Multicultural Health Care: A Quality Improvement Guide was developed by the National Committee for Quality Assurance (NCQA) in collaboration with Eli Lilly and Company. In late 2006, NCQA and Eli Lilly and Company began discussions about developing a comprehensive quality improvement guide and toolkit to help health care organizations as they seek to provide culturally and linguistically appropriate services and reduce health care disparities in the populations they serve. Without Lilly’s substantive support, and in particular, the direction provided by Dr. Kathleen Shoemaker, the publication of this guide would not have been possible.

We would like to recognize the important contributions of the Multicultural Health Care Quality Improvement Guide Expert Panel, who provided guidance and support in the development and creation of this Guide. None of the members of the Expert Panel received compensation for their services.

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We would like to recognize the following individuals for their contribution to the Guide: Jessica Briefer French, Diane Schiff, Esther Han and Robin Weinick for composing the text; Annie Chiu and Jayaram Chelluri for their involvement in the collection and analysis of examples gathered for inclusion in the accompanying DVD; Judy Lacourciere, Gerald Stewart, Ledia Tabor and Jeff Van Ness for their continuous support and review of all materials and text; Patty Salmerón and Lori Fox for creative design and layout; Sarah Hudson Scholle, Kathi Mudd, Greg Pavlison and Phylis Torda for their leadership and support on this project.

NCQA is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

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Introduction

The Institute of Medicine’s (IOM) landmark 2003 study, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, showed that racial and ethnic disparities in care exist across a wide range of health conditions and health care services. The report also showed that most disparities remain, even when controlling socioeconomic status and other access-related factors.

In an earlier work, Crossing the Quality Chasm, the IOM established equity as one of the six integral components of quality health care — so it follows that reducing disparities is essential to any quality improvement (QI) effort.

According to the Office of Minority Health (OMH), culture has a particularly strong influence in how care is administered, in part because different cultures often define health and disease differently and have different beliefs about the human body, illness and health care. Improvements in cultural and linguistic competency contribute to enhanced communication and understanding among patients and providers, and to improved quality of care for culturally, ethnically and linguistically diverse patients. While there is limited evidence on the types of interventions needed to reduce racial and ethnic disparities in quality, indigenous QI efforts and interventions that address cultural and language needs have both been successful; thus, there is value in combining our knowledge and efforts in quality with those of culturally and linguistically appropriate services (CLAS).

Many health care organizations have used QI initiatives to improve the quality of clinical care they deliver to patients. A significant gap remains, however, in the quality of care that racial and ethnic minorities receive — especially when compared to the quality of care that White patients receive. In recent years, many organizations have begun to use the basic tenets of QI to tackle this gap in the quality of care they provide. Thus, while there are many factors that affect health, research suggests that improving cultural competence and language access can reduce poor health outcomes and enhance quality of care. Culturally appropriate services may also contribute to reduced disparities.

About this Guide

While there is widespread agreement that reducing disparities in health care is important, until recently, organizations have found little guidance on developing culturally and linguistically competent programs and few models of tested and successful approaches to reducing disparities.

These disparities are associated with worse outcomes, and must be eliminated in order to provide equitable care. Resources for sharing knowledge and experiences of organizations that have already done this work are limited. This publication will serve as a starting point for some organizations and as a bank of resources for others who already have experience in pursuing QI initiatives to improve CLAS.

Multicultural Health Care: A Quality Improvement Guide (“the Guide”) was created to provide a QI framework for health care organizations seeking to promote more culturally appropriate care, provide equitable access for individuals with limited English proficiency and reduce health care disparities. The Guide applies to a variety of organizations, including managed care organizations (MCO), public health organizations, community clinics, disease management (DM) organizations, hospitals and other organizations that arrange for or deliver health care services. The accompanying DVD offers a collection of ready-to-use tools that have been used successfully in other health care settings, along with several comprehensive reference documents.

TERMS AND DEFINITIONS

Cultural and Linguistic Competence: “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and as an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.”

Culturally and Linguistically Appropriate Services (CLAS): “Health care services that are respectful of and responsive to cultural and linguistic needs.”

Health Care Organization: A public or private institution involved in any aspect of delivering or financing and arranging for health care services.

Health Care Disparity: “A difference in treatment provided to members of different racial or ethnic groups that is not justified by the underlying health conditions or treatment preferences of patients.”

Health Disparity: “Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.”

Provider: An institution or organization that provides health care services. Examples of providers include hospitals, clinics and home health agencies.

Practitioner: A professional who provides health care services and is usually required to be licensed as defined by law.

Quality Improvement (QI): In this guide, includes any change in an organization’s design, programmatic offerings, benefits, delivery system structure, and administrative or clinical processes designed to improve health care quality or customer experiences, including efforts that specifically address cultural or linguistic competence and focus on reducing disparities in health care.

REFERENCES


Making the Case for CLAS
There are hurdles to effectively tackling cultural competence, language access and disparities reduction. In addition to financial and other business challenges, there may be several organization-specific barriers, not the least of which is scarcity of leadership and organizational support that may stem from a lack of understanding of the issues and opposition to change.

The support of senior leadership for CLAS and disparities initiatives is essential to their success. Organizations whose leadership supports efforts to improve cultural competence and language access and reduce disparities will certainly appreciate the benefits of this support. For organizations without such backing, making the case for implementing QI initiatives to improve care for diverse populations will be crucial in attempting meaningful change. The argument for this work can be based on legal regulatory compliance,12 good business practices or even on moral grounds.

The leadership and staff of many health care organizations recognize the inherent value of meeting the cultural and linguistic needs of their diverse patient populations. According to a 2007 Alliance of Community Health Plans (ACHP) report, Making the Business Case for Culturally and Linguistically Appropriate Services in Care: Case Studies from the Field,13 many organizations that have engaged in or implemented CLAS standards...are doing so because they believe it is the right thing to do, and not because they are required to do so by law or regulation. Organizations with a history of meeting the needs of diverse patient populations view their role in addressing the needs of all patients they serve as an important part of their organizational culture.14

QI teams and other individuals committed to improving care for diverse populations will undoubtedly appreciate the importance of an organization that supports their efforts — not only through support of specific projects or initiatives, but also by creating an organizational culture that stresses equitable care and cultural and linguistic competence as goals for staff and leadership alike. Differences in health care quality and outcomes have been shown to result from differences in the culture of health care organizations, and differences in culture may also be responsible for different degrees of improvement in the provision of culturally competent and equitable care.15

Where business-level rationale is needed, there is evidence that pursuing cultural competence can bring a noticeable return on an organization’s investment. For example, the ACHP report states that health plans providing CLAS have achieved increased enrollment and market share among the insured. According to the report, ‘cultural competency attracts business,’16 and leads to reduced cost of interpretation services and length of hospital stay and increased patient and provider satisfaction.

How to Use This Guide
Multicultural Health Care: A Quality Improvement Guide is organized into four chapters that follow the steps of a basic QI process.

1. Assessment
2. Planning
3. Implementation
4. Evaluation

Each chapter contains explanatory text, information on following the process and examples from a variety of settings. The accompanying DVD contains tools, resources and reference materials. References to specific materials in the text are highlighted by this icon. Most materials can be downloaded directly from the DVD; others are on Web sites, in e-learning courses or in other interactive tools available only on-line.

The Guide refers to those who are carrying out these activities as the ‘QI team.’ QI Teams generally include representatives with different knowledge, skills, experiences and perspectives, often from different departments or divisions within an organization and even from the community or external stakeholders that are affected by the problems targeted or the changes proposed. QI Teams are especially helpful when the process or system in question is complex or cross-functional, when no one person in the organization knows all the dimensions of an issue or when the process involves more than one discipline or area of operation, as is often the case. The collective contributions of the various individuals that make up the QI team can be a source of cooperation and creativity and may be valuable when seeking leadership and organization-wide support.17

Within the Planning and Implementation phases of the process, the Guide encourages the use of small tests of change in which the QI team plans and implements initiatives on a small scale or implements smaller components of a larger initiative, in order to evaluate them and make necessary modifications before moving forward with the next small test. Small tests can be implemented until all potential problems or unintended consequences are identified and can help reduce the risks that come along with changes or new programs in any organization. Refer to Chapter 2 and Chapter 3 for a more detailed discussion of small tests.

While the Guide promotes small tests of change and the practice of breaking larger changes or projects into smaller components for testing before moving forward, it is important not to lose sight of the larger goal. Whatever the initiative, the organization should not forget why it is doing this work, what it hopes to change and who the changes will affect. As the QI team moves forward, it should continue to assess its progress and ensure that with every change, the initiative is doing what it is intended to do — taking the organization one step closer to improved health care for its diverse population.

Esther S. Han, MPH
Anita W. Chiu

REFERENCES
Introduction


15 CA Dept. Managed Health Care Code Title 28, § 1300.67.04.


18 The Alliance of Community Health Plans Foundation’s 2007 publication, Making the Business Case for Culturally and Linguistically Appropriate Services in Care: Case Studies from the Field. (www.achp.org/library/download.asp?id=7035).

Assessment is the act of collecting systematic information about an organization in order to determine its current level of performance. An organization can self-assess to gauge how well it addresses the needs of its members, the community it serves or other stakeholders. Assessment provides a valuable snapshot of the organization’s strengths and weaknesses, as well as opportunities for improvement.

According to Reflect & Learn (http://reflectlearn.org), “Many organizations pose the question, ‘how are we doing?’ The organizational assessment serves as a tool that responds to this question – telling you how you are doing, what you are doing well, and why you may not be doing well. Also, it should identify the areas that need improvement or change.”

Diane Schiff
Esther S. Han, MPH
Jessica Brieler French, MHSA
Chapter 1 Assessment

An organization seeking to provide CLAS and reduce disparities in health care must ask, “What are the needs of the diverse population we serve?” and “How well do we meet the needs of our racial and ethnic minorities?” An assessment can help answer these and similar questions and provide the information necessary to make important strategic and program decisions.

A well-developed assessment can equip the organization for change.

Based on the information it gathers, the organization might decide that it is ready to grow or to slow its growth, expand or merge services, eliminate programs or create new ones.

