HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal:** Pharmacy Claims Report
PCMH CAHPS Survey		**6C2,3** **6D5,6**** **6E1,4~**	https://www.cahps.ahrq.gov	**2014 CAHPS** is being sent with **CY 2013 Annual Profile Reports**

[1] Health Equity Measure selected by DSS.

* A measure may be used once for Element 6A. If your practice decides to use the measure for one or more of the categories it fits in 6A Factors 1-3, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

** A measure may be used only once for Element 6D. This measure could fit the category 6D7 because your practice's population with Medicaid insurance could be considered a vulnerable population. If your practice decides to use the measure for one of the categories it fits in 6D Factors 1-6, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

~ May select this measure to demonstrate that your practice tracks results over time, assesses the effects of its actions, and achieves improved performance if used for 6A, 6B, or 6C.

Adult PCMH Measures	Measures	2014 NCQA Crosswalk	Resources	CHNCT Available Reports
Adults ages 18-75 with a diagnosis of Type I or Type II diabetes who had at least one LDL-C screening during the measurement period[1]	HEDIS Measure CDC Component	**6A3,4*** **6D1,2,7**** **6E1,2~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.hrsa.gov/quality/toolbox/measures/diabetes/index.html http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/diabetes/index.html http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report **Online Secure Provider Portal**: Adult Diabetes Screening Tests-Gaps in Care
Adults ages 18-75 with a diagnosis of Type I or Type II diabetes who received at least one eye screening for diabetic retinal disease[1]	HEDIS Measure CDC Component	**6A3,4*** **6D1,2,7**** **6E1,2~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.hrsa.gov/quality/toolbox/measures/diabetes/index.html http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/diabetes/index.html http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report
Adults ages 18-75 who were discharged alive for AMI, coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) of the year prior to the measurement period or who had a diagnosis of ischemic vascular disease (IVD) during the measurement period and the year prior to the measurement period that had an LDL-C screening performed during the measurement period. This is a component of the "CMC" HEDIS measure	HEDIS Measure CMC Component	**6A2,3,4*** **6D1,2,7**** **6E1,2~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.ahrq.gov/professionals/clinicians-providers/ehclibrary/heart/index.html http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer**: Provider Effectiveness Report and Provider Detail Report **Online Secure Provider Portal**: Adult Diabetes Screening Tests-Gaps in Care
Post-admission follow up percentage of adults ages 21-75 with inpatient "medicine" admissions with a claim for post-admission follow up with a physician, PA, or APRN within seven days of the inpatient discharge. A "medicine" admission is any admission including behavioral health that is not surgical or maternity related[1]	The "medicine" definition is a HEDIS concept from the "IPU" measure	**6B1,2** **6D3,4,7**** **6E1,3~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx	**Online Secure Provider Portal**: Inpatient Claims Report; Inpatient Daily Census Report

Adult PCMH Measures	Measures	2014 NCQA Crosswalk	Resources	CHNCT Available Reports
ED Usage	HEDIS	**6B1,2** **6D3,4,7**** **6E3~**	http://pso.ahrq.gov/ http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx	**CareAnalyzer:** HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal:** ED Utilization Report
The percentage of members ages 19-64 during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year[1]	HEDIS Measure ASM	**6A3,4*** **6B2** **6D1-4,7**** **6E1-3~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.uspreventiveservicestaskforce.org/	**CareAnalyzer:** HEDIS Module - Summary Report and Detail Report; **Online Secure Provider Portal:** Pharmacy Claims Report
The percentage of adults who were given new psychiatric diagnoses and medication by a PCP who received a follow-up visit within 30 days[1]	DSS Specs	**6B1** **6D3,4,7**** **6E1,3~**	http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2014.aspx http://www.ctbhp.com/ www.ctbhp.com/providers/pdfs/CT_BHP_Provider_FAQ.pdf	**2013 Annual Provider Profile Report**
PCMH CAHPS Survey		**6C2,3** **6D5,6**** **6E1,4~**	https://www.cahps.ahrq.gov	**2014 CAHPS** is being sent with **CY 2013 Annual Profile Reports**
Readmission rate - 30 days after discharge	DSS Specs	**6B1,2** **6D3,4,7**** **6E3~**	http://pso.ahrq.gov/ http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf Page 34 Plan All-Cause Readmissions Rates	**2013 Annual Provider Profile Report**: Inpatient Claims Report; Inpatient Daily Census Report

[1] Health Equity Measure selected by DSS.

* A measure may be used once for Element 6A. If your practice decides to use the measure for one or more of the categories it fits in 6A Factors 1-3, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

** A measure may be used only once for Element 6D. This measure could fit the category 6D7 because your practice’s population with Medicaid insurance could be considered a vulnerable population. If your practice decides to use the measure for one of the categories it fits in 6D Factors 1-6, then you should stratify the data by race, ethnicity, age, gender, language needs, education, income, disability, or health status.

~ May select this measure to demonstrate that your practice tracks results over time, assesses the effects of its actions, and achieves improved performance if used for 6A, 6B, or 6C.

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VII. Communication Resources

IMPROVING COMMUNICATION WITH PATIENTS FROM DIVERSE RACIAL AND ETHNIC BACKGROUNDS

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

Safety Net Medical Home Initiative, Patient-Centered Interactions
http://www.safetynetmedicalhome.org/change-concepts/patient-centered-interactions

This implementation guide was created for use by safety net providers (such as community health centers and small group physician practices) and focuses on provider communication strategies to improve the patient-centered experience. There also are related implementation guides on how providers can engage patients in their health and health care and on measuring the patient experience in a patient-centered medical home. The website also has webinars available on patient-centered interactions, transforming primary care, patient self-management support, health consumer engagement, and establishing patient and family advisory councils for a patient-centered medical home.

National Committee for Quality Assurance and Eli Lilly Company, Toolkit for Multicultural Health Care: A Quality Improvement Guide (2007)
http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf

This quality improvement guide includes tools for physician practices to assess, plan, implement, and evaluate improvements in the quality of health care provided to multicultural patients. Included are specific tools for assessing and improving linguistic competence, cultural competence, and reduction of health care disparities, including obtaining data from multiple sources and through multiple methods, and applying quality improvement tools and techniques to make improvements. The chapter on measurement and evaluation uses an example of a diabetes care program to describe how quality improvements and reductions in disparities can documented.

Agency for Healthcare Research and Quality, Health Literacy Universal Precautions Toolkit (2010)
http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf

This toolkit includes nine tools for providers on understanding health literacy, improving spoken communication (including the teach-back method and brown bag medication review), improving written communication, improving self- management and patient empowerment (including patient action plans and getting patient feedback) and improving health delivery systems to support improved communication with all patients.

