Disparity Reduction Plan Template

Milestone:
Develop and implement a plan to reduce a disparity in at least one HEDIS®-like metric related to your population of focus. Plan should include feedback and participation from staff and patients or community partners. Note: All Appendices at the end of this document are OPTIONAL tools that will not be required for submission

1. Population of Focus
[automatically displayed]

2. Selected HEDIS®-like Metric * required
(e.g., Well-child visits, postpartum care, diabetes management, etc.)

Metric Name: _____

3. Identified Disparity * required
Briefly describe the disparity you're aiming to reduce (e.g., While our overall colorectal screening rate is 63%, the rate for Spanish-speaking patients is 42%)

Tip: Identifying a disparity might require stratifying your population of focus by a demographic variable (ex. gender, race, language, insurance status, etc.) and comparing the outcome of your selected HEDIS metric to average of your clinic/system and/or across groups within this demographic variable of focus in your selected population of focus. As a note, the population identified can also be white, English speaking, etc. depending on the make-up of the total population served.

Description:

4. Understanding the Population of Focus (optional)
Identifying and naming current conditions behind the identified disparity for your population of focus (optional)

What is known about current conditions in your practice/system in the context of your identified disparity facing your population of focus? Below are questions we **recommend** you reflect on to help you develop a broad understanding of the disparity of focus:

How does this population receive care? (ex. telephone vs. video calls, in-person, etc.)	
How often is this population of focus going to the emergency room and/or being hospitalized?	
How consistently are patients in this population following up with your practice/system after a hospitalization?	

How successfully are patients in this population scheduling appointments for PCP-placed referrals (ex. registered dietician appointments, neurology referral, DM pharmacy visit, etc.)?	
If social quality metrics are available, what social barriers is affecting this population? (ex. 60% of this population screened high risk for financial stress, 50% of this population has transportation difficulties, etc.)	
What are patient's barriers to care? (ex. distrust, technology, etc.) **Tip: refer to current literature to identify patient barriers to your disparity of focus**.	
For this population of focus, how do their other quality metrics compare?	
Are there differences in language, age, or other factors compared to other groups?	
For the disparity you identified: how does your HEDIS-metric outcome compare statewide and nationally? **Tip: refer to current literature to identify possible barriers contributing to your disparity of focus.**	
What else do you know from the data (e.g. no show rates, average visits per year, PCP continuity)?	