Assessment should provide regular feedback. It is the first step that any organization must take in its QI cycle, and regular assessments will help the QI team continuously improve performance. This kind of commitment benefits sustainability of QI activities and integration of efforts throughout the organization.

What to Assess

Determining what to assess can be challenging and the answer will vary among organizations. A good way to start the process is by asking questions:

• Disparities: What population do we serve (or could we serve)? What do we know about our target population and community? Are there disparities in the quality of care we provide? In access to the services we provide? In utilization of the services we provide? In the health of our members?

• Cultural Competence: How effectively do our practitioners and staff deal with a diverse population? Do we have effective services for people of different racial and ethnic backgrounds? How does the concept of equitable care fit with the organization’s goals and objectives?

• Linguistic Competence: Do we provide adequate language access for members with limited English proficiency?

In order to conduct an assessment that yields useful information for supporting QI efforts related to cultural competence, language access or health disparities, the QI team should know what questions to ask and who will look at the results. By considering how results will be used, the QI team can more effectively focus activity and decide on types of questions, and how information will be gathered.

Assessing too many things at once can blur the picture, resulting in the unnecessary utilization of resources and providing a weak platform for intervention planning. Assessing too few things can leave gaps in knowledge necessary to inform next steps. The QI team must strategize, keeping in mind that different issues can be explored at different times through repeated assessments.

Assessing the Population Served

The QI team must thoroughly understand the characteristics of its target population before it can tailor its services to meet those needs or reduce existing disparities.

When assessing its population, the QI team should collect the following information:

Demographic Characteristics.

Race/ethnicity; age; income, education; language spoken (including primary or preferred languages); geographic distribution (including home and workplace).

Additional information on both of these methods is available, but because they rely on assumptions that have significant weaknesses, QI teams should use them carefully or in conjunction with other methods.

Assessing the Delivery System

This requires measuring how well the number, type and location of practitioners and providers meet the population’s needs for CLAS and the extent to which there are disparities in care or services delivered.

When assessing its delivery system, the organization should collect the following information:

• Demographics. The race/ethnicity of physicians and other practitioners. Languages spoken by practitioners and other staff – including ancillary service providers – such as pharmacy and laboratory. Location of primary care physicians (PCP), specialists, diagnostic testing facilities, pharmacies, hospitals, clinics or other health care facilities in relation to the population served.

• Cultural Competence and Language Capabilities. Availability of practitioners and office staff who speak patients’ primary languages; availability and use of professional health care interpreter services, language lines, or bilingual staff for interpretation; availability and use of health education materials, prescription labels and other patient materials in patients’ primary languages and at appropriate reading levels.

How well do practitioners understand patients’ various cultural practices and belief systems? Are practitioners and staff sensitive to these practices and belief systems, and do they respect them?
Chapter 1 Assessment

Getting Started

If you want to capture member- or patient-level race, ethnicity and language preference, we recommend that you collect this data either during enrollment or registration, when conducting health risk appraisals (HRA) or enrolling patients in disease management (DM) programs. Gathering this information early can help speed data analysis efforts later; gathering it systematically, in conjunction with these processes, may make it easier.4

There are no federal laws prohibiting the collection of member or patient race and ethnicity data. State laws and policies support data collection, and only four states limit collection of race and ethnicity data by health insurers under certain circumstances. No state prohibits post-enrollment data collection by insurers.5

Performance. The quality of care delivered, the rates of preventive care services delivered, and patient or member satisfaction and experience with care.

To establish the fit between the population and its delivery system, it may help to survey practitioners about the characteristics of their patient populations. Practitioners in a specific location might serve a population that is unlike the organization’s overall population – the QI team may want to assess whether practitioners serve diverse patient groups or whether their patient populations are heavily represented by specific minorities.

Assessing the Culture of the Organization

An organization’s culture is important to its efforts to improve care for diverse populations. Many health care organizations have established an environment of continuous learning, evaluation and improvement; they foster respect for diversity and awareness of the needs of the populations they serve. This kind of atmosphere supports the staff and the delivery system.

Ideally, these values permeate the organization and are reflected in the organization’s structure, policies, hiring practices and reward systems.

When assessing the culture of the organization, analyze the following attributes:

Structure. The organization’s governance, including its committees and boards, executive staff, policies and diversity of staff at various levels. How much time and effort does the organization invest in staff training and QI?

Cultural Competence. Cultural awareness and the ability of managers and staff to work effectively with people from diverse backgrounds.

Linguistic Capabilities. The organization’s ability to collect, access, analyze and report data on services and outcomes stratified by race, ethnicity and language. Thoroughness, accuracy and source of the data.

Care should be given to bias and the potential for bias. Hidden biases may exist as unspoken assumptions, stereotypes and shared beliefs, filtering through the organization’s assessment.

Assessing the Community

This includes assessing relationships with local and state governments, non-governmental organizations, advocacy groups and other community organizations that serve populations important to the organization. It may also be useful to assess channels of communication between the organization and the community, including community representation on the organization’s advisory boards or committees and the organization’s involvement in community events. When assessing its community, the QI team should collect the following information:

Demographics. The racial and ethnic make-up, age, socio-economic, education and linguistic profile of the surrounding community.

Capabilities. The various resources available in the community, including community organizations and health care and non-health care facilities. Schools and other educational institutions are often great resources for the surrounding community, as are churches, social service networks and regional, state or local government programs.

Needs. Information about specific needs and difficulties of a community can be collected from the same programs and institutions that serve as community resources. If specific information is unavailable, community advocates and focus groups of various community members may provide additional insight.

Assessing Disparities in Health Care

This is a quantitative process that includes a review of clinical and service performance data stratified by race/ethnicity and primary language. When coupled with an assessment of cultural and linguistic competence, an assessment of disparities can help identify areas for improvement. To determine whether disparities in care exist, measures of quality are stratified and compared for each racial/ethnic group against the care and outcomes of the most advantaged population.

Chapter 4: Evaluation discusses methods for evaluating disparities.

When assessing disparities in health care delivery and health outcomes, the QI team should measure what is relevant to the populations it serves. Competing resources may require the QI team to focus on measures for which disparities are suspected because they have been shown in the literature and in other organizations. For example:

• Use of recommended screening and preventive services
• Differences in prescribing and prescription dispensing patterns
• Emergency room utilization rates
• Clinical outcomes and intermediate outcomes, especially those that have shown high prevalence of disparities (e.g., diabetes, blood pressure, cholesterol and asthma control, vaccinations, obesity)
• Patient experience and satisfaction with care and services
• The rates of grievances and complaints
• Utilization management authorizations for services
• Disenrollment rates
• Physician change requests

Writing an Assessment Plan

Once the QI team decides what to assess, the next step is to create a written plan to guide the assessment process. Creating a written plan facilitates assessment and gives the QI team an opportunity to identify gaps in the assessment plan before it is implemented.

When possible, a culturally diverse committee of individuals and departments within and outside the organization (e.g., providers, community representatives, patients, members) should be involved in creating and approving the plan. If

Conclusion
the organization has an existing QI structure, the QI team may strengthen it by increasing diversity rather than by establishing a parallel structure. A comprehensive written assessment plan will answer the following questions:

- What is being assessed?
- Why is the assessment being done?
- How does the assessment support the organization’s goals and mission?
- When will the assessment occur?
- Who will conduct the assessment?
- Who will collect the data?
- What data will be collected?
- Who will analyze the results?
- How the results will be reported?
- Who will receive the results of the assessment?

Collecting the Data

It is not necessary – or prudent – to assess too much at once. Assessment should be an ongoing process that occurs at scheduled intervals. As mentioned before, start small. Be explicit about the work being conducted. Include enough time for planning and preparing for the assessment, and for designating the appropriate fiscal and personnel resources. A detailed schedule of activities and target dates will ensure that all participants are aware of their responsibilities and deliverables before the assessment begins. The assessment should begin with a meeting of all individuals involved in the process, including data collectors, reporters, assessors and administrative staff. Each person should be clear about the assessment’s goals, its process and desired outcomes. The group should decide how to communicate project status, who will make decisions and how they will be made. Assessment leaders should review the written plan, explain to participants how the assessment supports the organization’s mission, and answer participant questions about roles and responsibilities. To assist in future assessment activities, a list of all issues and their resolutions should be kept.

Quantitative Data

Common sources of quantitative information include existing surveys and administrative, clinical and program data such as the following:

- **Surveys.** Survey results may contain information that can be obtained only by directly asking program staff members, clinicians or patients. Information that may help with assessment can include patients’ experiences in the program, their knowledge about their condition and optimal self-care, and the attitude of clinicians toward integrating the program into their ongoing clinical practice.

- **Administrative Data.** Claims or billing information, which includes diagnosis and procedure codes; insurance claims for in-patient or out-patient visits, medical procedures, prescriptions filled, and physical therapy; mental health or other specialty referrals. Other types of administrative data include demographic information (e.g., age, gender, place or residence) obtained when an individual enrolls with the organization or registers as a patient.

Qualitative Data

Quantitative Data

GETTING STARTED

If this is your first time creating an assessment plan, keep it simple to ensure success. Focus on a limited number of areas that will yield high-value information. Plan to conduct multiple simple assessments, rather than one overwhelmingly complete one.

- **Clinical Data.** This information contains more details about clinical care and is typically easier to obtain from electronic medical records than from paper charts. Types of information obtained from clinical records include dates of screening tests, lab test values and prescription details.

- **Program Data.** Cost, staffing and resources devoted to specific tasks or programs.

- **Race/ethnicity and Language Preference Data.** These data may be collected directly from patients or members on enrollment or registration forms or on Web sites, or they may be extrapolated using geocoding or surname analysis.

- **Community or Target Population Data.** Information about a specific population and its needs may already be collected by other groups or organizations in the community. The QI team should establish relationships with other organizations and consider pre-existing data sources to limit the amount of new data that must be collected.

