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Bringing Equity into QI: Practical Steps for Undertaking Improvement

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PREPARED BY:

AUTHORS

Angela Marks, MSEd[*];
Marsha Regenstein, PhD[†];
Patricia Heinrich, MSN[‡]; and
Sunita Mutha, MD[§]

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Refer to Part 1 of this guide, Bringing Equity into Quality Improvement: An Overview and Opportunities Ahead, to read acknowledgements for this two-part guide and for more information about ACTION and Center for the Health Professions.

* Center for the Health Professions, University of California, San Francisco
† The George Washington University Medical Center, School of Public Health and Health Services
‡ Independent Quality Improvement Consultant
§ Department of Medicine and Center for the Health Professions, University of California, San Francisco

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“Knowledge is a treasure, but practice is the key to it.”

—Lao Tzu

The roots of health care disparities are complex and therefore multifaceted, patient-centered solutions are required to improve care. Making changes to improve equity is a critical, but challenging endeavor. The intent of this guide is to offer practical information for organizations to augment their quality improvement (QI) efforts in ways that will allow them to improve quality and equity of care.

This guide uses the framework of the Model for Improvement.[1] The recommendations and guidelines are substantially informed by experiences and lessons learned from the ACTION and Speaking Together programs which are described in detail in part one of this guide. The improvement efforts from these two programs encompass a range of organization type (health plans, hospital systems, and community clinics), clinical conditions and patient populations. As a result, the practical information contained here is relevant for a broad array of improvement initiatives.

ACTION PROGRAM, CENTER FOR THE HEALTH PROFESSION, UCSF

Twenty California organizations, chosen through a competitive application process, received funding to catalyze their efforts to improve equitable care for a range of clinical conditions. Using the Model for Improvement framework, the organizations undertook a 12-month QI process and received technical assistance. ACTION was funded by The California Endowment.

SPEAKING TOGETHER: NATIONAL LANGUAGE SERVICES NETWORK

Ten hospitals across the U.S. participated in this 18-month learning collaborative, funded by the Robert Wood Johnson Foundation, aimed at using QI practices to improving the delivery of language services and reduce health care disparities.

Improving equity in care is challenging work and requires time and commitment; the good news is that there are many QI tools and approaches to use and learn from. We strongly encourage you to start your efforts by gathering existing tools and information and evaluate if they need to be adapted to your organization and your improvement effort. This approach is reinforced throughout this guide.

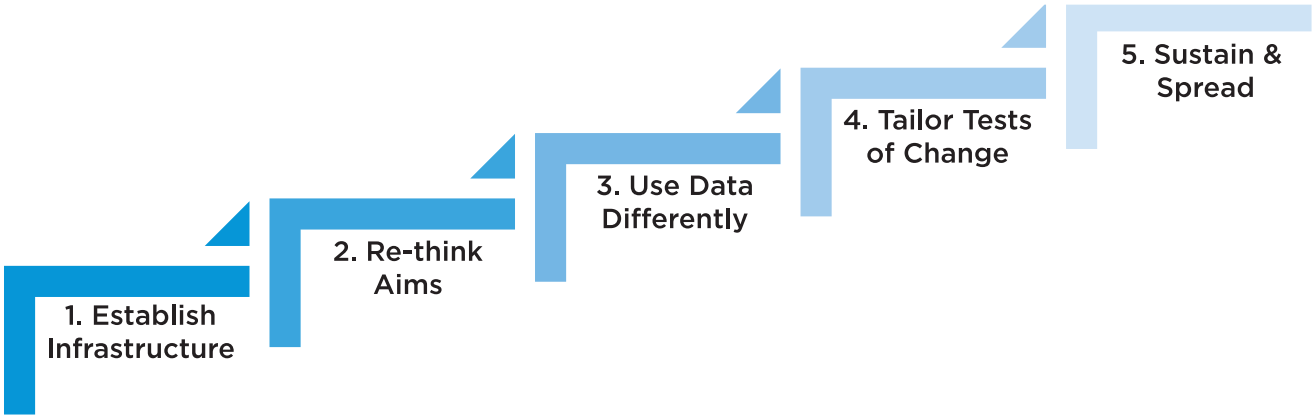
Find useful tools and examples here:

Advancing Health Equity
http://www.advancinghealthequity.org/

Institute for Healthcare Improvement
http://www.ihi.org/

Figure 1 on the following page depicts the 5 building blocks necessary for undertaking equity focused quality improvement. Each building block highlights the mix of tools, supports and knowledge needed to set the stage for the next step and to achieve reductions in health disparities.

