



**Health Disparities, Cultural Engagement, and Linguistic Accommodation:
A brief history of CAPG's Commitment to Improvement**

An introduction from Wells Shoemaker MD, Medical Director, CAPG January, 2009

A committed cluster of leaders within CAPG's groups gathered in early 2008 to create the framework for a formal committee...or more accurately a taskforce...to use CAPG's demonstrated strengths to confront the challenges of health disparities within our organizations and the communities we serve. Those strengths include the formal structure of coordinated care systems for large populations, commitment to continuous quality improvement, comfort with measurement and accountability, and realistic approaches to affordability and sustainability.

CAPG's Board endorsed this pursuit in July, 2008, and created our formal structure in September, 2008. The CAPG Disparities, Culture, and Language Committee honored the formative energies of Robert Beltran MD, Medical Director at Monarch Health in Orange County, with the unanimous invitation to serve as founding Chair.

This conference will hopefully display what we have learned, offer new audiences for voices of wisdom and creativity, provide direction for actions for our immediate future, and lay foundations for an educated, responsive, and representative healthcare workforce of California's future.

We're glad you are here to help us succeed. Thank you!

We would like to share the presentation to the CAPG Board, along with some specific action steps developed to date, by our committee.

Definition: Health Disparities describe a situation by which people receive different health care access, care processes, safety precautions, satisfaction, and, crucially, clinical outcomes, based upon ethnicity, language, age, gender, diagnosis, income, insurance status, and geography... among other differentiators.

Considerations:

1. Health Disparities have been robustly documented in California with increasing academic, media, and political attention. Disparities exist within CAPG's coordinated care model, to a variable but poorly quantified degree.

2. Beyond impact upon the individual people we serve, disparities result in inescapable negative consequences for medical groups:
 - a. Decrements in measures of clinical performance (P4P, HEDIS) which obligatorily lower achievable scores, rewards, and recognition.
 - b. Inflated costs for avoidable complications of chronic illness, delayed or missed preventive screenings, and delayed or inappropriate interventions for acute illnesses. All of these errors increase the total cost of care for a population and make prepaid, comprehensive care in the delegated model increasingly expensive to purchasers.
 - c. Missed opportunities to serve a growing, influential minority population with superior coordinated care models.
3. CAPG's organized systems of clinical care, coupled with business acumen in population care, represent an ideal vector to systematically reduce the prevalence and impact of disparities, as we have demonstrated for a host of clinical conditions.
4. The business impact of health disparities, as well as the relative effectiveness and ROI of different interventions, have not been well documented in the coordinated care model. Fiscal measurements and feasible sustainability shall be incorporated into the committee's work planning.
5. CAPG's ~150 medical groups include a substantial number of seasoned leaders with personal life experience, academic exposure, and community awareness of disparities, plus experience with change processes within medical groups, plus personal commitment to reduce disparities.
6. A committee structure focused upon this challenge has the potential to accelerate the deployment of strategies across a broad range of CAPG groups.
7. While the Latino population is the largest identified group experiencing health disparities in California, other determinants of disparities and other populations deserve equally motivated consideration.

Elements of CAPG program:

1. Create a regular forum within CAPG for discussion and sharing of experiences and strategy.
2. Disseminate a toolkit of finished education resources, and maintain on CAPG website (in place early July, 2008).
3. Encourage CEO's and medical directors to address frontline practitioners and office staff regarding cultural engagement and language accommodation. Formal, group-

endorsed, possibly incentivized programs with measured participation and outcomes will likely have better penetration than *ad hoc* or sporadic offerings.

4. Assess real-time CAPG group capabilities through Standards of Excellence survey.
5. Interweave elements of cultural responsiveness into CAPG's educational discussions and committee proceedings throughout the year.
6. The California Quality Collaborative will include these themes with the intensive QI and leadership curricula offered to CAPG groups (underway).
7. Create a best practice inventory with summaries and contact information. Some specific examples:
 - Expand language capabilities in group's high risk and chronic care case management staff—how to find, train, and support group personnel
 - Involvement of Latino and other minority practitioners for analysis, insight, peer teaching, and future leadership development
 - Patient self management support—using cultural beliefs and practices as a clinical adjuvant, not an obstacle.
 - Formal liaison with community organizations which can extend patient centered care well beyond the traditional boundaries of the clinic office.
 - MA training and support of expanded responsibilities for staff in frontline teams, with support, supervision, and ongoing education.
 - Support of local junior college and other programs to encourage minority students to enter healthcare workforce. Groups can offer proactive engagement as training sites, faculty, personal inspiration.
 - Use of “vetted” materials—print, audiovisual, and curricula—for patient education and professional education.

Thank you.
Wells