Qualitative Data

It is often not possible or feasible to quantitatively capture all the information necessary to inform an assessment or a QI effort. In this case qualitative data are an extremely valuable source of information and may yield important information not reflected in quantitative data, or may give additional insight or context to results. Creating a focus group composed of representative members of the target population, or interviewing experts or key community or organization informants, allows the QI team to ask personalized questions and collect a wealth of information that may not be captured in a report or survey. Simply observing the target population or processes in question is also worthwhile and can yield useful insights to inform the planning and implementation processes.

GETTING STARTED

It is important to share information about areas in the organization that need improvement, as well as organizational strengths. Let staff know that improving cultural competence, providing high-quality language services and reducing disparities is an important undertaking, and its success depends on the organization’s strengths. Areas where the organization excels can be leveraged to address gaps.

Analyzing Results

Whoever conducts the assessment will be responsible for analyzing and interpreting the data so that the results are meaningful to the organization and useful in developing an implementation plan. In most organizations, the group that created or approved the assessment plan analyzes its results. Results will highlight areas for improvement as well as organizational strengths; both should be shared. It can be especially helpful for member, patient or client representatives to review assessment results, since they can provide a unique perspective.
• **Analyze the Data.** Staff charged with analyzing the data should be identified in the assessment plan. It is best to have a cross-cultural, cross-departmental group assess the data. Including community representatives and patients, clients or plan members on the panel will add an extra level of analysis and involve the population being served, and will emphasize the organization’s commitment to providing CLAS and its commitment to reducing disparities in health care. Multiple analyses of the same data over time allow useful goal setting and data comparison and help direct future and ongoing intervention plans.

• **Report the Data.** Modify the presentation of data to a specific audience. For example, a presentation to general staff may be done with a slide show that provides an overview of findings, while a presentation to senior staff or board of directors may require a more strategic focus.

• **Make Decisions.** Once data have been analyzed, the QI team must decide what activities or changes might reduce disparities or improve the provision of CLAS. If, as a result of the assessment, decision makers are ready to act, the specific interventions or programs must be identified and thoroughly planned before they are implemented. This is detailed in the next chapter.

**REFERENCES**


Chapter 2  Planning

The first step in planning the intervention is to identify the problem. At this stage in the process, the QI team has gathered and analyzed data that reveal disparities in health care delivery or health outcomes or gaps in the provision of CLAS.

Once a problem is identified, the team must determine its causes or contributing factors in order to determine what changes can be made to effectively solve or mitigate it. As illustrated below, any one or a combination of issues could contribute to a problem.

Esther S. Han, MPH
Jessica Briefer French, MHSA
Example: Identify the Problems and Their Causes

Problems Identified
1. Chart review data shows that a significant and increasing prevalence of members in a health plan are overweight and that a large percentage of children or adolescents are at or above the 95th percentile for body mass index (BMI) for their age range. Latino children have significantly higher rates of BMI > 95th percentile than other children in the sample.

2. Physician assessment data reveal that the large majority of physicians in a health care organization do not use interpreters when they see patients with limited English proficiency.

1. Possible Causes or Contributing Factors

Problem 1
- Poor diet and lack of exercise for various social, cultural, economic and lifestyle reasons.
- Patients do not understand the negative effects of being overweight and how to combat the problem.
- Physicians are uncomfortable discussing the topic with patients.
- Physicians feel unprepared to discuss the topic with patients of different cultural or ethnic backgrounds.

A significant and increasing number of members in a health plan are overweight. Approximately 20% of children or adolescents are > 95th percentile for BMI for their age range. Latino children have significantly higher rates of BMI > 95th percentile than other children.

2. Possible Causes or Contributing Factors

Problem 2
- Physicians do not know whom to call or contact when they need an interpreter.
- Many physicians do not have equipment to comfortably use telephone interpreter services.
- Physicians are unhappy with the amount of time they have to wait after requesting an interpreter and are often put on hold for long periods of time when using telephone interpreters.
- Locally available in-person interpreter services are costly, and it is faster and easier to use a relative or friend to interpret.

The majority of physicians in a health care organization do not use interpreters when seeing patients with limited English proficiency.

To identify possible causes or factors contributing to the problem, the QI team may find answers in the assessment it conducted. If earlier assessments did not identify the causes of a problem, the team may want to collect more, or different, data.

L.A. Care Health Plan, a local public agency serving residents of Los Angeles County, California, recognized the impact that excessive weight was having on its members and began measuring the prevalence of overweight and obesity in selected members from 2001–2003.

In a chart review, the plan extracted more than 2,000 well-child and adolescent well-visit medical records. As in Problem 1 in the example on the previous page, data showed that for members in the population sampled, approximately 20 percent of children and adolescents met or exceeded the 95th percentile for BMI for their age. They also found that Latino children were more likely to be overweight or at risk for overweight than the overall sample.

As a part of its assessment, L.A. Care Health Plan surveyed practitioners about their training on treating obesity in their patients. More than 98 percent of the practitioners indicated that they would be interested in training on how to treat and prevent obesity. The QI team learned that practitioners feel unprepared to discuss such a sensitive topic with their patients and that they might benefit from training on how to do so effectively, or from tools to use in their offices when addressing the topic with patients.

Other methods can also help organizations identify causes or contributing factors. The National Public Health Performance Standards Program’s Users Guide suggests the following steps to determine a problem’s causes or contributing factors.
1. Brainstorm. Invite people familiar with the problem to develop a list of all possible causes, using the resources gathered to date—which includes the analysis performed during the assessment phase and the data.

2. Organize causes into similar categories. For example, people (e.g., personnel shortages, poor training, limited experience or expertise), methods (e.g., systematic barriers, slow response times, confusing protocols) or information (e.g., lack of information about the causes of disparities, lack of awareness or education).

3. Visualize. Chart causes and effects. Graphic cause-and-effect representations can help people visualize the connection between problems and their potential causes. Refer to Figure 1 for an example of an effective graphic representation known as a fishbone diagram or a cause-and-effect diagram.

   A fishbone diagram can foster discussion during brainstorming and help sort ideas into useful categories. In the example above, causes are listed under five categories.
   1. Physician Encounter
   2. Materials
   3. Limited English Proficiency
   4. Economic
   5. Culture & Lifestyle

   The QI team can use section names that best categorize the causes it identifies. It can simply ask itself why a problem occurs and make the connection. Individual causes can branch off major categories in clusters or subcategories.

   Prioritize
   A problem can arise from many different related—or unrelated—contributing causes. For this reason, it is important to determine and prioritize which cause or causes have the greatest effect. Some may be beyond the control of the organization or impossible to solve. In the example above, the QI team recognizes that the organization cannot change the economic situation of its members, and will need to choose a different cause to address first. Answering these questions will help.
   - Which causes affect the target population most?
   - Which causes have the greatest effect on the problem? Which are most likely to be successful?
   - Which causes have the greatest effect on the organization’s income or expenses?
   - Which causes are most important to the organization?
   - Which causes are most important to the organization’s stakeholders (e.g., members, patients, employers)?
   - Which causes are most easily addressed?

   One way to identify causes to address first is with a Pareto diagram (Figure 2), which displays the relative importance of each factor contributing to the problem. In the absence of data, a group of people who have experience with a problem but may have differing viewpoints about it can brainstorm and negotiate priorities. Including members of the targeted population on the team will guard against bias.

   To construct a Pareto diagram, the QI team can segment data into different categories according to the causes or issues it has identified. After determining how often each occurs, the team can chart them in order of decreasing frequency to visibly depict which causes are most significant and where to focus its efforts. The example in Figure 2 shows that the first three categories account for 80% of all of the physician concerns identified; therefore, the QI team may choose to focus its efforts there.

   Identify a Solution
   After identifying the problem and root causes, the QI team must identify specific changes necessary to solve or mitigate the problem, and consider all possible solutions. There could be several possible interventions for each high-priority root cause identified, depending on the resources available in the organization or the community. At this stage, the team should consult all stakeholders who could be affected by projects developed to solve the problem. Stakeholders include patients, family members, patient advocates, health care practitioners, staff members, administrators, community service organizations and others who can contribute information from a unique point of view.

   All possible solutions should be evaluated for feasibility, cost and probable effect so the organization can compare and choose the most effective interventions. A good solution will solve a problem by attacking individual root causes. Although it might be tempting to look for a solution that will solve the problem in its entirety, the project must be realistic and achievable.

   GETTING STARTED
   If you are just getting started, you can help build momentum and support for the project by choosing to remedy an easy-to-solve problem first before moving onto more complex causes, even if addressing the more complex cause will probably have a greater impact on the problem.
Why should the organization undertake this project? How will the problem be addressed? What problems will this project address?

The health plan has identified these solutions:
- Educate families or parents about obesity risk/prevention through culturally and linguistically appropriate mailings.
- Create incentives for members to achieve and maintain a healthy weight.
- Develop and conduct culturally effective outreach to Latino members with children.
- Create a DM program for overweight and at-risk children and their families.
- Provide training for practitioners to effectively counsel children and their families on obesity and weight loss.
- Develop and disseminate tools for physicians to use when counseling children and their families on obesity and weight loss.

Example: Identify a Solution

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- Develop and disseminate tools for physicians to use when counseling children and their families on obesity and weight loss.

Developing a Project Plan

The QI team needs a comprehensive project plan to build program support among stakeholders and prepare for future replication, modification and scaling. A project plan can be used to justify the need for the program, reveal potential benefits and map the solution. If the QI team gathered enough comments and suggestions from stakeholders during the assessment and planning process, the project plan will help the organization build enthusiasm for and commitment to the program and its goals. In this way, the planning phase itself can foster communication among stakeholders and be a platform for building strong working relationships.

When developing the project plan, the QI team should ask the following questions:
- Why should the organization undertake this project? This question may be the most important part of the project plan. The QI team must state the project’s purpose and explain how a problem or disparity negatively affects the organization and its populations.
- What problems will this project address? The plan should clearly describe the identified problem and the project’s goals and objectives.

Example: Developing a Project Plan

A clinic with a diverse patient population and a primarily English-speaking professional staff has begun an effort to improve language services for its patients. An assessment identified languages commonly spoken in the community, as well as those spoken by various clinical and administrative staff. It also uncovered gaps in available services and revealed that there are no trained or certified health care interpreters in the community.