Figure 1: Building Blocks for Equity Focused QI



STEP 1: ESTABLISH INFRASTRUCTURE

Improving equity requires the integration of new elements into traditional QI and a solid infrastructure to support and reinforce the added complexities (e.g., stratifying data, tailoring interventions) that are an essential part of reducing inequalities in care. The lack of an established foundation in quality improvement should not preclude your organization from tackling equity improvement activities. In fact, taking steps to address equity can be done in concert with overall QI capacity building.

Human Capital

As with all quality improvement efforts, the strength and effectiveness of a project team and the individuals making up the team are highly predictive of a project's success. At its core, QI focused on equity is about improving care using established tools and approaches and monitoring data to track progress over time. The first step is to bring together a team with a breadth of roles and expertise, including knowledge of clinical care, organizational systems and the population being served. The next steps are to clarify roles and responsibilities of team members and to hold members accountable for their input and contributions. The attributes of an effective team would include:

- **Quality improvement expertise –** Include at least one team member with a strong foundation in improvement approaches such as rapid cycle change. Having knowledge of QI fundamentals will help ensure the changes the team tries and tests result in better care and reduced disparities. Teams that lack QI knowledge often experience substantial challenges in establishing aims and in identifying and testing evidence-guided improvements. They also can stumble in implementing and testing the impact of the changes which leads to difficulty ascertaining whether the changes have resulted in improved equity.
- **Understanding the cultural, contextual, and community-related factors –** Ideally, individuals with QI knowledge will be paired with one or more team members knowledgeable about linguistic and culturally appropriate care to ground and guide the changes that are tested. These individuals bring an understanding of the cultural, contextual, and community-related factors for the population(s) of focus. For example, an initiative to improve breast cancer screening rates among Spanish-speaking patients

could include team members who understand how to effectively use interpreters, are able to communicate in Spanish, or understand the cultural and health beliefs of the target population. A team that does not have knowledge and understanding of the target population may develop interventions that are not culturally relevant for their patients and therefore do not achieve the intended results.

- **Proclivity for data and measurement –** Data driven decision-making is at the core of any QI effort. It is therefore essential to have a team member who is comfortable working with data and communicating results. It is also helpful if this person understands how to stratify quality measures by patient characteristics such as race/ethnicity or language. The ability to access demographic data and indicators of quality care are critical for this undertaking. That need may be best addressed by engaging health information technology (IT) staff to help formulate a plan for identifying and collecting the necessary information. Many organizations find that linking data from multiple systems is less challenging than anticipated and once reporting templates are created data can be reviewed on a regular (e.g., weekly or monthly) basis to monitor improvement over time. Tools to help with this process can be found in Appendices C and D.
- **Active clinical champions –** Include a clinician on the team who is an enthusiastic advocate, engaged in the process, and dedicated to advancing equity. Many efforts require some change in clinician behavior (e.g., integrating the "teach back" method to improve patient understanding of the care plan) which may require training or changes in workflow to be able to achieve the desired result. The champion helps promote buy-in and provides additional support and guidance to the project team around the testing, diffusion and implementation of changes. Another health care professional (e.g., a medical assistant) often serves as the day-to-day leader responsible for ensuring all project activities (e.g., new workflows, data collection, testing changes) are occurring correctly and in a timely manner. The day-to-day leader is critical for making progress toward the desired aim. Many organizations use a clinical champion as a liaison between the senior leadership and the project team to assure that there is good communication and alignment between strategic goals and improvement efforts.
- **Representation of staff –** Include team members who represent all levels of staff affected by the improvement effort. Given that all staff play an important role in the delivery of high quality, equitable care, the inclusion of an array of staff adds an invaluable perspective to improvement efforts. For example, registrars and medical assistants are frequently the first staff with whom patients interact. They can provide important insight into patients' communication needs and cultural beliefs, as well as help improve workflows, and play a role in data collection. Frontline staff, who are often more culturally diverse than clinicians or administrators, can also provide important insights into cultural and health beliefs of communities with whom they identify. It is worth noting that some staff may need support and training as they may be unfamiliar with medical terminology or QI concepts.

It is ideal to have an improvement team consisting of members with QI knowledge, varied backgrounds, skills and roles in the organization. Interpersonal communication skills and

the team's ability to function effectively as a unit are also critical to the success of an improvement effort.[2]

Leadership support

Senior leaders are vital to the success of any QI effort. Leaders can make the organizational or business case for improving equity and channel organizational resources, help overcome barriers, and in other ways support the project team. Leaders can also assure that improvement efforts are aligned with strategic priorities, and help communicate the importance of delivering high quality care to all patients to internal and external audiences. Engaging the support of senior leaders can send a powerful message to staff that efforts to improve equity are a priority for the organization.[3]

Communicating early wins and modest improvements can help keep leaders engaged, aware, and supportive of improvement effort. This can be done through presentation at existing meetings, through memos or emails, and more effectively by sharing patient stories and experiences that highlight how the organization has succeeded or fallen short in delivering patient-centered care. Find opportunities to share information about your project and your team's data. Show progress towards milestones either in regular updates during quality improvement committee meetings or other forums, or via short, succinct, targeted messages to management at various levels. For example, organizations have found that acknowledging champions at regular department meetings is an effective way to recognize individuals while also communicating information about project progress.

