

**ADDRESSING HEALTH DISPARITIES:  
IS THERE A ROLE FOR PRIVATE PAYERS IN REDUCING  
THE INCIDENCE OF TYPE 2 DIABETES AMONG U.S. HISPANICS?**

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## **ABSTRACT**

Susan Cleland Helm-Murtagh

**ADDRESSING HEALTH DISPARITIES:  
IS THERE A ROLE FOR PRIVATE PAYERS IN REDUCING  
THE INCIDENCE OF TYPE 2 DIABETES AMONG U.S. HISPANICS?  
(Under the direction of Sandra B. Greene, DrPH)**

There is a role for private payers to play in reducing the incidence of type 2 diabetes among Hispanics in the United States. However, given the barriers to reducing or eliminating racial and ethnic health disparities in general that health plans currently face, successfully filling that role is a long-term proposition – one that must be preceded by much foundational work and patience by all stakeholders in the health care system. In the meantime, there is a more critical and immediate role that all private payers should play, if they have not begun to do so already – and that is to join the fight to reduce all racial and ethnic disparities in health and health care. Broader industry action will raise the level of the quality of care delivered to racial and ethnic minorities in general; improve the overall health of those populations; create additional momentum for necessary federal policy changes; enhance industry knowledge and expertise in addressing health disparities; increase the evidence base for program outcomes; and reduce the time it will take to solve this serious problem.

The successful resolution of the overall problem of racial and ethnic health disparities, whether measured by prevalence or incidence, and regardless of the target population or the target disease, will require the involvement of and action by all health care system stakeholders – payers, providers, members, communities, the government, agencies, and foundations. Health plans are in a unique position to influence the majority of

these players, through advocacy, strategies, interventions, incentives, partnerships, policies, and programs. This study presents a series of best and promising practices for health plans to take to begin to address racial and ethnic health disparities.

**To Rory:**

A ghrá mo chroí, go raibh míle maith agat. Giorraionn beirt bothar.

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## **LIST OF ABBREVIATIONS**

AA	African-American
ADA	American Diabetes Association
AHRQ	Agency for Healthcare Research and Quality
BCAP	Best Clinical and Administrative Practices
CHW	Community Health Worker
CLAS	Culturally and Linguistically Appropriate Services
CMO	Chief Medical Officer
CRC	Colorectal Cancer
EMR	Electronic Medical Record
HbA1c	Glycosylated Hemoglobin
HDI	Health Disparities Index
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IVR	Interactive Voice Response
LDL-C	Low-Density Lipoprotein Cholesterol
MCO	Managed Care Organization
NHPC	National Health Plan Collaborative
ROI	Return on Investment

## CHAPTER 1: INTRODUCTION

### ***Study Overview and Specific Aims***

A *health disparity* is a particular type of difference in health; it is a difference in which disadvantaged social groups -- such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination -- *systematically experience worse health or greater health risks than more advantaged social groups.*<sup>1</sup>

In the United States, health disparities in the incidence and prevalence of disease between racial and ethnic groups are striking.<sup>2</sup> For example, heart disease is the leading cause of death for all racial and ethnic groups in the United States, but rates of death from cardiovascular disease are about 30 percent higher among African American adults than among white adults. In addition, in women, overweight and obesity are higher among members of racial and ethnic minority populations than in non-Hispanic white women. In men, Mexican-Americans have a higher prevalence of overweight and obesity than non-Hispanic men, and approximately 300,000 deaths in the United States each year are associated with obesity and overweight. Finally, the prevalence of diabetes among American Indians and Alaska Natives is more than twice that of the total population, and the Pima Indians of Arizona have the highest known prevalence of diabetes in the world. The prevalence of Type 2 diabetes is 70 percent higher among African Americans and nearly 100 percent higher among Hispanics than among whites.<sup>2-4</sup>

The list goes on; the presence of racial and ethnic health disparities is well known and documented, as are the impacts to individuals and to society. To illustrate this point,

the 2003 Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, reviewed more than a hundred studies published in the last decade that focused on the direct and indirect effects of race and ethnicity in the process, structure and outcomes of healthcare.<sup>5</sup> In addition, a March 2008 Google™ search on the term netted 815,000 “hits.” The facts are indisputable: *Whether measured by disease prevalence or incidence, life expectancy, or infant mortality, Americans of African, Hispanic, Native American, or Alaskan Native origin experience poorer health outcomes than do their fellow white citizens.*

From an individual standpoint, those who suffer from chronic disease often experience severe degradations in quality of life – ranging from dependence on medications, an inability to afford treatment, mobility limitations, and a shortened life expectancy – just to name a few. From a societal standpoint, disparities represent a basic inequity: Why should an American’s racial or ethnic heritage determine his or her health status? If those factors are not convincing enough, consider this: Racial and ethnic health disparities are not just a “minority problem;” they add significant costs to the health care system, which are borne by all participants – federal, state and local governments; taxpayers; employers; employees; and anyone paying health insurance premiums or seeking health care.

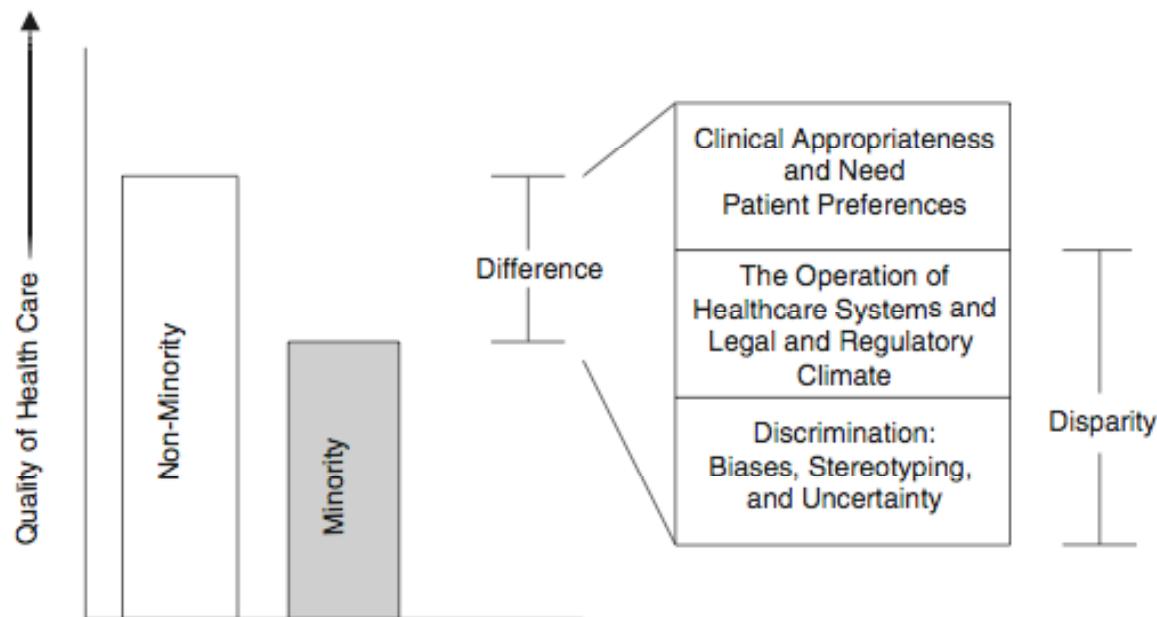
Understanding and addressing the drivers of ethnic and racial health disparities, then, is critical for national health, economic and social justice reasons. At a national level, the groups experiencing poorer health status are growing as a proportion of the total US population,<sup>6</sup> so it is easy to argue that the future of this nation’s health is at stake. From an economic standpoint, this erosion of health status will continue to increase health care costs in a system that is already too expensive for a growing number of Americans.<sup>7</sup> And finally,

each and every American should have the opportunity to achieve his or her optimal health status, regardless of race or ethnicity.

In order to begin solving the problem of racial and ethnic health disparities, we must first understand what causes such differences in health outcomes. The robust discussion of this issue has generated a broad range of theories (and a vigorous ensuing debate) about the sources and drivers of health disparities. The evidence of racial and ethnic disparities in healthcare is remarkably consistent across a range of healthcare services and diseases – with few exceptions. These disparities are associated with socioeconomic differences. In a few cases, they diminish significantly or disappear completely when such factors are controlled.<sup>5</sup> The majority of studies find, however, that disparities persist even after adjusting for socioeconomic differences and other healthcare access-related factors.<sup>8-10</sup> Furthermore, biological differences between racial and ethnic groups as a source of the variations among them in areas such as disease incidence and prevalence, life expectancy, and infant mortality have generally been discarded in favor of three broad categories of drivers: health system factors, patient-level factors and patient/provider interaction.<sup>11</sup>

The Institute of Medicine's groundbreaking study asserts that health disparities exist even when insurance coverage and ability to pay are not factors. Furthermore, it states that racial and ethnic differences in patient preferences, care-seeking behaviors, and attitudes toward care do not fully explain health disparities; instead, key drivers of disparities are present in the operation of healthcare systems and the clinical encounter. What does this mean? Factors such as cultural and linguistic barriers, the geographic availability of healthcare institutions, provider bias (or prejudice) against minorities, greater clinical uncertainty that providers experience when interacting with minority patients, and beliefs or stereotypes held by the provider about the behavior or health of minorities are important drivers of healthcare disparities (see Figure 1).<sup>5</sup>

**Figure 1. Differences, Disparities and Discrimination: Populations with Equal Access to Healthcare.<sup>12</sup>**



This theory suggests that potential solutions to racial and ethnic health disparities lie in the actual *delivery* of health care. In other words, the ways in which individuals at risk for certain diseases or conditions are identified, evaluated, educated, treated, and monitored play key roles in whether they develop a disease or condition; they also impact how (and how well) that disease or condition is managed by the patient over time.

Many private payers have begun to develop various methods to address the rising costs of some of the very same chronic conditions that are over-represented in minority populations.<sup>13</sup> Such methods include provider “pay for performance” programs, care quality scorecards, disease management and population health management programs. While these approaches show great promise in addressing the two key drivers of racial and health disparities proposed by the Institute of Medicine study committee -- the operation of healthcare systems and the clinical encounter -- the vast majority of these programs currently do not focus on racial or ethnic groups. Members of these groups are usually

captured in the process of identifying affected or high-risk health plan members. As a result, most current programs do not include, for example, the collection and storage of race or ethnicity demographic data, or the explicit provision of culturally and linguistically appropriate services (CLAS) – and the lack of CLAS is described by many sources describe as an important contributor to health disparities.<sup>14-16</sup>

Furthermore, in spite of the broad awareness and discussion of the topic of health disparities, there have been few attempts to evaluate and summarize the available evidence about the effectiveness of interventions designed to improve health outcomes among racial/ethnic minorities and reduce health disparities. Those that do evaluate effectiveness focus on managing the disease, as opposed to preventing it – in effect, *controlling* costs and *managing* quality of life instead of *avoiding* costs and *maximizing* quality of life. In addition, none address the potentially powerful role that private payers can play in reducing health disparities. This is surprising, given the ability of payers to influence the funding and delivery of health care and patient and provider actions through the multiple facets of the payer/provider and payer/patient relationship.

This study will seek to fill those critical gaps by answering the following question: *What specific measures can private (e.g., non-government) payers take to reduce health disparities in type 2 diabetes incidence among adult Hispanics in the United States?* Type 2 diabetes was chosen because racial and ethnic minorities bear a disproportionate burden of the diabetes epidemic; minorities experience higher prevalence rates, worse diabetes control, and higher rates of complications.<sup>17</sup>

Why Hispanics? First, Hispanics are by far the fastest-growing racial/ethnic segment of the U.S. population, and they are falling further behind whites in quality of health care -- while other minority groups are closing the gap<sup>a</sup>. The federal government, using data mostly

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<sup>a</sup> This is particularly true for the treatment of diabetes, mental illness and tuberculosis.

from 2002 and 2003, measured 40 types of disparities in the quality of health care between whites and minorities. Among blacks, 58 percent of those disparities were becoming smaller and 42 percent were becoming larger. In contrast, among the disparities between whites and Hispanics, 41 percent were becoming smaller, while 59 percent were growing.<sup>18</sup> With respect to diabetes in particular, Hispanics in the United States are twice as likely as white Americans to be diagnosed with the disease.<sup>19</sup>

It is important to note that the Hispanic population in the United States is culturally heterogeneous and includes individuals of Mexican, Puerto Rican, Cuban, and Spanish descent – and of many other Latino countries. While health outcomes do vary between these sub-populations, the overall health of the U.S Hispanic population as a group is poorer than that of U.S. whites, particularly when it comes to type 2 diabetes.<sup>20</sup> For purposes of this study, then, the Hispanic population will include all population sub-groups that are typically associated with the terms “Hispanic” and “Latino.”

In addition, there is much debate in Hispanic/Latino communities about which term (“Hispanic” or “Latino”) is more appropriate and acceptable, as each has political, social and generational connotations. The vast majority of the sources tapped for this work used the term “Hispanic.” For the sole purpose of remaining consistent with those published sources, this study will also use “Hispanic.”

Finally, incidence reduction was chosen as an objective to maximize the value and impact of the intervention(s). The promise of incidence reduction, after all, is the avoidance of disease -- and its human and economic toll -- altogether.<sup>b</sup>

There is one critical underlying assumption on which this study is based: *Racial and ethnic health disparities persist even when socioeconomic status, insurance coverage and ability to pay are not factors. Furthermore, racial and ethnic differences in patient*

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<sup>b</sup> While the primary objective will be to examine incidence reduction, both prevalence and incidence reduction techniques will be considered, as both may be applicable to the goals of this study.

*preferences, care-seeking behaviors, and attitudes toward care do not fully explain health disparities. Instead, key drivers of disparities are present in the operation of healthcare systems and the clinical encounter.* (Recall that this is the theory posited by the Institute of Medicine, and is one that is reflected thematically in much of the more current research on the drivers of racial and ethnic health disparities.)

### ***Benefits of this Research***

To answer the question, “Is there a role for private payers in reducing the incidence of type 2 diabetes among U.S. Hispanics,” this study summarizes methods employed by health plans or other organizations<sup>c</sup> that are designed to accomplish any one of the following:

- Reduce the incidence of diabetes
- Provide more effective care to groups (such as Hispanics) that may experience barriers to care as a function of gaps in health care operations and the clinical encounter
- Specifically address the health disparities experienced by Hispanics
- Reduce the incidence of any health condition(s) among Hispanic
- Reduce the incidence of diabetes among Hispanics

This project uniquely integrates findings from three sources: peer-reviewed literature, payer industry findings (report summaries, reports, articles, press releases, presentations, toolkits, conference proceedings, web-based audio-visual presentations and web pages), and qualitative data and conclusions from key informant interviews held with

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<sup>c</sup> Other organizations include government payers, health care providers, employers, third party administrators, or any other player that can and does have influence over the funding or delivery of health care.

subject matter experts at organizations planning, implementing or currently executing programs aimed at reducing health disparities in Hispanics with diabetes.

This study also includes a discussion and evaluation of outcomes data or other evidence provided by the evaluated programs that indicates success against its stated objective(s). Examples of such markers include reduced incidence of diabetes for Hispanics and/or other populations, indications of improved care for Hispanics or groups that typically experience disparities in health outcomes, and reduced incidence of any health condition(s) among Hispanics.

This integration of existing and new information will provide health plans and other organizations interested in reducing the racial and ethnic disparities in health and health care for Hispanics with diabetes with a consolidated source of insights into the design, objectives, challenges, successes, results and lessons learned by other organizations that have undertaken such initiatives.

#### ***Product of this Research: A Plan of Action***

This project provides a specific plan of action for health insurers interested in reducing racial and ethnic health disparities among Hispanics with diabetes. This plan of action is built on the detailed summary and outcomes review, and consists of recommended actions, or “promising practices” for health insurers or other organizations to take to reduce gaps in diabetes care and outcomes among Hispanics in the United States.

## **CHAPTER 2: REVIEW OF THE LITERATURE**

The focus of this study is to identify successful and, in particular, replicable payer intervention strategies to reduce the incidence of diabetes among Hispanics. Population health management programs are one promising payer-based solution that may provide important insights into the crucial intersection of health improvement for specific populations and payer strategies for doing so.

Population health management differs from traditional disease management in several key ways. First, these programs focus on the whole person and that person's propensity to develop one or more diseases (as opposed to a particular disease or condition). In addition, they encompass more types of illnesses than typical disease management programs, and consider both chronically ill and high-risk healthy patients (as opposed to traditional disease management that focuses solely on chronically ill patients). Finally, population health management programs apply the concept of "one stop shopping," in which patients with multiple conditions are managed through a single point of contact and coordination.<sup>13</sup>

Such programs pose interesting questions for this study. What diseases and populations do population health management programs address? Where have they succeeded or failed in reducing disease incidence and health disparities, and why? What lessons do they offer for future payer interventions to address racial and ethnic health disparities?

To answer these questions, a systematic review of the literature was conducted, using formal methods of literature identification, selection of relevant articles, information abstraction, and synthesis of results, to determine the mechanisms that have been identified

as possible solutions for racial and ethnic health disparities, define the mechanisms employed by population health management programs, and measure the success (or lack thereof) of such programs.

The review was performed in February of 2007 by searching: (1) MEDLINE®, (2) the Cumulative Index of Nursing and Allied Health Literature (CINAHL®), (3) The Cochrane Library®, and (4) Academic Search Premier®. In addition, the *American Journal of Managed Care* was identified as a priority journal (based on the number of citations produced in the database search), and the tables of contents for issues from 2001-2007 were scanned for relevant articles. Reference lists of key review articles from the database search were also scanned, and “snowballing” (reviewing lists of related articles) from the original database search return lists was also employed.

The results of the searches were imported into EndNote X®, a reference management software program. The software was used to identify/remove duplicates and store citations and abstracts.

### ***Definitions***

*Population health management programs* were defined as programs that: 1) Focus on the whole person and that person's propensity to develop one or more diseases (as opposed to a particular disease or condition); 2) Encompass more types of illnesses than typical disease management programs; 3) Consider both chronically ill and high-risk healthy patients (as opposed to traditional disease management that focuses solely on chronically ill patients); and 4) Apply “one stop shopping,” in which patients with multiple conditions are managed through a single point of contact and coordination.<sup>13</sup> The term *racial health disparity* was defined as ‘racial or ethnic differences in the quality of healthcare that

are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.<sup>5</sup> The terms *race* and *ethnicity* were used interchangeably and defined as all non-white or non-Caucasian ethnicities, including Asian/Pacific Islander, American Indian/Native American/Alaskan Native, Hispanic and African American.

