Example Disparity Reduction Plan Template from Prime Wellness

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

Children and Youth

2. Selected HEDIS®-like Metric * required

(e.g., Well-child visits, postpartum care, diabetes management, etc.)

Metric Name: Depression Screening – 12-17yo

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:

While overall depression screening rates for adolescents ages 12–17 at Prime Wellness Community Health Center are 78%, the rate among Spanish-speaking patients in the same age group is 54%. This gap suggests language and cultural barriers are contributing to lower screening completion and documentation rates during well-child and acute visits.

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.)	The majority of Spanish-speaking children and youth are seen in-person for visits, typically accompanied by a parent or guardian. Telehealth use remains low (under 10%) due to technology access and language barriers. Interpreter services

	are used when available, but bilingual providers and staff are preferred by families.
How often is this population of focus going to the emergency room and/or being hospitalized?	ER utilization among Spanish-speaking youth is moderate, mostly for urgent respiratory or minor injury visits. Behavioral health–related ER visits are rare but may be underreported due to stigma and lack of mental health literacy. Hospitalization rates are similar to peers.
How consistently are patients in this population following up with your practice/system after a hospitalization?	Post-hospital follow-up rates are inconsistent (~55%), often due to communication barriers, limited parent understanding of discharge instructions in English, and scheduling difficulties during work hours.
How successfully are patients in this population scheduling appointments for PCP-placed referrals (ex. registered dietician appointments, neurology referral, DM pharmacy visit, etc.)?	Referral completion for behavioral health or psychiatry services is low (under 40%), especially for Spanish-speaking families. Barriers include limited availability of Spanish-speaking behavioral health providers and long wait times.
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.)	Data from SDOH screenings show 58% of Spanish-speaking families report financial stress, 47% report transportation challenges, and 33% face housing instability. These social factors reduce preventive visit consistency and follow-up adherence.
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**.	Primary barriers include language differences, limited access to Spanish-language behavioral health resources, parental stigma around mental health, and low digital literacy for completing screening forms electronically.
For this population of focus, how do their other quality metrics compare?	Spanish-speaking pediatric patients show slightly lower completion rates for well-child visits (82% vs. 90%) and lead screenings (69% vs. 81%), but similar rates for immunizations. Preventive mental health screening remains the lowest-performing measure.
Are there differences in language, age, or other factors compared to other groups?	Spanish-speaking families represent 48% of the pediatric patient panel, with higher proportions of recent immigrant families and lower socioeconomic status. English-speaking families are more likely to engage in telehealth and complete online screening tools.
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.**	Prime Wellness CHC's overall adolescent depression screening rate (78%) is near the California average (80%), but screening among Spanish-speaking patients (54%) is significantly below both the statewide benchmark (77%) and national average (79%).

What else do you know from the data (e.g. no show rates, average visits per year, PCP continuity)?	Qualitative feedback from Spanish-speaking parents shows discomfort discussing emotional topics, especially when interpreters are present. Providers also report that time constraints and translation delays make PHQ-9 or PHQ-A completion more difficult during short visits.