National Health Law Program, Providing Language Services in Small Health Care Provider Settings: Examples from the Field, The Commonwealth Fund (2005)
http://www.commonwealthfund.org/publications/fund-reports/2005/apr/providing-language-services-in-small-health-care-provider-settings--examples-from-the-field

This report compiles examples among community health centers, solo and small group physician practices, and family planning clinics to improve access for patients who speak languages in addition to English, including assessing patients' language access needs, identifying and training bilingual staff and interpreters, using telephonic interpreter services, providing written translations, and obtaining patient feedback. An appendix has a useful guide for assessing and planning language assistance services.

U.S. Department of Health and Human Services Office of Minority Health, A Physician's Practical Guide to Culturally Competent Care https://cccm.thinkculturalhealth.hhs.gov/

This online Continuing Medical Education program (up to 9 AMA PRA Category 1 Credits are available) was developed by the U.S. Department of Health and Human Services Office of Minority Health for physicians to learn more about culturally competent care, language access services, and organizational supports through a self-assessment and self-paced educational program.

U.S. Department of Health and Human Services Office of Minority Health, Communication Tools https://www.thinkculturalhealth.hhs.gov/Content/communication_tools.asp

These tools from the U.S. Department of Health and Human Services Office of Minority Health include a Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations and a fact sheet on how to work effectively with a health care interpreter.

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

Prepared for the Connecticut Department of Social Services

By Ignatius Bau, Health Policy Consultant and
Meryl Price, Health Policy Matters

Funded by the Connecticut Health Foundation

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VIII. Quality Improvement Interventions for Selective Measures

QUALITY IMPROVEMENT INTERVENTIONS FOR SELECT QUALITY MEASURES

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

Child/Adolescent Asthma

American Academy of Family Physicians, *Family Practice Management Toolbox: Disease Management: Asthma*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys97912

Centers for Disease Control and Prevention, Asthma Action Plans
http://www.cdc.gov/asthma/tools_for_control.htm

Child Well-Care Visits

American Academy of Family Physicians, *Physician Encounter Forms*
http://www.aafp.org/fpm/2006/0900/p63.html

American Academy of Family Physicians, *Family Practice Management Toolbox: Encounter Forms*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys99885

Adolescent Well-Care Visits

American Academy of Family Physicians, *Physician Encounter Forms*
http://www.aafp.org/fpm/2006/0900/p63.html

American Academy of Family Physicians, *Family Practice Management Toolbox: Encounter Forms*
http://www.aafp.org/online/en/home/publications/journals/fpm/fpmtoolbox.html#Parsys99885

Adult Diabetes (LDL-C screening and annual retinal exam)

American Academy of Family Physicians, *Family Practice Management Toolbox: Disease Management: Diabetes*
http://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=10

St. Peter's Medical Clinic Standing Order for Diabetes
http://www.diabetesinitiative.org/resources/tools/documents/19-PROV-StandingOrdersMAPlannedvisit_web.pdf

Chin MH, Drum ML, Guillen M, Rimington A, Levie JR, Kirchhoff AC, Quinn MT, Schaefer CT. Improving and sustaining diabetes care in community health centers with health disparities collaboratives. *Med Care Res Rev.* (2007);45(12):1135-1143
http://www.ncbi.nlm.nih.gov/pubmed/18007163

Landon BE, Hicks LS, O'Malley AJ, Lieu TA, Keegan T, McNeil BJ, Guadagnoli E. Improving the management of chronic disease at community health centers. *New Eng J Med*. (2007);356(9):921-934
http://www.ncbi.nlm.nih.gov/pubmed/17329699

Post-Hospitalization Follow up

Schall M, Coleman E, Rutherford P, Taylor J. *Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*, Institute for Healthcare Improvement (2009)
http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx

Care Transitions Intervention
http://www.caretransitions.org

Community-Based Care Transition Program
http://www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html?itemID=CMS1239313

Follow up after New Psychiatric Diagnosis/Medication

SAMHSA-HRSA Center for Integrated Health Solutions, *Screening Tools*
http://www.integration.samhsa.gov/clinical-practice/screening-tools

National Council for Community Behavioral Healthcare, *Behavioral Health/Primary Care Integration in the Person-Centered Healthcare Home* (2009)
http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

Agency for Healthcare Research and Quality, *Integrating Mental Health Treatment into the Patient Centered Medical Home* (2010)
https://pcmh.ahrq.gov/citation/integrating-mental-health-treatment-patient-centered-medical-home

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If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

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IX. Quality Improvement and Data

ANALYZING PRACTICE-LEVEL QUALITY DATA TO IMPLEMENT INTERVENTIONS TO REDUCE RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

A key success factor for any person-centered medical home will be its ability to analyze its own practice-level quality data to identify opportunities to continuously improve the quality of care provided to patients.

Among the elements required to obtain recognition as a Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA) are the capability to collect and analyze, on an ongoing basis, quality data from the practice (NCQA PCMH Elements 6A1 and 6A2).

Another NCQA requirement calls for the stratification and analyses of that quality data by race, ethnicity, and other demographic variables. This requirement is designed to assist the practice in identifying racial and ethnic and other disparities in health care processes and outcomes (NCQA PCMH Element 6A4).

Another NCQA PCMH element requires practices to set goals and implement interventions to reduce identified disparities in health care processes and outcomes (NCQA PCMH Element 6C3).

To date, health care practices have typically relied on administrative claims data to measure and analyze quality within their practice. Since claims data often cannot provide adequate information required to measure health care quality for one's patient's in an accurate, comprehensive, and timely manner, many practices and quality experts prefer to collect and analyze data from other sources such as registries and electronic health records (EHRs). At the same time, many practices do not have the infrastructure or resources to collect and analyze actionable quality data.

While most person-centered medical homes ultimately will use an EHR to support their practice transformation and quality improvement efforts, health care quality data can be collected and analyzed even without an EHR. Providers can use patient registries to document quality of care for a subset of patients by condition or disease, such as all the practice's patients with diabetes.

A patient registry can:

- Alert both the practice and the patient about regular hemoglobin A1c and LDL-C testing and annual foot and eye exams, and monitor related issues such as weight and obesity
- Identify and prioritize patients whose lab results are abnormal or out of range for further follow-up, health education, and engagement.

Similarly, a simple immunization registry can assist a pediatric or family medicine practice in ensuring that all the children in that practice are up-to-date with all their immunizations.