### ***Eligibility Criteria for Database Search and Title/Abstract Review***

The following criteria were used to exclude articles: published prior to 1999 (for relevance, currency and volume control), did not take place in the United States, did not include human data, did not provide a full article, and were not written in English.

For the set of possible solutions for racial health disparities, the database search terms originally included the terms *racial, disparities* or *inequalities* and *interventions* or *solutions*. That method of search resulted in a substantial number of articles; subsequent searches narrowed the criteria to include research specific to drivers of diseases or conditions typically addressed by disease or population health management programs (chronic obstructive pulmonary disease – COPD, diabetes, ischemic heart disease, asthma, heart failure, and obesity/overweight).

For the interventions employed by population health management programs, the search term *population health management* was used. Unfortunately, as these programs are nascent, the only available information describing mechanisms and evaluating outcomes was published by commercial organizations marketing such programs to payers. The search was then modified to include the more established term *disease management*.

Titles and abstracts were then reviewed for relevance. Articles that did not directly address possible interventions or solutions to health disparities, or that examined diseases

or conditions outside those typically addressed by disease management or population health management programs were excluded.

### **Article Review**

Each remaining article was reviewed against the following criteria: (1) it included a specific, actionable, and repeatable solution or intervention; (2) the solution or intervention included an evaluation or measurement of its efficacy, not just a description of the program; and (3) the solution or intervention was within the realm of influence of disease management or population health management programs. For an article to be considered eligible, it had to meet all three inclusion criteria.

The *realm of influence* for disease management or population health management was defined as one or more of the following areas: population identification processes; evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance); process and outcomes measurement, evaluation, and management; routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).<sup>21</sup>

### **Results**

Results of the literature search and review process are summarized in Figure 2. The search criteria initially yielded a total of 431 articles; of these, 158 qualified for title and abstract review. Only seven articles, including one literature review, met all three of the inclusion criteria outlined above.

**Figure 2: Summary of Literature Search and Review**

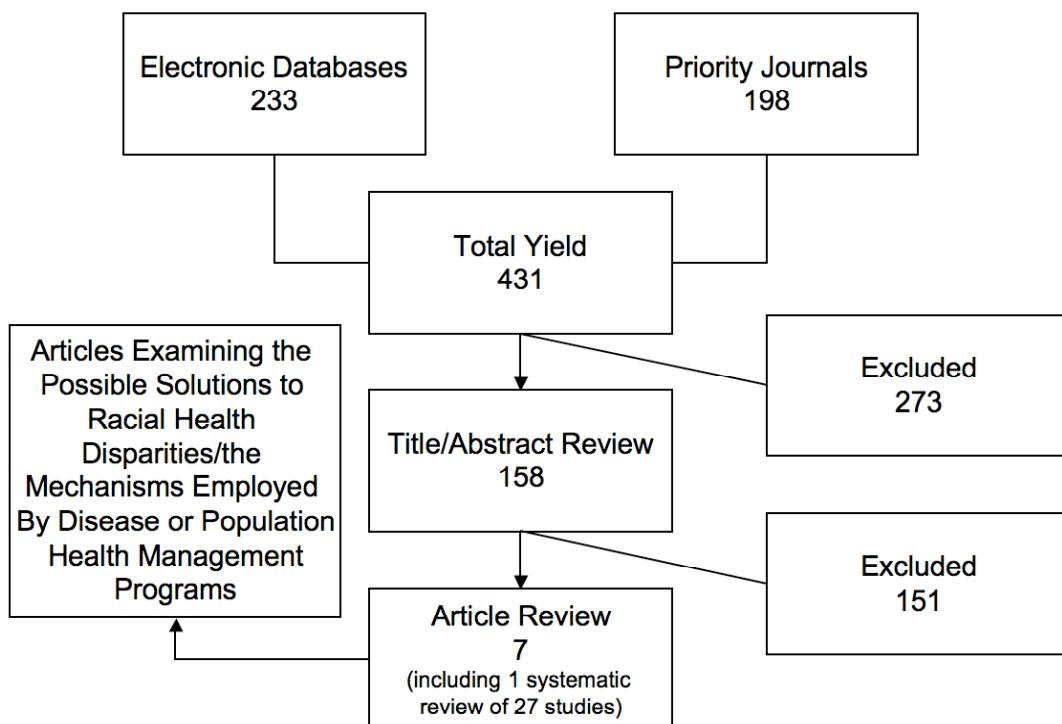


Table 1 provides a summary of key article characteristics. All studies were published between 2004 and 2006. Study settings included managed care plans, primary care facilities, and disease management programs. (The systematic review considered multiple settings.) The majority of the articles focused on diabetes; heart disease, preventive care and multiple conditions (from the systematic review) were also considered.

In terms of interventions, the majority of studies ( $n=4$ ) examined outcomes in managed care or disease management programs. One article compared diabetes patient status outcomes between managed care and traditional care in a mixed minority population, and another examined the differences in outcomes for minority patients receiving care delivered by a nurse following diabetes-specific treatment algorithms versus those who received usual care from doctors. The authors of the literature review included in this

analysis found that 25 of the 27 articles that qualified for inclusion focused on the patient/physician encounter.

**Table 1: Summary of Studies**

		<b>Number of Studies</b>
<b>Publication Date</b>	2004	2
	2005	3
	2006	2
<b>Study Setting</b>	Various	1
	Managed Care Plan	3
	Primary Care Setting	2
	Disease Management Program	1
<b>Disease or Condition</b>	Diabetes	4
	Heart Disease	1
	Preventive Care <sup>d</sup>	1
	Multiple	1
<b>Intervention</b>	Patient Participation in Managed Care	3
	Disease or Case Management	2
	Use of Treatment Algorithms	1
	Various	1
<b>Patient Ethnicity</b>	All Non-White	3
	African American	3
	Hispanic	1
<b>Evaluation or Measurement of Efficacy</b>	Patient Health Status	7
	Healthcare Process	2
	Patient Ratings of Care	1

Most studies examined the differences between white and all non-white or non-Caucasian populations (n=3) or between white and African American populations (n=3). One study examined Hispanics. All but one study used one or more measures of patient health status (A1C levels, LDL levels, blood pressure levels, functional status or quality of life) as the evaluation or measurement of the intervention's efficacy. Two articles examined healthcare process. The literature review considered patient ratings of care, in addition to patient health status and healthcare process, as an outcome measurement.

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<sup>d</sup> As measured by influenza vaccination, mammography and prostate-specific antigen screening.

**Table 2: Summary of Interventions and Outcomes**

Intervention(s)	Disease or Condition	# Studies	Outcome Assessment
Managed Care Program	Preventive Care Diabetes	1 2	Mixed Participation in managed care did not narrow racial differences between blacks and whites in preventive care. In one study, racial differences in diabetes control did not diminish over time; another found that race/ethnicity was not consistently associated with worse processes or outcomes and that not all differences favored whites.
Disease Management Program	Diabetes Heart Disease	1 1	Favorable Glycemic control was substantially improved in the low-income, ethnic minorities. Differences in functional status between whites and blacks disappeared over time.
Use of Treatment Algorithm by RN	Diabetes	1	Favorable Nurses making clinical decisions based on detailed treatment algorithms in a minority population did a better job of achieving recommended process and outcome measures than did physicians providing usual care.
Various, but 25 of the 27 articles reviewed focused on the patient/physician encounter	Various	1	Favorable All but two of the 27 reported favorable outcomes; the two that did not demonstrate improvement were also rated as being of poor quality by the authors. Ten studies examined tracking and/or reminder systems, all with positive results. <sup>e</sup>

### Managed Care Programs

Outcomes assessments from the managed care studies were mixed. One study examined preventive care use (influenza vaccination, mammography and PSA test utilization) among adults aged 65 years and older, comparing rates between those enrolled in a Medicaid managed care program and a fee for service program. This study found no

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<sup>e</sup> As measured primarily by appropriateness of care.

significant differences among blacks and whites between the programs, concluding that the managed care program in this case did not narrow racial differences in preventive care.<sup>22</sup>

Another longitudinal study of managed care examined differences in diabetes outcomes over 4-8 years for black versus white members of a single HMO, as measured by HbA1c levels. The analysis found that racial differences in diabetes control did not diminish over time, leading the authors to conclude that factors other than quality of care were to blame for the persistent racial differences in HbA1c levels. These findings were in contrast to the authors' initial hypotheses that such differences would diminish over time due to standardization of care, and that there would be few or no racial differences among patients with newly diagnosed diabetes (due to the consequences of improved quality of care in the later years of the study).<sup>23</sup>

The third managed care study reviewed for this analysis examined the effects of race, ethnicity, socioeconomic position and quality of care for adults with diabetes enrolled in managed care.<sup>24</sup> By assessing a wide range of process of care assessments (HbA1c, [A1C], lipid and proteinuria assessment; foot and dilated eye examinations; use or advice to use aspirin; and influenza vaccination) and patient health status (HbA1c, LDL and blood pressure control) among five racial/ethnic groups, the authors concluded that belonging to a minority ethnic group (being non-white, in this case) was not consistently correlated with worse processes or outcomes. In addition, the study found that not all differences in processes or outcomes between race/ethnic groups favored whites.

### Disease Management Programs

Two studies examined the impacts of disease management programs on healthcare disparities; both reported positive impacts on health disparities as a result of participation in

such programs. Both programs involved extensive interventions, including risk identification and stratification; the application of evidence-based practice guidelines and algorithms; identification of potential barriers to care; development of culturally and linguistically appropriate individualized treatment and education strategies (including monitoring of appointments and rescheduling of those that were missed and provision of transportation to improve visit completion); and centralized, active coordination of care (including identification of necessary ancillary medical services, follow-up to ensure receipt of services, and results retrieval and reporting to the primary care provider).

The first study, a before-after cohort study, examined differences in quality of life and functional status between blacks and whites with heart disease over a two-year period.<sup>25</sup> The authors concluded that quality of life disparities did not exist between blacks and whites, either at baseline or over the course of the study, but that functional status differences, present at baseline, did disappear over time.

The second study, a case-control trial, evaluated HbA1c differences in a low-income minority population (>55% minority representation) between participants and non-participants in a diabetes case management program over a two-year period.<sup>26</sup> The authors found substantial improvements in glycemic control for the participant group and concluded that diabetes case management can help reduce disparities in diabetes health status among low-income ethnic populations. This study did not examine outcome differences between racial or ethnic groups.

#### Registered Nurse (RN)-Administered Treatment Algorithms

One study isolated the impacts of the administration of diabetes treatment algorithms by registered nurses in a Hispanic population, asserting that most diabetes disease

management programs had a “modest” effect on glycemic control.<sup>27</sup> After one year, the authors concluded that nurses simply following detailed treatment algorithms under the supervision of an endocrinologist had a significant and positive impact on glycemic control, even in a poor and poorly educated minority population.

### Literature Review of Provider Interventions

Finally, the literature review included in this study evaluated the impact of interventions targeted at health care providers on health care quality for racial/ethnic minorities.<sup>28</sup> The authors performed a systematic review of articles published between 1980 and 2003, and found that, of the 27 studies meeting the review criteria, 25 reported favorable outcomes. Ten studies examined tracking/and or reminder systems, forming the largest base of studies for a single type of intervention. All ten studies demonstrated positive outcomes (as measured primarily by appropriateness of care). Interestingly, however, the study notes that only two articles were specifically targeted at addressing racial/ethnic healthcare disparities; all others were generic quality improvement strategies (a finding echoed by this analysis).

### ***Discussion***

This review attempted to identify successful, measurable intervention strategies designed to reduce racial/ethnic health disparities. The original objective was to examine the impact of population health management programs; given their proactive stance, broader disease focus and patient-centric approach, they seemed to provide a promising set of potential solutions. Their nascence, and the resultant lack of evidence surrounding their impact on health outcomes, however, required the search to be broadened to include more

traditional disease management programs and any type(s) of patient or provider education or intervention. Even so, only seven studies that both specifically addressed disparity reduction strategies and reported measurable results were found.<sup>f</sup>

### ***Summary of Findings***

All seven studies reported mixed or favorable results (based on health outcomes). While simply participating in a managed care plan or program does not seem to provide better outcomes for racial and ethnic minorities, disease management programs, use of treatment algorithms administered by registered nurses, and targeted health care interventions in the primary care setting do hold some promise for reducing or eliminating health disparities. A common theme that begins to emerge is that the application of treatment algorithms and tracking and/or reminder systems seem to be effective at reducing health disparities, but the body of research examining and measuring even this limited set of potentially successful interventions is as yet too small to draw any valid conclusions. Against the backdrop of the entire health care delivery process, and the broad array of potential strategies to reduce racial/ethnic health disparities that it presents, the knowledge base is indeed extremely limited.

Research examining cost or performing cost/benefit analyses is even more sparse than that which addresses intervention strategies and outcomes. Most organizations have resource constraints and therefore allocate those scarce resources to programs or initiatives that show some evidence of efficacy; the successful adoption of strategies to reduce racial and ethnic health disparities will rely on their cost, feasibility and ability to measurably improve outcomes. In none of the six specific studies was cost considered or measured; in

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<sup>f</sup> For purposes of this discussion, the literature review may be referred to as one study or may be disaggregated into its 27 component studies. The latter approach will be used to highlight specific finding(s) useful to this analysis.

the provider intervention literature review, only one of the 27 studies cited costs – in this case, for a renal insufficiency case management program (for which no health benefits were found).

The health disparity knowledge gap extends to specific populations. Most studies focused on white vs. all non-white populations or on white vs. black populations; only three of the 33 (including the 27 contributed by the literature review) separately examined Hispanic populations and none addressed Asian/Pacific Islander or American Indian/Alaskan Native populations.

### ***Implications for Future Research***

More focused research examining and evaluating strategies for reducing racial/ethnic health disparities is needed. Specific recommended areas of study include determining which strategies for reducing healthcare disparities are most effective; examining the costs of such strategies; evaluating the impacts of interventions in Hispanic, American Indian/Alaskan Native or Asians/Pacific Islander populations; and assessing patient outcomes as opposed to healthcare process (and determining the linkages between the two).

This will be no easy task: As this review found, vast differences in diseases and programming, and the lack of standardization within and across studies will make any conclusions difficult to draw and the reliability of such conclusions even more challenging. Outcomes are impacted by a large number of variables, including the type of disease or condition, the number and types of components of the intervention strategy, the administration of the strategy (e.g., incentives for the participants and/or providers, methods of assuring that planned actions do in fact occur, etc.), program enrollment/study population

(population size, density, geography, ages, co-morbidities, socioeconomic status, etc.), the quality of the program or intervention, and the outcome measure itself. In the latter case, for example, how does a lower glycemic index compare to enhanced functional status for a diabetic? Which one is considered the better outcome? Finally, it is reasonable to expect different responses, and therefore different outcomes, by unit of analysis (e.g., by community, by particular race/ethnicity, by individual, etc.).

### ***Limitations***

The limitations of this review are inherent in the number of articles that ultimately met the search criteria, even after the original constraints were relaxed to include less stringent definitions of strategies or interventions. Possible future modifications to expand the number of studies qualifying for review include the consideration of articles published prior to 1999, as well as those that took place outside the United States. In addition, no rigorous quality evaluation or scoring was conducted as part of this review, in large part due to the paucity of material found. Articles were deemed of sufficient quality on the basis of their publication in reputable journals; future research should include a measure or score of evidence quality.

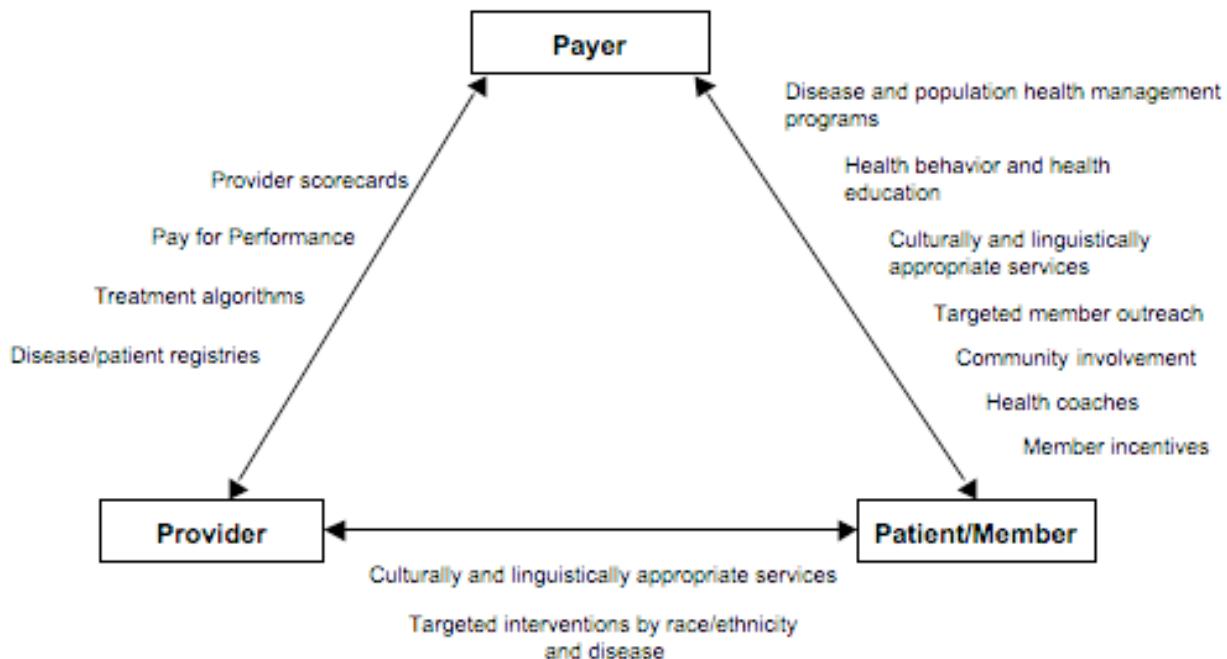
## **CHAPTER 3: METHODS**

### ***Description of Conceptual Model***

This study involves the evaluation of the interactions between the three key stakeholders in the delivery of health care – the payer, the provider and the member/patient (see Figure 3). Specifically, this study examines current practices within the realm of payer influence, as well as opportunities for intervention methods that actually succeed in, or show promise to, reduce health disparities in diabetes amongst Hispanics in the U.S. in three key areas:

1. *Interactions between payers and members*, including disease and health management programs, treatment and place of service incentives and disincentives for patients (as provided by their benefit plan design), community outreach programs, health coaches, and information designed to improve patients' self-care. These are referred to as "payer-member interventions" in this study.
2. *Interactions between payers and providers*, including provider scorecards which measure quality of care, programs which reward providers for desired outcomes – "pay for performance," and treatment algorithms. These are referred to as "payer-provider interventions" in this study.
3. *Interactions between providers and members*, including the provision of culturally and linguistically appropriate services, and other methods designed to improve the effectiveness of the clinical encounter for Hispanics. These are referred to as "provider-member interventions" in this study.