5. Root Cause Exploration (optional)

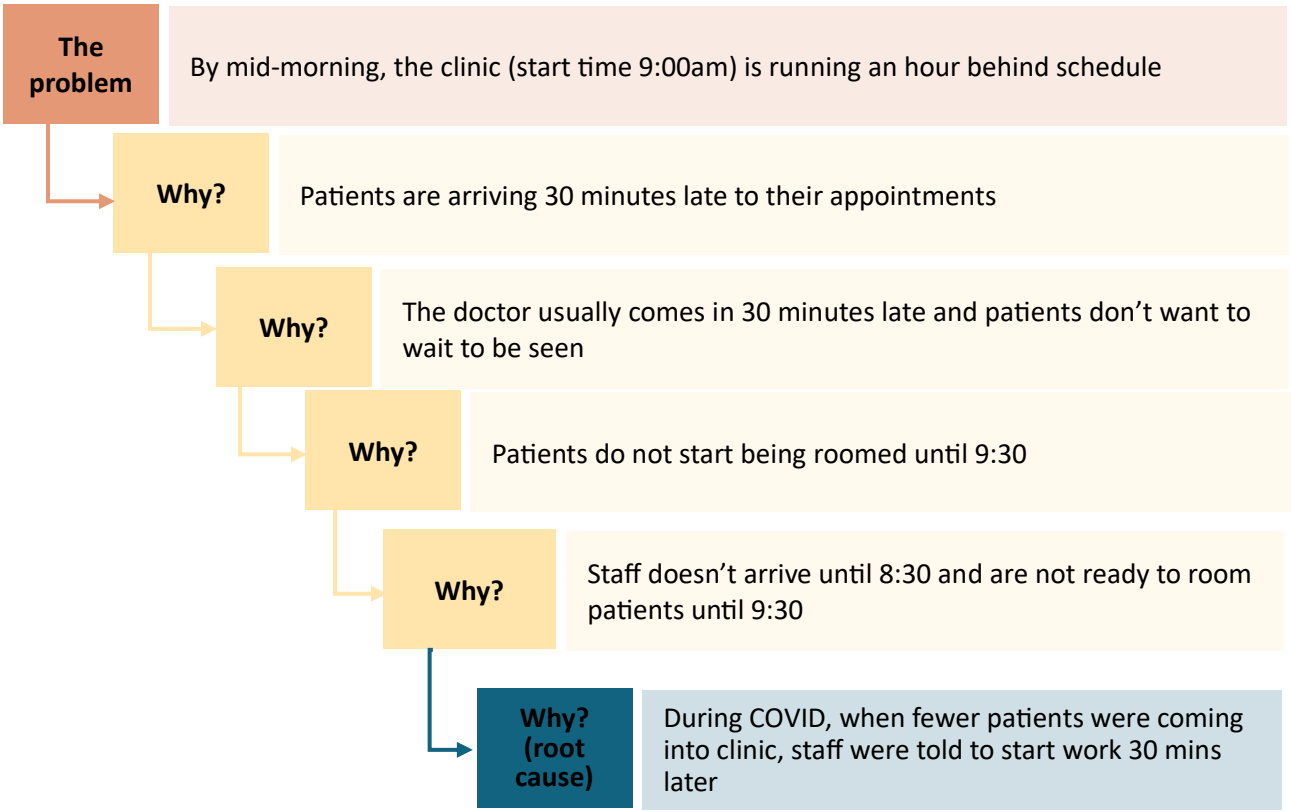
Identifying possible causes from staff

Share the information you have gathered with staff. You might ask questions such as:

- What have you observed that might help us understand the factors contributing to this disparity?
- What factors could make it hard for people to access care?
- Is this care that people have been declining? If so, what have they shared about their reasons?

Try using the **Five Why's** to dig deeper together…

What are the Five Why's? A way to dig deeper into the root or systematic causes of a disparity or gap. It seeks to continue to question why (at least five times) to uncover "latent" or hidden problems that drive the problem on the surface.



You might learn that there are several possible root causes contributing to the disparity of focus. If it helps, you could organize root causes into respective categories using examples below:

1. Workflow issue (ex. patients scheduled for 4:45 PM in-person visits are unable to turn in their FIT kits in time before lab picks up samples)
2. Lack of resources (ex. not enough FIT tests available by Friday mornings)
3. Provider and/or healthcare partner (ex. FIT kit offer rates by provider)

Once you organize your thoughts, review staff-identified causes with your team:

- What challenges or observations are staff sharing with us?
- What information do they need?
- What might we do to address each of the challenges identified?

Our practice came up with an idea to address challenge(s) identified:

- Example: Hold a clinic-wide huddle at the end of the month to inform staff to come into clinic 30 minutes earlier to stay on schedule.
    - Issue identified: "During COVID, when fewer patients were coming into clinic, staff were told to start work 30 minutes later"

Staff Involvement (limit responses to 1-5 sentences) * required

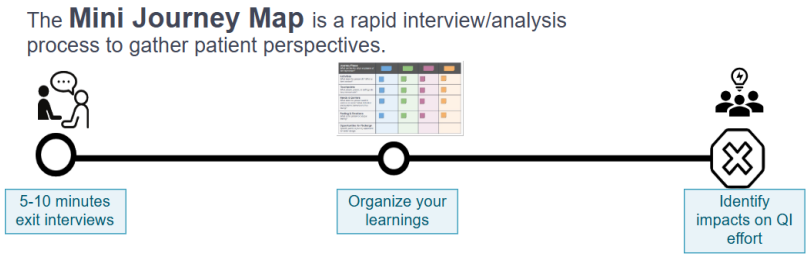
How many staff members did you talk with?	
How was their input gathered?	
What ideas did you hear from staff about the reason for the disparity?	#1
	#2
	#3
	#4
If unable to interview multiple staff, what were common barriers to gather staff input?	#1

	#2
	#3
	#4
What insights did you gather from these or other sources about how to improve care?	Intervention #1
	Intervention #2
	Intervention #3
	Intervention #4

Identifying possible causes from patients

The approach outlined on this page is optional and meant to provide ideas for how to complete the exercise