Practices that have achieved or are transforming themselves to achieve NCQA recognition as a patient-centered medical home have new incentives and potential support to begin to collect and analyze their own quality data, improve performance, and identify and reduce disparities.

For practices that have operational EHRs, most Office of National Coordinator for Health Information Technology-certified EHRs have the capability to generate lists of patients by condition or disease, and then compile the appropriate lab and other test results conducted and the clinically recommended procedures completed, for each of the patients on the list.

Using this technology, a practice can generate reports periodically (for example, once a quarter) and review the data for missing or out-of-range results, and for missed or overdue procedures. For example, a practice could query its EHR to generate a list of all its patients with diabetes, compile the appropriate blood test results, and display the last dates for annual foot and eye exams completed. The EHR also should have to capability to highlight or otherwise alert the practice to abnormal results and overdue procedures.

In order to organize the practice's data to identify and reduce racial and ethnic disparities in quality, providers would need to stratify their data by race, ethnicity, and preferred language. All three of these patient demographic characteristics should already be documented in the EHR. Practices can then review stratifications by race, ethnicity, and language in processes of care (for example, percentages of patients with diabetes having annual foot and eye exams, or rates of immunizations for children) or in quality of care outcomes (for example, hemoglobin A1c levels for patients with diabetes). When stratified, the data would reveal whether any racial and ethnic disparities exist within the practice.

Data for each racial and ethnic group should first be compared to the best performing group (for example, by percentage, quartile, or some other measure), with the goal of getting all patients to the "best of the best" level of care.

Once any racial and ethnic disparities in either processes of care or outcomes are identified, the practice can then develop and implement culturally and linguistically appropriate interventions to reduce those disparities. There are many tools and an emerging evidence base demonstrating that culturally and linguistically tailored interventions can be effective in reducing racial and ethnic disparities.

This proposed step-wise approach to identifying and addressing racial and ethnic disparities in health care utilizes a practice's own quality data as the practice transforms itself into a person-centered medical home.

Example:

A practice reviews its quality data and notes that its African American patients with diabetes receive regular hemoglobin A1c testing 15% less than White patients. The provider develops a mail and phone call reminder system tailored towards African American patients with diabetes, highlighting the importance of regular testing to avoid more serious complications. Six months after implementing the reminder system, the practice has narrowed the gap in the rate of testing between African American and White patients to 10%. The practice continues the intervention and will analyze its data again in six months to see if the trend continues moving towards closing this disparity.

Prepared for the Connecticut Department of Social Services

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Meryl Price, Health Policy Matters

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http://www.aafp.org/fpm/2006/0400/p47.html

California HealthCare Foundation, *Tools for Clinics: Four Health Centers Use Chronic Disease Management Systems (*2008)
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/T/PDF%20ToolsForClinicsCDMScasestudies.pdf

Summer L. *Using Health Information Technology to Improve Health and Health Care in Underserved Communities: The Primary Care Information Project*, Academy Health (2010)
http://www.academyhealth.org/files/publications/HIT4AKPCIP.pdf

National Committee for Quality Assurance and Eli Lilly Company, *Toolkit for Multicultural Health Care: A Quality Improvement Guide* (2007)
http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf

Keppel K, Pamuk E, Lynch J, et al. Methodological Issues in Measuring Health Disparities, *Vital Health Stat* (2005;(2)141
http://www.cdc.gov/nchs/data/series/sr_02/sr02_141.pdf

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http://www.safetynetmedicalhome.org/change-concepts/quality-improvement-strategy

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X. Using Data to Reduce Disparities and Improve Quality

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Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Using Data to Reduce Disparities and Improve Quality: A Guide for Health Care Organizations

April 2014

Unless specifically measured, racial and ethnic disparities in health care can go unnoticed by health care organizations, even as these organizations seek to improve care.[i] Stratifying quality data by patient race, ethnicity, and language is an important tool for uncovering and responding to health care disparities. Using race, ethnicity, and language data strategically allows health care organizations to:

1) Discover and prioritize differences in care, outcomes, and/or experience across patient groups;
2) Plan equity-focused quality improvement efforts and measure their impact; and
3) Tell (and revise) the story of how patients are experiencing health care.

This brief recommends strategies that health care organizations can use to effectively organize and interpret race, ethnicity, and language data to improve equity for their patients. It is intended for health care organizations that already have quality data stratified by race, ethnicity, and language. This document does not discuss collecting or stratifying data, as there are other resources available elsewhere. Organizations who are engaged in quality improvement efforts can use data-driven strategies to identify and reduce disparities in their care delivery.

I. Using Data to Discover and Prioritize Disparities in Care

To reduce disparities in care across patient groups, health care organizations must first understand where disparities exist, the magnitude of the disparities, and why these disparities are occurring within their patient population. Examining disparities allows organizations to understand differences in how patients experience care and improve care processes to ensure appropriate care for all patients. Organizations may have pre-existing ideas of how conditions vary in specific patient populations based on observations and anecdotal evidence. However, providers often underestimate the magnitude of disparities in their own

About *Aligning Forces for Quality*

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at http://www.rwjf.org/en/our-topics/topics/health-care-quality.html.

About the Authors

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS is a technical assistance provider for the Robert Wood Johnson Foundation's *Aligning Forces for Quality* regional collaborative.

Finding Answers: Disparities Research for Change is a national program of the Robert Wood Johnson Foundation with direction and technical assistance provided by the University of Chicago. Since 2005, *Finding Answers* has funded research on innovative interventions to reduce racial and ethnic disparities in health care, performed systematic reviews of disparities research, and provided technical assistance to organizations implementing disparities interventions, including *Aligning Forces for Quality* regional collaboratives.

Rachel DeMeester and Roopa Mahadevan authored this publication.

patient panel, and staff may not notice barriers patients face during the course of usual care. Disparities also may exist in different groups or conditions than expected. Closely examining performance data stratified by race, ethnicity, or language is the most reliable way to reveal the type and magnitude of a disparity and thus either verify "hunches" or re-direct the organization's focus.

For example, one practice participating in the Aligning Forces for Quality (AF4Q) Equity Improvement Initiative knew anecdotally that they had a very diverse African American patient population. They were also aware that some of these patients from immigrant communities might need some additional support in navigating care due to their refugee status and low English literacy. However, without a systematic understanding of need, it was difficult to decide where and how to provide additional support. The practice used its R/E/L-stratified quality data to identify subgroups based on language and identified a disparity in diabetes outcomes for their Somali immigrant patients. They created an intervention targeted to these patients, and they plan to revisit their R/E/L-stratified data to monitor progress.