**Figure 3: Conceptual Model for Evaluating Potential Private Payer Interventions to Reduce the Incidence of Diabetes Among Hispanics in the United States.**



### ***Study Design***

This study employed qualitative research methods, in a two-part model. The first component, a “best practices” document review, was performed to examine existing interventions employed within the private payer industry. The document review served two primary purposes: it broadened the scope of the original literature review beyond peer-reviewed journals to include commercial and government information sources, and it assisted in the identification of organizations and individuals to tap for key informant interviews.

In addition, the study included key informant interviews involving subject matter experts at health insurance companies implementing diabetes or racial/ethnic health

disparity intervention programs. The objective of these interviews was to develop a more detailed understanding of the objectives, drivers, structure, effectiveness, level of organizational commitment, and lessons learned from the development and implementation of the programs – and to tap into any information not readily available through public access means.

### ***Data Collection***

#### Document Review

The document review consisted of a Google™ web search in August of 2008, using the following combinations of terms:

1. Health insurer OR insurer OR payer AND
2. Diabetes AND
3. Hispanic OR Latino AND
4. Disparities AND
5. Interventions OR methods OR strategy
6. NOT blog

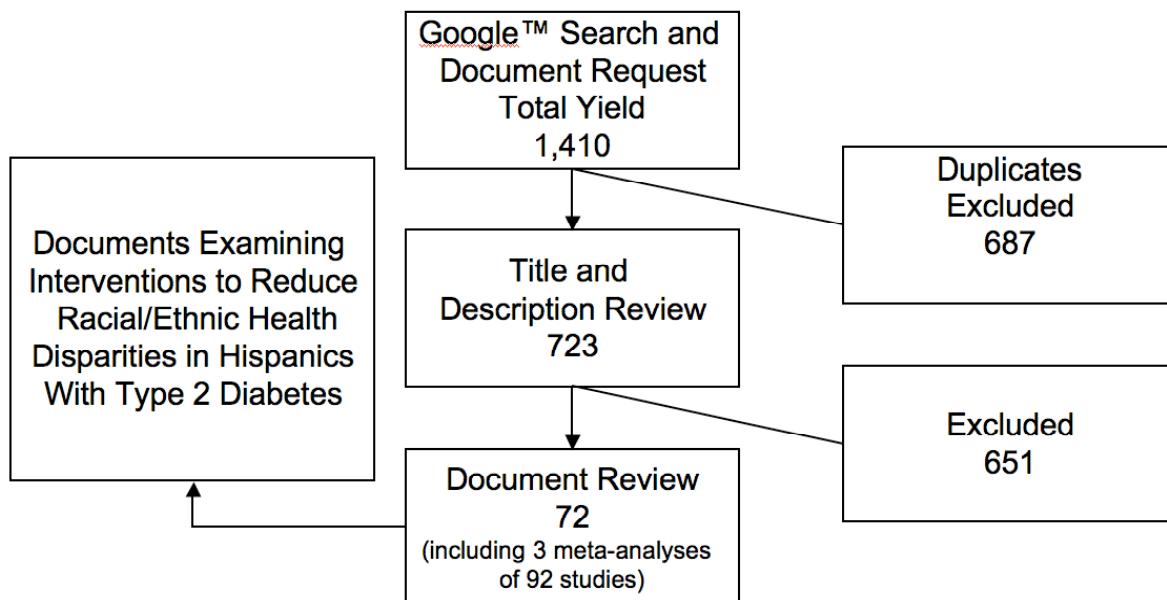
The search was restricted to results from the United States, published in the English language, and those that were updated within the past year.

A total of 1,410 results were returned in the original search. Results were initially reviewed to identify sources cited more than once in the results and health insurance organizations mentioned in association with these search terms. To augment this strategy, references and reference lists from sources identified via the web searches were reviewed.

The types of documents reviewed included report summaries, reports, articles, press releases, presentations, toolkits, conference proceedings, webinars (web-based audio-visual presentations) and web pages. They were obtained primarily via direct downloads from websites and electronic journals; in some instances, documents were received directly from the author or original source (as in the case of unpublished documents).

All documents that involved Hispanic or Latino racial and ethnic categories, diabetes, and interventions that encompassed interactions between payers and providers, payers and members/patients, or members/patients and providers were included. Interventions at the community level were also included, in an attempt to examine additional interventions that may be of potential value for payers to consider. Any documents that described interventions of any type that took place outside the United States were excluded.

**Figure 4. Summary of Document Search and Review**



Results of the document search and review process are summarized in Figure 4. A total of 72 documents, including three meta-analyses of 92 studies, met the qualifications

outlined above. The primary sources from which documents examined for this portion of the research are summarized and described in Chapter 4.<sup>9</sup>

### Key Informant Interviews

The selection of health plans for participation in the key informant interviews was based on purposeful sampling. First, the organization was selected for inclusion in the sample if it was determined during the document review that it has either implemented or is in the process of implementing a program or programs to improve the overall health of the organization's Hispanic population. The program(s) could be focused on Hispanics only or specifically on Hispanics with diabetes. Within that population, health plans were specifically recruited to ensure representation across three categories: geographic coverage (national, regional, and local, as defined below); organizational type (for-profit and not-for-profit); and delivery system type (integrated and contracted). These categories, which are described below, generally serve as key differentiators between health insurance plans in terms of geographic reach, variability of markets served, resource availability, marketplace pressure on profitability, and the organization's level of control over its delivery system – in other words, its care providers and facilities. While the sample size is not large enough to draw definitive conclusions about these differentiators and how they might play a role in each organization's efforts to reduce health disparities, the inclusion of organizations that represent each one of these variables provides for a more representative sample of the health insurance industry.

For purposes of this study, the term "national health plan" means that the organization markets and services health insurance coverage in ten or more states. A

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<sup>9</sup> Documents include report summaries, reports, articles, press releases, presentations, toolkits, conference proceedings, webcasts (web-based audio-visual presentations) and web pages.

“regional health plan” is an organization operating in more than one state and less than ten. A “local health plan” operates in one state or less. Health plans were classified for the study without the inclusion of national accounts (such as Interplan Programs or IPP, for Blue Cross and Blue Shield plans), in which a local, regional, or national health plan has a national presence by virtue of cooperative claims processing and network usage arrangements with other payer(s) in other states.

This study also uses the accepted, widely published definitions of *not-for-profit* or *non-profit* and *publicly traded*. A *not-for-profit* or *non-profit organization* is an incorporated organization in which no stockholder or trustee shares in profits or losses, and it usually exists to accomplish some public, charitable, humanitarian, or educational purpose. A *for-profit* organization is one that is established or operated with the intention of making a profit.<sup>29</sup>

In a contracted network arrangement, hospitals, physicians and other health care providers engage in a contractual arrangement with the health plan to provide services, usually for a set fee, based on procedure codes (known as a fee schedule). Contracted entities are also obliged to meet certain criteria to remain in the network of providers and facilities. However, the contracted entity (or the health insurance plan offering the contract) may terminate the relationship as allowed by the specific contract between the two entities.

An integrated delivery system (IDS) is a network of health care providers and organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served. Services provided by an IDS can include a fully-equipped community and/or tertiary hospital, home health care and hospice services, primary and specialty outpatient care and surgery, social services, rehabilitation,

preventive care, and health education and financing, usually using a form of managed care.<sup>30</sup>

Fifteen organizations were ultimately included in the sample. Potential respondents were selected for participation on the basis of their responsibilities related to either the implementation or ongoing oversight of such program(s) and were invited by email to participate in 60-minute semi-structured telephone interviews. As part of the invitation, respondents were informed that the purpose of the interview was to develop a deeper understanding of the mechanisms – both current and potential – that health insurers are using or may use to help address health disparities in diabetes between Hispanics in the United States and white Americans.

Recruitment continued until a representative of an organization refused to participate, or until three consecutive contact attempts went unanswered. Contact was initiated via email; non-respondents were then telephoned and sent a follow-up email.

Eight of the fifteen (53%) organizations invited participated in the key informant interviews. Of the seven organizations that were not included in the study, one explicitly refused to participate (citing advice of internal legal counsel), four did not respond to any of the email and follow-up voice mail requests, and two were unable to schedule the necessary individual(s) during the interview phase of this study.

Table 3 provides an overview of the distribution of both participating and non-participating health plans across the three categorical variables of geographic coverage, organizational status, and type of delivery system. Both participating and non-participating plans were evenly distributed across the geographic and organizational status categories. In the only notable difference between the participating and non-participating groups, both of the health plans with integrated delivery networks elected to participate in the study. There do not appear to be any material difference between the two groups that might impact study

results or suggest any bias; however the inclusion of two integrated delivery systems does allow for some comparisons between contracted and integrated delivery systems in the participant group.

**Table 3: Categorical Descriptions of Health Plans Included in Key Informant Interview Sample, By Participation Status**

Health Plan	Geographic Coverage	Organizational Status	Type of Delivery System	Participated in Study?
Health Plan #1	Local	Not-for-Profit	Contracted	Y
Health Plan #2	Local	Not-for-Profit	Contracted	Y
Health Plan #3	Local	Not-for-Profit	Integrated	Y
Health Plan #4	Regional	Not-for-Profit	Integrated	Y
Health Plan #5	Regional	Not-for-Profit	Contracted	Y
Health Plan #6	National	For-Profit	Contracted	Y
Health Plan #7	National	For-Profit	Contracted	Y
Health Plan #8	National	For-Profit	Contracted	Y
Health Plan #9	Local	Not-for-Profit	Contracted	N
Health Plan #10	Local	Not-for-Profit	Contracted	N
Health Plan #11	Regional	For-Profit	Contracted	N
Health Plan #12	Regional	Not-for-Profit	Contracted	N
Health Plan #13	Regional	For-Profit	Contracted	N
Health Plan #14	National	For-Profit	Contracted	N
Health Plan #15	National	For-Profit	Contracted	N

A total of ten individuals at eight organizations were interviewed. All key informants came from either the marketing division or the health care division. In a health plan, the marketing division is typically responsible for marketing, sales and enrollment functions. These functions include market research, product development, prospecting, sales and enrollment of new and renewing members into the plan of coverage selected or purchased. The health care division is usually responsible for disease and population health management programs, utilization management, case management, care quality improvement programs, provider credentialing, medical policy and member and provider appeals. This division employs clinical personnel, such as physicians (typically as medical directors) and nurses (usually as case managers and health coaches).

Interviews took place from October to December of 2008. Due to the geographic spread of key informants and the cost parameters of this study, interviews were conducted by telephone. They were recorded using Audacity (version 1.2.5), an open-source digital audio editor, and transcribed into Microsoft® Word 2004.

See Appendix A for the key informant interview guide. The guide was pre-tested by three individuals with roles similar to those of the key informants prior to the first interview. Interviews were semi-structured; the script was modified both before and during the course of the interview. Modifications made before the interviews were based on information gained during the document review about the relevant programs the health plan had in development or underway. The objective of these changes was to target the questions to produce more specific information about the program(s). Those modifications made during the course of the interview were based on the participant(s)' responses to the preceding questions.

### ***Data Analysis***

Both primary data (from the key informant interviews) and secondary data (from the document review) were collected for this study. The information obtained from the key informant interviews was primarily qualitative. In some cases, organizations had performed internal quantitative analyses of their program; any such data made available by that organization was also included in the study as secondary data. In addition, information specific to any one organization and its health disparities reduction efforts, programs and initiatives gathered in the document review was validated in the key informant interviews. If the information was valid, it was used for triangulation and data enrichment purposes.

The interview recordings and transcriptions were reviewed to identify themes and to compare and contrast responses across interviews. In addition, themes such as “multi-factorial interventions” that were illuminated by the initial document review were included as a component of the analytical framework. Themes were coded and, where possible and appropriate, counted and weighted by frequency of mention or extent of treatment. Extent of treatment was measured by counting lines of text in the transcription. Finally, themes were grouped for discussion and conclusion purposes.

## **CHAPTER 4: DOCUMENT REVIEW FINDINGS**

### ***Description of Sources***

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities. The Center works directly with states and federal agencies, health plans, and providers to develop programs to better serve people with complex and high-cost health care needs; its activities focus on three primary priorities, one being the promotion of national efforts to reduce racial and ethnic disparities.<sup>31</sup> The CHCS website includes a wide array of resources, including webinars, journal articles, case studies, meeting highlights, technical assistance tools, and policy and issue briefs.

The CHCS is also a key player in two important collaborative efforts specifically aimed at reducing racial and ethnic health disparities. These two initiatives involve ten commercial health insurers (the National Health Plan Collaborative) and twelve Medicaid stakeholder organizations (the Improving Health Care Quality for Racially and Ethnically Diverse Populations Workgroup). Both groups have published several reports, toolkits and technical assistance tools that address both health disparities in general, as well as disparities specific to Hispanics with diabetes.

Other important sources for documents included the following websites: RAND Health, Pew Hispanic Center, the Robert Wood Johnson Foundation, the Agency for Healthcare Research and Quality (AHRQ), the Institute for Healthcare Improvement (IHI), the Kaiser Family Foundation, the American Medical Association (AMA), the National

Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), the American Diabetes Association (ADA), the National Business Group on Health (NGBH), and various health plan websites.

In addition, trade publications, such as *Best's Review*, *Managed Care*, *Health Affairs*, and *Managed Care Quarterly* were reviewed for relevant articles. Sources at the Blue Cross and Blue Shield Association, which has a multi-plan committee focused on the reduction of healthcare disparities, were also contacted; several documents were made available by the head of that committee.

Finally, three meta-analyses, or systematic reviews, of interventions designed to reduce health care disparities that contained information about diabetes were included. These papers were published in *Medical Care Research and Review* after the original literature review was performed in February of 2007.<sup>32-34</sup> Relevant findings from the individual studies included in the meta-analyses are discussed below.

### ***Key Findings***

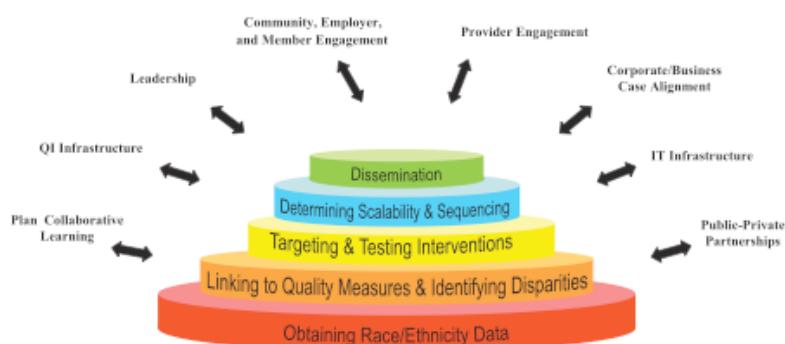
The National Health Plan Collaborative (NHPC), originally formed in December of 2004, now includes ten major health insurers that cover 87 million members -- almost half of commercially insured Americans and several millions served by Medicare and Medicaid. Current members include Aetna, CIGNA, Harvard Pilgrim Health Care, Highmark, Inc., Humana, Kaiser Permanente, Molina Healthcare, UnitedHealth Group, and Wellpoint, Inc.

The NHPC is managed and coordinated by the Center for Health Care Strategies, in coordination with the RAND Corporation, with funding and leadership support from the Agency for Healthcare Research and Quality (AHRQ) and The Robert Wood Johnson Foundation. Its stated mission is as follows:

“We have come together because we are committed to reducing racial and ethnic health disparities and improving the quality of care all Americans receive. While others in America’s health care system—purchasers, patients and providers—also have critical roles to play, this effort by health insurance companies is a way to do our part to solve this unacceptable problem. For more than 20 years, research has documented persistent gaps in health care quality that disproportionately affect Americans from specific racial and ethnic backgrounds. In 2002, the Institute of Medicine specifically identified the need for health insurance companies to collect, report and monitor patient care data to build a foundation for solutions to the problem of racial and ethnic disparities in care. The Institute of Medicine’s recommendation spurred us to action. Through this collaborative, we believe we are making a positive difference in closing the gaps in health care quality.”<sup>35</sup>

The organization has adopted a four-level framework for considering interventions to reduce racial and ethnic health disparities.<sup>36</sup> Activities rest on a foundation of having data on enrollee race/ethnicity with which to examine disparities. Figure 5 depicts the framework and the steps involved; the bi-directional arrows refer to collaborations with the array of partner activities necessary to support plan efforts at reducing disparities.

**Figure 5: National Health Plan Collaborative Four-Level Framework for Considering Interventions<sup>36</sup>**



QI refers to quality improvement, while IT refers to information technology.