REAL Data

The adage, "you can't fix what you can't measure," is of utmost importance in QI and contributes to one of the greatest infrastructure challenges for addressing equity. Data can serve as motivator, teaching tool to help generate interest, build will, and engage leaders, clinicians, and staff. And, as the first step in every improvement effort, data can also help attain buy-in from leadership.[4]

While there is now greater consensus in measures of quality, there is not yet a similar consensus for measuring disparities in care. However, there is growing agreement that an ideal way to do this is to stratify quality measures by race, ethnicity, and language (REAL) data. Significant effort has been made over the last several years to identify and implement systems to help systematically capture accurate REAL data.

Collecting these data, and creating the infrastructure for doing so, requires concerted staff effort and some resources, neither of which will transpire without considerable motivation. The motivation can exist either in the form of a "business case" or external requirements to assure the information is collected. Examples of infrastructure for collecting data include creating fields in electronic health record to capture information such as race/ethnicity, preferred language for health care communication, need for interpreters, and level of health literacy. If you do not yet have an electroic health record (EHR), you may need to create a system for combining data from two or more unlinked systems (e.g., chart or practice management system and disease registry) to enable ongoing monitoring of quality indicators stratified by REAL characteristics. Another example of the data infrastructure is training staff how to accurately and reliably collect and use REAL data. Several excellent resources to help you with REAL data collection efforts are listed on the right. Additional

recommendations and tools related to data and measurement are covered in the relevant sections below.

While the existence of REAL data does not, in and of itself, assure that care will improve, its absence guarantees that actions will not reduce or eliminate inequities. Without REAL data there is no truly effective means for identifying inequities and best practices that improve care.

RESOURCES FOR REAL DATA COLLECTION

Health Research and Educational Trust (HRET) Disparities Toolkit
http://www.hretdisparities.org/

Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement
http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx

STEP 2: RE-THINK AIMS

One of the fundamental questions to answer when initiating an improvement effort is - what are we trying to accomplish? This is the first question posed in the Model for Improvement and helps define the overall aim of an effort.[1] A clear aim statement focuses the goal of the improvement and serves as a critical touchstone throughout the improvement effort.

General Improvement Aim: Regardless of whether the QI initiative is focused on equity or not, key qualities of a strong aim statement is that it is "SMART" – i.e., specific, measureable, attainable, realistic and timely.[5]

EXAMPLE: *By December 2012, increase the percentage of patients 50 -75 years of age with an up-to-date colorectal cancer screening test (FOBT) by 25% over baseline.*

Equity Focused Aims: In 2001, the Institute of Medicine (IOM) listed equity as one of its six overarching aims for improving health care[6]; many organizations use the IOM aims to help guide the development of their own. To develop an aim statement designed to increase equity for a population(s), consider the following questions:

WHAT?	• What is the clinical or process improvement of interest? • Is improvement aligned with strategic interests of your organization and other Q1 Efforts?
FOR WHOM	• Which group is affected by unequal or disparate care? • Is there a best-performing group with whom they can be compared, either within your organization or using a state or rational benchmark?
HOW MUCH & WHEN	• What is your disparity reduction goal and by when do you hope to achieve it?

To address "For Whom", it is essential to have confidence in the quality of your organization's demographic data; making decisions based on inaccurate data can lead to misdirected efforts. This is especially true in the absence of REAL as the occurrence or direction of disparities may not be what you expect.

Equity focused projects can involve some new demographic data collection. If you do not already, you should consider collecting race, ethnicity, and language (REAL) data at more granular levels for populations who make up a substantial portion of your patients. For example, if 20% of your patients are Asian, you may identify the specific groups that make up this large category such as Chinese, Vietnamese, and Korean to understand how various subpopulations fare in terms of quality. You may need to devote time at the outset reviewing and refining the quality of the data collected to make sure that it is accurate and reliable. Getting the right data to measure performance in any QI project, whether or not it is focused on equity, can itself be a sizable undertaking.

Questions often arise about the adequate number of individuals (or sample size) needed to effectively compare groups of patients. Because this is quality improvement, and not research, sample sizes do not necessarily need to be statistically significant. The choice of how small to go depends on your patient population, your organization's resources and priorities, and whether the information will help guide improvement. Keep in mind, however, that if the sample size over or underrepresents the patient populations for the groups in question, this could misrepresent the state of care.