Recommended Variables for Race, Ethnicity, and Language (R/E/L) Data[ii]

The Institute of Medicine recommends that organizations collect the following race, ethnicity, and language variables:

Race	Ethnicity	Language
• Black or African American • White • Asian • American Indian or Alaska Native • Native Hawaiian or Other Pacific Islander • Some other race	• Hispanic or Latino • Not Hispanic or Latino • Granular Ethnicity ○ Locally relevant choices from a standard list of approximately 540 categories ○ "Other, please specify:______" response option	• Spoken English Proficiency: Very well/well/not well/not at all • Spoken language preferred for health care ○ Locally relevant choices from a national standard list of approximately 600 categories ○ "Other, please specify:______" response option ○ Including sign language in spoken language need list and Braille when written language is elicited

For information on data collection, view these resources:

- ***Standardizing the Collection of Race, Ethnicity, and Language Data***
- ***REL Data Training***

Health care organizations should stratify quality measures that reflect their organizational priorities and that would be most sensitive to disparities. These can include measures of access and care delivery (e.g., missed appointments or immunization rates), clinical outcomes, satisfaction, cost, or others. Because managing data can be time and resource intensive, organizations can reduce this burden by choosing measures that overlap with quality improvement work they are already pursuing (e.g., patient-centered medical home certification) or required reporting (e.g., Meaningful Use or health plan reporting). Preferably, data also should be easy to collect or readily available through sources such as registries, electronic health records, medical charts, and health plan/payor data files. Organizations may also want to prioritize domains of care expected to differ the most across racial/ethnic groups. The National Quality Forum offers some principles for identifying these "disparities-sensitive" measures:[iii,iv]

- **Prevalence:** How prevalent is the disease or condition (targeted by the quality measure) in the disparate population?
- **Impact of the condition:** What is the impact of the condition on the health of the disparate population relative to other conditions (e.g., mortality, quality of life, years of life lost, disability, stigma)?

- **Impact of the quality process:** How strong is the evidence linking improvement in the chosen measure and improvement in outcomes? (See also Appendix A for a table of NQF measures that have been matched to documented disparities.
- **Quality gap:** How large is the gap in quality between the disparate population and the group with the highest quality for that measure?
- **Communication:** Does the process for achieving the outcome depend heavily on patient communication/outreach?

Choosing Strategic Comparisons to Identify Disparities

Correctly identifying disparities requires a two-step process: first, identifying how a chosen quality measure is distributed within each racial/ethnic group (rather than how the measure is distributed across the whole population); and second, comparing the distribution in one group against the distribution in another. (See Appendix B for a step-by-step visual discussion of data comparisons, including how to choose appropriate denominators.) Looking at the distribution within each group answers the question: "What is happening within each racial/ethnic group?" Comparing across groups answers the question: "How is quality within one racial/ethnic group different from quality in another racial/ethnic group?"

Practices should use the group that is doing the best as a point of comparison, since the highest-performing group indicates what is currently possible in that health care organization. Often, the majority population shows the best overall outcomes, which is why practices tend to choose the majority population as a benchmark. Other options for comparison include two minority racial/ethnic groups or the all-patient average. The end goal is to bring all patients up to the same level of good care by identifying meaningful differences.

Meaningful differences are often identified through statistical analysis, but organizations do not need to do rigorous statistical analyses to identify meaningful differences. Instead, organizations can identify measurable differences by benchmarking current data against historical data from within their own organization or against comparison data from other organizations.

- **Historical data:** For example, what was it like a year ago for the same group of patients? Historical data are relatively easy to collect within an organization, though they may be less appropriate for conditions likely to improve over time regardless of intervention.
- **National or local data:** For example, regional quality reports, community needs assessments, and quality data from parent organizations or health plans. External data show the priorities and performance of other peer health care organizations. They also can indicate whether the quality for an organization's highest-performing patients is on par with the quality that generally occurs outside of that organization.

In addition to using appropriate benchmarks to find meaningful differences, organizations may need to examine multiple measures. Using multiple measures allows organizations to identify disparities and their causes in a way that may not be apparent in a single measure. For example, an outcome measure may show that an increasing number of patients with diabetes are being seen in the emergency room for diabetes-related complications. A process of care measure could reveal that few patients with diabetes are being checked for their blood glucose levels. Using these two measures together would give an organization more information about *why* disparities are occurring than if the organization examined only the single outcome measure.

Recommendation

When possible, stratify measures by demographic data *other than* race, ethnicity, or language to further uncover disparities. Consider insurance status, zip code, income, age, health literacy, gender, sexual orientation, and other determinants of health for identifying disparities.

Additionally, trends in quality among groups can vary across different measures. An organization's African American population could be receiving higher rates of diabetes care but lag behind other populations for rates of cancer screening. Or within the same condition, an organization's Asian population may be screened more often but still experience poorer clinical outcomes than other patient groups. Organizations may need to examine an issue from several angles to identify the root causes of disparities and areas for improvement.

Using Data to Identify Causes of Disparities and Intervention Opportunities

After using stratified data to identify disparities in care or outcomes, organizations should then determine the causes of the identified disparities and design appropriate interventions and processes in response. While quantitative data are vital to identifying and eliminating disparities, they do not tell the full story. Focus groups, surveys, and interviews can help organizations collect qualitative insight from patients and staff. Qualitative data lend a personal voice to the trends in quantitative data and help pinpoint causes of disparities that may not be apparent in quantitative data alone.

Patients have important insight into why disparities exist and therefore what might be the best way to address them. For example, stratified data may show low rates of HbA1C screening among Hispanic patients but say little about how to respond. Patient input could illuminate transportation difficulties, a need for additional patient education, or other barriers that the organization can help address. One practice in the AF4Q Equity Improvement Initiative learned that their diabetic patients felt they needed more emotional coping support rather than simply additional education on their diabetes.

Staff members have practical experience in how care is delivered. For example, staff could report trouble using an automated call system to make Spanish-language appointment reminders as another reason for low screening rates among Hispanic patients. Such insight from either patients or staff is not "quantifiable" but is necessary for organizations to address disparities.

Qualitative data are especially useful for organizations where minority populations are small or for organizations with substantial diversity across several racial, ethnic, or language groups resulting in small sample sizes for a given measure. These organizations may find it more difficult to identify quantitative trends but can use qualitative data to respond meaningfully to all populations.

Organizations also can look to qualitative data sources outside the organization to find further contextual clues about the causes of disparities. For example, community data can reveal local disease prevalence, common patient behaviors in the community (e.g., substance use, smoking), and environmental risk factors in geographic locations where there is a high concentration of minority groups (e.g., food deserts, availability of safe walking spaces).