The NHPC has engaged in a two-phased effort. In Phase One (2004-2006), member health plans focused on the collection of member race/ethnicity data and the

**Table 4: Summary of National Health Plan Collaborative (NHPC) Plan Disparity Reduction Activities<sup>36</sup>**

Plan	Method of Obtaining Member Race/Ethnicity Data	NHPC Pilot Interventions	Other Activities
Aetna	Direct, voluntary collection from members (have data on approximately 4 million members)	Culturally tailored disease management, translation services, exploration of role of health literacy	Direct to member outreach around mammography and prenatal care
CIGNA	Indirect methods; also has implemented collection of individual-level race and ethnicity and primary language spoken, on a voluntary basis	In-depth analysis of correlates of disparities, disease management	Health literacy activities in Memphis, Tennessee, and with the American College of Physicians
Harvard Pilgrim Health Care	Indirect and direct methods	Community and member interventions to increase receipt of eye exams	<ul style="list-style-type: none"> <li>- Member intervention to reduce disparities in colorectal cancer (CRC) screening</li> <li>- Quality improvement grants to provider groups for disparities reduction initiatives in diabetes and CRC screening</li> <li>- Coordination with Harvard Pilgrim Foundation programs that fund disparities reduction efforts by community-based groups</li> </ul>
HealthPartners	Direct collection at practice group levels	Cultural competency training for providers, identification of clinics in need of additional translator services	Engagement of many business leaders and community groups in disparities discussions – the speaker's bureau reached more than 5,000 people in 2006
Highmark, Inc.	Indirect and direct methods	Provider education in practices with higher than average minority members with identified gaps in care	Reducing disparities has become part of Highmark's 2007-2009 corporate strategic plan
Kaiser Permanente	Indirect methods	Planning to implement pilot member educational intervention and universal prescription for aspirin-lovastatin-lisinopril (ALL) in target region	Extensive mapping to identify areas of highest yield for interventions
Molina Healthcare	From Medicaid offices	<ul style="list-style-type: none"> <li>- Nurse advice line offers 24-hour access to bilingual nurses, which increased outreach to members by direct telephonic contact in member-preferred language</li> <li>- The diabetes disease management program provides both language- and culturally appropriate telephonic counseling.</li> </ul>	<ul style="list-style-type: none"> <li>- The Molina Institute for Cultural Competency has been developed from the TeleSalud Project (originating from a Robert Wood Johnson Foundation Grant) to extend cultural knowledge and sensitivity</li> <li>- Distributed a cultural resource manual about language, culture, and religious sensitivity and understanding</li> </ul>
UnitedHealth Group	Indirect measures and CMS data from prior research project	Pilot test of provision of data on quality of care and race/ethnicity to physician practices	<ul style="list-style-type: none"> <li>- Multi-Cultural Organizational Assessment completed to promote the alignment of resources to meet the overall needs of the member population</li> <li>- Community Health "Centers of Excellence" initiative</li> </ul>
WellPoint, Inc.	Indirect; direct measures from prior research project	Disease management, changes in co-pay structure for diabetes testing supplies	Examination of disparities among employee population; mapping to identify areas of highest yield for interventions; alignment of clinical, marketing and human resources responsibilities

examination of diabetes performance data for disparities. During this phase, five plans implemented one or more pilot interventions to reduce racial and ethnic health care disparities. These pilots are summarized in Table 4, along with a description of the method(s) used by each plan to collect member race and ethnicity data.

There are two fundamental ways to collect member race/ethnicity data: indirectly and directly. Indirect techniques include the evaluation of language utilization data, geo-coding, and surname analysis (with and without first name analysis). *Geo-coding* uses a member's residence to approximate the likelihood of a member's race or ethnic background; this technique is used primarily to identify enrollees who are likely to be African American. *Surname analysis*, typically used to identify Asian and Hispanic members, compares a person's last name to a long list of surnames known to have a high probability of belonging to someone from the specified racial or ethnic group.<sup>37-39</sup>

Direct data collection techniques include the use of mailed member surveys, paper and online enrollment forms, health risk assessments (HRAs), electronic medical records (EMRs) and online member services. Other, less common, direct collection techniques include the evaluation of requests for translation and birth data. Direct data collection techniques, while widely acknowledged as being more accurate, are also costly and slow.

Pilot intervention activities among the Collaborative members varied widely, and included such methods as: Culturally tailored disease management; language translation services; direct to member outreach around mammography, eye exams, colorectal (CRC) screening and prenatal care; quality improvement grants to provider groups for disparities reduction initiatives in diabetes and CRC screening; cultural competency training for providers; identification of clinics in need of additional translator services; changes in co-payment structure for diabetic testing supplies; and many others.

Available results of the pilot interventions, as published by the NHPC, were largely positive (see Table 5). Aetna, through intensified outreach to more than 500 African-American and Hispanic members with diabetes and their physicians, succeeded in getting 38% of non-adherent members to obtain both HbA1c and LDL-C screenings. Diabetics in the intervention group also had better HbA1c control than those in the comparison group. Harvard Pilgrim held free retinal screening events in Hispanic communities with low screening rates; while attendance at the actual events was poor, 31% of Harvard Pilgrim members who received an associated outreach mailing did obtain an eye exam (compared to 26.5% of those in the control group). Highmark launched an intervention in which physicians in practices with higher than average disparities in diabetic care sent letters to diabetic patients, reminding them to obtain needed testing; physicians have reported that the intervention is bringing targeted patients into their offices. Molina Healthcare identified members with a stated preference for Spanish language and/or Hispanic ethnicity, and developed and distributed materials and conducted outreach specific to those members' cultural norms; as a result, quality measures with respect to diabetes have improved, and members have experienced improvement in their diabetes management self-confidence and a coincident decrease in their program level of care requirements.<sup>40</sup>

The National Health Plan Collaborative published its *Phase One Summary Report* in November of 2006. At that point, the Collaborative had learned three key lessons, the first of which was that the size of health plans can be both an advantage and a disadvantage. Advantages come from the number of insured Americans and providers touched by member plans, and the awareness of health disparities that the Collaborative has been able to raise among the government, the health care community and the public at large. Disadvantages come from the difficulty in gaining enterprise-wide support for disparities reduction across the large and diverse organizations that comprise the Collaborative.

The second lesson learned by the NHPC is that the collection of plan members' racial and ethnic data, while politically sensitive, is both essential and feasible. Education – both internal and external – is key. Stakeholders must be told about the objectives behind data collection and be given assurances about how it will be used. Member health plans are now collecting data from both primary and indirect sources, but the health care industry lags behind others, due in no small part to the absence of federal guidelines for the collection and disclosure of race and ethnicity data in health care quality improvement.

The third and final lesson is that collective action is a key to progress in disparities reduction. NHPC members have been able to raise understanding of the issue within their organizations, and they are learning from each other – what disparities are, what causes them, how to measure them, and how to reduce them. Members also understand more fully the limitations of acting independently to address an issue that will require the action of all stakeholders in the health care system.

In Phase Two (2006- 2008), the Collaborative focused on the collection of health plan members' primary race, ethnicity and language preference data, improving language access, and the determination of the business case and ROI for disparity reduction. In 2007, the group published a toolkit with resources such as lessons learned, best practices and tools developed from the efforts of its member plans, in order to assist other health insurers wishing to address the issue of racial and ethnic health disparities.<sup>41</sup> Topic areas include an introduction to healthcare disparities, the NHPC, and the toolkit; information about the collection of race, ethnicity and language preference data (including a discussion of national and local policies on data collection, the importance of communicating the importance of data collection to stakeholders, guidance on categories of race/ethnicity to use, and an outline of member plan methods for collecting data); information about language access programs; and guidance for the development of a business case for improving quality and

addressing disparities. Finally, the toolkit contains names and contact information for NHPC member plan representatives, one of the sampling sources for this study's key informant interviews.<sup>40</sup>

The NHPC has now turned its attention to facilitating the collection of primary data by health plans. The Collaborative is working to develop uniform approaches for collecting self-reported information about race and ethnicity, and it will seek the development of national guidelines for the collection and use of primary data in health care quality improvement. The Collaborative is also working to enhance access for non-English speakers through a language translation services model that can be replicated by others in the industry, supporting investment in disparities reduction (primarily through the education of the CHCS), and sharing lessons learned with each other and the public.

The Improving Health Care Quality for Racially and Ethnically Diverse Populations (IHCQREDP) Workgroup, a component of the CHCS' Best Clinical and Administrative Practices initiative, is comprised of a total of twelve organizations, including eleven Medicaid health plans and one state primary care case management program. Members include Blue Cross of California, HealthFirst (New York), Helix Family Choice (Maryland), L.A. Care Health Plan (California), Medica (Minnesota), Molina Healthcare (Michigan), Monroe Plan for Medical Care (New York), Neighborhood Plan of Rhode Island, Network health (Massachusetts), Oregon Collaborative, Oregon Department of Human Services, CareOregon, FamilyCare, Inc. (Oregon), Providence Health Plans (Oregon), SoonerCare PCCM (Oklahoma), and UPMC for You (Pennsylvania). The initiative is managed by the CHCS and is funded by the Robert Wood Johnson Foundation and the Community Fund.<sup>42</sup>

Workgroup members collaborated from 2004 to 2006 to develop new ways to identify members of racial and ethnic subgroups, to measure the gaps in care that these groups experience, and to explore ways to improve health care quality. The workgroup

developed methods to uncover and address disparities in three targeted areas: birth outcomes and immunizations, asthma care, and diabetes care. Its toolkit, *Reducing Racial and Ethnic Disparities: A Quality Improvement Initiative in Medicaid Managed Care*, was published in 2007, and includes key lessons in addressing disparities and several case studies in identifying and reducing disparities.<sup>38</sup>

In that document, the workgroup outlined three key lessons in addressing disparities: collecting and analyzing data; designing patient-centered and culturally sensitive care; and encouraging collaboration to reduce disparities. The first lesson echoes that of the National Health Plan Collaborative -- collecting data by race and ethnicity is a critical first step in identifying disparities in health care treatment and health outcomes, and in developing targeted strategies to address inequalities in care.<sup>38, 43-46</sup> However, the workgroup found that there are a number of challenges and barriers to the collection and use of data on race and ethnicity to address health disparities, the primary one being data accuracy. Accuracy problems stem from a lack of uniform standards in key categories like race, ethnicity, primary language, or country of origin; they also result from incomplete, missing or inaccurate data files transmitted from Medicaid agencies to Medicaid plans. Further, enrollee self-reporting of race and ethnicity, while more accurate, is usually voluntary and typically results in large data gaps. Finally, assignment of race and ethnicity based on indicators such as surname, geographic location, or physical appearance can also result in inaccuracies, particularly when members are multi-racial or multi-ethnic. However, such indirect methods, while somewhat imprecise at the individual level, can provide an accurate estimate of the racial/ethnic differences in quality when analyzed at the population or group level.<sup>38, 39, 45, 47</sup>

The second lesson, designing patient-centered and culturally sensitive care, stresses the importance of meeting the individual and cultural needs of plan members.

Recommended strategies include: one-on-one outreach to educate and motivate patients; seeking member feedback to strengthen commitment and adherence to medical regimens; and encouraging culturally competent contact between patients and doctors, through provider education, staff recruitment, staff training, translation services, and the development of linguistically and culturally appropriate health education materials.

The third lesson, encouraging collaboration to reduce disparities, cites examples in which health plans that went beyond corporate confines to build creative relationships in their communities were able to reach members more effectively. One health plan, UPMC for You, successfully partnered with community outreach representatives, social service agencies and local school districts to increase the number of women entering prenatal care during their first trimester and improve birth outcomes. Blue Cross of California, in a partnership with local pharmacies, succeeded in increasing HEDIS rates for the appropriate use of asthma controller medication from 68.6% to 84.6% for its target population of African Americans; those rates also improved similarly for Hispanics and whites. The health plan accomplished this by providing point-of-service prompting and reimbursement to pharmacists for asthma consultation through a computerized pharmacy data entry and claim system. These interventions were not culturally tailored, but did provide elements of personalization and face-to-face consultation.<sup>48</sup>

Finally, the toolkit provided a series of case studies describing different approaches for reducing health disparities in birth outcomes and immunizations, asthma care and diabetes care. Three case studies addressed methods to improve diabetes care among racial and ethnic minorities, using process measures such as screening rates to measure their effectiveness. In the first case study, SoonerCare Choice, Oklahoma's primary care case management program, educated Native American members with diabetes and their providers about plan benefits related to diabetes and the importance of screenings and

diabetes management. Outreach occurred through letters, one-on-one outreach and on-site clinic visits. Nurses followed up with members who missed screenings to reschedule appointments and to arrange transportation; the plan also alerted providers about members in need of screening. Finally, SoonerCare Choice evaluated practices at four high-performing sites, and used the information gained in those evaluations to develop educational sessions for low-performing sites. As a result, HbA1c screening rates rose from 20.2% to 28.9%, LDL-C screening rates rose from 16.5% to 17.9%, and eye exam screening rates rose from 2.1% to 17.7%.<sup>38</sup>

In the second case study, HealthFirst of New York identified African American and Hispanic members with diabetes who had had no HbA1c testing, eye exam, LDL screening or monitoring of nephropathy. The health plan used a multi-factorial approach that included mail and telephonic outreach; member and provider education using registered nurses, quality improvement coordinators, and culturally appropriate provider representatives; a \$50 member incentive to complete HEDIS monitoring services; and the use of an electronic, interactive machine that reminds high-risk members to perform self-monitoring. From 2004 to 2006, HealthFirst had reached 61% of its target population (3,995 members), and saw HbA1c testing rates rise from 60% to 79%, eye exam rates rise from 21% to 57%, LDL-C screening rates rise from 55% to 91%, and nephropathy monitoring rates rise from 30% to 52% in its target population.<sup>38</sup>

In the third case study, three health plans that represent almost half of the enrollees in the Oregon Health Plan used a variety of outreach methods to improve HEDIS diabetes screening rates among both high- and low-risk Hispanic members.<sup>h</sup> Outreach methods included diabetes education and screening reminders via telephone and mail, and reports to primary care physicians indicating which Hispanic patients had not had the recommended

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<sup>h</sup> High-risk members were those who had received no HbA1c tests in the preceding twelve months. Low-risk members had undergone all recommended preventive tests in the previous twelve months.

tests in the previous twelve months. While each of the strategies yielded slightly different results, the two health plans using telephone and mail reminders saw HbA1c screening rates increase by 80% and 30%. LDL-C screening rates among Hispanic members in the same two health plan populations also improved by 60% and 30%, respectively. The third plan, which used reports to primary care physicians, saw no increase in HbA1c screening rates and a slight decrease in LDL-C screening rates for Hispanic members.<sup>38</sup>

A summary of the diabetes interventions employed by the NHPC and the Improving Health Care Quality for Racially and Ethnically Diverse Populations Workgroup, and their results, is provided in Table 5.

Press releases, trade articles and information gleaned from health insurer websites reveal that, in addition to the collaborative efforts and case studies discussed earlier, several health insurance plans are actively addressing health disparities through a variety of mechanisms. In many cases, these efforts are linked to an organization's diversity initiatives and a growing recognition of the changing demographics and needs of the health plan's workforce and membership. In several instances, these activities highlight health plans' increasing focus on Hispanic populations.<sup>49, 50</sup>

For example, Blue Cross Blue Shield of Florida has several disparities-related initiatives, including the collection of race and ethnicity data directly from members (on a voluntary basis), bilingual (Spanish and English-speaking) case managers, a multilingual contact center and a series of Spanish language online tools. These tools include a medical library, hospital quality tools, outcomes and safety standards, a health care cost estimator, a provider directory, and member services. In addition, BCBSFL uses *Quality Interactions*, an online cultural competence program for network physicians to role-play with patients from different ethnic backgrounds. This training is voluntary for network physicians and required for all clinical staff, such as medical directors, case managers and health coaches. The

**Table 5: Summary of Interventions Employed by the NHPC and the IHCQREDP Workgroup to Reduce Racial and Ethnic Health Disparities in Diabetes (With Results)**

Payer-Member Intervention(s)	Population(s) and Coverage Type	Result(s)
Culturally tailored outreach, using bilingual nurses and materials that reflect Hispanic cultural norms (Molina Healthcare, p. 37)	Hispanics with commercial health insurance	<u>Positive</u> - Diabetes quality measures have improved - Members improved in their diabetes management self-confidence - Coincident decrease in program level of care requirements
Education and screening reminders via phone and mail to high- and low-risk members (CareOregon, p. 42)	Hispanics with Medicaid	<u>Positive</u> - HbA1c screening rates increased by 80% for one health plan and 30% for another - LDL-C screening rates improve by 60% and 30% for one health plan and 30% for another
Payer-Provider Intervention(s)	Population(s) and Coverage Type	Result(s)
Reports to primary care physicians on non-adherent members (CareOregon, p. 43)	Hispanics with Medicaid	<u>Neutral to Negative</u> - No increase in HbA1c screening rates - Slight decrease in LDL-C screening rates
Payer-Community Interventions	Population(s) and Coverage Type	Result(s)
Free retinal screening events in Hispanic communities with low screening rates (Harvard Pilgrim Health Care, p. 37)	Hispanics in targeted service area, regardless of coverage	<u>Mixed</u> - 2.5% of plan members invited attended - 20% of event attendees were plan members - 31% of plan members receiving mailing obtained an eye exam (compared to 26.5% of those in the control group)
Provider-Member Intervention(s)	Population(s) and Coverage Type	Result(s)
Physicians in practices with higher than average disparities in diabetic care sent screening reminders to patients (Highmark, p. 37)	African Americans and Hispanics with commercial health insurance	<u>Positive</u> - Physicians report anecdotally that targeted patients are getting screenings (no metrics reported)
Multi-Factorial Intervention(s)	Population(s) and Coverage Type	Result(s)
Intensified mailing outreach to more than 500 African-American and Hispanic members and their physicians, developed a cultural sensitivity program module for all DM staff, and implemented a nursing education program (Aetna, p. 36)	African Americans and Hispanics with commercial health insurance	<u>Positive</u> - 38% of non-adherent members to obtain both HbA1c and LDL-C screenings - Intervention group had better HbA1c control than those in the comparison group
Mail and telephonic outreach to non-adherent AA and Hispanic Medicaid members; member and provider education; monetary incentive for members; use of Health Buddy, an interactive, electronic self-monitoring device (or enrollment in mailing reminder program) (HealthFirst, p. 42)	African Americans and Hispanics with commercial health insurance	<u>Positive</u> - Reached 61% of its target population - HbA1c testing rates rose from 60% to 79% - Eye exam rates rose from 21% to 57% - LDL-C screening rates rose from 55% to 91% - Nephropathy monitoring rates rose from 30% to 52%
Member and provider outreach and education; provider alerts for non-adherent members; “best practices” training at low-performing sites (SoonerCare Choice, p. 41)	Native Americans with Medicaid primary care case management	<u>Positive</u> - HbA1c screening rates rose from 20.2% to 28.9% - LDL-C screening rates rose from 16.5% to 17.9% - Eye exam screening rates rose from 2.1% to 17.7

health plan also has a program, *For Florida's Health*, which allows Floridians who are underserved or are without health insurance to find low- or no-cost health care resources in all 67 counties; the program's website is bilingual. Finally, BCBSFL sponsors a multicultural diabetes education program, which provides information about diabetes and more importantly, how to prevent or delay the disease. Members can access diabetes information in English and Spanish by going to the health plan's home page and searching for "diabetes." Online information includes the warning signs of diabetes and identifies diabetes coverage benefits for members. The program also has an interactive diabetes risk assessment calculator so visitors can determine their risk of developing diabetes. These tools help patients engage their physicians earlier to develop a plan that can reduce their risk of developing the disease.<sup>51, 52</sup>