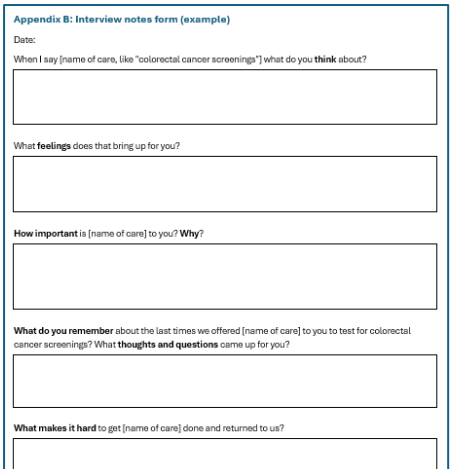
Optional: Use the Mini Journey Map framework to gather patient-identified causes contributing to the disparity of



The **Exit Interview** is a quick conversation, often as a patient is leaving an appointment, to get their perspective.

- **How long?** As short as 5 minutes
- **What method?** In person after/during appointment, by phone, via digital survey, or through a secure service line via text message that links to a survey
- **How many do I need to talk to?** Aim for 5 people, but if you can get 2, that's still valuable
- **Who does it?** Often a front office manager or medical assistant
- **Who are you talking to?** People who have the care gap you are working to close (for example, have NOT gotten the influenza vaccine or colorectal cancer screening). Can focus on people with a known disparity

Summarize your conversations in the interview notes form (Appendix B)


Appendix B: Interview notes form (example)

Date:

When I say [name of care, like "colorectal cancer screenings"] what do you **think** about?

What **feelings** does that bring up for you?

How important is [name of care] to you? **Why**?

What do you remember about the last times we offered [name of care] to you to test for colorectal cancer screenings? What **thoughts and questions** came up for you?

What makes it hard to get [name of care] done and returned to us?

Exit Interview Example: Colorectal Cancer Screening

Introduction: [name of clinic] is trying to improve how we take care of our patients, especially around how make sure they get all the recommended cancer screenings [or other health gap]. Do you have 5 minutes to answer a few questions and share your input?

[If yes]: I wanted to ask you about your experience around colorectal cancer screenings.

- When I say "colorectal cancer screenings," what do you **think** about?
- What kinds of **feelings** does that bring up for you?
- **How important** is colorectal cancer screening to you? **Why**?

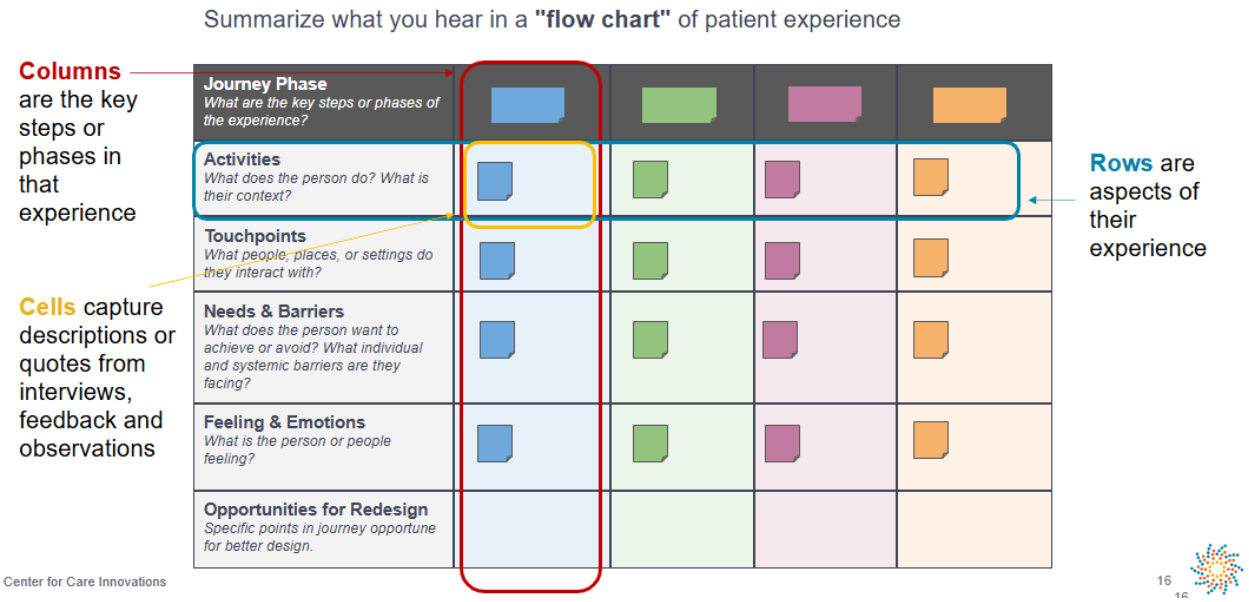
What do you remember about the last times we offered a FIT test to you to test for colorectal cancer screenings? What **thoughts and questions** came up for you?