RESOURCES TO HELP YOU USE DATA TO IDENTIFY DISPARITIES

Creating Equity Reports: A Guide for Hospitals.
http://www.rwjf.org/files/research/050608hospitalequityreport.pdf

Commissioned Paper: Healthcare Disparities Measurement
http://www2.massgeneral.org/disparitiessolutions/z_files/Disparities%20Commissioned%20Paper.pdf

When setting improvement goals, it is important to be realistic yet ambitious. The same holds true for establishing a goal for reducing disparities. While the ideal is to eliminate all disparities in care, your organizational priorities, resources, and populations will determine what can be realistically accomplished in the finite time period. If your target group is the predominant population for your organization (e.g., Latinos), you may not be able to use Whites (traditionally considered the benchmark group) as comparison due to their small numbers. If this is the case, you can compare improvement among Latinos against a benchmark for a given quality measure at a state or national level.

On the next page, the colorectal cancer example aim from page 5 is reframed to address equity, highlighting both quality improvement AND disparities reduction goals.

WHAT?	Deaths resulting from colorectal cancer (CRC) can be dramatically reduced by early detection. It is recommended that adults between the ages of 50-75 complete a fecal occult blood test (FOBT) every year. There is room for improvement in our CRC screening rates. Increasing these rates is a priority for our organization and is a new metric in our pay-for-performance program.
FOR WHOM	Stratifying the percentage of patients 50-75 years old with a completed FOBT in the past year by race/ethnicity, we find that the percentage for our Hispanic patients with completed screening is 30% while the rates for Non-Hispanic White patients, the highest performing group, is 50%.
HOW MUCH & WHEN	Our goal is to improve the rates of colon cancer screening to 60% for patients 50-75 years old and eliminate the gap between our Hispanic and Non-Hispanic White patients by the end of 2012.

EXAMPLE 2: *By December 31, 2012, decrease by 100% the gap between Hispanic and Non-Hispanic White patients ages 50 -75 years who have an up-to-date FOBT test, while improving colon cancer screening rates for all to 60%*

A useful worksheet to help think through details about who, what, how, when and why of your QI project can be found in Appendix A.

STEP 3: USE DATA DIFFERENTLY

The second question, is how will we know that change is an improvement?[1] Measurement, the process of planning, collecting, synthesizing, and interpreting data, is a challenging aspect of any quality improvement initiative. If systems are not in place to automate and facilitate those processes, adding equity into the measurement equation adds another layer of complexity.[7]

Defining Measures

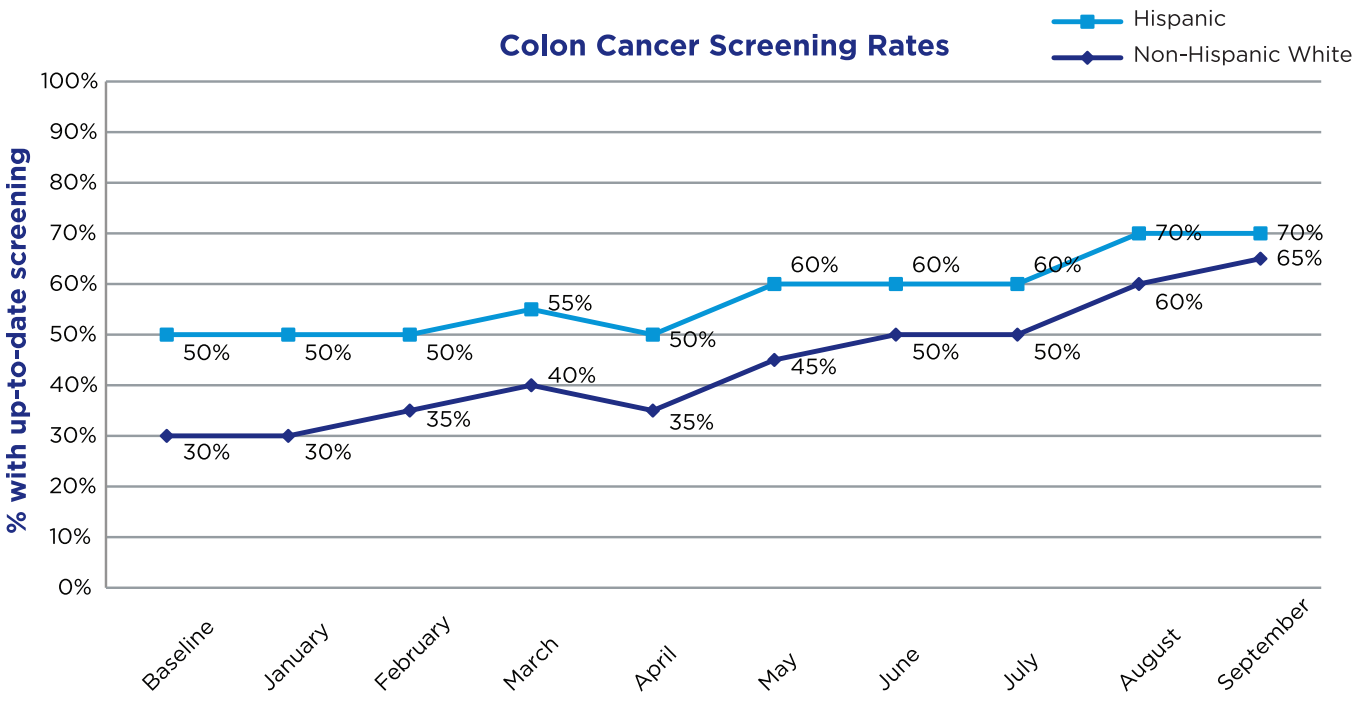
Measurement is a critical part of testing and implementing changes and will help you determine whether the changes you are making result in improvement. The overall framework for measuring improvement for equity projects is similar to the approach for any QI effort. You will typically choose three types of measures: outcomes, process and balancing. Outcome measures address the impact of the changes on patients' health and well-being. Process measures help assess if the parts or steps in the system are going as planned. Finally, balancing measures look to see if the changes that have been implemented are causing new problems elsewhere in the system. It is important to be clear about how each measure is defined and collected to improve the quality and reliability of the data. Where possible, include measures you are already collecting for reporting purposes (e.g., HEDIS, Hospital Compare, UDS). Your measurement plan should identify from the outset how each measure will be stratified (more on this below). And, like any improvement