Highmark, Inc., the Blue Cross and Blue Shield plan covering western Pennsylvania, has formed a multi-dimensional approach to focus on health care disparities, and has been addressing this issue for more than five years. Cultural competency training has been completed by all medical directors and more than 1,000 clinical staff and customer service representatives, and nearly all of Highmark's 19,000 employees receive diversity and inclusion training on an ongoing basis. The plan is working with its members to obtain self-identified race, ethnicity and language preference data through voluntary, confidential questionnaires and interactive voice recognition (IVR) telephone outreach, and has thus far received a 30 percent response rate from members. Through *Blues On Call*, Highmark addresses health disparities with customized outreach materials, in which individual members receive direct mail with targeted messages based on clinical needs and socio-demographic variables, such as age, geographic location, socio-economic status, literacy, and race/ethnicity. Highmark has also been engaging practicing physicians through newsletters, focused discussion groups, quality management physician subcommittees and

targeted educational interventions; in addition, an external advisory panel was created in 2007 that includes physicians and local and national experts to provide guidance and recommendations to improve quality health care and reduce racial and ethnic health disparities.<sup>53</sup>

In addition, many health insurers have established separate, private, not-for-profit charitable institutions known as *foundations*. These philanthropic entities allow health insurers, through grant-making and policy initiatives, to extend their influence beyond the traditional reach of the health care system. In 2005, Blue Cross and Blue Shield of Massachusetts awarded \$3 million in grant funds to reduce racial and ethnic health care disparities. These funds went to the Caring Health Center, Inc., to support program to reduce diabetes-related health disparities affecting African American and Hispanic residents in the greater Springfield area by addressing patient, provider, and system-level issues. The other recipient, Cape Cod Free Clinic and Community Health Center, proposed to develop a continuum of services to identify and coordinate care for African American, Latin American, and Native American residents that have untreated and poorly controlled diabetes.<sup>54</sup>

CareFirst, the Blue Cross and Blue Shield health plan covering northern Virginia, the District of Columbia and Maryland, is addressing health disparities among specific racial and ethnic groups through their *CareFirst Commitment* initiative. As part of this program, CareFirst has partnered with Baltimore Medical System (BMS) to improve care for African-Americans and Latinos who suffer from chronic illnesses such as diabetes and heart disease through innovative home intervention by *promotoras* – community health workers – and the introduction of electronic health records and education enhancements to better manage patient care. In addition, *CareFirst Commitment* contributed to La Clínica Del Pueblo, a D.C.-based clinic serving a mostly Latino clientele, in its unique diabetes management program. La Clínica has recruited 175 patients into a program to provide

comprehensive diabetic education and care, including in-home education for some patients to deliver care in a culturally sensitive way to patients who often forego care.<sup>55-58</sup>

A number of studies, papers and reports from researchers, agencies and health insurers strongly reinforced the need for the collection of race, ethnicity and language preference data to address health disparities, despite its many challenges.<sup>38-40, 43, 44, 46, 48-50, 53,</sup>

<sup>59-64</sup> Plans must have these data in order to identify differences in health status and utilization, and to develop, implement and monitor intervention programs aimed at reducing and eliminating gaps in care. Such data can also help plans set priorities, design programs, better understand the health needs of specific populations, evaluate performance differences among and within plans, geographic areas, physician groups, etc., and provide the foundation for rewarding good performance.<sup>38, 43, 46, 48, 62-64</sup>

How effective are current interventions in the health care system at addressing racial and ethnic gaps in care and outcomes? Peek *et al.*, in a systematic review of health care interventions to reduce health disparities in diabetes, found good evidence for the ability of current health care interventions to enhance diabetes care, improve diabetes health outcomes and potentially reduce health disparities among racial/ethnic minorities, including Latinos.<sup>65</sup>

While the study found no single optimal target for interventions, each type of intervention (patient, provider, and health care organization) brought about improvements in care and outcomes -- and provided specific lessons learned. At the patient level, interpersonal interventions using nurses, nutritionists or health educators were more successful than computer-based interventions. Culturally tailored interventions were much more effective among racial/ethnic minorities, while the effects of generalized diabetes self-management interventions were modest. This is not surprising, given that culturally tailored

interventions deal specifically with the barriers to health care that minorities face, such as language, cultural norms, and socioeconomic status.

Culturally tailored patient interventions provided positive impacts on health knowledge, behaviors and outcomes, although they varied in which health outcomes were affected. Examples of successful culturally tailored interventions include the provision of educational materials in the patient's language and at the appropriate literacy levels; dietary recommendations that consider cultural preferences for certain types of foods and access to substitutes; and physical activity recommendations that incorporate cultural norms about exercise and accommodate access to venues for such activities. This finding is supported by the multiple observational studies have found that culture, socioeconomic status, and social support, self-efficacy, and coping skills play a large role in explaining diabetes self-case and health outcomes.<sup>66, 67</sup>

At the provider level, in-person performance feedback to physicians was superior to computerized decision support in effecting sustained provider behavioral change and health outcomes. In one study, feedback consisted of face-to-face, one-to-one sessions between an endocrinologist and the physician providing care. These sessions, occurring every two weeks and lasting five minutes apiece, consisted of a review of individual provider actions or outcomes specific to the patients seen by that provider. Emphasis was placed on achieving American Diabetes Association goals and on acting appropriately when values such as blood sugar levels were abnormal during patient visits.<sup>68</sup> Evidence also suggests that targeting providers and facilities that serve racial/ethnic minorities for interventions may be highly effective in reducing health disparities.<sup>65</sup>

For health care organizations, the authors found that the use of case managers, community health workers, and nurses acting as clinicians (via treatment algorithms and physician support) positively affected both the processes and outcomes of care for racial

and ethnic minorities with diabetes. In particular, the use of nurse case managers improved both the quality of care and outcomes, including diabetes control and the onset of retinopathy. Community health workers (CHWs), given their effectiveness in acting as a patient adjunct to the primary care team and making and keeping patient appointments, may make case management a financially viable option for health centers with limited resources.<sup>69</sup> The study also found evidence that case management is particularly important in medically underserved populations because it addresses common barriers to adherence through patient education, identification of ancillary services (such as home health), providing ancillary services (such as testing and vaccinations), and overcoming logistical issues (such as transportation).<sup>70</sup>

In a related examination of the efficacy of generalized pharmacy-related health care organization interventions, Peek *et al.* found two studies of pharmacist-led medication management and patient education; both reported improvements in HbA1c levels.<sup>71, 72</sup> One study examined a clinic-based medication assistance program, in which uninsured individuals and Medicare enrollees received 2-3 month increments of pharmaceutical company-sponsored medication. The program improved medication adherence and resulted in clinical improvements in HbA1c, LDL and triglyceride levels.<sup>73</sup>

Finally, in a finding echoing that of this study's literature review, Peek *et al.* found mixed results for the efficacy of disease management programs at improving diabetes outcomes. One study that included a diabetes registry, case management and visit reminders found positive impacts on both diabetes control and process measures for African American women in a rural setting.<sup>74, 75</sup> Another study, a systematic review of effectiveness of disease management among patients with diabetes, reported better diabetes control and increased screening rates for neuropathy, dyslipidemia, and microalbuminuria.<sup>76</sup> In this case, disease management was defined as the identification of the population with diabetes;

guidelines or performance standards for care; management of identified people; and information systems for monitoring and tracking. A more recent study of 63 physician groups in 11 care, found improvements in processes of care, but not with improvements in health outcomes. In this study, disease management was defined as physician reminders, performance feedback, and structured care (the use of formal case management, diabetes guidelines, patient reminders and patient education). The authors concluded that more focus on direct measurement, feedback and reporting on intermediate outcomes (such as HbA1c, systolic blood pressure and LDL-C levels) is required.<sup>77-79</sup>

Several additional studies found that the provision of culturally and linguistically competent care has the potential to improve health care access, quality and outcomes, and reduce disparities in care.<sup>33, 39, 65</sup> Cultural competence is a term used to describe “a set of congruent behaviors, attitudes and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.”<sup>80</sup> Fisher *et al.* note that while this term often refers to the ability of clinicians to interact successfully with patients whose backgrounds differ from the mainstream culture, the term is also used to describe how health care systems interact with patients.<sup>34</sup>

Understanding and integrating cultural components, particularly for Latinos, is critical for success in closing gaps in quality of care.<sup>34, 48, 56, 81, 82</sup> In addition, Fisher *et al.* found that, while cultural competence is an important part of the solution to reducing health disparities, culturally leveraged nursing and community health worker interventions improved processes of care and outcomes. The authors define cultural leverage as “a focused strategy for improving the health of racial and ethnic communities by using their cultural practices, products, philosophies, or environments as vehicles that facilitate behavioral change of patients and practitioners.”<sup>34</sup> Other promising methods include the use of *promotoras* or

multicultural community health workers, peer support, family inclusion, community engagement, and participatory learning that considers low literacy levels for Latinos, as described below.<sup>34, 48, 56, 81, 82</sup>

Chin, *et al.* reviewed six papers examining the impacts of interventions using cultural leverage on cardiovascular disease, diabetes, depression, and breast cancer, and found that multi-factorial, culturally tailored interventions that target different causes of disparities (social norms, the patient environment, and the health care environment) seem to hold the most promise for reducing health disparities.<sup>33</sup> The authors argue that the success of culturally tailored quality improvements may be a result of their ability to provide a mechanism of individualizing care for ethnic minorities. For diabetes in particular, some of the most powerful interventions targeted patient, provider, organization, and community factors simultaneously, often employing multidisciplinary teams, patient registries and a variety of intervention techniques (patient education, nurse case management, treatment algorithms, community outreach with community health workers, patient incentives, continuous quality improvement, and group visits). Peek *et al.* (cited earlier) also found evidence that culturally tailored programs with enhanced community involvement may be an important factor in the success of multi-target interventions at improving diabetes health outcomes.<sup>65</sup>

The study also asserts that despite a lack of evidence in the studies examined, there are theoretical and practical reasons to believe that cultural tailoring may enhance the effectiveness of general quality improvement interventions among ethnic minority groups. Examples of this include the *Advancing Diabetes Self-Management (ADSM)* project at *La Clinica De La Raza* in Oakland, which uses a multifaceted approach to improve diabetes self-management for Spanish-speaking adults with type 2 diabetes. The program employs a theoretical model of behavior change, and incorporates peer support, bicultural community

health coaches (*promotoras*) and patient-centered counseling.<sup>83</sup> Other successful<sup>i</sup> examples of multi-factorial approaches to improving diabetes self-management for Hispanics include the Diabetes Health Disparities Collaborative, the *Campesinos Sin Fronteras* initiative, and the Open Door Health Center's Prescription for Health Diabetes Project.<sup>81, 82, 84</sup> These findings are supported by the Peek *et al.* study; while the authors found that there were few head-to-head comparisons between culturally tailored and generic quality improvement programs, the study's meta-analysis found that culturally tailored patient interventions resulted in a larger reduction in HbA1c values than general quality improvement interventions did.<sup>65</sup>

The National Quality Forum, in its August 2008 issue brief on closing the disparities gap, reiterates the need for evidence-based, targeted, culturally tailored interventions – based on early successes of such techniques.<sup>48, 60, 85, 86</sup> The report also outlines a series of analytic steps to target improvements in diabetes care for Hispanics.<sup>48</sup>

The Decreasing Disparities Strategy Workgroup of the Agency for Healthcare Research and Quality (AHRQ), whose aim is to reduce disparities in quality and/or access to care in priority populations through establishing improved methods of transferring knowledge from researchers to providers, purchasers, and policymakers, embarked on a learning network project to reduce the diabetes disparity in the Hispanic population. The Workgroup targeted community health centers with a predominately Hispanic population for this intervention, which was conducted from June 2006 to January 2007.

The project demonstrated that clinics can make significant progress in their patient goal-setting performance, even when patients participate in short learning sessions (4 hours) over an abbreviated period of time (6 months). The workgroup also learned that the likelihood of success is greater if interventions are culturally tailored, and produced a list of

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<sup>i</sup> Results are asserted but not specifically reported.

*Lessons Learned to Improve the Care of Hispanic Persons with Diabetes*, summarized as follows:

1. Any written materials for Hispanics in community health clinics should be developed for a low literacy level; many may be illiterate and not volunteer this information. Simple pictures on materials and tools have helped to increase interest and understanding.
2. Materials validated in Spanish may still be inappropriate for the clinic population if the concepts embedded are not familiar to the culture of the population being served. During this intervention clinics did not identify specific variances in the cultures of persons from Mexico or Central America that require a different approach in designing services.
3. Hispanics are generally family oriented, and this is important for motivating them for lifestyle changes and compliance to a care plan. Parents may be motivated to take better care of themselves in order to better care for their children.
4. Family members, preferably living with the patient, should be invited and encouraged to participate in classes for persons with diabetes. If the patient is male and there is a female in the home that prepares food, it is crucial to have this person present during classes and maybe clinic visits.
5. Food is very important in this culture, and mothers may use it as a reward within families. Recognize the importance of food and seek healthier ways to prepare food. Often Hispanics are open to trying other ethnic foods that can provide variety and still be healthier.
6. Many exercise options are not accessible or acceptable to Hispanics. Walking, biking, and dancing are common options used. Even walking can be hazardous in some

urban settings and suburban settings without sidewalks; very few localities have central *plazas*, a common feature in Latin American communities. Work with the patients in interactive goal setting to see what is feasible for individuals.

7. Hispanics often take the medical advice of a well-respected person in the community over that of the clinician in the clinic. Unfortunately, they usually do not discuss any differences of opinions with the clinician because he or she is an authority figure. For this reason it is even more critical for interactive goal setting with Hispanic patients to elicit what is important to the patient and what changes the patient is ready to make.
8. Latinos will keep appointments and attend classes better if the environment feels a part of their culture and they are comfortable in it. Facilities that are old and crowded can be more successful than facilities that are more spacious and clinical in appearance if patients and their families feel comfortable and welcomed by people they trust.
9. A myth exists in this culture that insulin can actually worsen the symptoms and complications of diabetes. The clinician must address why this myth exists (i.e., patients waited too long to start insulin and the damaging effects were already present) and why waiting can increase the complications of diabetes. However, clinicians should never intimate that patients who maintain good control will never have to use insulin. This can cause a trust problem since even patients with good control might eventually have to use insulin.
10. When translating materials or discussing mental health issues with Hispanics, avoid using the term "depression." The term evokes a more negative response in this culture, and patients will deny having symptoms. Instead ask, "Do you feel sad more often; do you have trouble finding energy to do the things you usually do?"<sup>84</sup>

What about the ability of provider pay-for-performance to reduce racial and ethnic health disparities? In an interesting examination of the effectiveness of such programs in closing care gaps, Chien *et al.*, finding only one empirical study examining the question, interviewed the leaders of fifteen pay-for-performance programs. The authors found that current pay-for-performance programs are not designed to reduce disparities and often lack characteristics that may be important in reducing disparities. The study recommends that health plans, in order to address these shortages, collect race and ethnicity data, emphasize conditions of higher prevalence in minorities to providers, reward improvement for reducing health disparities, and encourage nationally prominent organizations to establish disparity guidelines or measures.<sup>32</sup> The NQF, in its 2008 briefing on reducing gaps in care (cited earlier), also calls for such guidelines or measures.<sup>48</sup>

Despite the promising research and the increasing levels of activity aimed at reducing racial and ethnic disparities, questions about what types and combinations of interventions are most valuable and most cost-effective -- as well as how cultural competence and cultural leverage should be integrated into generic quality improvement initiatives to be most effective – continue to plague both researchers and health care system stakeholders.<sup>31, 34</sup> This presents a real challenge for both health care organizations and health plan purchasers, who often must know (or at least project with some certainty) whether the investment in a given intervention will produce the desired outcome, in order to secure and maintain funding and other organizational support for the intervention(s). Lurie *et al.* point out that valid assessment of the true financial impact of any intervention necessitates strong evaluation design, which will in turn require access to data that is often costly and sometimes difficult to obtain (for example, member race/ethnicity, programming costs, and utilization patterns over time). Such designs are also better suited for

interventions and outcomes that are measurable in a relatively short period of time, which is typically not the case for a chronic disease such as diabetes.<sup>33, 41, 87</sup>

In an effort to facilitate the development and use of ROI analysis for health plans and other organizations requiring a business case to secure funding and support for health disparities programs, three members of the National Health Plan Collaborative piloted and refined several ROI analysis tools. These tools, which use both prospective and retrospective techniques for forecasting and program evaluation, are now published on the CHCS website.<sup>88</sup> The forecasting calculator also includes an “evidence base” dataset, which allows users to populate forecast assumptions with data from comparable initiatives and published studies. Clinical topics include asthma, congestive heart failure, depression, diabetes and high-risk pregnancy.

Health insurers and employers face additional challenges in the quest to produce a business case for interventions. First, any returns might not be realized for quite some time after the investment is made (a problem particularly applicable to a long-term, chronic disease such as diabetes), and second, given that potential delay in ROI, compounded by the fact that many members, patients and employees switch health insurance carriers, physicians and employers over time, any returns may accrue to other parties (for example, other -- and sometimes, competing -- health insurers, physician practices or employers) who made no investment in the intervention.<sup>41, 87</sup>

Thus, the business case for interventions to improve care quality and reduce health disparities is as yet unclear, and will likely remain so for the foreseeable future, given the complexities and costs of designing and implementing valid intervention assessments that successfully address the issues outlined above. The business case for addressing racial and ethnic health disparities in diabetes is particularly difficult, given the long course of the disease, its multiple drivers, and the fact that most studies have only examined

improvements over a 1-2 year period – likely too short an evaluation period to definitively determine the long-term impact and sustainability of those improvements.<sup>33, 78</sup>

Despite these challenges, many observers -- noting the hundreds of articles and papers written, presentations made, and studies conducted on racial and ethnic health disparities -- are suggesting that it is time to move beyond simply documenting the problem and turn our efforts toward taking actionable steps to eliminate health disparities.<sup>39, 49</sup> Specifically, Lurie *et al.* assert that health care organizations, in the absence of an airtight, quantitative business case, can take targeted steps to reduce disparities in ways that use scarce resources effectively. Suggestions include: targeting health care providers that serve large numbers of minority patients and that provide lower-quality care; using geographic information systems (GIS) tools, along with care quality data, to map by census-tract areas of poor quality care; and partnering with other community stakeholders to reduce disparities. This latter approach, Lurie suggests, can not only improve the effectiveness and sustainability of the program(s) but, by involving more stakeholders, it can lower the costs to any one organization.<sup>87</sup>

## **CHAPTER 5: KEY INFORMANT INTERVIEW FINDINGS**

### ***Descriptive Analysis***

The organizations included in this portion of this study are on the leading edge of private payer industry with regard to the movement to reduce racial and ethnic health disparities. This point is important to set a relative context for the findings contained herein: These health plans arguably have levels of experience, commitment, organizational readiness and maturity that surpass the vast majority of health plans in the United States.

