CCIP Standard 2: Health Equity Improvement Part 1

This Standard identifies key components of an effective Health Equity Improvement strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

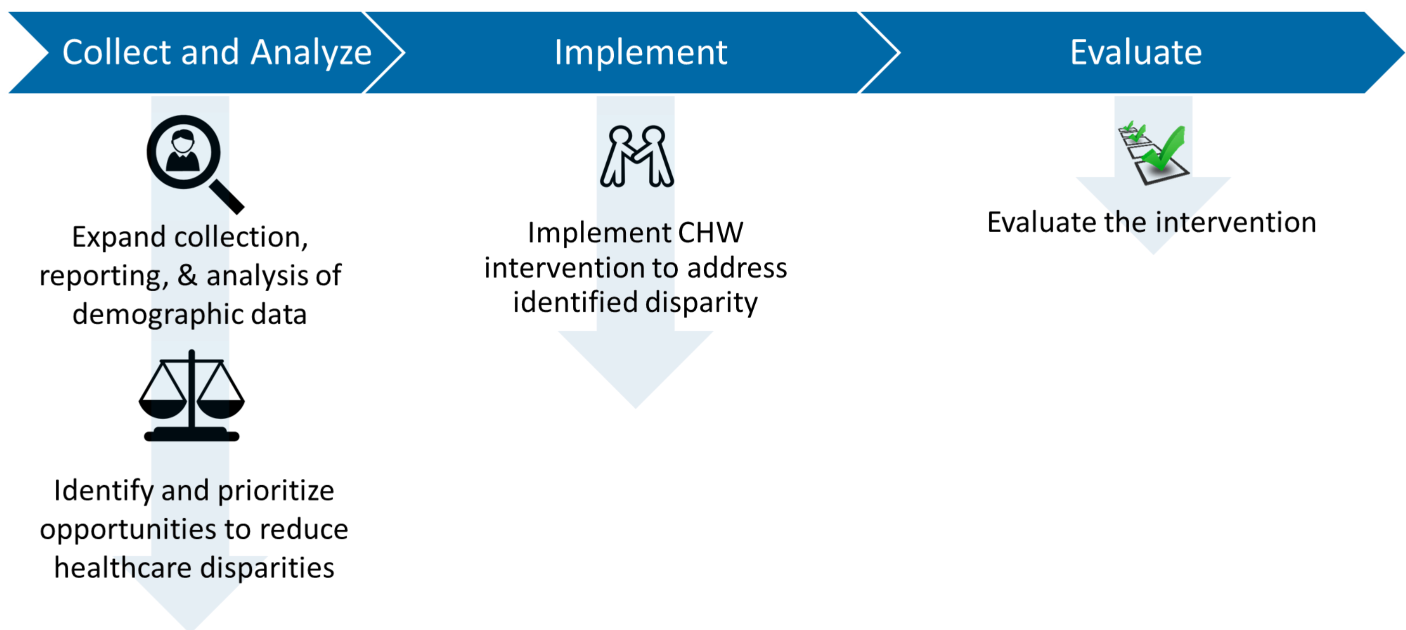
Your network has a **clear, documented policy and procedure** to collect granular race/ethnic data, analyze the data to identify disparities in care, and conduct root cause analyses to identify and implement interventions to address those disparities.

85% of the practices in your network have fully implemented the policy and procedure.

Process Measures:

1. Increased collection of CDC compliant race and ethnicity data documented in the EHR
2. Increased collection of sexual identification and gender identity data documented in the EHR
3. Increased collection of preferred language data documented in the EHR

Key Elements of Health Equity Improvement



Expand the collection, reporting, and analysis of standardized demographic data stratified by sub-populations