What makes it hard to get the FIT test done and returned to us?

What could we do to help answer your questions and support you in getting the test done?

See Appendix A for examples for other populations of focus

After the exit interview phase of the Mini Journey Map, organize your learnings into a flow chart like the one below OPTIONAL:



Organizing your learnings in a "flow chart" of patient experience is one way to make sense of what you have heard. See Appendix C for a sample flow chart that you can adapt.

Across the top, you want to list the steps that people go through *(e.g., Step 1: Get a fit test in the mail; Step 2: Get reminder call; Step 3: Go in for appointment).* Down each column, list the activities people describe doing, who/where they interact, what their needs and barriers are, and how they describe feeling.

For example, in our FIT test example, we saw a lot of emotions and potential barriers ("Ugh, poop!" "Do I have to go to the post office?" "I lost my kit on my pile of mail." "Reading the instructions is too much!")

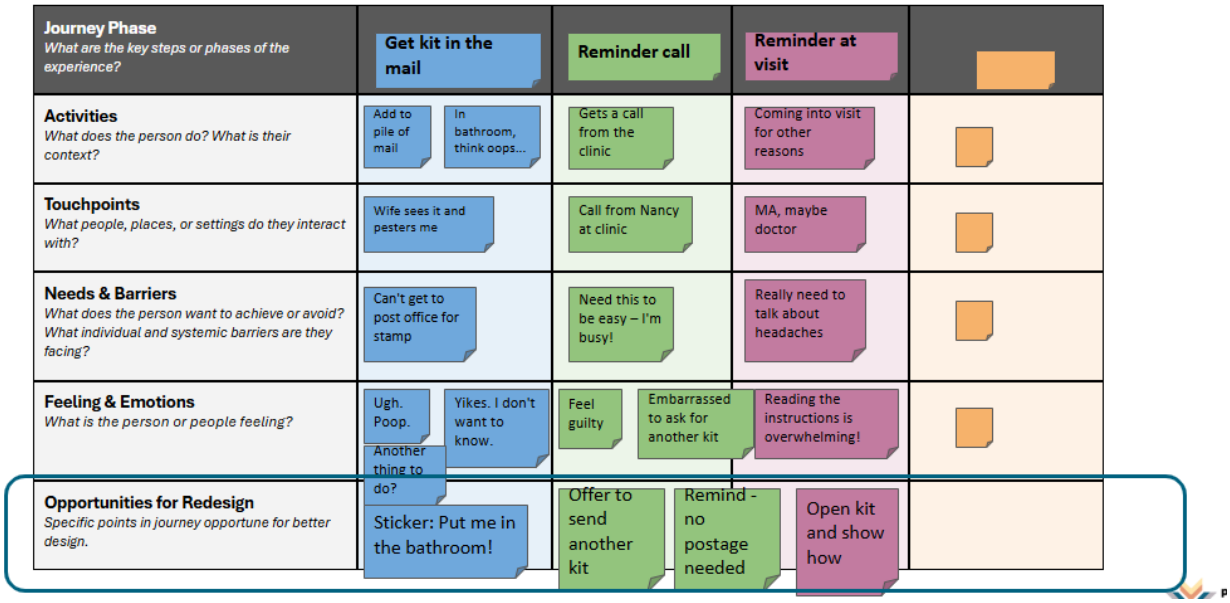
Example:

Once you organize your thoughts, review your journey map as a team.

- What challenges are patients sharing with us?
- What information do they need?
- What might we do to help patients address each of the challenges identified?

Our practice came up with a few ideas…

- A sticker to remind people to put the kit in the bathroom
- Offering to send another kit when making reminder calls
- Reminding people that no postage is needed
- Opening a sample kit at a visit to show people how to use it.