5. Root Cause Exploration (optional)

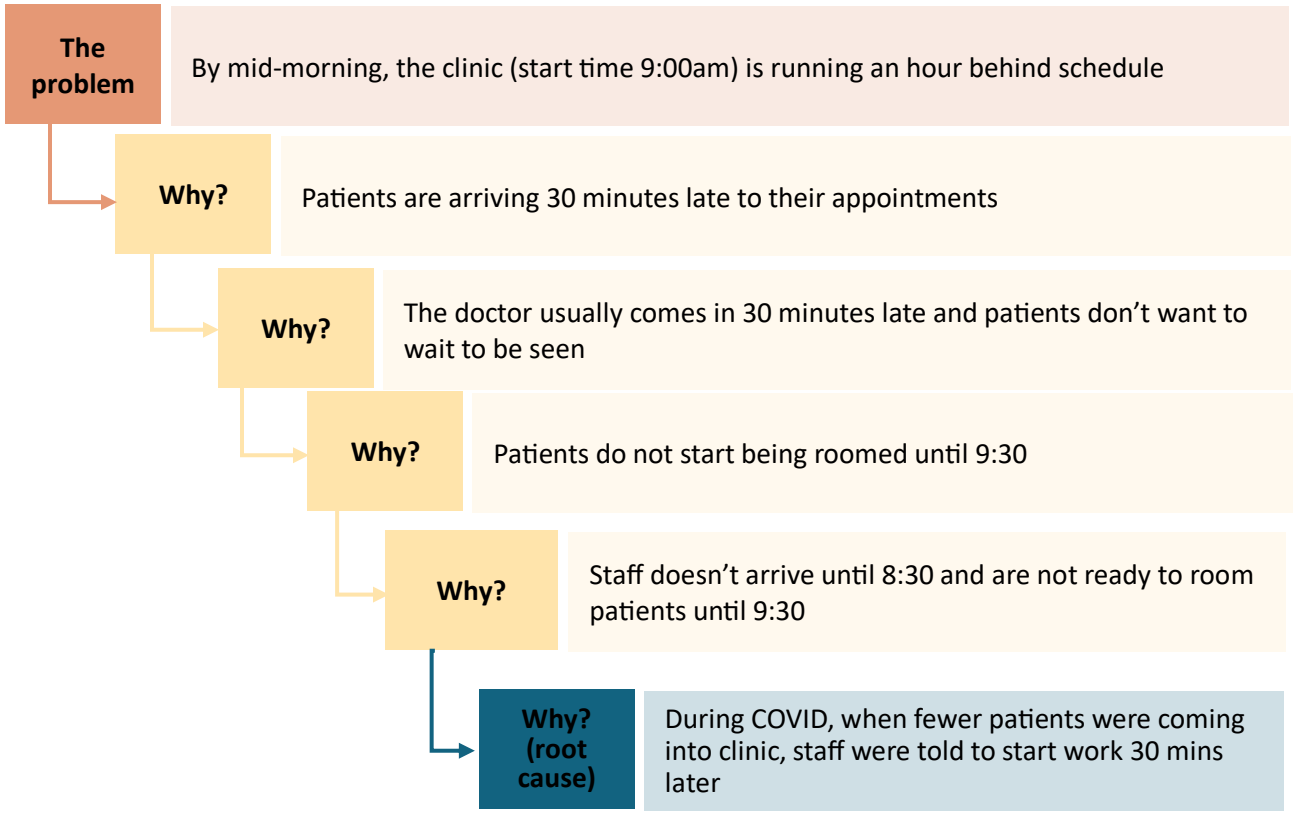
Identifying possible causes from staff

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

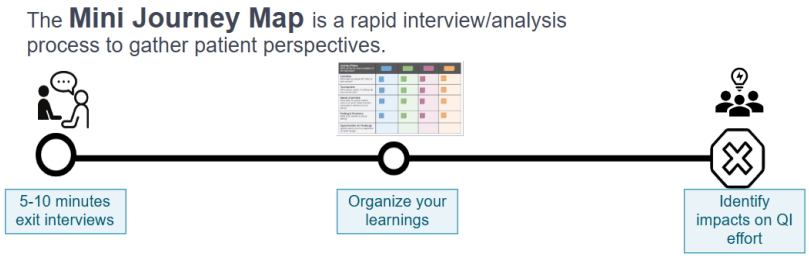
How many staff members did you talk with?	4 staff members – 1 Primary Care Provider (PCR), 2 Medical Assistants (MAs), and 1 Administrator.
How was their input gathered?	Input was gathered during a scheduled team huddle focused on pre-visit planning and quality metrics.
What ideas did you hear from staff about the reason for the disparity?	#1 The team identified that Spanish-speaking families often feel uncomfortable discussing depression due to cultural stigma and lack of understanding about screening purpose. Staff also noted that PHQ-A forms are not always available in Spanish, and interpretation time during visits reduces provider ability to complete screenings consistently.
	#2
	#3
	#4
If unable to interview multiple staff, what were common barriers to gather staff input?	#1 All staff participated. The only limitation was time availability, as discussions were held between patient visits to avoid disrupting clinic flow.