effort your team will need to look at data for measures on a regular basis (no less often than monthly), charting results to make it easy to monitor improvement over time. (See Appendix B for a sample measurement plan). Demonstrating improvement in health outcomes can take a long time, which underscores the value of process measures and setting intermediate goals to help you acknowledge and celebrate early wins.

Stratifying Data

Stratifying outcome, process, and balancing measures by REAL data requires both high quality data and systems to facilitate or automate this task. Spreadsheets can help with this process. The tools shown in Appendices C and D helps assure clear definition of numerators and denominators and patient characteristic (REAL or some other demographic) by which the data are being stratified. Percentages are automatically calculated and placed beside raw numbers to help identify potential anomalies due to differences in sample sizes among different groups. (Note: these tools can only function as described if accessed electronically.) Given that improvement takes place over time, determining if it has really happened and is lasting requires looking at data over time. Run charts, which are graphs of data over time, are one of the most important tools for assessing the effectiveness of change. The data reporting tool can be set up to automatically generate run charts as data are entered.

Using the aim described above, an illustration of a run chart that would be generated using the data reporting tool might look like this:



Sampling

If you do not have electronic access to improvement data (e.g., through a disease registry or some other electronic format) and can only obtain them through a chart review, you may choose to look at just a sample of patients to minimize time consuming chart reviews. Keep

in mind that when you are monitoring improvement for multiple groups (e.g., patients from multiple ethnic groups), the chart review process can be sizable because of the need for an adequate sample for each group.[8]

STEP 4: TAILOR TESTS OF CHANGE

The third and final question in the Model for Improvement is what change can we make that will result in improvement?[1] This is the crux of equity improvement efforts –what specific changes are effective in improving equity and how should they be tailored to meet the cultural, linguistic, literacy or other needs of patients?

Tailoring Care

To improve equity, you can expect to tailor improvement strategies in response to health beliefs and cultural norms. Cancer screening reminders, for example, may need to address religiosity (e.g., beliefs about the ability to influence fate) or views of preventive care, both of which have been shown to affect screening adherence.[9,10] Likewise, educational materials could address cultural norms (e.g., family decision-makers) or health beliefs (e.g., use of complementary medicine) that influence patients' adherence and use of services.[11] For example, diet recommendations should include references to foods that are culturally relevant and the role of extended family should be referenced, when applicable, when providing instruction to caregivers and patients. Assuring effectiveness of your interventions requires a thoughtful approach to tailoring care, engaging patients and soliciting feedback whenever possible. (See Patient Engagement on page 12)

System Level Changes

Most improvements require a change at the system level. The system level change may be the primary intervention (e.g., integrating a standardized diabetes template into the electronic health record) or it can play a supporting role (e.g., reminders to counsel patients about need for vaccination). Planning and implementing a change to a system, no matter how straightforward, can divert attention from tailoring care to meet patient's needs. So, as you think about necessary changes to your system, consider whether the systems change may impact different patient groups in different ways.