The QI team launched an initiative with a goal to help the clinic’s doctors, nurses and other staff to better utilize interpreters when working with patients with limited English proficiency. A project team was created that included several community members as patient advocates. The team explored various options and selected several targeted strategies to address the problem.

Clinic and patient population assessments (refer to Chapter 1: Assessment) suggest that the number of patients who speak Spanish, Korean or Mandarin is large enough to support hiring more bilingual staff or on-staff interpreters in these languages. Because trained health care interpreters are not readily available in this clinic and hiring of bilingual staff must be addressed in the context of other required skills, this is suggested to organization leadership as a long-term development goal. In the interim, the team decides to implement organization-wide telephone interpreter services.

Here is the project plan’s summary.

What problems will the project address? The clinic lacks a comprehensive language-access plan to address patients with limited English proficiency. The team outlined different strategies for the various categories of staff, along with their rationale.
- Hire bilingual staff in languages most prevalent in the patient population: Spanish, Korean, Mandarin. This is a long-term goal.
- Use telephone interpreters.
Develop and distribute a comprehensive Language Access Plan that explains changes and provides a rationale. The document will also contain instructions for using the new interpreter services.

Why should the organization undertake this project?
The team used information gathered during the assessment and other information and literature to support the project; staff and facility resources; patient population needs; and staff for cost-analysis to determine the need to hire bilingual staff for the most prevalent languages.

Who will contribute to the project?
The project team identified affected staff and detailed proposed positions for new bilingual staff hires, including existing positions in which bilingualism should be a hiring criteria when incumbents leave the organization.

• The team listed all potential telephone interpreter vendors, along with cost-estimate analyses, contracting options, certification and interpreter quality information and any other information that would help it make a decision.

• The team included job descriptions and division of labor with existing staff and proposed new protocols for directing patients to staff who speak appropriate languages.

Where will the project take place?
The team identified the clinic’s affected areas (e.g., examination and consultation rooms that will need new dual handset telephones, public areas that will acquire new staff). The team also noted that staff scheduling and seating arrangements might be affected.

How will the problem be addressed?
The team included a budget analysis with the estimated cost of hiring and employing new full-time staff and the estimated use of telephone interpreters. While it was not possible to include the cost of not having interpreters, staff included the estimated cost of the different options proposed and their various combinations, along with literature and case-study information showing increased costs due to patient misunderstanding of medical or medication, appointment, follow-up or referral instructions due to poor communication between patients and physicians; the subsequent use of more costly diagnostic tests or invasive procedures; potential lawsuits; and dissatisfaction causing unhappy patients to seek care elsewhere.

The project plan identified three separate, and substantial, initiatives affecting various groups of people within the clinic. Each initiative can be broken down into smaller tests of change. Refer to Chapter 3: Implementation for more information.

When will the project start? When will it end?
The team created a timeline that included dates and clinic events with the potential to impact the schedule (e.g., annual audits and budget procedures, board meetings, a previously scheduled clinic renovation project). While these other events might not directly affect the project, there was a chance that staff time and resources might be diverted.

When answering questions about “why” and “how,” keep in mind that the project is likely to result in changes to the organization’s standard operating procedures. The QI team will need to add time for staff members, administrators, physicians and others to become accustomed to the changes and new procedures. Some people adapt quickly, but others require more time to acclimate to procedural changes, so there is the potential for a temporary decline in staff productivity. Planners should anticipate these effects by allocating sufficient time and setting goals accordingly.

Planning for Evaluation
For any QI initiative, evaluating the entire project after it is implemented is essential to deciding on the next steps. Because conducting an evaluation can be a significant undertaking, the best time to plan for it is during the project planning stage, when the QI team can determine what results to expect, how results will be evaluated and what data will support an informative evaluation. Planning early for evaluation enables the project team to ensure that it has access to needed data.

Any evaluator will find it difficult to assess a project at its conclusion if data are unavailable or inappropriate for evaluation. Conducting an evaluation early allows the QI team to document changes as the project progresses and to capture information most important to the evaluation. It is important to identify which measures will be used to evaluate the program and what data will be needed.

Think Big, Start Small
A comprehensive project plan is important for successful implementation of the plan, and ensures that the QI team is prepared for the changes to come and that the project has the resources needed to get there. The project plan should begin by identifying specific goals and objectives and emphasizing small tests of change. Testing, revising and retesting on a small scale can lead to larger, more comprehensive changes.

Starting small, especially when making significant changes or committing a lot of time, money or other resources to a project, will allow the QI team to minimize risk and make sure they got it right before moving on to the next step.
Implementation discusses in greater detail how to conduct small tests of change in implementing interventions to improve cultural competence and language access and reduce health care disparities.

The QI team should also remember to take time to observe every small test and evaluation and make sure the initiative is proceeding properly.

Team members can become focused on the operational details of small changes and allow the overall initiative to get side-tracked. Team members should frequently remind themselves about the larger initiative, of which the small tests are a part, and in this way work effectively toward accomplishing the goals identified at the project’s inception.

Example: Think Big, Start Small

A QI team developing an employee survey can “practice” on a small subset of employees before rolling the survey out to all employees. This will test the survey to make sure it does what it was intended to do, and answer the following questions for its creators.

Some questions to ask may include:

• Did the employees understand the questions? Did their answers give the desired information? Are the results useful? If not, the team may want to reword the questions and provide different answer choices or more specific instructions.

• How long did it take the employees to answer the questions? If employees thought the survey was tedious or burdensome, the team might want to remove questions and shorten the survey, or create shorter, more focused surveys for different types of employees instead of one general survey for all employees.

• How long did it take program staff to collect and analyze survey results? Could staff easily collect survey answers, or was there a lot of work collecting and organizing the answers before they could be used? If the data collection process is time-consuming or prone to error, the team might want to change the survey format, how the survey is collected or returned to project staff or how survey results are analyzed.

REFERENCES

Chapter 3 Implementation

While it is usually better to approach problems from multiple angles, time and resource constraints often govern what can reasonably be accomplished. If you want an intervention to have the greatest potential for success with the smallest investment and risk, it is a good idea to undertake it sequentially, using small tests of change, to ensure that each component operates as planned.

There are various models for conducting QI and testing changes, and no single model is endorsed here. These models each combine group process and systematic testing to solve routine operational problems. While this guide promotes a comprehensive approach to improving CLAS and reducing disparities through assessment, planning, implementation and evaluation, implementation will have a greater chance of success if the QI team breaks it into manageable steps, tests each step independently and, once ready, works on institutionalizing the proven changes.

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Chapter 3 Implementation

Pilot Testing
Pilot tests ensure that an intervention is likely to succeed before an organization invests significant time and energy in it. In addition to testing effectiveness, small tests of change can help establish the feasibility of a proposed initiative, or build support for a controversial change and make the change process more acceptable to staff and other stakeholders. Small tests can ensure that a proposed change has potential before it is applied on a broader scale, thus helping to break down resistance. Small tests allow those affected by changes to become accustomed to the changes gradually and provide useful feedback for continuous improvement. Moreover, those not involved in the initial tests can observe the results of their peers’ tests and see the benefits of successful change.

Monitor Performance
Small tests of change can be conducted in hours or days, and monitoring need not be resource-intensive. Following the plan for the test, the QI team collects quantitative and qualitative data to determine next steps. At each step and after each small test, these data are analyzed to identify barriers to improvement and make modifications as needed. The team can then determine whether the test should continue or be abandoned in favor of a new approach; whether it should continue with modifications or be expanded; or whether it needs new indicators of quality or effectiveness.

For each test, ask these questions.

- Should the test continue?
- Are changes needed?
- What else do we need to know about how this test works?

When each test is complete, the team should assess the work plan, make modifications if needed and decide on the next change to test, eventually testing and evaluating the entire intervention before full-scale implementation. Small tests of change can be rapid and sequential to avoid investing too much time on any one test, and each can identify ways to improve the proposed solution.

Example: Small Tests

Building on the example given in Chapter 2, the QI team began by making telephone interpreter services available to clinic practitioners.

Small Test 1
The team disseminated information on how to access the telephone interpretation vendor and held training sessions to teach practitioners how to work effectively with telephone interpreters. After the service had been used for two weeks, the team collected practitioner feedback.

- Feedback revealed that practitioners are satisfied with telephone interpreters but cannot comfortably use interpreters in exam rooms not equipped with dual-handset phones, and so often choose not to use the service.
- Practitioners expressed frustration with the long wait-time before an interpreter becomes available.

Should the test continue? Yes
Are changes needed? Yes. Dual-handset telephones should be installed in all rooms where patients are seen.
What else do we need to know about how this test works? In addition to retesting the service after installing double-handset phones, the QI team should analyze utilization and wait-time data provided by the service vendor to learn when, and with which languages, long wait-times occur.

Small Test 2
The QI team installed double-handset phones in select examination and consultation rooms and collected feedback after two weeks.

- Feedback indicated that practitioners found the phones useful and easy to use. Utilization of telephone interpreter service increased for patients with limited English proficiency who were seen in examination and consultation rooms with double-handset phones.

Should the test continue? Yes
Are changes needed? Yes. The phones tested in small test 2 should be installed in the remaining exam and consulting rooms.
What else do we need to know about how this test works? Data from the service vendor revealed that wait times are generally associated with patients needing Mandarin interpreters because the vendor does not have sufficient Mandarin interpreters. The QI team should discuss this need with the vendor and research other vendors while continuing to analyze user feedback.

Small Test 3
Practitioners must fill out and submit tracking forms each time a telephone interpreter is used.

- Feedback indicated that the paperwork was becoming burdensome to practitioners, who often fell behind in submitting the tracking forms or who did not fill out the forms completely.

- Many patients still brought friends or relatives to serve as their interpreters, not knowing that telephone interpreters were available.
- While some patients seemed pleased with the new service, others seemed wary and uncomfortable with the technology and practitioners sometimes felt uncomfortable negotiating with patients about the issue.

