

# Transformation Plan Element #8

## Quality Improvement Plan – Eliminating Racial, Ethnic, and Language Disparities

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### **Transformation Plan Guidance and Technical Assistance**

Oregon Health Authority’s technical assistance is designed to provide Coordinated Care Organizations (CCOs) with guidance on specific areas each plan should address; examples of approaches and outcomes that can help inform discussions and strategies as the CCO develops its plan; other resources and additional technical assistance available to CCOs; and staff assistance to answer specific questions through an assigned OHA contact. Please call or email your OHA Transformation Plan contact if you need assistance with a particular subject or item.

### **Overview**

As the primary agents of Health System Transformation, CCOs are responsible for integrated and coordinated health care for their community members’ physical health, addictions and mental health services, with a focus on prevention, improving quality (including culturally appropriate care), accountability, eliminating health disparities and lowering costs.

HB 3650 directs CCOs’ delivery system networks to emphasize patient-centered primary care homes, evidence-based practices, and health information technology; to improve the coordination of care for individuals with chronic conditions or experiencing health disparities.

Forty percent of Medicaid enrollees are people of color, who along with other culturally and socially diverse groups, continue to experience the most disparities in access, quality and outcomes of care.

### **Background**

Health equity and identifying and addressing health disparities are an essential component of Health System Transformation. Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing efforts to eliminate health disparities. Moving towards health equity will need specific investments and quality improvement strategies.

In order to reach transformation goals, CCOs need to provide care so that efficiency and quality improvements reduce medical cost inflation and improve health outcomes, in accordance with the Health System Transformation objectives and requirements established in HB 3650 (2011) and SB 1580 (2012). Studies nationwide and in Oregon have demonstrated that health systems that incorporate best clinical practices, coordination of benefits and care, and offer culturally specific care not only deliver better health outcomes but reduce health care costs.

As people of color account for forty percent of the Medicaid population, and are a significant percentage of CCO member populations in rural, frontier, and urban regions, achievement of cost savings and health goals will be more attainable with a focus on and organizational commitment to achieving health equity.

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*Original RFA request*

### **6.2. Technical Application Evaluation**

Evaluation of Applicant’s Technical Application will be based on criteria included in this RFA and OAR 410-141-3015, including but not limited to the Applicant’s demonstrated experience and capacity for:

**6.2.3.** Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the Members and in the CCO’s community.

### **A.3.5. Coordination, Transition and Care Management**

Care Coordination:

**A.3.5.f.** Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of non-traditional health workers, especially for Members with intensive care coordination needs, and those experiencing health disparities.

## **Section 4 - Health Equity and Eliminating Health Disparities**

**A.4.1.** CCOs and their providers are encouraged to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of Members. Describe how the Applicant and its providers will achieve this objective.

**A.4.2.** Describe how the Applicant will track and report on quality measures by these demographic factors that includes race, ethnicity, primary language, mental health and substance abuse disorder data.

### **Definitions**

**Culture** refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving.

- Culture is the systems of knowledge shared by a relatively large group of people.
- Culture is communication, communication is culture.
- Culture in its broadest sense is cultivated behavior; that is the totality of a person's learned, accumulated experience which is socially transmitted, or more briefly, behavior through social learning.
- A culture is a way of life of a group of people--the behaviors, beliefs, values, and symbols that they accept, generally without thinking about them, and that are passed along by communication and imitation from one generation to the next.
- Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts; the essential core of culture consists of

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- traditional ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other hand, as conditioning influences upon further action.
- Culture is the sum of total of the learned behavior of a group of people that are generally considered to be the tradition of that people and are transmitted from generation to generation.

Source: <http://www.tamu.edu/faculty/choudhury/culture.html>

**Cross-cultural communication-** The term “cross-cultural” implies interaction with persons of different cultural, ethnic, racial, gender, sexual orientation, religious, age and class backgrounds. “Cross-cultural communication” is a process of exchanging, negotiating, and mediating one’s cultural differences through language, non-verbal gestures, and space relationships. It is also the process by which people express their openness to an intercultural experience. (Clarke and Sanchez, 2001)

**Cultural Competence** (Please note: This definition was recently adopted and recommended by the Oregon Health Authority’s Cultural Competence Continuing Education Committee): A life-long process of examining values and beliefs, of developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider<sup>1</sup>-patient interactions and preserves the dignity of individuals, families and communities.

This process is applicable to all patients<sup>2</sup>; assumptions will not be made on the basis of a person’s expressed or perceived race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran’s status, sexual orientation, gender identity, gender expression, and gender transition, level of formal education, physical or mental disability, medical condition or any other consideration under federal, state and local law. The term “cultural” is used here in its broadest sense as “the totality of a person’s or a group’s accumulated experience”, and the term “competency” is defined as the “ability to do something well.” Based on this document’s definition of cultural competency, it would mean to adequately engage in the lifelong process or self-examination, inclusivity, awareness and respect in health care practice in accordance to the principles and standards below.

**Health care interpreter** means a person who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency.

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<sup>1</sup> For simplification, the term “provider” is used throughout this document and it intends to represent the broadest spectrum of roles in health care, including but not limited to physician, social worker, medical technician, community health worker or “promotor/a,” etc.

<sup>2</sup> For simplification, the term “patient” is used throughout this document and it intends to represent the broadest spectrum of roles in health care, including but not limited to patient representative, client, resident, consumer, patient’s family and community, etc.