Sources of Community Data	Primary Value
Regional newspapers, neighborhood newsletters, public bulletin boards (in libraries, community centers) and culturally-specific news media	Identify local priorities and current events among minority communities
Digital storytelling archives or photo-voice projects (often run by community-based organizations or public health campaigns)	Hear first-hand accounts of community needs (potential causes of disparities), particularly among more vulnerable populations
Meetings with local business leaders, cultural or religious figures, social services directors, school superintendents, consumer advocacy groups, and neighborhood coalition members	Promote equity efforts among diverse stakeholders, gain buy-in for future interventions, and access resources such as additional data or other kinds of data
Community needs assessments and health improvement plans, developed by local authorities for public health accreditation or regional planning efforts	Identify community priority issues that could affect your clinical data (e.g., the prevalence of disease, environmental hazards, and behavioral risk factors like smoking rates) Collaborate with public health entities that can help support and spread effective interventions
For information on designing interventions to reduce disparities, view these Finding Answers resources: - *Diagnosing the Disparity* - *Designing the Activity*	

Thus, using both qualitative and quantitative data helps organizations choose interventions or process improvements that will make the best use of their resources to meaningfully impact disparities in care.

II. Planning Quality Improvement Efforts and Measuring Their Impact

As organizations are choosing a course for reducing disparities, they should establish a cohesive evaluation plan so that using data is an integral part of implementation rather than an afterthought. Such an approach ensures that organizations have the data they need to support claims about the intervention's impact and track implementation progress and challenges. As an organization develops its strategic plan, there are two key steps that it should begin early:

1) Define goals for improvement and identify appropriate measures; and
2) Develop a process for reviewing data over the course of the intervention.

Defining Goals for Improvement and Tracking Appropriate Measures

As with any other quality improvement effort, organizations should define the degree of change they hope to see over time and define measures to track that improvement. Organizations should start with the measures they used to identify disparities in the first place but also should choose other measures that will reflect the intervention's impact and the care patients are receiving. Three types of measures are useful for successfully evaluating data: process, outcome, and intervention tracking measures. Process and outcome measures show an impact on patients (positive or negative) and are usually the measures organizations stratify to find disparities in the first place.

- **Process measures** refer to what is done to a patient. Ideally, organizations will use evidence-based process measures that have been demonstrated to improve patient outcomes (e.g., administering a flu shot, using an angiotensin-converting enzyme inhibitor medication for a patient with systolic heart failure, or eye screening for patients with diabetes). Process measures tend to improve faster than outcome measures since they focus on one part of care rather than on the constellation of factors that influence clinical indicators.

- **Outcome measures** refer to the actual results for the patient. These include clinical indicators such as blood pressure control in a patient with hypertension or hemoglobin A1C as a marker of glucose control in a patient with diabetes. Other outcome measures include results like the number of emergency department visits or hospitalizations and survey measures of patient experience. Outcome measures can be disease specific or general.

- **Intervention tracking measures** evaluate whether the intervention was successfully implemented as planned. These are new measures specific to the intervention efforts and help organizations avoid wasting time or resources as they adopt new intervention approaches, with implications for staffing, cost, and future sustainability. For example, an organization may track no-show rates or the number of calls it takes to reach a patient in order to show the effort required for "successful" patient contact. These data are usually specific to the quality improvement effort and generally come from workplans, staff assignment logs, or other project management tools. Intervention tracking measures can be measured as absolute numbers as well as rates. For example, an organization that is instituting a new referral program might track the *number* of people referred (25 people) for resource allocation but also the *rates* of people referred (80 percent of eligible patients) to show improvement over time. *See below for a more detailed example.*

Disparity	Intervention	Example Intervention Tracking Measures
Spanish-speaking Hispanic patients have worse glycemic control rates than other racial/ethnic groups (Disparity identified using clinical quality data in the electronic health record; intervention designed based on focus groups)	An after-hours diabetes education class, in Spanish, for Hispanic patients *Strategies:* • Culturally relevant nutrition and cooking techniques • Tips and stories from peers who have improved their physical fitness • Techniques for stress management • Provide incentive gift card • Pre- and post-intervention questionnaire on health behaviors	• Number of patients invited via phone; number of calls, per patient, required for successful contact • Number of patients who accept/ decline invitation to the class • Percentage of patients who attend at least two classes • Percent of patients who receive gift card (vs. number of gift cards sent) • Percent of patients who complete pre- and post-intervention questionnaire • Total cost of the intervention; cost per patient

For each type of measure, organizations can define goals in terms of: 1) the same population before and after the intervention (e.g., 10 percent increase in LDL screening rates), 2) a comparison to another group (e.g., equal rates between Hispanic/Latino patients and Asian-American patients), or 3) a comparison to a benchmark outside of the organization (e.g., 80 percent of the national rate for this measure). A control group can demonstrate change in a compelling way, but a control group may not be feasible or acceptable. (For example, organizations may not wish to exclude patients or have them wait to receive the "intervention" care.) In these cases, organizations often choose pre- and post-measurement to show improvement.

Developing a Process for Reviewing Data Over the Course of the Equity Intervention

Organizations should determine how often they will review data over the course of the intervention to monitor outcomes and adjust intervention processes as they learn what works and what does not. For example, organizations may measure baseline and then review every six months, quarterly, or monthly. By regularly reviewing data, organizations can break goals into manageable pieces, ensure accountability among involved staff, and address feasibility challenges before they compromise the intervention.

Regularly reviewing data ensures that an organization's efforts are not creating or worsening disparities. Organizations can use several tools for regular data review, including standard quality improvement methodology (such as Plan-Do-Study-Act (PDSA) cycles[v]) as well as project management tools (such as workplans, staff assignments, and timelines).

All organizations should regularly review data to adjust their intervention processes, and some organizations also may find it helpful to conduct "pilot testing" before the intervention begins. Pilot testing involves implementing change on a smaller scale before expanding the intervention in order to collect data that can suggest future changes. Future changes may include: 1) the scale of the intervention (e.g., more patients or more practices), 2) the population or condition of focus, 3) the intervention itself, and 4) stakeholder involvement (who and how to engage). Organizations that lack the staff time or institutional resources to perform dedicated pilot testing should look for ways to improve their intervention efforts within the data they regularly review.