1. Collect race and ethnicity categories for all patients that go beyond the broad OMB categories. The selection of additional categories must:
    a. Draw from the recognized “Race & Ethnicity—CDC’’ code system in the PHIN Vocabulary Access and Distribution System (VADS) or a comparable alternative;
    b. Have the capacity to be aggregated to the broader OMB categories;
    c. Be representative of the population it serves based on (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members
2. Collect information regarding sexual orientation and gender identity (SOGI) for all patients
3. Identify valid clinical and care experience performance measures to compare clinical performance between sub-populations. Such measures should:
    a. Maximize alignment with the CT SIM quality scorecard;
    b. Include the categories identified in 1 and 2above and preferred language;
    c. Address outcomes rather than process whenever possible;
    d. Meet generally applicable principles of reliability, validity, sampling and statistical methods
4. Analyze the identified clinical performance and care experience measures stratified by race/ethnicity, language, sexual orientation and gender identity, and geography/place of residence.
5. Establish methods of comparison between sub-populations by comparing measures internally against the network’s attributed population or to a benchmark.
6. Conduct a workforce analysis that includes analyzing the panel population in the service area, evaluating the ability of the workforce to meet the population’s linguistic and cultural needs, and implementing a plan to address workforce gaps

Identify and prioritize opportunities to reduce healthcare disparities

1. Document opportunities to reduce healthcare disparities identified through data analysis
2. Prioritize opportunities by engaging members of the sub-population.

Implement at least one intervention to address the identified disparity (see Part 2)

1. Conduct a root cause analysis for the identified disparity and develop an intervention. To conduct the analysis, utilize:
    a. Relevant clinical data
    b. Input from the focus sub-population for whom a disparity was identified
2. Design a pilot intervention that will meet the needs/barriers identified in the root cause analysis
3. Involve members of the sub-population who are experiencing the identified disparity in the intervention design
4. Implement an intervention in at least five practices

Evaluate intervention

1. Demonstrate that the intervention is reducing the healthcare disparity identified by:
    a. Tracking aggregate clinical outcome and care experience measures aligned with the measures used to establish that a disparity existed
    b. Achieving improved performance on measures
    c. Sharing evaluation findings with the focus sub-population
2. Identify opportunities for quality and process improvement

Standard 2: Health Equity Improvement Part 2

This Standard identifies key components of an effective Health Equity Improvement strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

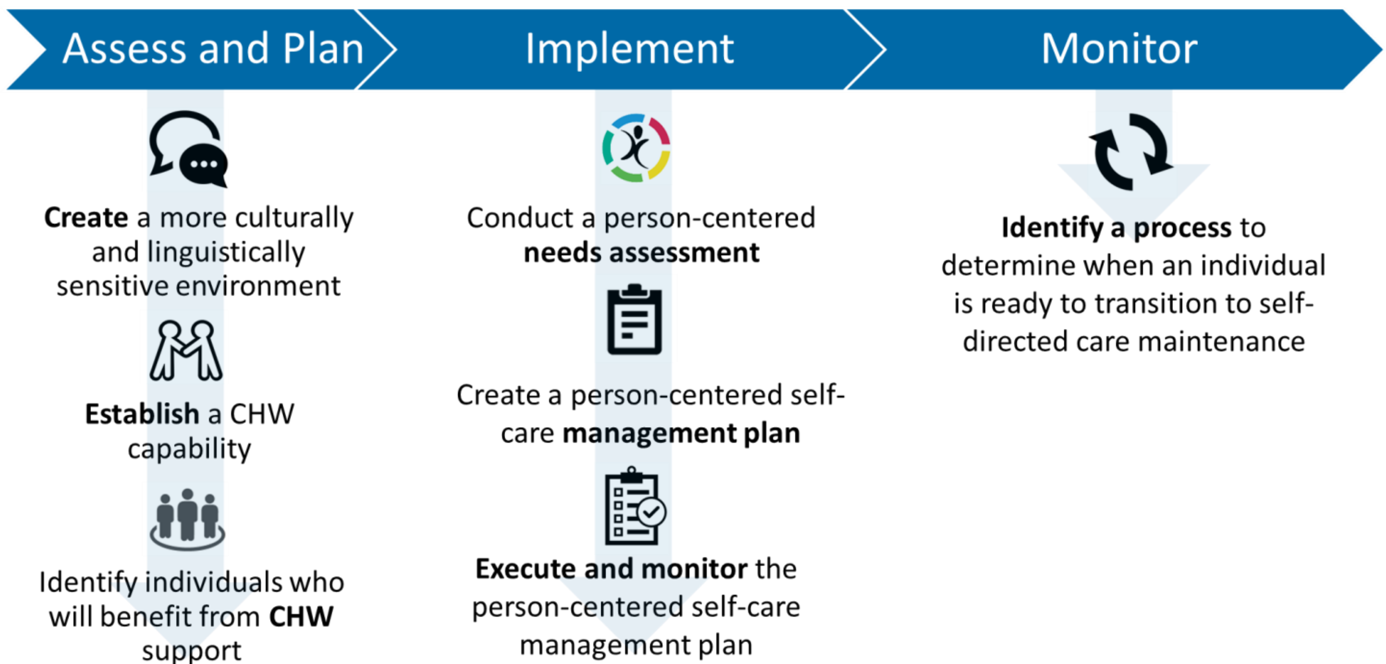
Your network has a **clear, documented policy and procedure** for identifying individuals who would benefit from a Community Health Worker capability, implementing that capability, and identifying when individuals are ready to transition to self-directed care.