Patient/Community Engagement (limit responses to 1-5 sentences) * required:

How many patients/community members did you talk with?	
How was their input gathered?	
What ideas did you hear from patients/community members about the reason for the disparity?	#1
	#2
	#3
	#4
If unable to connect with multiple patients, what were common barriers to gather input?	#1
	#2

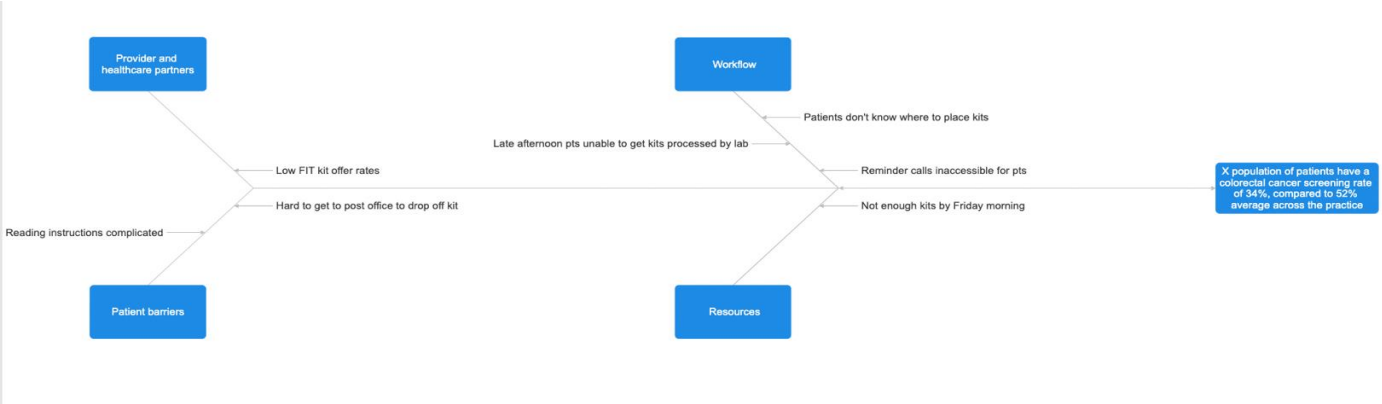
	#3
	#4
What insights did you gather from these or other sources about how to improve care?	Intervention #1
	Intervention #2
	Intervention #3
	Intervention #4

6. Plan to Reduce Disparity (optional)

Consolidating patient and staff perspectives

One helpful framework your team can use to consolidate patient and staff perspectives is to create a fishbone analysis. Using a fishbone, you can create overarching categories where numerous root causes may belong and identify root causes, you'd like to address. Create your own fishbone and organize staff-identified and patient-identified into their respective categories.