III. Telling the Story of How Patients Experience Health Care

Organizations should not simply collect and monitor disparities data. As organizations work to reduce disparities, they can improve their success by also sharing the results of the intervention. Sharing the results of equity efforts can encourage further action and highlight opportunities for improving implementation. By sharing results within and outside of the organization, organizations can:

- Receive feedback and ideas for ways to improve equity efforts;

- Celebrate progress (including “quick wins”) in order to maintain momentum;
- Understand why results came out as they did;
- Empower the people and communities who received the intervention by highlighting their improved outcomes;
- Lay the groundwork for future partnerships and encourage action from people not previously involved (e.g., partnerships with additional health plans or community-based organizations); and
- Maintain equity as a top priority by linking clear, compelling results to other high-priority programs in the organization (e.g., patient safety or care management).

Organizations can best share their intervention results by developing concise results statements targeted to the interests of their specific audiences. Visual tools such as charts or infographics also can be compelling ways to share results. For each audience, organizations should highlight a few data points and give context to make the results most pertinent to the audience’s priorities and concerns. Organizations might relate the data to national or local trends, to organizational goals, or to possible action.

Data Messaging for Different Stakeholder Groups

Stakeholder	Likely Concern	Building the Case
Leadership	Return on investment	Present data on potential positive financial impact
Providers	Office visit efficiency	Describe patients’ cultural background as information that, like family history, helps determine the best course of action with the patient. Give examples of how culturally tailored approaches enhance patient engagement and satisfaction, reducing redundancy or disconnect in visits and outreach.
Front-line staff	Clinic flow	Be honest about potential temporary impact but note how changes will ultimately improve flow (for example, reduce patient confusion). Solicit input for improvement.
Patients	How the clinic will use race/ethnicity/ language data (privacy) Health status	Discuss that data are private and help the organization make sure that discrimination and stereotyping do not exist and that everyone gets the good care they need
Community	Access to health care services and general wellness in the community	Emphasize project outcomes that benefit the community and include community partners in developing strategies to reduce disparities
Everyone	Patient outcomes	Explain equity efforts and how activity should affect outcomes

Not all interventions will successfully reduce disparities. Organizations may hesitate to share negative results, but even negative results can carry lessons for success. Where projects fail to have an effect, organizations can learn important lessons that they can incorporate into future implementation efforts.

Using Data to Support Future Sustainability

Equity data can help "prove" the value of a project and make the case for allocating resources to the project. Data also show which aspects of a program are essential for continued impact and which can be altered or minimized to make it easier to maintain efforts. As with other quality improvement efforts, having data allows organizations to best identify opportunities to improve care. Leadership, especially, may expect such data when evaluating their commitment to future disparities efforts.

Equity data support sustainability in several ways. First, using race, ethnicity, and language data to track disparities helps organizations maintain a focus on the importance of reducing disparities and providing equitable care among competing priorities. Second, using equity data helps organizations identify how factors that drive disparities (e.g., race, ethnicity, and language) also drive quality; thus, reducing disparities offers insight into improving other areas of quality. For example, an organization seeking to reduce emergency room use might find that utilization is being driven by one or a few racial/ethnic groups, suggesting that interventions targeted for these groups may be most effective. Finally, equity data can help organizations demonstrate their success to external entities, such as payors and foundations. These entities may have programs, partnerships, or grant opportunities that can support organizations' efforts—financially or otherwise—to reduce racial and ethnic disparities and thus improve quality.

Recommendation

Use a variety of methods to share equity data internally and externally.

Sharing data internally: Waiting room posters, staff meetings, provider "report cards," regular update emails.

Sharing data externally: Research publications, newsletters, conferences, blogs and social media, radio, television, and live talks. Where possible, partner with community-specific sources (e.g., a culturally specific newsletter).

IV. Conclusion

Race, ethnicity, and language data allow organizations to systematically improve care for all patients and reduce gaps in the quality of care between groups. Stratified R/E/L data best support quality improvement when organizations include analyzing and responding to data in the earliest stages of planning and continue throughout intervention implementation. Actively reviewing and responding to data allows organizations to reduce disparities and engage patients and the community in ways not possible without data. When used in this way, equity data tell a compelling story that motivates health care stakeholders—patients, providers, payors, community members, and others—to participate in achieving high-quality health care for all.

Appendix A: NQF Measures Matched to Documented Disparities[iii]

As discussed earlier, some measures are more sensitive to disparities than others, including those that have previously identified disparities successfully. This table lists quality measures from the National Quality Forum that have demonstrated disparities in the literature. Certainly, they are not the only measures that organizations could successfully use to measure disparities; but organizations may have the most success tracking and improving disparities with measures that have this level of evidence behind them.

Sample NQF-Endorsed™ National Performance Measures to Address Health Care Disparities

Priority Area	Measure Description
Asthma	Use of appropriate medications
Diabetes	Percentage of patients with most recent A1c level >9.0% (poor control)
Heart disease	Coronary artery disease: beta blocker treatment after a heart attack
Screening	Breast cancer screening Colorectal cancer screening
Prenatal care	Prenatal screening for HIV Prenatal anti-D immune globulin
Mental health	Antidepressant medication management
Immunization	Childhood immunization status Flu shots for adults aged 50 to 64
Prevention	Tobacco use assessment and cessation intervention
Patient experience	Ambulatory Consumer Assessment of Health Care Providers and Systems (ACAHPS)

Appendix B: Choosing the Right Denominator

This document outlines key considerations for organizing, interpreting, and acting on performance data stratified by race, ethnicity, language, or other demographics.

Key Consideration 1

Compare the distributions of disease within each racial/ethnic group, not just across the total population. This affects whether or not you can identify disparities because it allows you to compare the burden of disease among groups with different sample sizes.

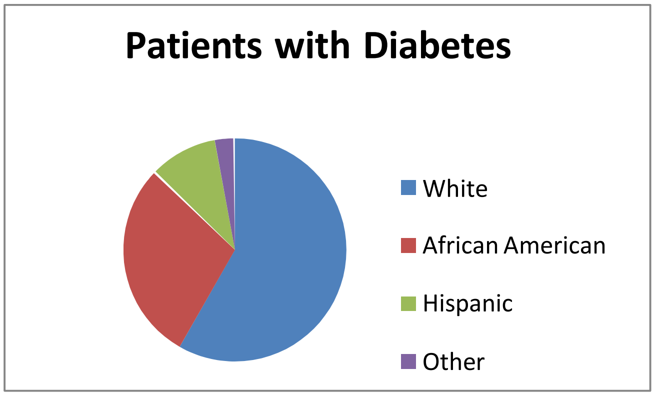
The first example below does not allow you to compare the burden of disease among groups. It shows what your data would look like if you looked across the total population instead of within each racial/ethnic group. This answers the question:

Among our diabetic patients, how many are White? How many are African American (etc.)?

