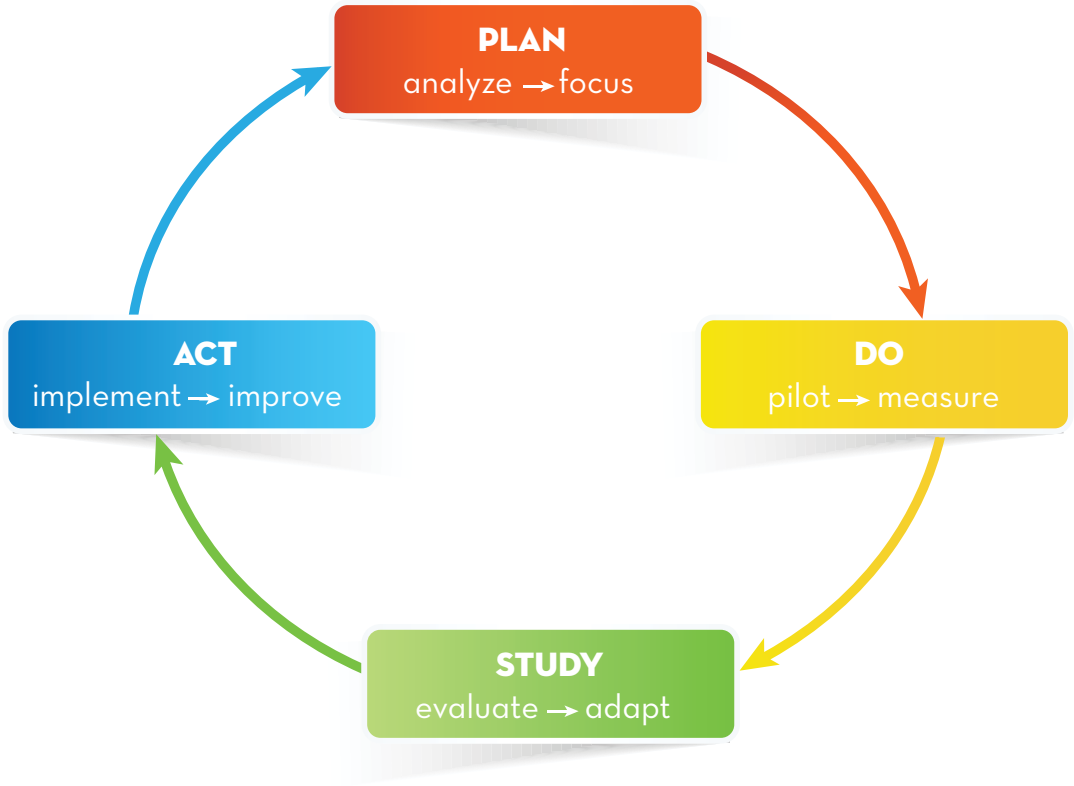
DISPARITIES IMPACT STATEMENT

Learn how to **identify, prioritize, and take action** on health disparities by championing the Disparities Impact Statement in your organization. Participants receive personalized technical assistance focused on strengthening your quality improvement program through a series of consultations from subject matter experts. To learn more, contact HealthEquityTA@cms.hhs.gov.

Health disparities are differences in health outcomes closely linked with social, economic, and environmental disadvantage – are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.



STEP 1: IDENTIFY VULNERABLE POPULATION(S)

[INITIATE YOUR COMMUNITY & STAKEHOLDER ENGAGEMENT PLAN]

Identify the vulnerable population(s) and health disparities within the population you serve.

- Area(s) of improvement you are considering:

_____

- Assess available data to identify vulnerable population(s) within the total population you serve who have notable health disparities.

  NOTE: Use multiple data sources to creatively compare and contrast populations and health disparities within the broader population in your service area. Use any available data you may have access to, including internal data, and publicly available, pre-tabbed data sets. The **Data Sources Handout** on page 16 suggests possible data sources you can use to understand your community.

  Vulnerable Populations may include:

  - Racial or ethnic minorities
  - Sexual and gender minorities (LGBT)
  - Individuals with a disability
  - Those living in rural or frontier communities and other medically underserved areas

  Health Disparities may be found by looking at differences between populations'

  - Health status
  - Disease prevalence
  - Mortality rates
  - Emergency department visits for potentially avoidable utilization or readmission
  - Utilization of preventive services
  - Access to care
  - Quality and safety
  - Chronic disease management

STEP 1 (CONT): IDENTIFY VULNERABLE POPULATION(S)

[INITIATE YOUR COMMUNITY & STAKEHOLDER ENGAGEMENT PLAN]

Identify the vulnerable population(s) and health disparities within the population you serve.