Clinician and Staff Training

Most efforts to reduce disparities involve patient or staff behavior change, which usually requires clinician and staff training. For example, you may need to conduct trainings for using new interpreter systems or new work flows for a disease registry. Or train clinicians to conduct motivational interviewing to improve patient-centered communication and to overcome health literacy barriers.

Examples of Equity Improvement Efforts from the ACTION Program

Organization	Clinical Area	Population of Focus	Tailored Patient Education	System Change	Provider/Staff Training
Asian Americans for Community Involvement	Diabetes Foot Care	Elderly Monolingual Chinese	Language-specific self-care patient education materials. Language concordant medical assistants (MAs) perform foot exam.	Work flow redesign to increase scope of effort of MAs to allow clinicians more time with patients.	MAs trained in foot exams. Entire care team trained in new workflow and documentation processes.
Health Plan of San Mateo	Early Prenatal Care	Latina, African-American and Pacific Islander women	Social marketing campaign providing culturally relevant messaging to community about importance of early prenatal care.	New 800# for presumptive eligibility information & referral for care. New uniform system for clinics to submit presumptive eligibility data.	
Contra Costa Health Plan	Obesity	Hispanic children	Low literacy, language appropriate patient education materials focusing on culturally relevant messages.	Access to desktop electronic tools to facilitate calculation of BMI. Revised policies and practices for clinician language certification and language assistance.	Clinicians trained on clinical practice guidelines, use of new forms and tools, and cultural barriers for Hispanic families attempting healthy behaviors.

Organization	Clinical Area	Population of Focus	Tailored Patient Education	System Change	Provider/Staff Training
Lifelong Medical Care	Hyper-tension	African-American Adults	Low-literacy, culturally appropriate health education material, with a health coach to help patients develop self-management plans. Stress reduction groups for patients.	Electronic panel management system. Hypertension focused clinic. Revised work flow to improve blood pressure measurement and to increase time with health coach.	Staff trained in patient self-management and goal setting techniques.
Ravenswood Family Health Center	Diabetes Care	Hispanic Adults	Low-literacy, culturally and linguistically appropriate educational materials (e.g., proper diet) and action plans.	Systematic screening for health literacy. Revised work flow to allow MAs to take on greater self-management support role.	Clinician and staff training in patient communication focusing on culture, language, and health literacy.

For detailed examples of other projects focused specifically on reducing inequities of care in cardiovascular disease, diabetes, and depression, refer to the Grants Portfolio of the Finding Answers: Disparities Research for Change Program.[12]

Testing changes

Plan-Do-Study-Act (PDSA) cycles or small tests of change are central to the Model for Improvement.[1] Improvement projects can begin on a very small scale such as focusing on one doctor, for one afternoon, and one change (for example, placing a brightly colored arrow on a form indicating the need for foot exams for patients with diabetes). These small tests allow teams to innovate and try out changes without creating new systems or disrupting existing ones. PDSA cycles help identify promising strategies, reject unsuccessful ones, and plan carefully for more widespread change. They allow you to engage in an iterative process of observation and revision before the more time and resource intensive process of implementing successful changes. It is important to take time to complete all the steps of the PDSA cycle: using the study period to learn and refine your interventions, review each test of change and then develop a plan for the next action (adopt, adapt or

abandon). Small tests of change provide the opportunity to reflect on an intervention and purposefully ask questions such as - what did we learn about the patient? Ensuring that interventions resonate with patients is central to the PDSA process.

Rather than waiting to identify the changes you think will result in more substantial improvement, start with something small, but move quickly to expand and refine the initial test cycles. For example, some hospitals test a variety of ways to increase awareness of patients' language barriers by listing the language next to the patient's name on inpatient unit white boards or adding a brightly colored wristband to signal the need for an interpreter. Data is collected on each of these tests of change for a short period of time – in some cases monitoring use over a few days. Moving quickly with multiple small tests of change enables teams to test improvements under variable circumstances and understand what works or does not work in a variety of situations and with different patient populations.

Patient Engagement in QI Activities

Engaging patients in QI initiatives is particularly important when addressing health care disparities. Several strategies have been used for including patients as advisors in improvement efforts.[13,14] For example, you can chose to create a patient advisory council (or engage an existing one) to help guide your QI activities. Patients should be included in planning of the effort, as well as the execution and the evaluation. If a patient advisory council is not feasible, you can choose to include patients who represent your target communities on your project team.