	#2
	#3
	#4
What insights did you gather from these or other sources about how to improve care?	Intervention #1 Staff recommended ensuring PHQ-A tools are readily available in both English and Spanish, providing a short staff script to explain the screening's importance to parents, and including depression screening reminders in the pre-visit checklist.
	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

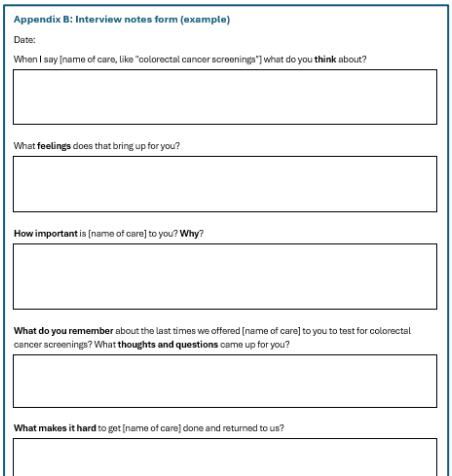
Optional: Use the Mini Journey Map framework to gather patient-identified causes contributing to the disparity of



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**?

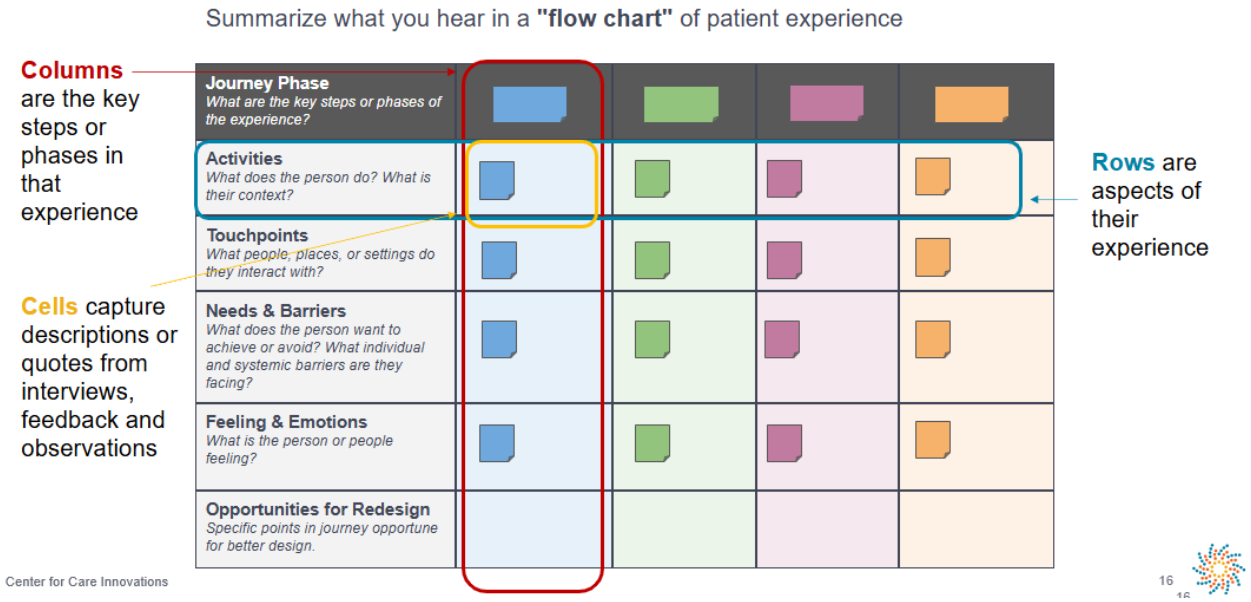
What do you remember about the last times we offered a FIT test to you to test for colorectal cancer screenings? What **thoughts and questions** came up for you?

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!")