Should the test continue? No. The forms are problematic and a new form should be developed and tested. A new test is needed to communicate with patients about the availability of interpreter services and to help them deal with the new technology.

Are changes needed? Yes. Tracking forms should be made more concise and easy to fill out. The QI team should work with clinic administration and communications staff to develop a strategy for informing patients and the greater community about the availability of interpreter services. The QI team should also teach practitioners and other staff members how to explain the service to patients so that they see the benefits of using professional interpreters but are still comfortable bringing friends or relatives for support. This will strengthen patients’ involvement in their health care.

What else do we need to know about how this test works? Cycles of small tests can continue as long as there are questions to be answered and multiple small tests can be implemented at the same time, as long as the resources are available.
organizational support will also be important, and responsible parties. Leadership and ongoing monitoring and feedback to stakeholders can further secure the new process through intervention and evaluate its effectiveness. The accountability system and protocols; and new operational procedures in written policies through communication; training; integrating point, the team will institutionalize change satisfied with their results and determine that All small tests are complete when the QI team is in changing their behavior. Examples include to reach individual patients and support them

**Types of Interventions**

Different problems demand different interventions, and as in the example above, some problems require multiple interventions. An organization’s interventions may be focused on patients, the community, individual practitioners or providers, or on the organization’s internal systems. Significant changes in outcome often require multiple changes that focus on many—or all—of these different elements, and integrate the different players involved in delivering health care.

**Patient-, Member-, or Client-focused Interventions**

These interventions include changes intended to reach individual patients and support them in changing their behavior. Examples include providing the following types of language services.

- Translated materials
- Interpreter services for patients or members with limited English proficiency
- Patient education material, consent forms, or discharge instructions
- Low-literacy patient education materials
- Language-appropriate pharmacy consultations and prescription labels

Before health care organizations that serve diverse communities can address the needs of members and patients, they must first understand what those needs are. There are many ways to collect information about race, ethnicity and language needs, from direct data collection to indirect methods such as geocoding and surname analysis (discussed in Chapter 1: Assessment).

**GETTING STARTED**

If your organization is just beginning to address language issues, a first step might involve testing different methods of capturing, documenting and storing information about patient or member language needs.

Other patient-, client- or member-focused interventions provide support, such as doulas (for birthing support), promotoras (or health advocates), patient navigator services, transportation, daycare and other non-health care support services to improve patient adherence, overcome barriers to keeping appointments and increase trust. While health plans usually make interpreter services available for customer service activities, some, such as Health Net of California and Chinese Community Health Plan, offer dedicated customer service, nurse advice lines, mailings and Web sites, in different languages.

In addition to addressing language needs and support services, health plans may offer culturally competent programs focused on disease prevention. For example, Chinese Community Health Plan and Health Resource Center has a bilingual Web site (www.cchrhealth.org) that provides patient-education materials in both English and Chinese for monolingual Chinese community members and for providers who want health education materials to share with their Chinese members (as well as English-speaking family or friends). The site also lists various community health events, such as Chinese Community Fitness Day.

Health care organizations also provide linguistically appropriate disease management programs, and glossaries or other tools to help members from different backgrounds understand how the health care system works. By considering the specific cultural values of the target population, these programs engage members of the community.

Health Net of California’s Salud con Health Net initiative is aimed at “meeting the needs of California’s Latino community with culturally competent care.” It is the first cross-border health care plan to offer affordable, high-quality care in California and Mexico through community-based and international partnerships, education and outreach. Salud con Health Net also offers a network of health care providers and organizations with extensive experience serving the Latino community. Health Net responded to community needs by opening its Community Solutions Center in East Los Angeles, the heart of the Latino community, to provide the face-to-face interaction that members said they wanted from their health plan. The plan also sponsors ProfiMex, a nonprofit research organization that specializes in Mexican studies, to produce a Spanish-language informational guide to educate Latinos about the U.S. health care system and medical insurance.1

**Practitioner-focused Interventions**

Many organizations offer or require cultural competence training for practitioners. Some develop their own training programs; some direct practitioners to publicly available resources, such as the online continuing medical education (CME) programs offered by the Office of Minority Health or American Academy of Family Physicians; some purchase proprietary training programs for their practitioners or work with specialists to develop customized training.

Health Partners and Kaiser Permanente have detailed programs to help health care providers deliver linguistically appropriate care; these are described in NCQA’s report on innovative practices. Some organizations provide detailed training in patient-focused communication strategies. Others provide resources to practitioners to help them work with diverse patients, such as L.A. Care’s multilingual patient-education materials for pediatric weight management (refer to Chapter 2). Some organizations that have collected data on race, ethnicity and language may be able to provide data and targeted feedback to their providers. Ideally, these data will provide practitioner-specific information about care processes (such as rates of testing or immunizations) and outcome (such as hemoglobin A1C [HbA1C] levels and blood pressure control), and reassure practitioners that differences can occur in care and outcome in the general population and in their own practices, as well.

If the organization does not have the data necessary to support its practitioners, it might facilitate the provision of data from other sources already in existence. Molina Healthcare of Michigan worked extensively with the Michigan Department of Community Health (MDCH) to provide patient-education histories to primary care physician’s offices. Physician offices were given free MDCH record audits and training sessions to assist in sustainable patient-level data collection as part of a project designed to increase the rates of childhood and adolescent immunizations among African American patients.

Another example from NCQA’s report on innovative practices highlights Blue Cross of California’s program to use disparity data to improve management of asthma among minorities. Health plan officials recognized that a key component of asthma management involves long-term controller medications, but use of these medications was low. To increase adherence, the Pharmacy and Quality Improvement Departments developed a...
point-of-service asthma pharmacy consultation program in which pharmacists were compensated for consulting with individuals who in the previous six months had filled prescriptions for three or more quick-relief medications, but only two or fewer long-term control medications. When such a patient came to the pharmacy, the pharmacist was prompted by an automatic “pop-up” notification to give a consultation and to log the transaction, or to provide a reason for not giving a consultation. When program evaluation results showed that eligible racial and ethnic minorities received fewer pharmacy consultations, pharmacies were shown this data and this disparity was subsequently reduced.

Teams of physicians, nurses, health assistants, other clinical and ancillary providers and front-office staff provide most health care, and organizations can apply to these teams many of the same interventions used with individual practitioners. Providing data on health care processes and outcomes and offering training and resources to support caring for a diverse population can be effective when offered in a team setting, where team members can discuss their different roles and how each can help meet patients’ needs.

### Provider Network Interventions

Provider network interventions include changes to the composition of the health care delivery system, such as hospitals, clinics, physician offices and ancillary services. Examples of provider network interventions include the following:

- Recruiting practitioners of the same race, ethnicity or language as patients can help meet the need for culturally sensitive care and language assistance; it is also likely to increase patient comfort and trust. Communicating to patients and members about the race, ethnicity and language skills of practitioners and their office staff can help patients choose practices where they feel comfortable. Some health plans have increased their networks to provide greater access to language- and culture-concordant providers; some offer provider directories in multiple languages or use directories to identify the language capabilities of the doctors and office staff.

CIGNA determined that its behavioral health care provider network was insufficient to meet the needs of its African American and Hispanic members, so it recruited African American and Hispanic practitioners to its network and developed a feature on its Web site where practitioners can introduce themselves. The site is searchable and displays photographs of the practitioners and information about their practice and staff and their practice style and treatment approach. This effort helps members to select a practitioner with whom they feel comfortable.

UnitedHealthcare responded to the needs and preferences of its Asian membership by enhancing its practitioner network, verifying language capability at the individual practitioner level and providing information for members on an in-language online directory. Through its efforts, the plan added 100 Asian practitioners in its Los Angeles HMO market, and estimates that over 90,000 members have accessed the in-language online and printed directories to find practitioners with language abilities and cultural backgrounds with which they are most comfortable.

UnitedHealthcare also maintains a Web site where practitioners can introduce themselves. The site is searchable and displays photographs of the practitioners and information about their practice and staff and their practice style and treatment approach. This effort helps members to select a practitioner with whom they feel comfortable.

### Community Interventions

A number of interventions are aimed at engaging whole communities in becoming healthier. Some community interventions focus on increasing public awareness of specific health issues through health fairs, screening events and public health information campaigns that are culturally and linguistically appropriate for certain populations.

In 2005, CareFirst BlueCross BlueShield of Maryland launched several community partnerships to reduce various disparities existing in the community, with its Closing the Gaps programs. In its Hair, Heart and Health initiative, the plan recognized that coronary heart disease (CHD) is a leading cause of death in African Americans. Members in this population have a higher prevalence of CHD risk factors such as hypertension and diabetes. Working with the University of Maryland School of Medicine, CareFirst launched a cardiovascular health education and screening program for African Americans in which outreach workers, barbers and hair stylists were trained to provide heart-healthy education and blood pressure screenings in Baltimore.

Keystone Mercy Health Plan and the Healthy Hoops Coalition created Healthy Hoops, a community-based asthma education basketball program. Using basketball as a platform, Healthy Hoops teaches participants (both children and families) how to manage asthma through appropriate medications, proper nutrition, monitored exercise and recreational activities. The goals of Healthy Hoops are to educate and reinforce asthma management and to provide asthma professional development to school nurses, community nurses, gym and health instructors and coaches.

Some community interventions are intended to provide better integration between the community being served and the organization. These interventions may include integrating community members into planning and evaluating organizational efforts; conducting surveys and focus groups; bringing information to community groups and seeking their feedback; and otherwise going directly to the served community to learn how to better meet its needs.
Health Care Organization Interventions

Health care organizations never intentionally promote health care disparities, nevertheless, how they are structured and the policies and procedures they follow sometimes reflect hidden biases that result in differential care. Some barriers to care are relatively obvious, such as lack of interpreters or translated materials for limited English-proficient individuals, while others are less conspicuous. The U.S. health care system is complicated to navigate, regardless of one’s ethnic background or English language abilities, thus posing another barrier that is sometimes overlooked. Navigating a health plan’s networks, understanding the plan’s rules and management policies, getting referrals to and coordinating with various specialists—these can be complicated ventures even for native English speakers.