Stakeholder & Community Engagement Planning is a vital part of every step in the DIS and needs to be initiated as soon as your process starts and continued throughout. As you establish and refine your partnerships, you can also work with your partners to create or update a community asset map that shows the community's strengths and opportunities you can leverage to target local disparities. Use the **Stakeholder & Community Engagement Plan** on page 12 as a guide.

- After considering the most vulnerable populations and greatest health needs, identify possible strategic collaborations with community stakeholders. Enter these collaborations in Step 1 of the **Stakeholder & Community Engagement Plan** on page 12.
- Select the vulnerable population(s) you will target and the health disparities you plan to address within your program service area and note them below:

Vulnerable Population(s) chosen to target:

_____

Disparity(ies) chosen to target:

_____

List all the data sources you used:

_____

STEP 2: SET SMART AIMS
[START YOUR ACTION PLAN]

Identify your aim(s). Be SMART.	• Your aim or aims are what you want to improve for the population(s) you identified, or your vision of success. Think about why this is important to you - you can come back to this rationale and use it to ground your team as you implement. • You may have one aim, or more than one, but be realistic about what you can take on and achieve. • Make sure your aim or aims are SMART (Specific, Measurable, Attainable, Relevant, and Time-based). ○ Use this resource for understanding and setting SMART aims: https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapigoalsetting.pdf. • Stakeholder collaboration will be key to your success when developing SMART aims. Enter these collaborations in Step 2 of the **Stakeholder & Community Engagement Plan** on page 12. • Enter your SMART aim or aims directly into the **Action Plan** on page 11. If you have more than one SMART aim, create one **Action Plan** for each aim.

STEP 3: DEVELOP AN ACTION PLAN
[WORK WITH YOUR TEAM & COMMUNITY]

Identify key system elements (Primary Drivers) necessary to achieve your aim. **Anticipate impact.**	• PRIMARY DRIVERS are the things that have to occur for you to achieve your aim. You can have multiple primary drivers. ○ It may be helpful to draw a driver diagram or flow chart. Use this resource for drawing driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf • Involve stakeholders and community members from the population(s) affected by the disparities you are targeting to gain buy-in and valuable insights when brainstorming your primary drivers and potential barriers. Enter these collaborations in Step 3 of the **Stakeholder & Community Engagement Plan** on page 13. • How many individuals in the vulnerable population do you anticipate impacting through your intervention? _____ • What barriers do you expect and how do you plan to address them? _____ • Enter your primary drivers into the **Action Plan** on page 11.
Identify activities or interventions (Secondary Drivers) to make progress.	• SECONDARY DRIVERS are the specific activities or interventions (the "how") needed to impact the primary drivers. ○ Each secondary driver contributes to at least one primary driver. You can have multiple secondary drivers for each primary driver. • Enter your secondary drivers into the **Action Plan** on page 11. • Enter any additional stakeholders and community collaborations for achieving your secondary drivers in the **Stakeholder & Community Engagement Plan** on page 13.

STEP 3 (CONT): DEVELOP AN ACTION PLAN
[WORK WITH YOUR TEAM & COMMUNITY]

Assess your readiness.

- Are you ready to address the drivers you noted above? Do you have the staff, infrastructure, and resources in place?

  YES NO What else do you need?

  _____

  - Do you have the right people in place to support your intervention and activities, including someone who will help motivate your team? YES NO
    - Enter your Health Equity Champion here:

    _____

  - Do you have the infrastructure in place to serve all of your patients? YES NO
    Who ensures compliance with, and training on, physical and language access laws and regulations (for example, ADA compliance and state and local laws)? Consider who you serve and whether your facilities and staff are meeting their needs now, or if more training or resources are needed.
    - Enter individuals accountable for maintaining disparities-related compliance and training:

    _____

- Resource:
  - Disability Competent Care Self-Assessment Tool (DCCAT)
    https://www.resourcesforintegratedcare.com/DCC_Self-Assessment_Tool

If you do not yet have the staff, infrastructure, or resources in place to address your drivers and activities, consider focusing your first DIS on building your internal capacity.

STEP 3 (CONT): DEVELOP AN ACTION PLAN
[WORK WITH YOUR TEAM & COMMUNITY]

Provide culturally competent & accessible services.

- How will you ensure services are provided in a culturally and linguistically appropriate way?

- Are providers and staff trained and prepared to communicate with patients in a way they understand? YES NO
- Consider the languages your patients speak, or communication barriers you know of. Are effective linguistic interpreters available and utilized at appropriate times? Are printed or electronic materials at appropriate reading levels and translated so patients and families can understand them? YES NO
- Consider the physical access barriers your patients have. Are staff trained to work with patients to ensure they can receive services? YES NO
- Are providers and staff trained and prepared to be sensitive to patients' cultural, linguistic, and physical access concerns? YES NO

If you answered "NO," you may want to focus your DIS on eliminating communication and access barriers for your patients. You may find this helps improve efficiency for your front-line providers and reduces disparities among the populations you serve.