Why? Most of the health plans that participated in the key informant interviews have been formally addressing disparities for more than four years. *Formally addressing* in this context means that the health plan has dedicated resources, a working committee or task force, specific organizational goals, or any combination thereof related to the reduction or elimination of racial and ethnic health disparities. The majority of the participating organizations began their efforts in 2004, shortly after the 2003 publication of the IOM report, and in conjunction with the initiation of the NHPC. In addition, each of these health plans is participating in one or more industry collaborative efforts with other health plans, so they have access to the collective pool of experience and knowledge developed through these partnerships.

One firm, while it is participating in one of the collaborative efforts to reduce racial and ethnic health disparities mentioned earlier, is not formally addressing disparities. Instead, it is focused on capturing the Hispanic market.

Our driver has not been addressing health disparities. Our driver has been to capture the Latino market. Now how we got there, or how we decided to go after the Latino market was because we found that the population was truly underserved. It's not a pure health disparity [issue], but that's a factor.

This case study is included because, although its objectives and approaches differ from the other health plans interviewed, this organization's strategy, methods and experiences provide interesting insights into the Hispanic population, from both marketing and health education perspectives. These insights are due in no small part to the fact that one of the key informants interviewed at this organization is of Hispanic heritage; this individual's deep understanding of the Hispanic culture served to validate, refute and enrich the hypotheses, assumptions and practices of other sources used for this study.

Multiple factors drove participating health plans to address racial and ethnic health disparities in general, but most respondents pointed to the widening and more obvious gaps in care that racial and ethnic minorities experience, the recognition that these gaps present barriers to improving the overall health of their members, and a growing awareness that broad stroke approaches to quality improvement will not adequately address the needs of these populations. Four respondents cited the 2003 IOM report -- and the visibility into the role of the health care system and the clinical encounter in health disparities that that report provided -- as one of their initial drivers; an equal number noted that addressing health disparities is "the right thing to do."

An organization cannot commit to a quality improvement agenda without addressing disparities.

Health disparities have emerged as a huge organizational priority for us. We are trying to do the right thing for our patients and members. We have an obligation to address health disparities, and we are pursuing that through the development of ideal practices and proving outcomes.

There was a very strong commitment that this was the right thing to do, and we really want to be responsive to our members' needs.

It was the 2003 IOM report on equal treatment. That's where we began.

Here's the thing: With the demographics of our country changing the way they are, you have to be engaged on this whole issue.

A strong push by senior management, anecdotal data from physicians, and industry trends were also mentioned. Industry trends included two main components: activity by the health plan's competitors to address health disparities, and growing demand from national accounts for evidence that the health plan is actively seeking to reduce health disparities. This latter factor is evidenced by the increasingly frequent inclusion of questions from potential customers about the plan's disparities reduction efforts in requests for proposal (RFPs), a formal method whereby groups seeking to purchase health insurance evaluate candidate health plans.

It's a potential marketing advantage. We know what we look like in the U.S. now, and we know what we will be like in the next 5, 10, 15 years [referring to the racial/ethnic composition of U.S. population].

Over the past year, we have seen more and more questions about what we're doing to address health disparities in our larger and national account RFPs. Our biggest customers are starting to demand that we take action.

Participation in the NHPC, pressure from workforce diversity initiatives to better serve the needs of an increasingly diverse marketplace, and a desire to capture the Hispanic market each received more than one mention by respondents. One respondent indicated that the anticipation of future accreditation and regulatory requirements to reduce health disparities and improve the cultural competence of health plans had played a role in the commencement of that organization's formal disparities reduction efforts. Interestingly, only one of the interviewees specifically mentioned health care cost savings as an initial driver.

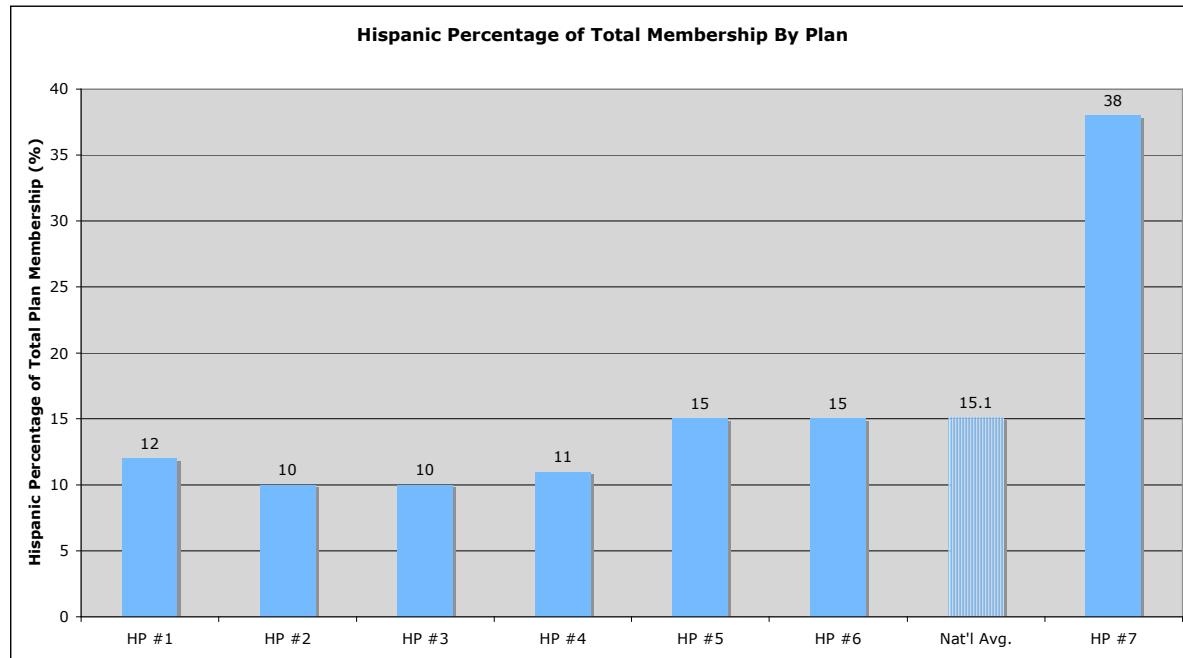
With one exception, the plans' percentage of Hispanic membership equaled or lagged that of the average for the US population (see Figure 6). Estimates ranged from less than 10% to 38%;<sup>j</sup> however, six of the seven plans with estimates were between 10%

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<sup>j</sup> The 38% estimate is for that health plan's target service area only, not for its total commercial membership.

and 15%. (The US Census Bureau reported that, as of July 1, 2008, 15.1% of the US population was of Hispanic/Latino origin.<sup>89</sup>) The growing Hispanic population in the United States -- and the expanding portion of the total population which it now represents -- make addressing health disparities for Hispanics increasingly essential for health plans.

**Figure 6: Hispanic Percentage of Total Membership By Participating Plan**



Finally, six of the eight health plans included in this study have one or more programs targeting Hispanics with diabetes (see Table 6). These programs may be part of a larger effort to reduce health disparities in diabetes among multiple racial/ethnic groups, or they may be solely focused on Hispanics. In a finding echoing that of both the literature and document reviews, the vast majority of these programs are still nascent, having been in place from less than a year to two years.

**Table 6: Hispanic Membership and Program Characteristics By Health Plan**

Payer	Hispanic Percentage of Total Membership*	Diabetes Program(s) for Hispanics	Duration of Program(s) (Years)
Health Plan #1	12	1	1
Health Plan #2	<10	1	2
Health Plan #3	15	0	--
Health Plan #4	15	2	2 and 5
Health Plan #5	11	0	--
Health Plan #6	10	1	<1
Health Plan #7	38 <sup>k</sup>	2	<1 and 2
Health Plan #8	Not known	1	2

\*As provided by key informants.

### ***Key Findings***

**Key Finding 1: Collecting member race/ethnicity data, and establishing institutional confidence in it, is critical to both confirm the presence of health disparities within the health plan's member population and to serve as a springboard for organizational action.**

All respondents stressed the importance of proving the existence of health disparities in the health plan's member population. For most plans, that involved the collection of race and ethnicity data on their member population and performing disparities analysis, usually of process measures (e.g., HEDIS).

I would say that, to get started – and that's always a big challenge for many programs and health plans – just start by doing health disparity analysis with whatever data you can get, whether it's state-sponsored data feeds...if you can get even just a portion of the [race/ethnicity] data and be able to demonstrate that disparities are a real issue...it becomes more compelling.

For [us], it was showing that our membership had disparities based upon our geo-coded data, and that helped drive a commitment. The geo-coded data helped our senior leadership say, 'Okay, let's collect the direct data.' So that was a key lever for us.

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<sup>k</sup> The 38% estimate is for that health plan's target service area only, not for its total commercial membership.

Participating plans are employing an almost equal mix of direct techniques, indirect/imputed techniques, and a combination of both. As outlined in Chapter 4, indirect techniques for the collection of race and ethnicity data include the evaluation of language utilization data, geo-coding, and surname analysis (with and without first name analysis). *Geo-coding* uses a member's residence to approximate the likelihood of a member's race or ethnic background; this technique is used primarily to identify enrollees who are likely to be African American. *Surname analysis*, typically used to identify Asian and Hispanic members, compares a person's last name to a long list of surnames known to have a high probability of belonging to someone from the specified racial or ethnic group.<sup>37-39</sup>

Direct data collection techniques include the use of mailed member surveys, paper and online enrollment forms, health risk assessments (HRAs), electronic medical records (EMRs) and online member services. Other direct collection techniques utilized by respondents include the evaluation of requests for translation and birth data. Such techniques, while widely acknowledged as being more accurate, are also costly and slow. Those plans using direct techniques alone reported having race and ethnicity data on 20-35% of their target population, while plans using indirect techniques reported having data on 90-100% of their target population.

One health plan, lacking race/ethnicity data on its members, analyzed its own employee population for disparities; the organization found them in prenatal visits, delivery complications, and diabetes care and complications between their Hispanic and African American employees and their Asian American and Caucasian employees. This finding supports the IOM assertion that health disparities exist even when factors such as access to health care and coverage are controlled, and suggest that a health plan's own population may be fertile – and valid – ground for establishing a business case for reducing health disparities.

It was very shocking to us that this level of health disparity existed among our own employees. I mean, this is a group that shouldn't have language barriers because we all work at [health plan] on a daily basis. We all have insurance through [health plan.]

Several respondents mentioned the importance (and difficulty, in some cases) of convincing internal stakeholders that health disparities do exist in the plan's member population. As one respondent put it, "Develop institutional confidence in your data; that can be a real distraction and impediment to forward progress." Another noted, "There were a number of people in senior management that refused to believe that we had a [health disparity] problem until we put the data in front of them. And then we had to convince them that the data were valid!"

**Key Finding 2: The relative nascence of programs aimed at reducing disparities in Hispanics with diabetes, combined with the absence of stakeholder incentives and the sole and predominant usage of member interventions, suggest that most organizations are adopting a cautious approach to this problem.**

Table 7 summarizes the types of interventions used, whether stakeholder incentives are included, and the number of years the program(s) have been in place for those programs aimed at reducing disparities in Hispanics with diabetes. A total of six of the participating health plans have one or more programs to reduce diabetes among Hispanics currently in operation. These health plans are predominantly using payer-member interventions; in fact, most of the programs in operation employ them exclusively. The study found only one instance each of the use of payer, community and multi-factorial interventions.

In a direct extension of general quality improvement programs, the most commonly used payer-member intervention is a culturally tailored diabetes screening reminder,

provided through mail and automated outbound telephone calls. *Culturally tailored* for most of the health plans means that the recordings used in telephone calls and the mailed materials are translated into Spanish. Two of the telephonic methods included interactive voice response (IVR) technology, which invites call recipients to request more information on diabetes from the insurer. This allows the health plan to capture important information about the respondent, such as a validated name, phone number, address, race/ethnicity category, and an indication that future interventions may be successful with this individual.

**Table 7: Summary Characteristics of Disparities Reduction Programs for Hispanics with Diabetes Implemented by Participating Health Plans**

Payer	Point(s) of Intervention	Stakeholder Incentives Provided <sup>1</sup>	Duration of Program (Years)
Health Plan #1	Payer-Member	No	1
Health Plan #2	Payer-Member	No	2
Health Plan #4	Multi-Factorial	No	5
	Payer-Community	No	2
Health Plan #6	Payer-Member	No	<1
Health Plan #7	Payer-Provider	No	2
	Payer-Member	No	<1
Health Plan #8	Payer-Member	No	2

One of the six plans has a disparities reduction initiative that includes Hispanics with diabetes and incorporates a payer-provider intervention, described by the respondent as follows:

For the providers...we take the health disparity profiles that we developed for a particular region and, depending on the local quality department's request, we might identify a few medical groups and their primary care physician office and we will map it out. For physician offices that fall into very heavily disparate zones, the quality improvement department might reach out to that particular medical group and just say that they seem to be practicing in a very health disparities heavy location and when we look at your member mix, it looks like there are health disparity patterns...Is this what you've observed? What do you think are the drivers that cause this? What can we do to help you?

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<sup>1</sup> Refers only to whether incentives specific to the program are in place. Several organizations have overall health disparity reduction incentives (e.g., for employees and providers), which may contribute indirectly to the performance of these programs.

For this plan, a contracted delivery system, there is currently no requirement or incentive for the provider to act upon this information.

Only one plan interviewed reported a community-level intervention targeted specifically at Hispanics with diabetes. Through a community health collaborative focused on health care access for Hispanics, this health plan is using subcontracted health behavior and health education resources to improve diabetes self-management in a catchment population with non-optimal blood sugar control. The program has been in place for three years now, and has achieved optimal glycemic control among more than 200 program participants to date.

Despite the fact that multiple sources in the document review extolled the promise and efficacy of multi-factorial interventions, only one health plan has a program aimed at reducing health disparities in Hispanics with diabetes that involves multiple stakeholders. In this case, the same health plan that is employing the community-level intervention just described (and one of the two integrated delivery systems included in this study), is using a disease/patient registry and a provider-initiated treatment protocol (a drug regimen) to reduce the risk of cardiovascular mortality among its Hispanic members with diabetes. Case managers and community health workers also follow up with members to increase their compliance with the program. According to the plan's medical director, the essential components for the success of this program were: bilingual, bicultural outreach to members; an engaged multidisciplinary team (physicians, nurses, pharmacists, case managers and community health workers); coordinated care delivery that involves the laboratory (for testing and results) and the pharmacy (for patient education and prescription activity data); and a disease/patient registry.

As outlined earlier, many health insurers have established separate, private, not-for-profit charitable institutions known as *foundations*. These philanthropic entities allow health

insurers, through grant-making and policy initiatives, to extend their influence beyond the traditional reach of the health care system. Several respondents indicated that their foundations were funding grant requests for community-level health disparity reduction programs, and two respondents indicated that their foundations had specific grant focus areas around reducing disparities. In general, however, these efforts were not coordinated with other disparity initiatives.

Neither member nor provider incentives are commonly used in programs aimed at Hispanics with diabetes. To illustrate, none of the health plans interviewed have changed benefit plan designs to induce members to change their care-seeking behavior. Examples might include lowering or waiving co-payments for screening visits or test supplies. (There is one indirect exception to this – the health plan that evaluated disparities in prenatal and diabetes care among its employee population to produce its business case. In that instance, the health plan waived prenatal visit co-pays as a standard benefit.)

All of the plans interviewed have considered provider pay-for-performance mechanisms for closing racial/ethnic gaps in care. None of them have yet implemented them – and they were at notably differing levels of readiness to do so.

The challenge for [us], and here's the main reason why we won't be including it [in pay-for-performance programs] any time soon, is that we don't have the member self-reported data. It's never that compelling when you're using estimated data. It's a lot more suspect...I don't know how we can ever make it a true pay-for-performance when, one, you don't have the data on everybody, and two, if you do through indirect methods, it's an estimate. The physicians are not going to buy it. That's not to say that as the industry changes because it is more of a high priority topic that people won't try to make it pay-for-performance.

It's pretty high level, but we have brought that up, that we may at some point like to look at that.

As part of our pay-for-performance program for our primary care physicians, we'll be measuring disparity-related process indicators, beginning in 2009.

One integrated delivery system does provide an optional performance bonus for contracted providers who collect race/ethnicity data. This is included as a process measure component of their pay-for-performance program.

Organizations are more likely to use employee incentives than they are provider incentives – at least from an overall health disparities reduction standpoint. For example, one of the integrated delivery systems interviewed bases a portion of provider compensation on a proprietary overall member health index. Another health plan is actually including an overall member health index (not specific to Hispanics with diabetes) as part of every employee's incentive compensation plan.

I mention the member health index that is not just HEDIS [measures] but includes a lot of other administrative data-related metrics as well. The member health index to those of us at [health plan] is an indication of how healthy our [member] population is...These numbers are actually a part of all [health plan] associates' performance incentive... It may not be huge<sup>m</sup>. It can range anywhere from 5 to 10% [of the incentive compensation package] given the years' priorities, but some portion of it is always tied to the overall improvement of these scores. Even if there isn't a distinct monetary ROI in the reduction in the medical cost of care, just the fact that if we're able to move the needle on improving these measures, that's a goal that everyone in the company would be pleased to reach as well.

Both respondents indicated that, while these incentives are not directly aimed at reducing racial and ethnic health disparities, there is likely an indirect effect, given that the rising health improvement tide must float all boats – regardless of race or ethnicity -- in order for the health plan to meet its goals.

These findings illustrate that, at least for now, addressing health disparities is risky business -- particularly for chronic and complex diseases like diabetes. The cultural barriers that Hispanic populations face in the health care system provide additional and substantial hurdles for health plans to cross. While the document review uncovered promising hints of the efficacy of cultural targeting at reducing disparities among Hispanics, that evidence base

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<sup>m</sup> Associates are employees of the health plan.

is still small. Thus, extending existing disease management programs (which primarily employ member interventions), avoiding the use of costly (and unproven) member incentives and potentially contentious provider incentives represent a rational approach in the face of such uncertainty.

**Key Finding 3: Health plans are beginning to realize the necessity of understanding the specific characteristics and needs of their target Hispanic population(s) to design effective interventions. They also recognize the risks of assuming that Hispanic populations will respond to literal translations and to the same messages and communication vehicles as non-Hispanic populations.**

[Health plans] need to go out in the communities and determine what the community needs are, and they need to be respondent [sic] and focused on meeting the needs of their community. To me, that's a very simple script.