Organizations with strong information system resources may be able to enhance decision support systems available to practitioners by building prompts and reminders for practitioners related to preventive or follow up care. In the example mentioned before, Blue Cross of California was able to provide a real-time prompt to pharmacists for patients who filled a prescription for asthma rescue medicine after too few controller medications had been dispensed. Data collected from the consultation transaction database—including reasons why pharmacists did not perform consultations—were compared to pharmacy records with members’ self-reported race/ethnicity to show that eligible racial and ethnic minorities received fewer pharmacy consultations even though pharmacists were unaware of the disparity.

Other health care organizations use decision support systems to conduct targeted outreach for missed or delayed routine screening, prevention or follow up care. Aetna has a culturally sensitive breast cancer screening initiative for African American and Latino women that it uses to encourage mammography screening among these members.

Health plans may be able to reduce disparities by reducing or eliminating copayments for certain preventive care services or by eliminating referral or prior authorization requirements for specific types of care, when these procedures are identified as significant barriers to care for certain populations. Some health plans offer incentives to patients instead. In its Shots for Shorties program, Molina Healthcare of Michigan offered free baby portraits to families that brought a child’s immunizations up to date by the child’s second birthday. Other organizations are implementing pay-for-performance (P4P) programs for providers that improve care.

REFERENCES
Chapter 4  Evaluation

After assessing the organization, identifying its needs and planning and implementing a program to improve care for diverse populations, some health care organizations may be tempted to assume the program works as intended and is producing the desired results. For this reason, evaluation is sometimes an afterthought, particularly if the need for the intervention was obvious and success was a foregone conclusion. Investing in an evaluation can be difficult if the resources might otherwise be used to sustain the existing program.

Despite this, evaluating programs that reduce racial and ethnic disparities in health care is critical to understanding the extent of their success. QI teams regularly make decisions about a program, even if the default decision is to continue existing efforts without significant change. Decisions are strongest when informed by accurate information about a program, how it is running and its success to date.

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Chapter 4 Evaluation

What An Evaluation Can Tell You
An evaluation can help answer three important groups of questions:

1. How well is the program running?
   • Is it being implemented as planned?
   • Do staff contribute as intended?
   • Is it running efficiently?

These questions focus on the program's processes and are generally the easiest to answer, largely because the QI team knows what it has done and what resources have been used.

2. Is the program successful?
   • Is it having the desired results?
   • Should it be continued?
   • Is it running efficiently?

While it may appear that these questions can be answered with a simple “yes” or “no,” in practice the answers may be more nuanced.

3. What factors contribute to the program's success?
   • What are its strengths and weaknesses?
   • What aspects should be continued or enhanced, or what additions are needed?
   • What should be discontinued or deemphasized?

These questions can be more difficult to answer but are important to understanding why the program works as it does. Without this information, it is difficult to know which aspects of the program need continued investment and what is required to adapt the program for use in other areas.

Decide What Outcomes to Measure
One of the most important decisions is what program results to evaluate. A clear consensus on what questions the evaluation seeks to answer and expectations about how evaluation findings will be used helps to ensure that the evaluation’s design will produce useful results. It helps to begin with the desired results stated at the beginning of the program.

A good evaluation includes a variety of measures that can be supported with available data. These measures may be related to the desired program results in obvious ways. For example, the desired result of an immunization campaign is to ensure that all two-year-olds have been immunized appropriately. In this case, the measure is the percentage of children who are older than 24 months and who have all the recommended immunizations, including those for measles, mumps and rubella (MMR) and chicken pox (VZV).

Conversely, measures may be less directly related to desired outcomes. A desired result of a diabetes program, for example, may be to reduce rates of blindness and amputation. These are long-term negative outcomes of poor diabetic care, but the QI team and sponsors may not want to wait 10 or 20 years to discover whether their program is successful based on these criteria. Since good blood sugar control now, as measured by HbA1c levels, has been shown in research studies to lower the rates of blindness and amputation, one measure for such a program might be the percentage of all patients with diabetes whose HbA1c levels are less than 7%.

All measures are not equal, and some have more desirable qualities than others. The National Quality Measures Clearinghouse of the federal Department of Health and Human Services, describes three groups of desirable qualities for measures, including the importance of the measure, scientific soundness and feasibility.

Importance of the Measure
- How relevant is the measure to various stakeholders (e.g., program managers, clinicians, patients)?
- How important is the measure for patients’ health?
- To what extent is the measure related to a factor the program can influence?
- Can the measure be used to understand racial and ethnic disparities in health care?

Scientific Soundness
- Is the measure reliable? That is, will different evaluators making the same measurement get the same answer?
- Is the measure valid? That is, does it measure what it says it does?
- Should the measure be adjusted to account for patient-specific factors, such as the level of illness? If patients of the North End clinic, for example, have multiple, complex health conditions and the patients of the North End clinic are relatively healthier and younger, then comparing the health outcomes of the two groups would be unfair. Statistical techniques help adjust for these differences between large groups of patients.

When evaluating programs on racial and ethnic disparities, measures should be equally sound for all racial and ethnic groups involved. For example, health care organizations often use surveys to understand patients’ experiences with care and levels of satisfaction. Such surveys should be reliable and valid for all racial and ethnic groups being surveyed so that the questions have the same meaning for each group. Any translation should accurately convey the meaning of the questions being asked, since word-for-word translations may produce undesirable results (e.g., “coping” for “co-payment”, “day program for lunatics” for “behavioral health workshop”).

Feasibility
- Is the description of the measure specific enough so that an evaluator can calculate it?
- Are the numerator and denominator defined clearly enough so that evaluators can count both, and so multiple evaluators counting the same numbers will get the same answers?

For example, a measure such as “the percentage of all children who are immunized” could be difficult to measure because different individuals may have different definitions for what constitutes “immunized” or may consider children of different ages. Making the definition specific, such as “the percentage of children in the program who have received three doses of DTaP [diphtheria, tetanus and pertussis] immunization by their first birthday,” improves the feasibility and reliability of the measure.

What Measures Tell You About a Program
Good measures can help the QI team understand different aspects of a program and its success. Figure 1 shows one way of understanding what different measures describe.

An organization could be interested in quantity or quality, and in its efforts or the effects they achieve. Measuring the quantity of effort answers the question, “How much did we do?” while measuring the quality of effort addresses, “How well did we do it?” Both questions address how well the program is running.
Chapter 4: Evaluation

Examples of “How much did we do?” measures:
- Number of prescriptions written
- Number of patients seen
- Hours spent on the program
- Number of presentations made to potential program participants
- Money spent
- Any other measures of effort that can be counted in a simple, straightforward way

Examples of “How well did we do it?” measures:
- Measures of efficiency such as unit costs
- Staff measures, such as turnover, staff-to-participant ratio or staff confidence using new program materials
- Wait-time for entering the program
- Activity-specific measures, such as the number or percentage of patients who feel their health has improved
- Receipt of services (such as percentage of program participants who report improved knowledge of self-care)
- Changes in attitude (e.g., finding self-care easier, less burdensome, less embarrassing)
- Change in behavior (e.g., changing diet or exercise patterns) or in clinical outcome
- Number or percentage of patients who feel their quality of life has improved

GETTING STARTED
As a practical matter, measures that have already been developed and tested and are widely accepted are likely to have many of these qualities. While they will not meet all measurement needs for any program evaluation, they are a good place to start—especially if the evaluation involves measuring the quality of clinical care. Some good sources for these types of measures are the following:
- NCQA HEDIS measures (http://www.qualitymeasures.ahrq.gov/)
- The National Hospital Quality Measures (http://www.qualityforum.org)
- The National Quality Measures Clearinghouse (http://www.qualitymeasures.ahrq.gov/)
- NCQA HEDIS measures (http://www.qualitymeasures.ahrq.gov/)
- The National Quality Forum (http://www.qualityforum.org)

Evaluating the quantity and quality of a program’s effects helps answer, “Is anyone better off?” Answering this question addresses the program’s success—getting to the heart of why organizations run disparity-reduction programs and asking whether things are improving. Organizations can use these measures to understand whether disparities are being reduced as a result of the program’s efforts, such as whether there is a reduction in disparities between Latino and White patients in self-care knowledge.

Examples of “Is anyone better off?” measures:
- Changes in attitude (e.g., finding self-care easier, less burdensome, less embarrassing)
- Change in behavior (e.g., changing diet or exercise patterns) or in clinical outcome
- Number or percentage of patients who feel their health has improved

Generally, it is easiest (and often least important) to measure how much was done, and hardest (but often most important) to measure whether anyone is better off.

Working with Data
Identifying Good Data Sources
Good measures are useless if there are no data to support them, and the best-designed evaluation goes nowhere without data that answer the key questions. Data must also be accessible to the evaluators. Data cannot support the evaluation if the cost of making them available is prohibitive, if data cannot be shared due to confidentiality concerns or if data are not available in a timely manner.

Identifying Available Data
When deciding what data will support an evaluation, the QI team can start by taking an inventory of data that are already available. Minimizing new data collection minimizes the cost of conducting the evaluation, but existing data may not be adequate to answer all of the evaluation’s questions. The team should conduct an assessment of data availability and information system capabilities before starting the evaluation.

Qualitative data can be useful when conducting an evaluation. These data can include information from focus groups, interviews with people involved with the program, including staff, clinicians and patients or observational data such as tracking of workflow. The information can help the QI team understand the factors that contributed to the program’s success, the program’s strengths and weaknesses and how the program could be improved.

Evaluating Changes in Disparities
Determine Which Racial and Ethnic Groups Should Be Compared
In evaluating a program designed to reduce racial and ethnic disparities in health care, it is important to understand the source of the data on patients’ race and ethnicity, as discussed in Chapter 1: Assessment.

Ideally, all racial and ethnic groups included in the program should be compared in the evaluation, but in practice there may be too few individuals in some groups to make statistically valid comparisons. In this case, for example, smaller groups of Chinese, Hmong or Vietnamese patients may need to be combined into larger groups such as “Asian.”