- Denominator = all patients with diabetes
- Numerator = number of patients with diabetes in each racial group

Patients With Diabetes, by Racial/Ethnic Group

	Diabetic patients in all racial/ethnic groups	Diabetic patients within each racial/ethnic group	Percent of total population
White	515	300	58.3
African American	515	150	29.1
Hispanic	515	50	9.7
Other	515	15	2.9



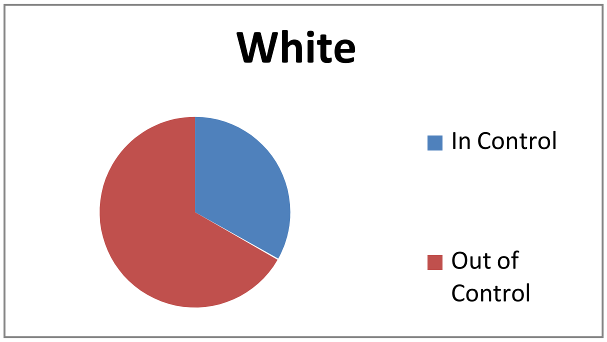
Because this analysis compares racial/ethnic groups to the total population of diabetic patients in the clinic, the White population appears to have the biggest burden of diabetes; this is not surprising because there are more White individuals in this example. This does not tell us where disparities exist or if they exist at all. In other words, we still do not know which group is most impacted by diabetes.

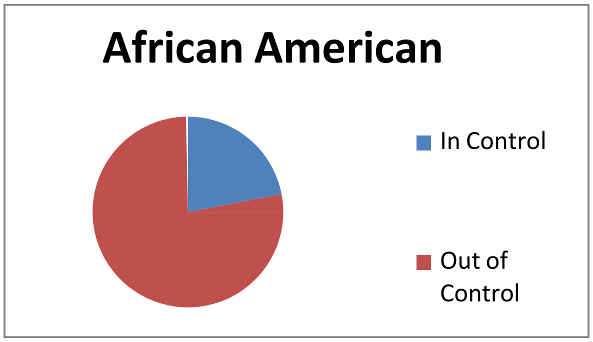
Instead, look at the distribution of uncontrolled diabetes *within* each racial group. This answers the question:

Among diabetic White patients, how many have HbA1C>7? Among diabetic African American patients, how many have HbA1C>7?

- Denominator = number of diabetic White patients
- Numerator = number of White patients "out of control"

Patients with HbA1C>7, by Race/Ethnicity				
	Diabetic patients in each racial/ethnic group	Diabetic patients with HbA1C>7 by racial/ethnic group	Percent of racial/ethnic group	Percent of total population (N=515)
White	300	200	66.7	58.3
African American	150	117	78.0	29.1
Hispanic	50	43	86.0	9.7
Native American	15	9	60.0	2.9





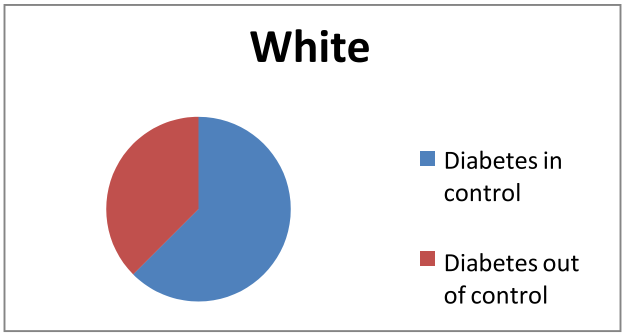
Here it is clear that some groups are more impacted by diabetes than others. Looking at rates relative to each population allows you to compare between groups and know whether a disparity exists or not, and where.

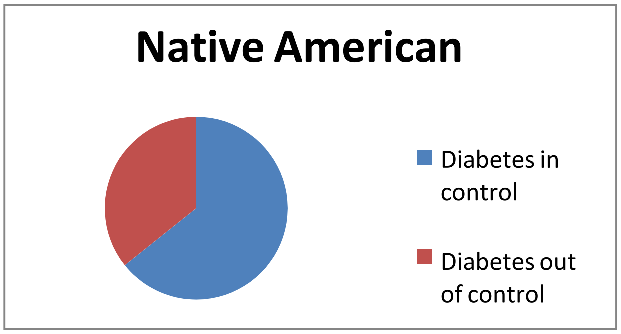
Sample Results Statements

There are 150 diabetic African American patients and **78 percent** of them are out of control, whereas there are 300 diabetic White patients—but only **67 percent** are out of control. As a group, our African American patients are bearing a greater disease burden than our White patients.

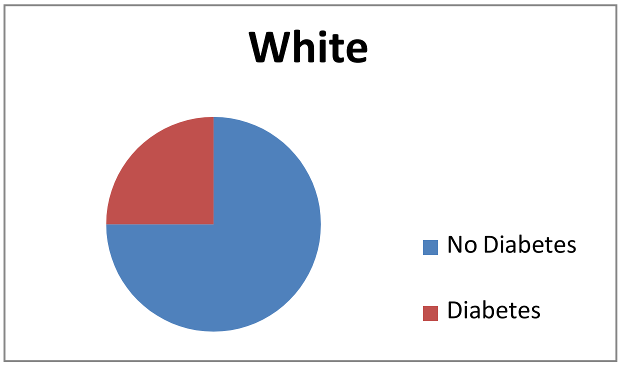
Key Consideration 2

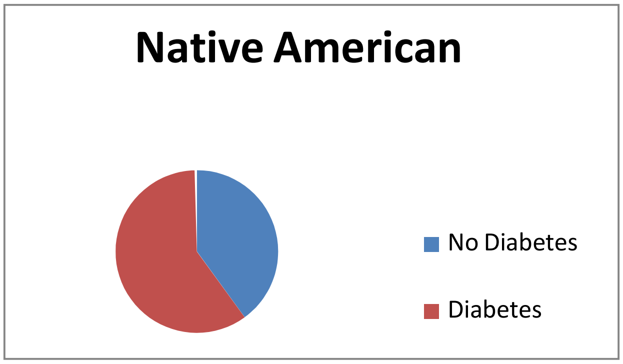
Equal Rates of Diabetic Control





Unequal Rates of Diabetic Control





Sample results statement

White patients and Native American patients have about the same proportion of patients with uncontrolled diabetes (about **60 percent in each**). That is, there does not appear to be a disparity in HbA1C levels between the groups. However, a much greater proportion of Native Americans *have* diabetes (controlled or uncontrolled) compared to White patients—**60 percent** of Native American patients vs. only **25 percent** of White patients. Given the prevalence of diabetes among our Native American patients, we may want to intervene with them, despite their small number.