Identifying opportunities to get patient feedback on materials and new processes will greatly enhance your ability to deliver patient-centered, cultural and linguistically appropriate care. Include the solicitation of patient opinions and feedback as part of your PDSA cycles. You can do this by asking patients for feedback at the end of visits or with a follow–up phone call. Teams have had a great deal of success soliciting feedback on educational materials, for example, from patients in the reception or waiting area. If more feedback is needed, you can consider conducting a brief survey or holding patient focus groups. Whichever approach you take, effectively engaging the community will take commitment as well as dedicated time and effort. Identify opportunities to involve patients from the start of your project and throughout your improvement effort, as engaging patients is an essential component of all of your QI work.

STEP 5: SUSTAIN & SPREAD

Planning for sustaining improvements and spreading effective changes throughout your system is important to your improvement work. You can find helpful strategies for sustainability and spread in a number of places including the Institute for Healthcare Improvement.[15] Each of the steps outlined -garnering senior leadership support, engaging physician champions and representatives from all levels of staff, and putting the necessary infrastructure in place -will help you be successful in your efforts to sustain and spread improvements in equity. As you plan for spread, keep in mind that one size still does not fit all. The changes you initially tailored may need to be tailored again. As you endeavor to do PDSAs at a new site, new clinician, or new group of patients, remember to continually ask – are we learning something new about these patients?

There is no magic formula for eliminating disparities in health care. The five steps described here have been used to accelerate and guide improvement efforts to achieve equity in care. Bring together the right people for the project, including staff, leadership and patients. Be explicit about equity in your project aim and goals. Use your data to help target your efforts. Tailor interventions to meet the values, preference, and linguistic needs of your patients. And lastly, keeping with the spirit of QI, try these strategies without the fear of failure.

REFERENCES

1. Langley GL, Moen R, Nolan K, et al., The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. 2nd ed. San Francisco, CA: Jossey-Bass Publishers; 2009.
2. Shortell SM, Marsteller J, Lin M, et al., The Role of Perceived Team Effectiveness in Improving Chronic Illness Care. *Med Care*. 2004. 42(11): 1040-1048.
3. Kotter JP. Leading Change: Why Transformation Efforts Fail. *Harvard Bus Rev*. 1995. March-April: 59-67.
4. Speaking Together, Robert Wood Johnson Foundation. Interpreting the Bottom Line: The Case for Language Services from the C-Suite; 2008.
5. Keller J. Attitude is Everything. Tampa, FL: INTI Publishing & Resource Books, Inc.; 1999.
6. Institute of Medicine, National Academies Press. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC.; 2000.
7. Weissman JS, Betancourt J, Green A, et al., Commissioned paper; Healthcare dispariites measurement. Disparities Solutions Center; 2011.
8. Provost L, Murray S. The Health Care Data Guide: Learning from Data for Improvement. San Francisco, CA: Jossey-Bass; 2011.
9. Skinner CS, Strecher VJ, Hospers H. Physicians' recommendations for mammography: do tailored messages make a difference? *Am J Public Health*. 1994. 84(1): 43-9.
10. Lauver DR, Settersten L, Kane JH, Henriques JB. Tailored messages, external barriers, and women's utilization of professional breast cancer screening over time. *Cancer*. 2003. 97(11): 2724-35.
11. Fisher TL, Burnet DL, Huang ES, Chin MH, Cagney KA. Cultural leverage: interventions using culture to narrow racial disparities in health care. *Med Care Res Rev*. 2007. 64(5 Suppl): 243S-82S.
12. Robert Wood Johnson Foundation. Finding Answers: Disparities Research for Change. [cited July 15 2012]; Available from: http://www.solvingdisparities.org/.
13. Robert Wood Johnson Foundation. Lessons Learned: Engaging Consumers to Improve Ambulatory Care; 2012.
14. Coulter A. Patient Engagement - What Works? *J Ambul Care Manag.* 2012. 35(2): 80-89.
15. Massoud MR, Nielsen GA, Nolan K, Schall MW, Sevin CA. Framework for Spread: From Local Improvements to System-Wide Change, in IHI Innovation Series white paper. Institute for Healthcare Improvement; Cambridge, MA; 2006.

APPENDIX A: PROJECT PLANNING WORKSHEET

The (Name of your organization)

intends to accomplish (This is an overarching statement describing what you intend to accomplish through your work and the process that will be used; words like improve, reduce, and increase are often used)

by (Timeframe, i.e., month/year in which you intend to accomplish improvement)

for (What group(s) of patients are you focusing your efforts to improve quality & equity of care?)

because (The rationale and reasons to work on this improvement project – include any data that you have to support the rationale)

how (Who will undertake the work? what does the team intend to do and where will the project start?)