Compare all Groups to the Highest Performing Group
When assessing changes in disparity over time, racial and ethnic minority patients are frequently compared against White patients. A better approach involves comparing all groups against the most advantaged group.

Measure Changes Over Time for Each Individual Group and Changes in Gaps among Different Groups
When evaluating disparity-reduction efforts, one question that often arises is whether to measure reductions in disparities among two or more racial or ethnic groups or whether to measure improvements in quality for the most disadvantaged groups. This question is relevant because changes in disparities can follow many trajectories over time. While the typical expectation is that disparities are likely to decrease as quality improves, this may not be true in all situations.

If quality improves for all groups as a result of a given program, disparities can remain constant—or even increase—if improvement happens as quickly, or more quickly, for the most advantaged groups. As a result, it may be better to measure changes over time for each group and changes in gaps among different groups. Measuring both also helps ensure that disparities do not appear to shrink solely due to decreasing quality of care provided to the most advantaged group.
Chapter 4  Evaluation

Make the Evaluation Useful
When considering how rigorous the design of the evaluation should be and how much to invest in conducting the evaluation, consider three key points. First, do not let the perfect be the enemy of the good. It is possible to design an extraordinarily rigorous evaluation worthy of publication in a top-tier academic journal that does not provide any of the basic information decision makers need to move forward with a program. A practical approach that uses readily available data and simpler analytic techniques may yield more useful information, and in many cases, may be less expensive and faster. Remember, the goal of a practical evaluation is to answer questions such as:

- How well is the program running?
- Is it successful?
- What factors contribute to its success?
- Should the program be continued or changed?
- Is the quality of care for minority patients improving?
- Are disparities decreasing?

These questions do not require advanced statistical techniques or complex study designs to develop useful, actionable information that staff and leadership can use when making decisions about the program.

Second, it is important to understand what evaluation questions the available data will answer. The best evaluation design cannot compensate for a lack of data. The most practical evaluation will result from maximizing the use of available data and supplementing that information with additional data collection where needed.

Finally, it is important not to put the evaluation results on the shelf once the work is finished. Sharing results with the QI team, sponsors, individuals and coalitions that support (or object to) the program can help advance dialogue and decision making about the program and similar, future efforts. Sharing results can give more detailed feedback and perspective about why results look the way they do and engage leadership and staff in making necessary program changes to improve performance.

Evaluation conducted after implementing the entire initiative is different from smaller evaluations performed throughout planning and implementing each small test of change. The QI team can use the latter to modify and mitigate risk, and learn about changes that should be made before moving forward. The final program evaluation lets the QI team measure the success of the program as a whole and ensure that it is accomplishing the goals set at the beginning of the initiative.

Evaluation Examples
The following initiatives and evaluations are taking place in various health care organizations.

Example 1

Disparities topic: Improving asthma care for African American and Latino children
Evaluation issue: Measuring patient outcomes—Is anyone better off?

Nationally, asthma poses a significant challenge for African American and Latino populations. In southeastern Pennsylvania, 16.2 percent of African Americans and 17.7 percent of Latino children have asthma, compared with only 6.7 percent of White children.

To improve care to this disproportionately affected population, Keystone Mercy Health Plan, a winner of NCQA’s 2006 Recognizing Innovation in Multicultural Health Care Awards, designed the Healthy Hoops program to use basketball as a platform to teach children and their families how to manage asthma more effectively. Program goals were to reduce emergency room (ER) visits and hospital admissions, increase the use of appropriate medications, educate families about asthma management, and integrate fitness into a comprehensive asthma management program for children and families.

Healthy Hoops included a kick-off program with professional basketball coaches, asthma screenings and education programs, basketball clinics and environmental assessments of participants’ homes to identify asthma triggers and family fitness programs. The program focused on African American and Latino children in West Philadelphia.

The Healthy Hoops evaluation approach focuses on measures that help answer the question “is anyone better off?” [See Figure 1] Staff showed that the program lead to the following improvements:

- A decrease in the proportion of children waking at night because of their asthma
- A 35 percent reduction in weekly use of rescue medications and a substantial increase in the proportion of children using regular controller therapies

Example 2

Disparities topic: Language services
Evaluation issue: Tracking a small number of measures across facilities

Speaking Together: National Language Services Network is a national program funded by the Robert Wood Johnson Foundation that aims to improve how hospitals provide language services to patients with limited English proficiency. A learning collaborative of 10 hospitals nationwide shares strategies for improving the quality and availability of language services and for assessing different approaches. Speaking Together uses QI techniques to improve hospital-based language services.

With 10 separate sites involved and many different activities at each site, evaluating this project poses a significant challenge. The George Washington University Department of Health Policy, which runs Speaking Together, developed a set of measures to allow the hospitals to examine how they communicate with non-English-speaking patients and focus attention on how hospital staff can structure and manage language services programs for effective, efficient and timely communication with patients with limited English proficiency.

To develop these measures, Speaking Together used a nine-stage process that included reviewing research literature, interviewing...
experts and getting feedback on a set of draft measures from people who were likely to use them on a day-to-day basis. They also field-tested the measures to understand how feasible data collection would be, including challenges and barriers to data collection, and to identify useful data reporting formats.

The five measures in this project answer, “How well are we doing?” [See Figure 1]

- The percentage of patients screened for their preferred spoken language
- The percentage of patients with limited English proficiency who received an initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers assessed for language proficiency
- The percentage of encounters when patient wait-time for an interpreter is 15 minutes or less
- The percentage of time that interpreters spend providing medical interpretation in clinical encounters with patients
- The percentage of encounters where interpreters wait 10 minutes or longer to provide interpreter services to provider and patient

While tracking such a small number of measures may seem simple, there were considerable challenges to implementing these measures in multiple facilities. Marsha Regenstein, PhD, the director of Speaking Together, reports that it took four to five months for the hospitals to become familiar with data collection. To get ready to collect data for these five measures, hospitals needed to become familiar with the measures, revise existing data systems and develop new systems to collect data.

Some measures required a fundamental change in what hospitals’ Interpreter Services Departments thought about high performance in this area.

Dr. Regenstein notes, “Speaking Together hospitals were required to account for each limited English proficiency patient who came for care, and identify whether they received appropriate language services—from a trained medical interpreter or through the direct use of a bilingual provider whose language proficiency has been assessed—at two strategic points in the inpatient stay or outpatient visit. That process required completely new data collection systems and techniques to document whether patients who say they prefer care in another language actually receive it. Documenting whether limited English proficiency patients get care that comes with adequate communication should be among the most important factors that hospitals look for when they think about the quality of their language services programs.”

For more information on Speaking Together, go to www.speakingtogether.org.

Example 3

Disparities topic: Navigator programs to support patients with cancer
Evaluation issue: Defining the evaluation should answer

Patient navigator programs use lay professionals to help patients and their families manage cancer diagnoses and overcome common barriers to obtaining timely and appropriate cancer care and treatment. These programs work on the assumption that having a well-trained coach available throughout treatment from the time abnormal test results are reported would help improve patients’ health outcomes and their experiences with care. Navigators can help by teaching patients and family members how to work through the phone calls, documents and appointments that accompany a cancer diagnosis. They can also help patients deal with the emotions involved and teach them how to communicate more effectively with their providers. In many cases, these programs are targeted toward patients from racial or ethnic minority groups, those with lower incomes or other groups that may experience health care disparities.

While navigator programs are generally believed to help, little work has been done to evaluate their effectiveness. As a result, in 2005, the National Cancer Institute funded the study of eight different navigator programs for five years. While each program uses its own approach to evaluation, all are organized around a core group of questions the Institute has set out to answer.

- How well did the patient navigator program help patients coordinate services? For example, did the program help overcome access barriers for patients, such as financial difficulties and lack of information?
- Does the program help provide more timely access to high-quality cancer care for all patients?
- Does having a patient navigator who is the same race, ethnicity or gender, or one fluent in the patient’s primary language, help patients adhere to treatment recommendations or affect patients’ satisfaction with the health care system?
- How cost-effective are patient navigator programs? Do they meet the goals of providing patient support, eliminating access barriers and improving the timely delivery of high-quality care?

By clearly defining these questions to be answered, the Institute has provided significant guidance in how to design the evaluations. One of the Institute’s evaluation programs is at the University of Rochester, in Rochester, New York. This program, directed by Kevin Fiscella, MD, MPH, is designed to determine whether having a trained navigator shortens the time between an abnormal test result and a definitive diagnosis, and whether the navigation improves adherence to treatment recommendations, the ability to talk to the doctor, patient satisfaction with care and quality of life. Although his research project will address the experiences of all patients with abnormal colon cancer results, a key question is whether members of underserved populations derive a greater benefit from patient navigators.

Dr. Fiscella points out the importance of having a clearly defined evaluation question before the efforts begin, and how it helps shape the evaluation effort. At the same time, his comments highlight some of the challenges that even large evaluation efforts face.

“We initially proposed to examine whether patients at greater need/risk derive greater benefit from navigation than those with less needs/risk. To address this question, we will collect patients’ socioeconomic status [multiple measures], self-identified race and ethnicity, and health literacy along with assessments of their satisfaction with care, activation, health status, and quality of care [for those with cancer]. Focus on this aim has also forced us to think carefully about how relationships between navigators and patients evolve over time and how this continuous relationship impacts care. While some patient needs, such as transportation, housing, or insurance, can be addressed in one or two sessions, other needs, such as fear of procedures, mistrust, and reluctance to ask their physician questions, require coaching in the context of a longitudinal relationship between the patient and their navigator. We recognize that quantitative data alone, how detailed they are, would not fully capture the work of the navigators. As a result, we have begun collecting qualitative data from both patients and navigators. For example, we now conduct semi-structured exit interviews with all patients to better understand their health care experience, whether navigated or not. We will also be collecting patient-specific narratives [interviews from navigators to better understand exactly how navigators work with patients over time].”

For more information on the National Cancer Institute’s Patient Navigation Research Program, see http://crchd.cancer.gov/pnp/pnrp-index.html.