STEP 3 (CONT): DEVELOP AN ACTION PLAN
[WORK WITH YOUR TEAM & COMMUNITY]

Provide culturally competent & accessible services (Cont).	• Resources to improve the patient experience:
	  ○ ADA Requirements, Health Services & Facilities https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm
	  ○ A Practical Guide to Implementing the National CLAS Standards https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf
	  ○ Guide to Developing a Language Access Plan https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf
	  ○ HHS Think Cultural Health https://www.thinkculturalhealth.hhs.gov/clas

Identify key accountable individuals and organizations.	• Enter the specific key accountable staff, partners, stakeholders, or members of the community leading and contributing to the secondary drivers into the **Action Plan** on page 11. • Fill in the details of your stakeholder and community partnerships and specific activities in the **Stakeholder & Community Engagement Plan** on page 13.

STEP 4: MONITOR, IMPROVE, DISSEMINATE

[PDSA & SHARE WHAT YOU'VE LEARNED]

Define metrics to monitor progress and assess impact toward your aim.	• Define measures and metrics you will use to track progress toward your aim(s) in the **Action Plan** on page 11.
	• Define how you will measure success and how often monitoring will take place.
	• Data Streams:
	  ○ Quantitative and qualitative data sources you'll need to measure change.
	  ○ How will you stratify your data to compare populations and monitor emerging disparities?
	• Define who will be responsible for monitoring and continual feedback loops.
	• How often will you revisit your **Action Plan** and update it based on what you observe?
	• Involve stakeholders and community members when developing measures. This will help you identify mutual interests and you can find partners to share and analyze data that you don't have internally. Enter these collaborations in Step 4 of the **Stakeholder & Community Engagement Plan** on page 13.
	• Enter metrics, measures, and data streams into the **Action Plan** on page 11.

Document measurable outcomes & actual impact.	• Document outcomes in your **Action Plan** on page 11. These may be left blank initially and filled in as you implement and monitor. • Outcomes should be aligned with and linked to your aim, with timelines noted. • How many individuals from the vulnerable population were actually impacted by your interventions? _____

STEP 4 (CONT): MONITOR, IMPROVE, DISSEMINATE

[PDSA & SHARE WHAT YOU'VE LEARNED]

Improve: Use quality improvement methods to keep a pulse on your progress.	• Use the **Plan, Do, Study, Act (PDSA)** quality improvement methodology to adjust and document your course of action (tests of change) based on your findings and monitoring.
	• Enter your tests of change into the **PDSA Plan** on page 14.
	• Barriers/Challenges: Engage stakeholders in your community to address barriers and challenges as you implement interventions.
	  ○ Enter these challenges into the **PDSA Plan** on page 15.
	  ○ Enter these PDSA collaborations in Step 4 of the **Stakeholder & Community Engagement Plan** on page 13.

ACTION PLAN (PRINT ONE FOR EACH SMART AIM)

Health Equity Champion (Disparities Impact Statement Lead): **Organization:** **Date:**

Program, Model, or Demonstration(s): **Projected Timeline (e.g., 6 months to plan, begin implementation on XX/XX):**

SMART Aim What are you trying to improve for the populaton you identified?	Primary Drivers What is needed to achieve your aim? You may have more drivers. Print a second page to add rows.	Secondary Drivers List interventions that will help you achieve the primary drivers.	Key Individuals & Organizations Key staff, partners, stakeholders, or members of the community accountable for the secondary drivers.	Metrics What will you monitor? What data will you use to track progress toward your aim and how often?	Measurable Outcomes/ Impact Should align with aim.
AIM	Primary Driver #1				
	Primary Driver #2				
	Primary Driver #3				

STAKEHOLDER & COMMUNITY ENGAGEMENT PLAN

You can use this as a tool to report to leadership and your community.

Develop a plan to engage and collaborate with partners—both internal and external—who serve the vulnerable population you're focused on, as well as other key individuals in your community. Talk with your partners about the local resources, services, skills, and opportunities you can leverage to close the identified gap or gaps. You may want to create an asset map so you have a sense of what local resources you can bring to bear on your work. You might find this helps you identify new partners with strengths you can draw on.

Consider:

- **Who** will you engage? Who will be accountable?
- **When** will you engage them (at what step in the process)?
- **Why** did you choose the particular stakeholder(s)?
- **What** will the stakeholder bring to the project (how will they be contributing)?
- **How** will you ensure the stakeholder(s) are a continued part of monitoring and improvement? How will you share monitoring data with them?