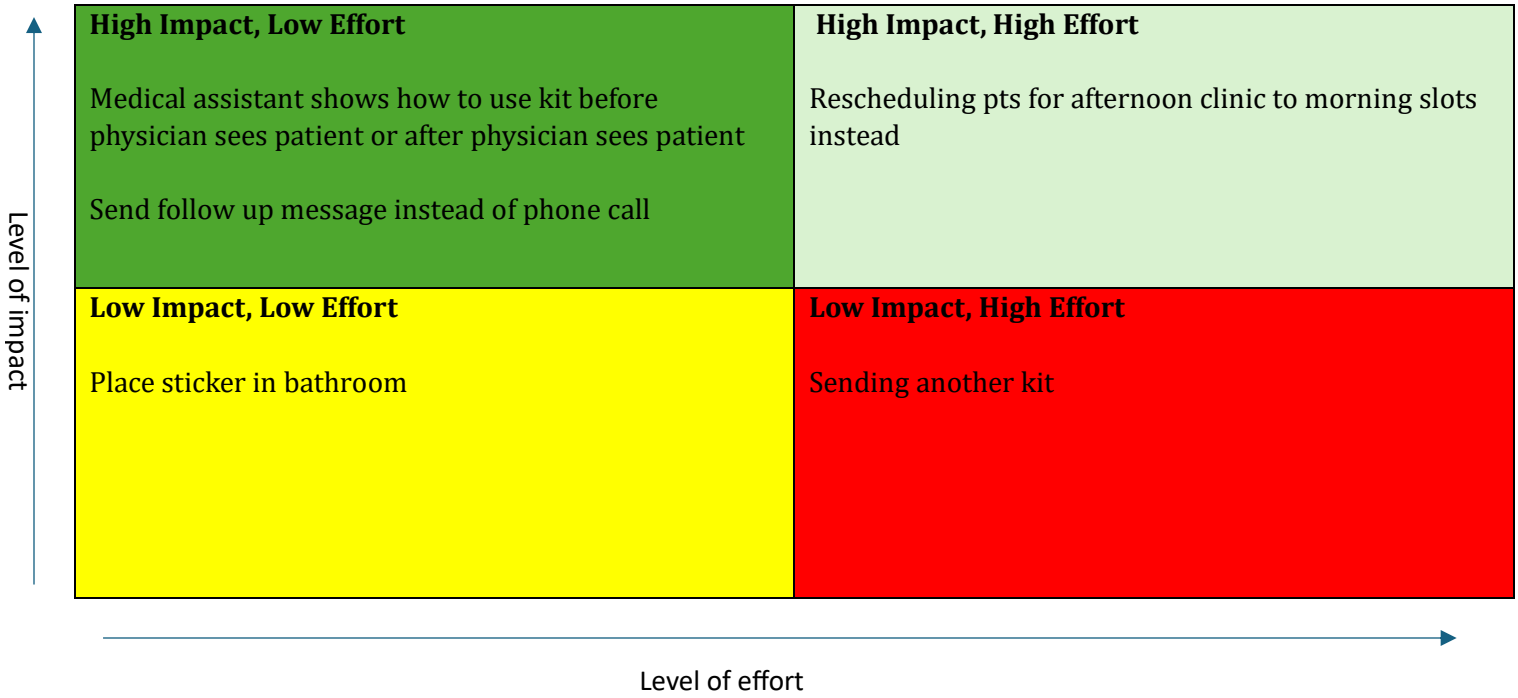
Example:



Choosing a high impact, low effort intervention

When deciding which intervention to implement, it could be helpful to use the action priority matrix. This framework is a tool to identify which interventions for each root cause has a higher or lower impact with a higher or lower effort. Ideally, higher impact with low effort interventions can be an excellent way to start addressing a disparity. When deciding what intervention is feasible to implement, you can think of the following:

- Who from your practice would implement this practice?
- What is their capacity to implement this?
- Could they be key stakeholders in leading this intervention?
- How will they be notified on implementing this practice?
- What resources or training do they need to implement this practice?



[Refer to Appendix D to create your own fishbone and action priority matrix.]

Finalizing your disparity reduction plan:

Overview of Intervention Strategy (limit responses to 1-5 sentences) * required:

What specific actions or changes will you implement?	
How does the strategy address the identified root causes?	

Key Activities & Timeline * required:

Action/Change	Root cause addressed	Lead (who is responsible)	Timeline	Notes

Tip: Set up a meeting NOW on your calendar for the end of the timeline (the end of the first PDSA cycle) AND set a reminder a few days earlier for the person pulling the process and outcome measures to get them ready for that meeting. Your goal will be to assess how well the initial proposed actions worked (or if they happened) and decide what to do next.

7. Evaluation Plan *** required***

For each of our proposed actions/changes, we want to establish process and outcome measures and plan for how we will use those measures.

Process measure: How will you know if the action is happening?

(Ex. patient encounter by medical assistant confirming FIT test review)

Outcome measure: How will you know if the action has the desired effect?

(Ex. colorectal screening rate)

Added September 2025: examples for each PoF:

Pregnant People
- Process measure: *Number of OB intake packets updated to include depression screening prompt*
- Outcome measure: *Increase in % of patients screened for perinatal depression*

Children & Youth
- Process measure: *Number of reminder calls sent to families with upcoming well-child visits*
- Outcome measure: *Increase in up-to-date immunization status (CIS Combo 10)*

Adults with Chronic Conditions
- Process measure: *Percent of visits where staff print a BP recheck slip when BP is elevated*
- Outcome measure: *Increase in % of patients with controlled blood pressure (<140/90)*

Adults with Preventive Care Needs
- Process measure: *Number of FIT kits mailed each week*
- Outcome measure: *Increase in completed colorectal cancer screenings*

Adults with Behavioral Health Needs
- Process measure: *Number of PHQ-9 templates opened in the EHR during visits*
- Outcome measure: *Increase in % of patients with documented follow-up after positive depression screen*

(Limit responses to 1-5 sentences) * required:

How will you know if your plan is really happening? (process measure)	
How will you know if it is affecting the outcome? (outcome measure)	

How often will you look at those measures?	
Who will pull and review the measures?	