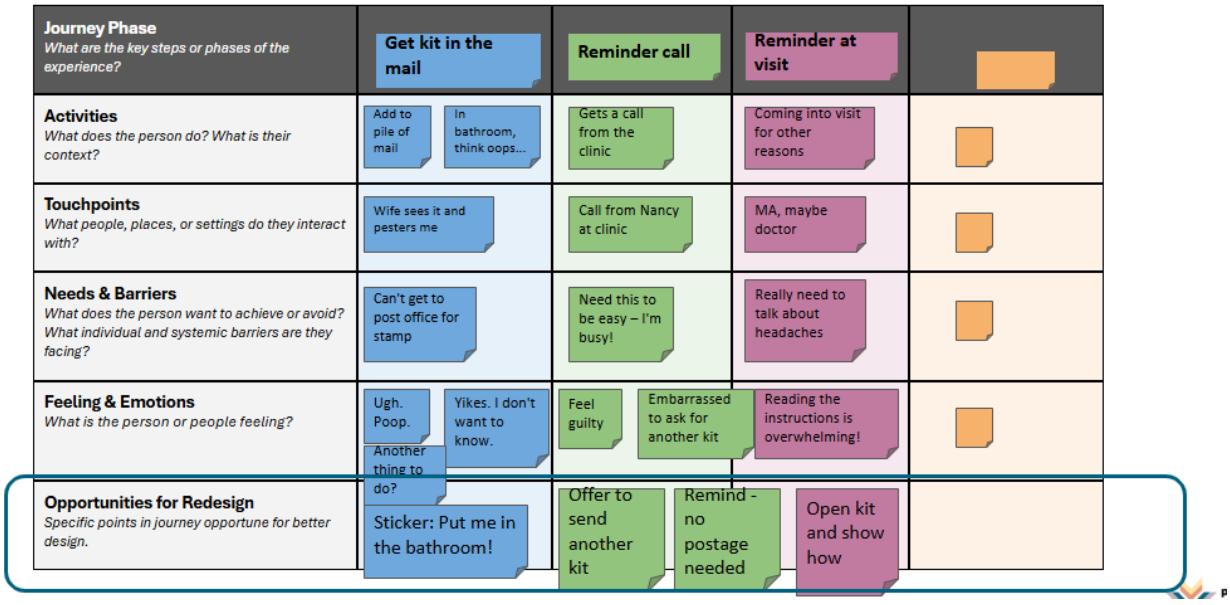
Example:

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.



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

How many patients/community members did you talk with?	5 patients/families were interviewed, all Spanish-speaking parents of adolescents aged 12–17 who had not completed depression screening.
How was their input gathered?	Input was gathered via brief exit interviews conducted by a bilingual Medical Assistant immediately after visits.
What ideas did you hear from patients/community members about the reason for the disparity?	#1 Families reported discomfort discussing mental health topics, lack of understanding about the purpose of the PHQ-A screening, concerns about privacy, and preference for speaking directly with a bilingual provider rather than filling out forms or using an interpreter.
	#2
	#3
	#4
If unable to connect with multiple patients, what were common barriers to gather input?	#1 Scheduling limitations, short visit times, and patient/family time constraints sometimes made it difficult to conduct interviews.
	#2
	#3
	#4
What insights did you gather from these or other sources about how to improve care?	Intervention #1 Insights included providing PHQ-A forms in Spanish, offering a brief verbal explanation of the screening purpose, integrating screening reminders into pre-visit planning, and emphasizing confidentiality.
	Intervention #2
	Intervention #3

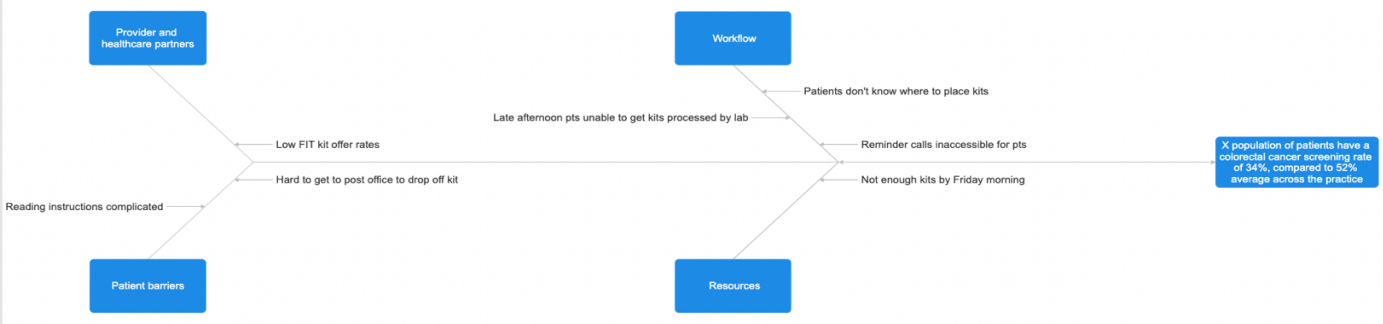
	Intervention #4

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:



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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?