- List team members on improvement team
- What initial activities or PDSAs will the project team focus on?
- Provide specifics of where you will start including site or specific provider or team.

Our goals include: (State the measures your team is committed to improving, AND a numeric goal for that measure – be ambitious, stretch the system to work better for patients. This answers the question, "how will we know that changes we make are an improvement?")

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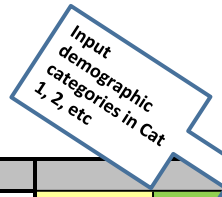
Adapted from Institute for Healthcare Improvement

APPENDIX B: MEASUREMENT PLAN TEMPLATE

Measure Type (Process/ Outcome/ Balancing)	Measure Name	Description	Calculation		Collection Method & Frequency	How will you stratify this measure?	Goal/ Target
			Numerator	Denominator			
						Race/ethnicity Preferred language Literacy Income Gender Education level Other: _____	
						Race/ethnicity Preferred language Literacy Income Gender Education level Other: _____	
						Race/ethnicity Preferred language Literacy Income Gender Education level Other: _____	
						Race/ethnicity Preferred language Literacy Income Gender Education level Other: _____	
						Race/ethnicity Preferred language Literacy Income Gender Education level Other: _____	

APPENDIX C: DATA TRACKING TOOL V1



ORGANIZATION NAME / PROJECT NAME

Input raw #s here

Measure 1: Description	Baseline					Month 1 - Date				
	Cat 1	Cat 2	Cat 3	Cat 4	Total	Cat 1	Cat 2	Cat 3	Cat 4	Total
Denominator: *Description*	250	300	200	350	550	250	300	200	350	550
Numerator: *Description*	56	150	26	180	206	70	150	30	190	220
Percentage	22%	50%	13%	51%	37%	28%	50%	15%	54%	40%
Measure 2: Description	Baseline					Month 1 - Date				
	Cat 1	Cat 2	Cat 3	Cat 4	Total	Cat 1	Cat 2	Cat 3	Cat 4	Total
Denominator: *Description*										
Numerator: *Description*										
Percentage										
Measure 3: Description	Baseline					Month 1 - Date				
	Cat 1	Cat 2	Cat 3	Cat 4	Total	Cat 1	Cat 2	Cat 3	Cat 4	Total
Denominator: *Description*										
Numerator: *Description*										
Percentage										
Measure 4: Description	Baseline					Month 1 - Date				
	Cat 1	Cat 2	Cat 3	Cat 4	Total	Cat 1	Cat 2	Cat 3	Cat 4	Total
Denominator: *Description*	0	0	0	0		0	0	0	0	
Numerator: *Description*										
Percentage										
Measure 5: Description	Baseline					Month 1 - Date				
	Cat 1	Cat 2	Cat 3	Cat 4	Total	Cat 1	Cat 2	Cat 3	Cat 4	Total
Denominator: *Description*										
Numerator: *Description*										
Percentage										

APPENDIX D: DATA TRACKING TOOL V2

Measure 1: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1	804	1352	59.47%	819	1334	61.39%	920	1334	68.97%
Cat 2	119	304	39.14%	114	304	37.50%	200	304	65.79%
Cat 3	612	1116	54.84%	633	1131	55.97%	700	1131	61.89%
Cat 4	255	588	43.37%	633	1111	56.98%	750	1111	67.51%
Cat 5	78	116	67.24%	86	116	74.14%	95	116	81.90%
Total	1868	3476	53.74%	2285	3996	57.18%	2665	3996	66.69%

Measure 2: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1									
Cat 2									
Cat 3									
Cat 4									
Cat 5									
Total									

Measure 3: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1									
Cat 2									
Cat 3									
Cat 4									
Cat 5									
Total									

Measure 4: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1									
Cat 2									
Cat 3									
Cat 4									
Cat 5									
Total									

Measure 5: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1									
Cat 2									
Cat 3									
Cat 4									
Cat 5									
Total									

Measure 6: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1	0	0		0	0		0	0	
Cat 2	0	0		0	0		0	0	
Cat 3	0	0		0	0		0	0	
Cat 4	0	0		0	0		0	0	
Cat 5	0	0		0	0		0	0	
Total	0	0		0	0		0	0	

Measure 7: Name	Baseline			Month 1			Month 2		
	Numerator	*Denominator*	*%*	*Numerator*	*Denominator*	*%*	*Numerator*	*Denominator*	*%*
Cat 1									
Cat 2									
Cat 3									
Cat 4									
Cat 5									
Total									

Center for the Health Professions
University of California, San Francisco
3333 California Street, Suite 410
San Francisco, CA 94118
http://futurehealth.ucsf.edu