The disparity of focus your practice is addressing will help close an inequity facing your identified population of focus. Before implementing your intervention, it is helpful to identify what an equitable outcome is for the disparity your team is addressing.

(Limit responses to 1-5 sentences) * required:

What is your target goal for your process measure? (Ex. 90% of patients who have FIT test care gap have an e-message encounter for FIT test drop off reminder)	
What is your target goal for outcome measure? (Ex. 70% colorectal cancer screening rate for Spanish speaking patients)	
How will you know your intervention reduced the disparity of focus? (Ex. 0-2% difference in screening rates between Spanish-speaking patients and clinic average)	
Optional: How do your evaluation goals compare to state and national averages for your HEDIS-metric? You can use this as a benchmark to guide your own goal setting.	

8. Reflections at end of first PDSA cycle

Amazing work! Your team has nearly completed a full PDSA cycle. At this point, your team has planned an intervention, implemented it, and evaluated it. Now, it is crucially important to reflect on the outcomes of your intervention. The PDSA templates provided in Appendices E and F provide a framework to guide your team on asking key questions on your first PDSA cycle including:

(Limit responses to 1-5 sentences) * required:

What worked or did not work in your first effort at your disparity reduction plan?	
How were patients impacted?	
How were staff impacted?	
What change will you make in the next attempt (PDSA Cycle)?	

Appendices: All Appendices are OPTIONAL tools that will not be required for submission

Appendix A: Sample interview questions for other Populations of Focus

Example for Colorectal cancer screening

Introduction: [name of clinic] is trying to improve how we take care of our patients, especially around how make sure they get all the recommended cancer screenings [or other health gap]. Do you have 5 minutes to answer a few questions and share your input?

[If yes]: I wanted to ask you about your experience around colorectal cancer screenings.

- When I say "colorectal cancer screenings," what do you **think** about?
- What kinds of **feelings** does that bring up for you?
- **How important** is colorectal cancer screening to you? **Why**?

What do you remember about the last times we offered a FIT test to you to test for colorectal cancer screenings? What **thoughts and questions** came up for you?

What makes it hard to get the FIT test done and returned to us?

What could we do to help answer your questions and support you in getting the test done?

Example for well-child visit

Introduction: [name of clinic] is trying to improve how we take care of our patients, especially around how to make sure kids get the well-child visits they need growing up. Do you have 5 minutes to answer a few questions and share your input?

[If yes]: I wanted to ask you about your experience around well-child visits.

- When I say "well child visits," what do you **think** about?
- What kinds of **feelings** does that bring up for you?
- **How important** are well-child visits to you? **Why**?

What do you remember about the last times we scheduled a well-child visits for your child? What **thoughts and questions** came up for you?

What makes it hard to get well child visits done?

What could we do to help answer your questions and support you in getting well child visits?

Appendix B: Interview notes form (example)

Date:

When I say [name of care, like "colorectal cancer screenings"] what do you **think** about?

What **feelings** does that bring up for you?

How important is [name of care] to you? **Why**?

What do you remember about the last times we offered [name of care] to you to test for colorectal cancer screenings? What **thoughts and questions** came up for you?

What makes it hard to get [name of care] done and returned to us?

What could we do to help answer your questions and support you in getting the test done?

Appendix C: Patient flow chart to understand patient experiences (mini-journey map)

Organize what you learn from patients and staff here. Along the top, write down each step of the experience for patients (e.g., Step 1: called to tell me I'm due for a mammogram; Step 2: Call to get an appointment; Step 3: Go in for appointment). Down each column, list the activities people describe doing, who/where they interest, what their needs and barriers are, and how they describe feeling.