**Example 4**

| Disparities topic: Reducing disparities in diabetes care |
| Evaluation issue: Evaluation questions and sample measures |

**“Improving Diabetes Care” (IDC)**

Consider a hypothetical disease management program called Improving Diabetes Care (IDC), designed to improve care and reduce disparities for patients with diabetes. The QI team works with patients in two clinics: South Street and North End.

This program may have multiple desired results, such as:

1. Improving the frequency of HbA1c testing
2. Improving blood sugar control
3. Reducing disparities between Latino and White patients in both areas

The QI team needs to make decisions about many issues, such as:

- Whether to continue the IDC
- Whether to hire more telephone outreach nurses to encourage patients to participate
- Whether these nurses should be bilingual (English and Spanish)
- Whether to add group education classes on diabetic nutrition or additional one-on-one counseling with dieticians
- Whether to continue a community-based component of the program that conducts outreach to parents of school children

An evaluation can help answer these questions.

**Evaluation Questions**

1. **How Well is the Program Running?**
   - For the IDC program, the QI team may want to know:
     - The amount of time spent staffing the telephone outreach component
     - Whether the phone numbers in the patient database are accurate
     - Whether language information in the data-base is accurate so that Spanish-speaking patients receive their first telephone call from a Spanish-speaking nurse

2. **Is the Program Successful?**
   - In the IDC program, some results may be achieved more readily than others.
     - The program could be successful at improving HbA1c testing rates because the outreach nurses are skilled at convincing patients of the need for such testing, but the program might have difficulty with the more complex task of helping patients improve their blood sugar control.
     - The program could be successful for one group of patients but not another. Processes could improve for both groups, but disparities could remain unchanged.
     - The program could be successful, but at too high a cost to continue.

3. **What Factors Contribute to the Program’s Success?**
   - For the IDC program, involvement of a physician champion or the availability of outreach workers in the evening might be critical to success, while mailing letters to encourage patients to come in for blood tests might yield little benefit.

In addition, the QI team and sponsors of the IDC program might want to understand why the program was more successful for Latino patients, whether having educational materials translated into Spanish helped achieve the program’s goals and whether additional translated materials would be useful.

For another program involving group visits for African American patients for asthma care, the QI team might want to understand why having extended hours three nights a week did not increase attendance, including whether transportation, the race of the nurse conducting the group visits or lack of child care were contributing factors. Without such information, it is difficult to know how to modify the program.

**What is the Average Number of Visits to Diabetes Case Manager Per Patient Enrolled in the IDC Program?**

**Type of Measure**
- How much did we do?

**Is the Measure Important?**
- This measure is primarily important to the QI team and the diabetes case manager for planning future budgets, staffing levels and patient outreach activities.

**Is the Measure Scientifically Sound?**
- The measure is likely to be reliable, since different clinic staff members can count the number of visits and come up with the same answer. It is valid, since the visit count provides accurate information on the actual number of visits. It can be adjusted for patient-specific factors, such as how long a patient has had diabetes and the value of the patient’s last HbA1c test.

**Is the Measure Feasible?**
- The measure is very clearly specified by two numbers: the total number of visits and the total number of patients in the program.

**Are the Data Available?**

**Where Will They Come From?**
- The South Street clinic uses an electronic medical record (EMR) that can easily identify all patient visits to the case manager in a way that can be easily searched. A simple query of the system provides the needed data.

The North End clinic is a different story. It uses paper charts, so a staff member must pull the charts of all diabetic patients and look through each one to count the number of visits each patient had. It helps that the clinic has a list of all diabetic patients, prepared for the DM company, so at least it knows which charts to pull.

**Overall Assessment**
- This is a good measure for program planning and management. It does not provide information about patients’ health.

**How Much Did Patients’ Understanding of Diabetes and How to Care for Themselves Increase After the IDC Ran its Educational Program?**
- This is measured using the Summary of Diabetes Self-Care Activity measure, a widely-accepted, well-tested scale of diabetes knowledge that asks patients to answer 25 questions.

**Type of Measure**
- How well did we do it?

**Is the Measure Important?**
- Since improving patients’ understanding of diabetes and good self-care is important for optimal health outcomes, this measure is likely to be important to many stakeholders, especially clinicians and patients.

**Is the Measure Scientifically Sound?**
- The measure’s scientific soundness depends on the scale being used. When adopting measurement tools that were developed...
elsewhere, it is best to see if research has been done to ensure their reliability and validity. This type of measure can be adjusted for patient-specific factors. For a program such as the IDC, which aims to reduce disparities between Latino and White patients, it is important that the questions are accurately translated and meaningful to Latino patients in the program.

**Is the Measure Feasible?**

This measure needs clarification before it is feasible to implement. For example, a clearer specification of this measure might read:

[Patient’s score after educational program — Patient’s score before educational program] summed for all patients and divided by the total number of patients participating in the educational program. This shows the average number of points the scale increased.

Alternatively, it could be specified as:

[Patient’s score after educational program — Patient’s score before educational program] summed for all patients and divided by the average score for all patients before the program. This shows the average percentage increase in the scale.

It would help to specify when the two questionnaires should be completed. For example, the first questionnaire might be completed at the first IDC visit, whether that is a group educational class or a one-on-one appointment with a clinician. The second might be conducted at the first IDC visit and the second should be conducted at the eight-month IDC check-in visit.

**Are the Data Available? Where Will They Come From?**

This type of measure requires new data collection—asking patients to complete the questionnaire before and after the educational component of the program.

**Overall Assessment**

This measure can be helpful for assessing the effectiveness of the educational component of the IDC program.

**How Much Did Patients’ Blood Sugar Control Improve as Measured by the HbA1c Blood Test?**

**Type of Measure**

Is anyone better off?

**Is the Measure Feasible?**

Some clarification would help regarding how many HbA1c tests will be compared when they should happen. For example, the measure could note that two HbA1c tests will be compared. The first should be conducted at the first IDC visit and the second should be conducted at the eight-month IDC check-in visit.

**Are the Data Available? Where Will They Come From?**

HbA1c values are available from lab tests. The South Street clinic uses an EMR system that can easily identify all lab test results; a simple query of the system will provide the needed data. The North End clinic’s paper records can easily identify all lab test results; a simple query of the system will provide the needed data. The North End clinic’s paper records make this more challenging. A staff member must pull the charts of all diabetic patients and look through each one to get lab test values.

**Overall Assessment**

This measure is likely to be very helpful for assessing the program’s overall impact.

**Compare All Groups to the Highest Performing Group**

If the IDC program includes Whites, Asians, Latinos and African Americans, and data show that Asians had the greatest reduction in blood sugar levels, all groups should be compared against Asians. Doing so ensures that comparisons are always made against the top-performing group.

**Measure Changes Over Time for Each Individual Group and Changes in Gaps Among Different Groups**

1. Proportion of White patients receiving HbA1c tests in the correct time period
2. Proportion of Latino patients receiving HbA1c tests in the correct time period
3. The gap between White and Latino patients receiving HbA1c tests in the correct time period
4. Changes in blood sugar control for White patients
5. Changes in blood sugar control for Latino patients
6. The gap in changes in blood sugar control between White and Latino patients

**REFERENCES**

3. This figure comes from Friedman, M., Trying Hard Is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities, 2005, Victoria BC: Trafford.
In 2000, the federal Department of Health and Human Services (HHS) set forth its 2010 Objectives and established goals for the elimination of racial and ethnic disparities in health care. In these objectives, it identified six major areas of concern: cancer; cardiovascular disease; infant mortality; diabetes; HIV/AIDS; and child and adult immunizations. To date, there has been little change in these indicators of illness and death. We hope that this Guide will help organizations as they take steps toward reducing disparities within the populations they serve and, in this way, contribute to the goals set forth by the 2010 Objectives.

As shown in the preceding chapters, the QI process for improving CLAS and reducing disparities in health care follows a pattern that has become common in health care organizations. As more organizations have adopted QI programs, they have followed a course similar to that outlined in Chapters 1–4 of this Guide.

1. Assessment
2. Planning
3. Implementation
4. Evaluation

This approach follows the basic steps of the QI process. As this Guide suggests, the organization begins the process of minimizing disparities by first assessing the problem (Chapter 1: Assessment) and identifying gaps in cultural and linguistic competence. Are there gaps among the staff, or among providers, programs or services—or in each of these areas? How wide is the gap between providing “ideal” care and care that the organization currently delivers? Does the organization reach all patients, members or clients that it could reach or has it disenfranchised members of certain minority groups because it fails to address their needs in a culturally and linguistically appropriate manner? A thorough assessment that considers the opinions of stakeholders within the organization and outside the organization will help QI teams identify gaps.

Now the QI team can plan an appropriate response to the problem. As detailed in Chapter 2: Planning, this part of the process may be the most challenging because it involves pinpointing a problem’s root cause. During the Assessment Phase, the QI team assessed the lack of cultural and linguistic competence, but if it failed to identify the root causes, the organization may need to collect and analyze more data. Only after root causes have been recognized can potential solutions to problems be identified and the intervention properly planned.

Once the root causes are recognized and possible solutions identified, the organization can work on implementing interventions (Chapter 3: Implementation). The organization must develop different interventions to address different problems, and many problems will require multiple interventions. Interventions may be directed at problems that involve the system, individual practitioners, staff, patients, the community—or a combination of these. Perhaps the gaps in delivering culturally competent care will require a series of interventions. This Guide accounts for such scenarios by preparing the organization for small tests of change, evaluating the results and conducting more small tests. After each test, the QI team analyzes the results and refines its process.

If analyzing results of the individual components of an intervention is necessary to develop a solution, evaluating the full set of interventions (Chapter 4: Evaluation) is critical to understanding the intervention’s level of success. Decisions about programs to improve culturally and linguistically appropriate care and to reduce disparities are best made when informed by accurate information about the program, how it is running and its success to date. In other words, as data on results are routinely gathered, analyses are updated and new changes are introduced.

Ideally, the end result of efforts to improve the provision of cultural competent care and language services and to reduce disparities is a continuous cycle of quality improvement. Organizations that undertake this approach are making a great start. Even small changes made now will add up and contribute to more patient-focused, responsive and higher quality care for diverse populations.