Opportunities to Engage Could Include:

- Name a community board or advisors, establish regular check-ins with your community, and find opportunities to dialogue with patients.
- Create formal and informal relationships and opportunities to convene and learn from each other.
- Write out rough timelines or list key dates when you plan to engage your community, patients, and local partners.

Collaborations from **Step 1:**

Collaborations from **Step 2:**

STAKEHOLDER & COMMUNITY ENGAGEMENT PLAN

You can use this as a tool to report to leadership and your community.

Collaborations from **Step 3:**

Collaborations from **Step 4** and **PDSA tests of change:**

Sharing your lessons and progress with your community can also establish credibility with your stakeholders and bring new partners into your work, building momentum. How do you plan to share your success with your local community and partners or even policy makers at the federal and state levels?

Resources:

- If you are communicating with a few different stakeholder or community groups (audiences), you can use this Communication Plan template to stay organized: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/CommunPlan.pdf.
- To learn more about asset mapping, read: https://www.minorityhealth.hhs.gov/npa/blog/BlogPost.aspx?BlogID=3939.

PLAN, DO, STUDY, ACT (PDSA) PLAN

Explain any "tests of change" from Step 4 during your efforts to reduce disparities in your targeted vulnerable population.

This may include:

- Interventions attempted
- Results/findings
- Lessons learned or emerging issues
- New data identified
- New stakeholders involvement needed
- New actions warranted
- How you will monitor and improve upon your aims
- Are there measures or outcomes that, if observed, will mean you need to make a change in your aims or actions? For example, changes that go the wrong direction or flag that your actions are having an unintended consequence.

Timing and Feedback:

- How often will you assess your progress?
- Who will be accountable for providing feedback to your team and stakeholders on progress targeting the vulnerable population (continuous feedback loops of communication to the front line and leadership are recommended)?

PDSA findings/interventions/feedback loops**:**

PLAN, DO, STUDY, ACT (PDSA) PLAN (CONT)

Explain any "tests of change" from Step 4 during your efforts to reduce disparities in your targeted vulnerable population.

Barriers/challenges identified after interventions:

Resources:

- PDSA cycle: https://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle
- Tests of Change: http://www.ihi.org/resources/pages/howtoimprove/scienceofimprovementtestingchanges.aspx

DATA SOURCES HANDOUT

*Use this table of data sources to help you with Step 1 of your **Disparities Impact Statement**.*

Data	Description	Level	Health & Health Care					Demographic					
			Q/O	C	A	U	P	SES/ SDH	R/E	L	D	SO/ GI	R/U
Mapping Medicare Disparities Tool *Centers for Medicare & Medicaid Services*	Identifies disparities in health outcomes, utilization, prevalence, and spending by race and ethnicity and geographic location.	County, State	●	●		●	●		●		●		●
Community Health Status Indicators *Centers for Disease Control*	Provides indicators of health outcomes, access and quality, health behaviors, social factors, and the physical environment.	County	●		●	●	●	●	●	●	●		●
Healthcare Cost and Utilization Project *Agency for Healthcare Research and Quality*	Contains diagnoses and procedures, discharge status, patient demographics, and charges for all patients regardless of payer.	County, State, National	●	●		●		●	●				●
Area Health Resource Files *Health Resources and Services Administration*	Compares population characteristics, health resources, and demographics.	County, State, National		●	●	●		●	●	●	●		●
Health Indicators Website *National Center for Health Statistics*	Describes community's health status and determinants.	Varies (Hospital, County, State, National, Region)	●	●	●	●	●	●	●		●	●	
County Health Rankings *Robert Wood Johnson Foundation, University of Wisconsin*	Ranks the health of nearly every county in the nation, with social determinants.	County	●	●	●	●	●	●	●				●
Dartmouth Atlas of Health Care *Dartmouth Institute*	Provides medical resource distribution, hospital care intensity, variations in care/ procedures, end of life care, and cost.	Hospital, County, State, Region	●	●	●	●		●	●			●	●
Community Health Profiles *Community Commons (CHNA)*	Provides data layer maps with demographic elements, SES, clinical care, health behaviors, and outcomes.	County, State	●		●	●	●	●	●	●	●		●
Additional local data sources: State or Local Health Department Data, Local Community Health Needs Assessment (CHNA), Stakeholder Interviews, Administrative Claims, State Medicaid Data, American Communities Survey (ACS), Behavioral Risk Factor Surveillance System (BRFSS)													

Key

Q/O	Quality & Outcomes	**P**	Prevalence of conditions/disease	**D**	Disability Status
C	Cost	**SES/ SDH**	Socio-economic Status/ Social Determinants of Health	**SO/GI**	Sexual Orientation & Gender Identity
A	Access	**R/E**	Race/Ethnicity	**R/U**	Rural/Urban
U	Utilization of care	**L**	Language		