[Health plans] really need to do their homework and understand the population that they're trying to serve; [they need to] really understand what the population is and what the problems are that are in that community.

There are important differences between sub-segments of the Hispanic population. Such differences include -- among other things -- socioeconomic status, language isolation, and country of origin. This latter variable drives significant cultural differences between Hispanic groups -- from language to cultural norms and values – that are critical to understand in order to effectively reach these populations. As one respondent put it, “Determination and pursuit of the required granularity associated with the data is critical to designing the most appropriate interventions.”

It’s really important that the messaging is not just in Spanish, but in the right Spanish. All Latinos are not the same...so our communications style has to be a generic, safe, [we have to] get away from all of the colloquial words and just make it very professional, safe, easy to understand communication. That’s very important.

In addition, communication and outreach methods developed for and by persons of non-Hispanic heritage are not always effective with Hispanics, underscoring the need to acquire specialized skills to develop those methods.

We did a lot of talking with the [Latino] community and realized that our traditional methods of even marketing or educating would not work in the Latino community.

I think that a lot of times we assume a number of things with our own cultural filters [such] that we are not really developing things that truly reflect the population.

It's really important that the imagery is right. Latinos are all about family, not about anything else. So that's what needs to be reflected.

We found that it is very effective to hire vendors who specialize in [Hispanic] markets to come up with the materials because they live and breathe the requests or the needs of those communities day in and day out.

...our market research department is uniformly Caucasian. If you're going to be interviewing...Latinos, you really want a facilitator who is reflective and who is bilingual in the case of the Latino population. Our vendor is able to do that, and our internal department is not.

Two respondents specifically mentioned that their organizations had successfully used *novelas* in both health education and marketing aimed at Hispanics. *Novelas*, which use the art of story-telling (in photo or video form) to get messages across to readers or viewers, are being used increasingly by marketers and health educators to more effectively reach the Hispanic market.<sup>90, 91</sup>

[The *novela*] is the exact mechanism that we chose to educate employees during an open enrollment meeting where a plan is being offered as an option for them to sign up. We created three mini-*novelas*...that talk about the benefits of health care... When we show the DVD to a prospective audience where, prior to our doing any work we would get 20% of Latinos signing up for health care, after showing the video, it jumps to 90 to 100% enrollment.

We realized that they [Hispanic focus group members] were so familiar with this medium [*novela*] and it was so comfortable for them, that they immediately dove in and identified with the characters in the story. They were talking about the same trials and tribulations that the characters were experiencing, and how they had the same things in their lives...The comments were, "I can use this to talk to my family members about taking better care of our health, or to understand more about my diabetes." It was a piece that clearly had a lot of resonance, so I would say that you want to find those pieces.

Echoing the findings of the AHRQ's Decreasing Disparities Strategy Workgroup of the Agency for Healthcare Research and Quality, several respondents stressed the importance of family and trust in the Hispanic culture:

That's what we really struggle with – with our [corporate culture] – it's a very Anglo rational linear approach to health disparities and how we can address them. It's "Well, we'll work with them on consumer-directed health and get them to take care of themselves." That won't work. It's about doing it within the context of the family and the community, a very circular relationship.

Also, it's really important that the imagery is right. Latinos are all about family, not about anything else. So that's what needs to be reflected... When we say family in the Latino culture, it is not mom, dad and 1.2 kids. It's really aunts, uncles, grandparents, nieces, nephews, friends, godparents, people that aren't blood related but they're still family. It could be huge.

A lot of folks want to serve the Latino market, but they start doing direct mail pieces, just like they would in the Anglo market, and it doesn't work. The Latino's view of brand is very different than a non-Latino's view of brand. The brand has to be humanized, and that sounds really strange, but it's really about building a relationship with the brand. When a Latino makes a purchase, and we're great consumers, but we make purchases based on, "Is that a nice person I'm buying from, and is that company a nice company?" Price and quality become secondary to all of this. It really is about that emotional connection with people.

Finally, simply translating English to Spanish is risky, ineffective, and a potential waste of money.

People need to make sure that they don't just translate. They need to *transcreate*. I'll give you one quick example of how you can get into trouble translating. You've seen those billboard ads that say, "Got milk?" A literal translation of that [into Spanish] would be "Are you lactating?"

What we found is that when we have offered...screening reminders in Spanish, the translation is technically accurate. Grammatically it is correct, but it sounds very, very formal and stilted. It sounds translated. If you look at the English screening reminder script, it is very warm and friendly and personable. In the translation process, all that is lost.

**Key Finding 4: In a testament to the costs and difficulties of creating strong evaluation designs, and the time interval required to measure sustained improvements for chronic diseases such as diabetes, most of the programs in operation are using process measures; in addition, the majority of plans are not yet ready to report results.**

This is a particularly relevant finding, given the fact that most of these organizations have been formally addressing racial and ethnic disparities for more than four years. It speaks to the length of time necessary to develop and implement programs; to allow for measurable impacts to be made; to design evaluations methods; to collect, integrate, analyze and verify data for a complex, chronic condition such as diabetes.

Table 8 provides a summary description of the interventions employed by the health plans with programs to reduce disparities in Hispanics with diabetes, along with the goal(s), type(s) of measure, and results for each program. In the table, programs are grouped by intervention type employed (payer-member, payer-provider, payer-community, and multi-factorial).

Most plans are tracking and reporting against process measures; only one is tracking outcome measures. While all eight programs have stated goals, five goals are process measures (improving HEDIS diabetes screening rates for Hispanic members, increasing Hispanic member enrollment in disease management programs, and identifying members for whom additional interventions may be appropriate and effective). One plan's stated goal, to reduce gaps in care, is neither reported nor tracked. Only two programs have goals that are outcome measures; interestingly, they are associated with the same organization (one of the two integrated delivery systems included in the study).

**Table 8. Intervention Descriptions, Goals, Measure Type and Results for Programs Implemented by Participating Health Plans (by Intervention Type)**

Payer-Member Intervention	Goal(s)	Type of Measure	Results
Disease management program outreach to Hispanic members through telephone and mail	Increase diabetes disease management enrollment among Hispanic members	Process	Not yet reported.
Ethnic-tailored, interactive voice response telephone call offering members more information about the complications of diabetes	Identify members for whom additional interventions (e.g., health coaching) may be successful	Process	Initial campaign of 24,000 calls netted 4,000+ positive responses. <sup>n</sup> Second campaign planned for 2009.
Culturally tailored diabetes screening reminders via automated outbound telephone calls.	Increase HEDIS diabetes screening rates <sup>o</sup> for Hispanic members	Process	Not yet reported.
Culturally adapted diabetes screening reminders via automated outbound telephone calls.	Increase HEDIS diabetes screening rates for Hispanic members	Process	No observed impact to date.
Mail and automated outbound telephone screening reminders	Increase HEDIS diabetes screening rates for Hispanic members	Process	Not yet reported.
Payer-Provider Intervention	Goal(s)		Outcome(s)
Plan outreach to physician practices operating in heavily disparate zones to build awareness of the issue and to offer health plan assistance <sup>p</sup>	Close care gaps	Outcome	Not tracked or reported
Payer-Community	Goal(s)		Outcome(s)
Using health behavior and health education resources, educate and assist Hispanic diabetics in disease and self-management	Improve diabetes self-management	Outcome	200 patients with notable reduction in HbA1c levels
Multi-Factorial	Goal(s)		Outcome(s)
<u>Payer-Provider:</u> Health plan provides physicians with a disease/patient registry to identify Hispanic diabetic members at risk for cardiovascular disease.  <u>Provide-Member</u> Patients are prescribed a drug regimen to reduce morbidity and mortality risk  <u>Payer-Member:</u> Outreach program to educate Hispanic members in diabetes self-management and cardiovascular risk reduction program adherence	Reduce cardiovascular mortality of Hispanic diabetic patients by 50% and save \$300 per patient per year	Outcome	Not yet reported. A 2006 small cohort study found a 65% adherence rate. <sup>92</sup>

<sup>n</sup> Numbers represent diabetic patients of all races/ethnicities who were called and responded.

<sup>o</sup> HEDIS diabetes screening measures include eye examination, HbA1c test, LDL-C test, and nephropathy monitoring.

<sup>p</sup> Target population includes, but is not limited to, Hispanics with diabetes.

**Key Finding 5: The sustainability of industry funding for health disparity reduction initiatives is questionable, given the pervasive absence of dedicated funding, the difficulties in producing a formal business case for health disparities, and the weakening economy. This is particularly true for diabetes.**

None of the health plans included in this study have a specific line item budget for expenses (other than for full-time employees), either for health disparities reduction in general or for specific programs. Each program or intervention is funded on a project-by-project basis. This suggests that funding will evaporate in the continued absence of a demonstrated return on investment for health disparities efforts. It also indicates that organizations do not yet see addressing health disparities as an ongoing component of their health care operations, as they do for such functions as quality improvement and disease management.

Only one of the health plans interviewed, a for-profit firm, has developed a formal business case for addressing health disparities to date. Most organizations were either leveraging senior executive support and/or the visibility of their participation in highly visible external partnerships such as the NHPC. As one respondent noted, though, executive support on its own can be a shaky foundation for health disparities efforts: “We’re just trying to keep the [health disparities] initiative alive. We lost our executive sponsor.”

While most respondents felt the need to eventually establish a business case or ROI, there were varying degrees of urgency about producing one.

We have a health equity and quality area whose purpose was created in September of this year [2008], and our tasks are to lead the corporate initiatives around health equity, health disparities and language access and health literacy. That’s our business case. We have a work plan. We have goals. We have measures. We won’t be asked to demonstrate a return on investment.

It’s too soon to tell [whether our health plan has a business case for addressing health disparities]. We’ll know more next year. That’s a huge discussion point that many have had in terms of the ROI [return on investment] on this. A lot of work has been done through the NHPC [National Health Plan Collaborative] about the

business case for reducing disparities. I don't think we have the answer quite yet. I don't think anyone has the answer.

In this regard there was a difference between not-for-profit and for-profit firms.

Those health plans that felt the most pressure and had expended the most energy and effort to establish a business case, regardless of their success to date, were the for-profit firms. For example, one for-profit health plan used race and ethnicity data for its employee population to create a business case for addressing health disparities. (It lacked that data for its members at the time.) The organization found that female Hispanic and African American employees were utilizing significantly fewer prenatal visits, experiencing significantly more maternal and fetal complications, and driving much higher labor, delivery and post-natal costs than its Asian American and Caucasian employees. It found similar disparities between those groups in diabetes care and complications. The organization was able to extrapolate the total costs of health disparities in those two conditions across their entire member population -- and subsequently develop a very compelling business case for addressing health disparities through medical expense reduction.<sup>q</sup>

Finally, several respondents registered concern about the recent economic downturn and real and anticipated budget impacts on programs with -- as of yet -- no solid quantitative ROI. (These interviews occurred before the four-figure layoffs announced by Blue Cross Blue Shield of Michigan, Wellpoint, Aetna and Cigna in January of 2009.)<sup>93</sup>

What is being impacted is our funding for evaluations. We had hoped to do focus group evaluations of our materials. That has been cut...so I can say that there has been an impact.

We lost our project team [as a result of workforce reductions].

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<sup>q</sup> Respondent asked that specific figures on disparity differences and total cost savings not be disclosed.

**Key Finding 6: Despite the numerous obstacles to demonstrating the return on investment for reducing health disparities, plans have secured funding and support for health disparities reduction programs by starting small, demonstrating value relatively quickly, and then scaling. In addition, many have developed both internal and external partnerships to pool resources and knowledge, to help create critical mass in the industry, and to build visibility and momentum for health disparity reduction efforts.**

Respondents stressed the importance of testing small interventions in targeted segments, as opposed to tackling entire populations. This approach both minimizes programming costs and facilitates the design of robust and valid program evaluations.

Focus on things that have a quicker ROI so that you can really show the benefit. Then once you get that, it's like stepping-stones, you kind of build on your prior successes.

Just take a little piece at a time. If you do cultural competency of your work force, then you try to build on that to go out to your providers. Then you look at health literacy, or you build in health literacy at the same time. So you just, you have to have a working model out of which your key levers that you want to try to impact. For us, it's the clinical disparities; it's the continued collection of primary data and the use of that data; it's cultural competencies, both work force and providers; it's health literacy, it's making sure our language access meets the needs of our membership; it's on external community partners because we know we can't do it alone; it's on achieving an impact.

Internal partnerships between such areas as quality improvement, marketing, the diversity office and others allowed health plans to pool their internal resources and to building groundswell from the multiple perspectives represented. External collaboration, particularly high-visibility partnerships, exerted pressure on the organization to commit resources to programs and initiatives aimed at reducing racial and ethnic health disparities. Such partnerships also allowed health plans to share knowledge with other organizations and gain valuable knowledge and insights from the groups' collective experiences.

Until this year, we never had a dedicated staff, and the only way we were able to achieve anything is through collaboration internally and externally...[we] had the opportunity to participate in a[n external partnership]. Because that was a high-visibility initiative, [health plan] wanted to, once we had committed to participation, there was commitment to help us get the work done that was expected in the collaborative. So that was a key external partnership, and we could also leverage what some of the other health plans were doing.

As a part of the [external partnership], we all had to work on a disparities initiative...and we really wanted to make sure we were doing it right [because of the high visibility of the group].

**Key Finding 7: In a corollary to several earlier findings in the key informant interviews, several respondents indicated that reducing racial and ethnic disparities in diabetes is not the place for organizations to begin addressing disparities in a sustainable manner.**

As the necessity to establish a business case for addressing health disparities in general, already an imperative for for-profit firms, becomes even more critical during an economic recession, starting with diabetes may ultimately end up eroding organizational support for investments in disparity reduction efforts in general. This is supported by Leatherman *et al.*, who found that it took one health plan ten years to recognize a return on investment for its diabetes disease management program – and that such patience for conditions like diabetes is needed to fully amortize the start-up costs to avoid premature conclusions that such programs are not cost-effective.<sup>78</sup>

While this may lead to an unfortunate short-term focus on conditions other than diabetes, the establishment of a larger and more firm evidence base for the cost-effectiveness of racial and ethnic disparities reduction initiatives will likely stimulate an eventual focus on diabetes, given its toll on quality of life, its costliness, and its pervasiveness.

I would recommend that they start [with something other than] diabetes. Even though that's the hot topic of the decade...I would recommend that they start with

prenatal care or asthma, just because the chance of having ROI will be that much higher and quicker. Once they can demonstrate that, then they will be much more likely to secure funding for future programs.

The challenge with, I think diabetes in particular, is that it is such a long-term chronic condition. Extensive ROI like amputation, blindness or what not, there's no way we can get that kind of results, ROI calculated within say a year-and-a-half to two years. Whereas if you were to implement other disease management programs or health coaching programs that are geared toward more episodic types of conditions, case in point would be prenatal care and visits, or asthma-related...But with diabetes, even people who are taking care of their diabetes really, really well may be just deferring their complication. By many years, it's true, but maybe eventually they would still have blindness or tissue damage and what not. I don't believe that a true medical cost ROI is a part of the evaluation for diabetes, but if we do find that the HEDIS screening measures really work well, then presumably long-term this would help reduce the medical costs.

In a related finding, several respondents noted the criticality of appropriately managing the expectations of key stakeholders -- such as those in a position to approve or deny initial or additional funding -- about what can and cannot be accomplished, and when.

You have to be in this for the long haul. This is not a short-term win. This is not a fly-by-night strategy. If you want a quick hit, if you want quick cost savings, if you want to show something that's going to achieve huge impact in a short period of time, working on healthcare disparities, especially diabetes, is not your topic.

In a nutshell, for people who work in [reducing health disparities], I would caution them that there are times when you feel like you are not making progress, but you really are. I think everything builds on each other. The important thing is to start small and take baby steps and get whatever wins you can. If you can only do one or two custom pieces, do that, even if you don't get a full-on program. Eventually, it will build into a more robust program.

**Key Finding 8: Integrated delivery systems, given their inherent advantages in collecting data, influencing provider behavior, and delivering coordinated care, may be the bellwether for successfully addressing health disparities.**

A number of studies have examined the importance of coordinating the often-disparate components of primary care in the treatment of diabetes and other chronic illnesses, and have suggested that integrated delivery systems in the United States are

currently better positioned than contracted delivery systems to successfully treat such diseases.<sup>77, 94-96</sup> Such systems have control over more aspects of the delivery process, including provider performance measures, salaries and incentives. In addition, the relative uniformity of systems and processes between the health plans and providers in integrated delivery systems also makes investments in critical enabling technologies such as electronic medical records and disease/patient registries less risky and less complex. Such tools can greatly facilitate the exchange of data and information, such as member race and ethnicity, care alerts, treatment algorithms, etc. The organizational umbrella also promotes shared goals among a wider range of stakeholders.

Those findings are supported by the two integrated delivery systems included in this study. While one plan is not specifically addressing health disparities in Hispanics with diabetes, it is using electronic medical records in its hospitals and physician practices to collect member race, ethnicity, country of origin, and language preference data. The health plan is also measuring its performance on a statewide metric for “optimal diabetes care,” a composite of five measures, three of which are outcome measures (HbA1c, LDL-C and blood pressure); the other two are aspirin and tobacco use. In addition to providing translation services for more than 100 languages, the organization has implemented standard clinical improvements for its physicians (education and evidence-based guidelines).

The other integrated delivery system included in the key informant portion of this study has implemented an outcomes-based, multi-factorial intervention (payer-member, provider-member, and provider-payer) approach to reduce the risk of cardiovascular disease in Hispanics with diabetes. That same health plan has implemented a community-based program to improve glycemic control among Hispanics with diabetes, again measuring outcomes, and has seen a notable reduction in HbA1C levels among more than 200

patients. It was, notably, the only health plan in the study to use either a multi-factorial approach or to be measuring outcomes in its program(s) to reduce health disparities in Hispanics with diabetes. Finally, this health plan requires cultural competence training for all physicians, and it bases a portion of physician compensation on achieving benchmarks for eight medical indicators. Both of these cases provide compelling examples of the relative advantage of integrated delivery systems over contracted delivery systems in data collection, provider performance, evaluation design and technology application.