Key Consideration 3

Monitor the impact on different racial/ethnic groups throughout the project to avoid creating disparities as you intervene. If you choose an intervention that spans multiple groups, it may impact groups differently.

While interventions that are tailored to a population (even if it is a smaller group) are generally most effective, some practices choose to pursue broader interventions to:

- Raise the level of care for all patients or multiple groups.
- Impact a larger population, particularly when the sample size of the population not meeting clinical targets is rather small.

This approach may generally work, but it is important to make sure the intervention works well for all groups. If organizations choose not to tailor, they are unlikely to know ahead of time how specific racial/ethnic minority groups will react to the intervention. Monitoring individual groups throughout the intervention will allow organizations to adjust their intervention approaches as needed to avoid creating further disparities.

Key Consideration 4

Assess disparities in processes of care, not just clinical outcomes.

Assessing disparities in processes of care can:

- Help you identify an area to improve if disparities in clinical outcomes aren't readily apparent.
- Allow you to see progress more quickly after beginning interventions, since processes of care generally change more quickly than clinical outcomes. This progress helps maintain momentum. Support funding proposals, and continue leadership and staff buy-in.
- Give you a greater sample size to work with (a larger population to impact). For example, perhaps you have only five patients whose diabetes is out of control, but you have 20 patients who aren't getting tested. This could justify an intervention focusing on increasing testing rates.
- Even if you do see disparities in clinical outcomes, reviewing care processes can help you narrow down your intervention approach. For example, if two groups are receiving LDL screening tests at the same rate, but one

group has higher cholesterol levels, you will know to rule out access to LDL tests as a source of disparities and consider other possible causes of the disparity.

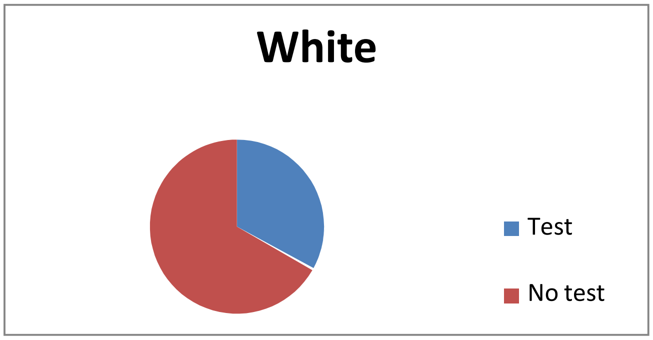
In looking at care processes, you can look at between-group differences (for example, who is getting tested?) in the same way that we compare clinical outcomes by racial/ethnic group.

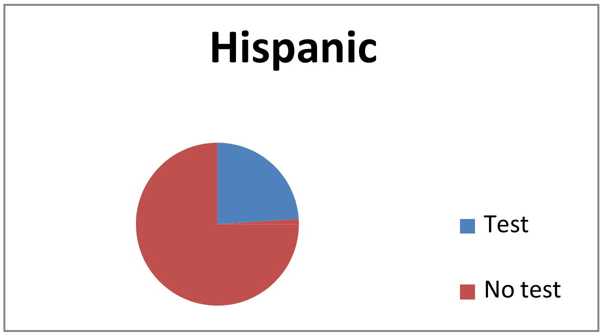
Among White patients, how many completed an HbA1C test? Among Hispanic patients, how many completed an HbA1C test?

- Denominator = number of diabetic White patients
- Numerator = number of White patients who completed a test

Patients With Completed HbA1C Tests, by Race/Ethnicity

	Diabetic patients in each racial/ethnic group	Diabetic patients in each racial/ethnic group with completed test	%
White	300	100	33.3
Hispanic	50	12	24.0





Sample results statement

Only **24 percent of Hispanic patients** have completed requested HbA1C tests, whereas **30 percent of White patients** have completed tests. Though every individual has different barriers, we would like to identify barriers that may affect a large portion of our Hispanic patients, causing them to miss needed tests more often than our White patients.

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[i] Sequist TD, Fitzmaurice GM, Marshall R, et al. "Cultural Competency Training and Performance Reports to Improve Diabetes Care for Black Patients: A Cluster Randomized, Controlled Trial." *Annals of Internal Medicine,* 152(1): 40-46, 2010.

[ii] *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Washington, DC: Institute of Medicine, 2009, http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx (accessed March 2014).

[iii] Weissman JS, Betancourt JR, Green AR, et al. "Commissioned Paper: Healthcare Disparities Measurement." Washington, DC: National Quality Forum, 2012, http://www.qualityforum.org/Publications/2012/02/Commissioned_Paper___Healthcare_Disparities_Measurement.aspx (accessed March 2014).

[iv] *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities: A Consensus Report*. Washington, DC: National Quality Forum, 2008, http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx (accessed March 2014).

[v] *The Model for Improvement*. Cambridge, MA: Institute for Healthcare Improvement, 2014, http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx (accessed March 2014).

If you experience difficulty accessing any of these sources, please contact us at 203.949.4194 or email pathwaytopcmh@chnct.org. Additional source information may also be available upon request.

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XI. Appendix

HUSKY HEALTH CONNECTICUT

Connecticut Person-Centered Medical Home

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Appendix Summary

The following resources in the appendix section are available to PCMH or Glide Path practices in an effort to improve quality outcomes. Quality improvement plans may differ between healthcare practices, depending on the goals and improvement measures set forth.

A. Quality Improvement (QI) Plan
   A tool to be used by the practice through the process of Quality Improvement. It can be saved to the EHR and completed and utilized by multiple members of the Quality Team.

B. Implementation Guide: QI Strategy, Part 1
   Information on how to develop a Quality Improvement Team within a PCMH practice. Provides different models on how to perform quality improvement that the practice team can choose to utilize. Provides case examples for illustration purposes.

C. Implementation Guide: QI Strategy, Part 2
   Deploying HIT in alignment with overall PCMH transformation allows practices to optimize their technology to support the workflows within their PCMH practices. Learn how to use the EHR system to best achieve workflows and patient care.

D. Quality Improvement Road Map to Emergency Department Utilization
   How-to guide in preventing avoidable Emergency Department visits. Improves workflows to achieve quality improvement tools and skills within the practice team.

E. Educational Resources
   i. Health Equity and PCMH Measures for Quality Improvement
   ii. NCQA
   iii. Behavioral Health
   iv. Child Adolescent Health Measure Resources
   v. Diabetic Improvement

F. Educational Resources Content
   All available articles regarding resources in section E.