5 of your practices have fully implemented the CHW capability

Process Measures:

Process measures will be unique to the subpopulation and disparity identified for your intervention

Key Elements of Health Equity Improvement



Create a more culturally and linguistically sensitive environment

1. Provide culturally and linguistically appropriate services informed by the root-cause analysis including:
   i. Culturally informed and health literacy sensitive methods of patient engagement, treatment, support, and education
   ii. Interpretation/bilingual services
   iii. Printed educational materials

Establish a CHW capability

1. Incorporate Community Health Workers into target practices. Options include:
   i. Employ the CHWs within the practice
   ii. Employ the CHWs at one or more hubs in support of multiple practices
   iii. Contract with community organizations for CHW services
2. Determine how CHWs will be made available to individuals identified for the intervention
3. Establish appropriate supervision and case load for CHWs
4. Establish training for all care team members involved in the CHW intervention annually to:
   i. Identify values, principles, and goals of the CHW intervention
   ii. Redesign the primary care workflow
   iii. Orient the primary care team to the roles and responsibilities of the CHW
5. Ensure CHWs receive core competency and disease-specific training based on the intervention

Identify individuals who will benefit from CHW support

1. Establish criteria to determine who receives CHW support by assessing whether an individual:
   i. Is part of the focus sub-population for the intervention
   ii. Has a lack of health status improvement for the targeted clinical outcome
   iii. Has cultural, health literacy and/or language barriers
   iv. Has social determinant or other risk factors associated with poor outcomes
2. Electronically alert the medical home team when individuals meet the criteria for a CHW intervention

Conduct a person-centered needs assessment

1. Conduct a person-centered needs assessment with individuals identified for the intervention that includes:
   i. Family/social/cultural characteristics
   ii. Behaviors affecting health
   iii. Assessment of health literacy
   iv. Social determinant risks
   v. Personal preferences and values
2. Establish a policy- **when, where, how, and by whom** the assessment is completed

Create a person-centered self-care management plan

1. The CHW, the individual, and their natural supports collaborate to develop a self-care management plan. The care plan should:
   i. Incorporate the individual's values, preferences and lifestyle goals
   ii. Establish health behavior goals reflective of the individual's stage of change
   iii. Establish social health goals reflective of identified needs/barriers

    iv. Identify actions steps for each goal and establish a due date
2. Establish a policy- **when, where, how, and by whom** the plan is developed

Execute and monitor the self-care management plan

1. Hold regular care team meetings and establish key touchpoints with individuals to monitor progress on self-care management plans
2. Establish a Policy:
    a. **Who** attends meetings and **Who** is involved in key touchpoints
    b. **When** and **Where** meetings and key touchpoints are held
    c. **How** individual's progress and risks are tracked and reported in a standardized way
    d. **How** health information is exchanged across settings to accommodate CHW support
    e. **How** individuals are connected to needed community services (i.e. social support services)

Determine when an individual is ready to transition to self-directed maintenance

1. Develop criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:
    a. Collaborating with the individual to assess their readiness to independently self-manage their care
    b. Assessing improvement on the relevant clinical outcomes
    c. Assessing achievement of individual identified care goals