High Impact, Low Effort Medical assistant shows how to use kit before physician sees patient or after physician sees patient Send follow up message instead of phone call	**High Impact, High Effort** Rescheduling pts for afternoon clinic to morning slots instead
Low Impact, Low Effort Place sticker in bathroom	**Low Impact, High Effort** Sending another kit

Level of impact

Level of effort

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

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Finalizing your disparity reduction plan:

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

What specific actions or changes will you implement?	Implement a workflow where Medical Assistants provide a brief verbal explanation of the PHQ-A screening in Spanish during check-in, ensure PHQ-A forms are available in Spanish, and incorporate a pre-visit reminder in the EHR to prompt screening completion.
How does the strategy address the identified root causes?	This strategy directly addresses patient discomfort, language barriers, and lack of understanding about depression screening. By providing bilingual forms and explanations, it reduces cultural stigma and confusion. EHR prompts ensure consistent implementation, and staff training equips the team to engage families effectively, increasing the likelihood that screenings are completed during the visit.

Key Activities & Timeline * required:

Action/Change	Root cause addressed	Lead (who is responsible)	Timeline	Notes
Medical Assistant provides a brief verbal explanation of PHQ-A in Spanish during check-in	Patient discomfort and misunderstanding about depression screening	Medical Assistant (MA)	Start 10/15/2025; review after 4 weeks	Use a short script; ensure all MAs are trained on cultural sensitivity
Ensure PHQ-A forms are available in Spanish both electronically and in print	Language barriers, lack of accessible screening materials	Administrator / MA	Complete by 10/20/2025	Check stock weekly; include EHR template update

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?

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(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)	Track the number of Spanish-speaking adolescent patients who receive a PHQ-A explanation from the MA at check-in, and confirm that Spanish PHQ-A forms are used and EHR pre-visit reminders are triggered for each eligible patient.
How will you know if it is affecting the outcome? (outcome measure)	Monitor the percentage of Spanish-speaking adolescents with a completed PHQ-A documented in the EHR during visits, and the number of follow-up plans initiated for positive screens.
How often will you look at those measures?	Measures will be reviewed weekly during staff huddles for process tracking and monthly for outcome trends.
Who will pull and review the measures?	The Administrator will extract data from eClinicalWorks, with review and discussion during team huddles.

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)	100% of Spanish-speaking adolescents receive verbal PHQ-A explanation, have access to a Spanish form.
What is your target goal for outcome measure? (Ex. 70% colorectal cancer screening rate for Spanish speaking patients)	Increase depression screening completion for Spanish-speaking adolescents from 54% to 85% within 3 months of implementation.
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)	The disparity is reduced when the depression screening rate for Spanish-speaking adolescents is within 5% of the overall clinic rate (target ≥83%).
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.	The 85% target is above the California average (77%) and near the national average (79%) for adolescent depression screening, closing the gap for Spanish-speaking patients.

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?	What worked: MAs consistently provided verbal explanations, and Spanish PHQ-A forms were available for nearly all patients. What did not work: EHR pre-visit reminders were occasionally missed due to inconsistent dashboard updates, and some parents still expressed hesitation despite explanations.
How were patients impacted?	Patients were more informed about the purpose of depression screening, and several Spanish-speaking adolescents completed the PHQ-A who might have otherwise declined. Families reported feeling more comfortable discussing mental health topics with bilingual staff.

How were staff impacted?	Staff reported increased confidence using culturally sensitive scripts and felt better prepared to explain screenings. MAs noted slightly longer check-in times but appreciated seeing higher completion rates.
What change will you make in the next attempt (PDSA Cycle)?	Next cycle will focus on improving EHR pre-visit reminder reliability, integrating a brief staff checklist to ensure all steps are completed, and adding additional patient education materials to further reduce hesitation and clarify confidentiality.