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**Health Literacy:** Health Literacy is defined in the Institute of Medicine report [Health Literacy: A Prescription to End Confusion](#) as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations. For example, it includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems.

**Limited English Proficiency:** Individuals who do not speak English as their primary language, who have a limited ability to read, write, speak, or understand English, and who have not developed fluency in the English language may be limited English proficient, or "LEP." They may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

#### **References/Resources**

##### *Organizational Assessment Tools*

American Medical Association – Ethical Force Organizational Assessments

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication/organizational-assessment-resources/view-surveys.page?>

Guide to inform organizational self-assessment in cultural competence

<http://www11.georgetown.edu/research/guchhd/nccc/documents/ncccorgselfassess.pdf>

Cultural Competence Health Practitioner Assessment (CCHPA)

<http://nccc.georgetown.edu/features/CCHPA.html>

##### *Health Equity and Quality Improvement*

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care:

<http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>

A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety, 2009:

[http://www.iom.edu/~media/Files/Activity%20Files/SelectPops/HealthDisparities/Commissioned\\_local\\_disp.pdf](http://www.iom.edu/~media/Files/Activity%20Files/SelectPops/HealthDisparities/Commissioned_local_disp.pdf)

Assuring Healthcare Equity: A Blueprint:

[http://www2.massgeneral.org/disparitiessolutions/z\\_files/Assuring%20Health%20Care%20Quality\\_Equity%20Blueprint.pdf](http://www2.massgeneral.org/disparitiessolutions/z_files/Assuring%20Health%20Care%20Quality_Equity%20Blueprint.pdf)

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Toward Health Equity and Patient-Centeredness: Integrating Health Literacy, Disparities Reduction, and Quality Improvement. Workshop Summary

<http://www.iom.edu/Reports/2009/Toward-Health-Equity-and-Patient-Centeredness-Integrating-Health-Literacy-Disparities-Reduction-and-Quality-Improvement-Workshop-Summary.aspx>

Multicultural Health Care: A Quality Improvement Guide:

[http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS\\_toolkit.pdf](http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf)

### **Components of Health Equity and Quality Improvement**

**OHA Expectations:** OHA expects CCOs to determine what disparities exist among their members and to identify and implement promising approaches to address them. One initial step CCOs may take to advance this work is to complete a self-assessment of your organizational competence in eliminating disparities. Identify and address the areas of greatest need for improvement.

- As a suggested starting point, CCO's may identify a particular number of health disparity priority areas per year for PDSA (plan, do, study act) quality improvement cycle, and communicate and institutionalize what works (3-5 is a recommended starting point).

**Measurement Methodology:** Without granular data, CCOs will be unable to demonstrate their progress.

- An approach might include the CCO identifying and explaining how they will define, operationalize and report their baseline and improvement metrics (benchmarks and milestones) to ensure that the transformation activities are effective, including:
  - Identify what metrics and analytical approaches CCO will use to understand racial, ethnic, and linguistic disparities in access, quality, experience, and outcomes of care in member population
  - Include how CCO plans to analyze other information for race, ethnicity, such as through complaints, grievances, and hearings.
  - Include process for how CCO will collect, confirm (so CCOs assure that client self-report matches DMAP enrollment data), analyze and use racial, ethnic, and linguistic data to achieve health equity
  - Include timeline for production of an annual report for OHA and CCO membership on progress toward health equity by race, ethnicity and language

### **Baseline**

Baseline is defined as the contractor's status in effect on the Contract effective date, primarily in light of any policies, procedures, operational or contractual arrangements or provider arrangements, including but not limited to materials submitted during the RFA as well as information submitted to OHA during the review process.

Areas you may include are:

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- Identify the % of missing demographic data (including, but not limited to race, ethnicity, and language)
- Provide current outcome or process data by sub-groups (including, but not limited to race, ethnicity, and language) of 3-5 health disparity priority areas

#### **Transformative Activities**

The CCO should explain, in detail, the activities they will engage in to improve the baseline measure, which may include the following elements:

- Providing training to front line staff on best practices and up-to-date standards for respectfully and effectively collecting race, ethnicity, and language data
- Providing training to quality assurance and data analytics staff on best practices for analyzing, interpreting, and reporting data by race, ethnicity, and language
- Developing partnerships with members, culturally specific providers, and culturally diverse organizations, health professionals, and community experts to inform analysis of data and planning of strategic interventions to evaluate in PDSA cycles
- Engaging the Quality Committee, Community Advisory Council, and the Clinical Council in developing health care and community health/prevention strategies that move the CCO and its network of providers towards eliminating racial and ethnic health disparities.
- Completion of PDSA cycles, as well as budget, staff and committee identified to facilitate this process
- Developing and implementing strategies for using racial, ethnic, and language data to inform periodic review of person-centered plan of care practices/policy/procedures

#### **Improvement Metric**

Describe your planning and monitoring process that will result in the types of information needed to evaluate progress. Your description could include:

- How CCO will use the learning from your community health improvement plan any CCO quality improvement work to reduce the % of missing demographic data for CCO members. Include target reduction amount and time frame (milestones and benchmarks).
- How CCO will use the learning from your community health improvement plan and the rapid cycle improvement (PDSA) work to eliminate avoidable gaps in health care access, quality, experience, and outcomes. Include target reduction amount and time frame (milestones and benchmarks).
- How the CCO will know that the baseline measure is improving – longitudinal measures that show the change over time. This discussion includes milestones (progress reports) and benchmarks (the ultimate goal value the CCO plans to achieve).