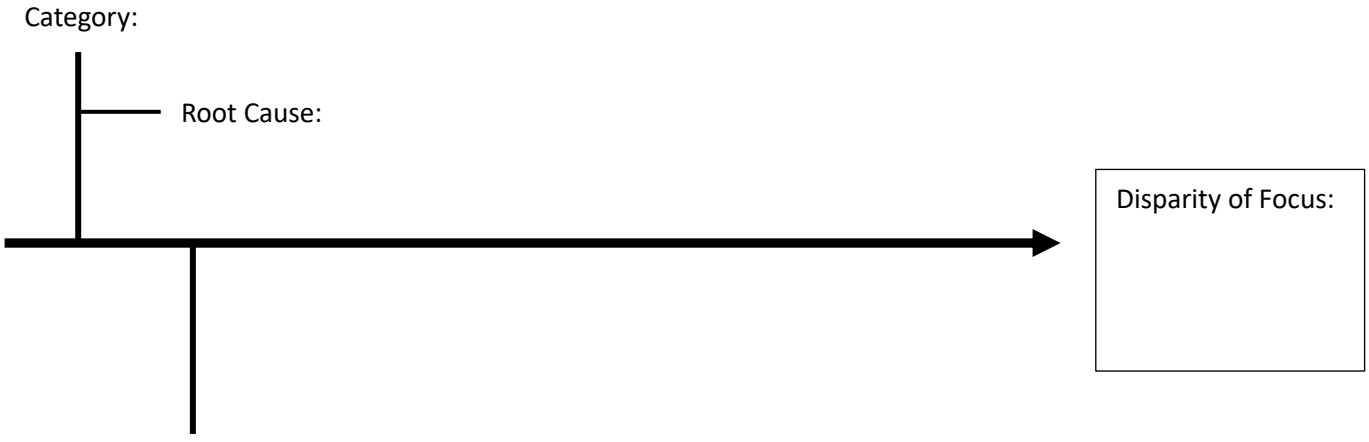
After you have organized your thoughts, share this back with staff and discuss: What are the opportunities for redesign?

Journey Phase *What are the key steps or phases of the experience?*	Step 1:	Step 2:	Step 3:

Activities *What does the person do? What is their context?*			
Touchpoints *What people, places, or settings do they interact with?*			
Needs & Barriers *What does the person want to achieve or avoid? What individual and systemic barriers are they facing?*			
Feeling & Emotions *What is the person or people feeling?*			
Opportunities for Redesign *Specific points in journey opportune for better design.*			

Appendix D: Fishbone and Action Priority Matrix

For your fishbone, create categories (ex. workflow issue, resource issue, etc.) and then list root causes under each category based off staff and patient insights.



For your action priority matrix, list out interventions you discussed with your team to address root causes you identified above. Ideally, you want to implement an intervention that is high impact, low effort.

High Impact, Low Effort	**High Impact, High Effort**
Low Impact, Low Effort	**Low Impact, High Effort**

Appendix E: Template PDSA Short-Form

For instructions to use this tool, please see the *QI Essentials Toolkit*.

Date: _____ Change Idea: _____ PDSA#: _____

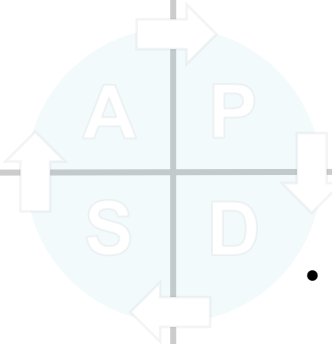
Objective (What question(s) do we want to answer?): _____

4) Act: "What's next?"

- Adapt? Adopt? Abandon? Run again?

1) Plan: "What will happen if we try something different?"

- What will you do? When and where will you do it? Who will do it?
- What data will you collect and how will you collect it?
- What do you predict will happen?



3) Study: "What happened?"

- Did the test go as planned?
- What did you learn?
- Was your prediction right or wrong?

2) Do: "Let's try it."

- Run the test: Carry out the plan. Collect and record the data.

Appendix F: PDSA Tracker Worksheet

pop health LEARNING CENTER

Equity and Practice Transformation (EPT) Payment Program
Disparity Reduction Plan Deliverable Template

Project Name/Description:

Aim or Problem to be solved:

	PLAN				DO	STUDY	ACT
Cycle #.	**What will you do?**	**What do you predict will happen?**	**Who will do it?**	**What will you measure?**	**Date(s) of test**	**Results or Key Learning**	**What next? Adapt Adopt Abandon**
1							
2							
3							
4							
5							