**Key Finding 9: Finally, recognizing the importance of enterprise involvement in the effort to address health disparities, most health plans are employing a cross-functional committee approach -- often with dedicated leadership or support from one or more full-time employees – and are requiring cultural competence training for employees and providers.**

In general, these cross-functional committees create goals and objectives for the organization's health disparities reduction efforts, oversee activities, review the organization's progress against the plan and goals, suggest new programs, and in some cases, review funding requests for programming. They are typically composed of representatives from quality improvement, case management, informatics, marketing, customer service, the diversity office, human resources, and, in some cases, community relations.

We have a multi-departmental committee that reviews and sort of sets the agenda throughout the enterprise on healthcare disparities, and that reports up to the highest levels of quality management at [health plan] on a regular basis.

[Our CMO] pulled together a multidisciplinary group across the entire enterprise of [health plan] not only on the commercial side, but on the Medicaid side, as well, to talk about how we can really move our company forward, knowing we have enhanced and increased diversity in the population we cover...We met monthly over the past year to look at various aspects of a multicultural approach in the business, specifically in the clinical arena.

In a finding consistent with the observation that most plans see the reduction of health disparities as a quality improvement responsibility, half of the respondents indicated that the health care division leads their organization's committee. Those same organizations have dedicated from one to three full-time employees, employed by the health care division, to support or lead their health disparities reduction committee or task force; none of the other four plans interviewed have dedicated staff. Each of these plans has a project manager, program manager, program director or medical director; two of those plans have one to two data analysts reporting to the program director or medical director. For example, one health plan has created a specific functional area, staffed by three full-time employees, to lead corporate initiatives around health equity, health disparities, language access and health literacy. This functional area leads a multi-departmental committee, which in turn sets the health disparities agenda for the enterprise; creates supporting goals and objectives; develops and manages the workplan to achieve those goals and objectives; and reports the results of quarterly progress reviews and the annual program evaluations to the organization's senior executive team.<sup>r</sup>

From a cultural competence training standpoint, most of the participating health plans require it for all clinical personnel with member contact, at a minimum; half provide it to their physicians.

For us, one of our key levers [to impact health disparities] is cultural competency training, for both our work force and our providers.

We've embarked on cultural competency training for our employees for the last two years. We've done homegrown training. We done lunch and learns. We've done formalized training through Quality Interactions®, e-based learning tools. We've had probably close to 2,000 employees trained via Quality Interactions®.

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<sup>r</sup> Respondent preferred not to disclose the organization's specific goals and objectives for disparities reduction.

## **CHAPTER 6: DISCUSSION**

In order to address its central question of whether there is a role for private payers in reducing the incidence of type 2 diabetes among Hispanics in the United States, this study examined two key sets of questions:

1. What are health insurers and other organizations doing to help provide more effective care to groups (such as Hispanics) that may experience barriers to care as a function of gaps in health care operations and the clinical encounter? What measurable outcomes are being created as a result of such steps?
2. What, if anything, is being done by health insurers and other organizations to specifically address the health disparities experienced by Hispanics? In diabetes incidence among Hispanics? In the incidence of any health condition(s) among Hispanics? What evidence of reduced incidence currently exists?

The document review and key informant interviews were designed to provide insights into both sets of questions, with differing areas of focus. The objectives of the document review were to provide an industry-level overview of activities aimed at reducing or eliminating racial and ethnic health disparities; illuminate any measurable outcomes of such efforts; and to determine target organizations for the key informant interviews. The goal of the key informant interviews, in turn, was to develop a more detailed understanding of the objectives, drivers, structure, effectiveness, level of organizational commitment, and lessons learned from the development and implementation of program aimed at reducing the

incidence of diabetes among Hispanics – and to tap into any information not readily available through public access means. The findings of both study components – the document review and the key informant interviews -- are summarized along that analytical framework in this chapter.

***What are health insurers and other organizations doing to help provide more effective care to groups (such as Hispanics) that may experience barriers to care as a function of gaps in health care operations and the clinical encounter? What measurable outcomes are being created as a result of such steps?***

Concern about the impacts of health disparities continues to grow among health care system stakeholders, as does the number of health plans and other organizations taking visible and public action. This is due in large part to a dawning recognition that, as racial and ethnic minorities make up an increasingly larger segment of the U.S. population, addressing disparities is crucial to making further improvements in the quality of health care and health outcomes. The document review found evidence of action being taken to reduce health disparities (particularly for Hispanics and Hispanics with diabetes) by dozens of health insurers and other organizations. That total includes the nine member plans of the National Health Plan Collaborative; the eleven participants in the *Improving Health Care Quality for Racially and Ethnically Diverse Populations* workgroup; the AHRQ's Decreasing Disparities Strategy Workgroup; members of the Blue Cross and Blue Shield Association Healthcare Disparities Workgroup; and many others.

These groups, along with other health plans and agencies, have embarked on pilot projects and case studies to examine the efficacy of various intervention methods at

reducing racial and ethnic health disparities; examined the multitude of challenges surrounding the collection of member race, ethnicity and language preference data; and begun to tackle the barriers to producing a business case for addressing disparities. Through a series of publications of case studies, lessons learned and toolkits, these groups have sought to share their knowledge, results and experiences with other organizations seeking to join the fight against health disparities. They are also seeking to influence relevant policy issues, such as the development and enforcement of guidelines and standards for measuring health disparities and for categorizing races, ethnicities and languages.

The most visible effort, and the one most relevant to this study, is that of the NHPC. The nine member health plans have focused primarily on data collection and examination of diabetes-related performance data for disparities, implementing pilot interventions to reduce health disparities, collecting health plan members' primary race, ethnicity and language preference data, improving language access, and determining the business case and ROI for the reduction of health disparities.<sup>40</sup>

The Improving Health Care Quality for Racially and Ethnically Diverse Populations Workgroup, a component of the CHCS' Best Clinical and Administrative Practices initiative, developed new ways to identify members of racial and ethnic subgroups, to measure the gaps in care that these groups experience, and to explore ways to improve health care quality. The workgroup developed methods to uncover and address disparities in three targeted areas, including diabetes, and published three case studies describing intervention approaches to improve diabetes care, two of which addressed Hispanic populations.<sup>38</sup>

The Decreasing Disparities Strategy Workgroup of the Agency for Healthcare Research and Quality (AHRQ) embarked on a learning network project to reduce the diabetes disparity in the Hispanic population. The workgroup targeted community health

centers with a predominately Hispanic population for this intervention, which was conducted from June 2006 to January 2007. The project demonstrated that clinics can make significant progress in their patient goal-setting performance, even when patients participate in short learning sessions over an abbreviated period of time. The workgroup also produced lists of lessons learned at both the clinic and patient levels.<sup>84</sup>

Outside of these national collaboration efforts, many health insurance plans are individually and actively addressing health disparities through a variety of mechanisms. For example, Blue Cross Blue Shield of Florida has several disparities-related initiatives, including the collection of race and ethnicity data directly from members (on a voluntary basis), bilingual (Spanish and English-speaking) case managers, a multilingual contact center and a series of Spanish language online tools.<sup>50</sup> In addition, in 2005, Blue Cross and Blue Shield of Massachusetts awarded \$3 million in grant funds to reduce racial and ethnic health care disparities.<sup>54</sup> Highmark (also a member of the NHPC), has formed a multi-dimensional approach to focus on health care disparities, and has been addressing this issue for more than five years. The reduction of racial and ethnic health disparities is now a corporate goal for Highmark.<sup>53</sup> Finally, CareFirst, the Blue Cross and Blue Shield health plan covering northern Virginia, the District of Columbia and Maryland, is addressing health disparities among specific racial and ethnic groups through a variety of initiatives under their *CareFirst Commitment* program.<sup>55-58</sup>

In addition, organizations such as the Robert Wood Johnson Foundation and the Bureau of Primary Health Care are working with clinics and other community-level partners to reduce health disparities. Examples of this include the *Advancing Diabetes Self-Management* project at La Clinica De La Raza in Oakland, the Diabetes Health Disparities Collaborative, the *Campesinos Sin Fronteras* initiative, and the Open Door Health Center's *Prescription for Health Diabetes Project*.<sup>81, 82, 84, 97</sup>

According to the materials published by these organizations, these individual and collective efforts have resulted in measurable and largely positive outcomes (refer to Table 5). NHPC member health plans, through their Phase One diabetes-related pilot interventions, saw such results as: significantly increased HbA1c and LDL-C screening rates for previously non-adherent members, as well as improvements in those members' glycemic control; increased eye exam rates for Hispanic members with diabetes; success in getting diabetics in high disparity physician practices to visit their doctor for screenings; improved quality measures with respect to diabetes; and increases in diabetic members' disease management self-confidence (and a coincident decrease in their program level of care requirements).

The Improving Health Care Quality for Racially and Ethnically Diverse Populations Workgroup published several examples of successful interventions to reduce health disparities: an increase in the number of minority women entering prenatal care during their first trimester and improved birth outcomes; a significant increase in HEDIS rates for the appropriate use of asthma controller medication among a target population of African Americans and Hispanics) a significant increase in HbA1c testing rates, eye exam rates, LDL-C screening rates, and nephropathy monitoring rates among target populations of Hispanics with diabetes.

Community-based efforts such as the Open Door Health Center's *Prescription for Health Diabetes Project* and the Diabetes Health Disparities Collaborative have resulted in both improved diabetes self-management and processes of care for Hispanics.<sup>82, 97</sup>

In addition to producing outcomes-based results such as these, these individual actors and collaborative groups, along with researchers, foundations and agencies, are raising awareness of the issue across government, health care and public sectors. These players are accomplishing this heightened awareness through visible advocacy for the

reduction of racial and ethnic health disparities, and the publication and promotion of the results and analysis of pilot projects, case studies, and lessons learned. As a result, healthcare system stakeholders are deepening their understanding and knowledge of the issue, and there is emerging coalescence along several key themes.

One uniform conclusion reached by both health plans and other health care system stakeholders is that collecting race and ethnicity data on health plan membership is foundational to determining the impacts of health disparities and potential actions to address them; unfortunately, the majority of hospitals, health plans and physician practices do not routinely capture this data. As discussed earlier, a wide range of local, regional and national multi-stakeholder collaborative efforts are working to reduce disparities in healthcare, but efforts are still hampered by race and ethnicity data challenges – namely, its collection, quality, reliability and usability. As a result, considerable variability in methods for collecting race and ethnicity continue to exist, severely limiting the health system's ability to generate comparable information on health status and quality for all racial and ethnic groups. To help overcome these barriers, the NQF and NHPC, among others, are calling for the development of national guidelines for the collection and use of primary data in health care quality improvement, along with disparities-sensitive measures that can be used for public reporting, performance measurement and disparities improvement.

These steps will also be critical if provider pay-for-performance programs are to be leveraged in the fight to eliminate racial and ethnic health disparities. These programs currently lack the necessary characteristics to reduce disparities, and health plans, in order to address these shortages, must collect race and ethnicity data, emphasize conditions of higher prevalence in minorities to providers, reward improvement for reducing health disparities, and encourage nationally prominent organizations to establish disparity guidelines or measures.

Quality improvement programs are the logical starting point for health plans to reduce or eliminate health disparities in diabetes for Hispanics, but there is growing consensus they must be broadened and extended to incorporate multi-factorial and culturally tailored approaches. Dozens of reports and studies point to the efficacy of multi-factorial and culturally tailored approaches in reducing care gaps, and several have found evidence indicating that these methods specifically improve diabetes health outcomes and potentially reduce health disparities among Latinos. For diabetes in particular, some of the most powerful and successful interventions are multi-factorial, targeting patient, provider, organization, and community factors simultaneously. This finding supports the notion that collective action and partnerships among and between health plans, providers, communities and agencies are a critical component of reducing racial and ethnic gaps in care.

Cultural tailoring for Hispanics includes the use of bicultural community health workers, peer support, and family inclusion, as well as the integration of cultural components specific to the Hispanic population. Such cultural components include, for example, the importance of food, family and trust; the variances in language and cultural norms among the different Latino subpopulations, based on their countries of origin; the concept of physicians as authority figures in the Latino culture (and its impact on patient participation in self-care); and the low literacy levels among many Hispanic populations, among others. The success of culturally tailored quality improvements may be a result of their ability to provide a mechanism of individualizing care for ethnic minorities.

Finally, questions about what types of interventions are most valuable and most important for Hispanics with diabetes (as well as for other races/ethnicities and disease conditions) continue to plague both researchers and health care system stakeholders, as do the complexities and costs of designing effective evaluation techniques to measure the return on investment for these programs. In addition, the lack of long-term evidence of

outcomes success, particularly for diabetes interventions, continues to concern stakeholders. Most studies have only examined improvements over a 1-2 year period; however, diabetes is a long-term chronic disease and has a complex set of drivers and symptoms, making it difficult to definitively measure the efficacy and sustainability of interventions. These issues present a multitude of challenges to creating a solid business case and clear roadmap for addressing health disparities, which may make the allocation of scarce health plan resources to such programs even more difficult to achieve.

Despite these potential barriers, there is a clear call from many observers to move beyond documentation to action. A growing number of stakeholders and participants in the debate over what to do, how to do it, how much it will cost and how much value it will provide are beginning to assert that it is time for the health disparities dialogue to give way to concerted action.

***What, if anything, is being done by health insurers to specifically address the health disparities experienced by Hispanics? In the incidence of diabetes among Hispanics? What evidence of reduced incidence currently exists?***

As outlined above, a number of health plans, agencies, foundations and other players are taking visible and public action against racial and ethnic health disparities. As the document review revealed, many of these efforts are focused on Hispanics, due to their explosive growth as a segment of the nation's population, and the acknowledgement that this group, in particular, faces both cultural and linguistic barriers to care. While that portion of the analysis focused on and provided an overview of industry-level activities and outcomes, the key informant interviews were designed to provide deeper insights into any

health plan efforts designed to reduce the incidence of diabetes among their Hispanic members.

The eight health plans represented in the key informant interviews are strongly committed to reducing racial and ethnic health disparities. Most have been addressing the issue for several years, and thus represent the leading edge of health plan activities and efforts to reduce or eliminate racial and ethnic gaps in care. None of them are addressing the reduction of the incidence of diabetes in Hispanics, nor have they produced any evidence that incidence has been reduced.

All of the health plans included in the study have recognized the importance of collecting members' race and ethnicity data, and have allocated scarce organizational resources over a period of several years to that effort. The plans are using direct means (such as HRAs, member surveys, and enrollment forms), indirect methods (such as geocoding and surname analysis), or a combination of the two approaches to collect the data.

Most of the health plans included in this study are using cross-functional committees to coordinate their organization's efforts to address disparities. The majority of these programs is led by a member of the health care division, usually a medical director, program director or program manager from the quality improvement area. Committees are typically composed of representatives from quality improvement, case management, informatics, marketing, customer service, the diversity office, human resources, and, in some cases, community relations.

While many plans have dedicated full-time employees to the support and leadership of their disparity reduction efforts, and most are participating in external partnerships, none of the health plans have gone so far as to develop a specific line item budget for health disparity programming. Programs are treated and funded as specific projects. This may undermine any potential for synergies between programs and ultimately, the overall

effectiveness of individual projects or programs and the organization's portfolio of disparity reduction initiatives as a whole. That factor, combined with the seeming lack of integration with each health plans' foundation initiatives (typically targeted at the community level), may explain the relative absence of multi-factorial approaches in the study group.

Only one plan has produced a quantitative business case for addressing racial and ethnic health disparities, using the organization's own employee data. In this instance, the health plan discovered significant disparities between racial groups in prenatal and diabetes care, and in maternal, delivery and diabetes complications and claims costs, simultaneously proving the existence of racial and ethnic health disparities in the plan's member population and providing evidence of the potential medical cost savings of eliminating such gaps in care.

Primary drivers for these health plans to originally initiate actions to reduce racial and ethnic health disparities include the recognition that care gaps are widening; that overall population health improvement cannot be achieved without addressing these gaps; and that quality improvement programs are not currently positioned to effectively address health disparities. The 2003 IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, provided a compelling impetus for half of the organizations included in the study, as did the notion that addressing health disparities is "the right thing to do." Other drivers common to the group included a strong push by senior management, anecdotal data from physicians, activity by the health plan's competitors to address health disparities, and growing demand from national accounts for evidence that the health plan is actively seeking to reduce health disparities.

The health plans included in this study see strong ties between building organizational cultural competence and reducing health disparities, although the vast majority of current cultural competence training efforts are aimed at only a segment of plans'

employee populations – usually clinical personnel with customer contact (such as case managers and health coaches). This is not surprising, given that six of the eight plans participating in the study use contracted network arrangements. In one of the first differences between organizations at the categorical level noted in this study, the mandating of cultural competence training as a condition of employment for providers exclusively by the two integrated delivery systems reinforces the notion that these delivery systems may be better positioned to influence physician behavior, at least in the short term.

In a finding consistent with the document review, programs specifically targeted at Hispanics with diabetes are still nascent in the study group, most having been in existence from less than one year to two years. None of the eight health plans represented in this study are addressing the reduction of incidence. Instead, most plans are leveraging current quality improvement programs and methods, and are thus primarily focused on payer-member interventions (as opposed to payer-provider, provider-member, or multi-factorial interventions). Payer-member interventions most often include diabetes screening reminders delivered via mail and telephone. Only one plan is employing a community intervention, despite the preponderance of reports, studies and briefings extolling the effectiveness of such methods. (This finding excludes any community-level foundation efforts, which do not seem to be integrated with the organizations' mainstream disparities reduction efforts.)

None of the programs included member or provider incentives that were specific to the program itself. In another finding consistent with the document review, none of the plans include the specific reduction of health disparities as a component of their provider pay-for-performance program, citing a lack of race and ethnicity data and an accepted disparity measure. Two health plans have overall, composite health indices that are used as components of the organizations' employee incentive compensation and provider

compensation, respectively. While these incentives are not directly aimed at reducing racial and ethnic health disparities, there is likely an indirect effect, given that the rising health improvement tide must float all boats – regardless of race or ethnicity -- in order for the health plan to meet its goals.

While each of the eight programs aimed at reducing health disparities in Hispanics with diabetes has a stated goal – seven of which are measurable -- most program goals are process measures (such as improving HbA1c and LDL-C screening rates), as opposed to outcome measures. Only one of the programs tracking process measures has reported or observed any results to date – in this case, the number of members reached via outbound IVR calls that requested additional information about diabetes. In another observed difference between integrated delivery systems and contracted delivery systems, one of the two integrated delivery systems included in this study has two programs in place to address health disparities in Hispanics with diabetes – both of which are the only programs in the study group that include outcome measures.

Key informants supplied a fairly robust (and surprisingly uniform) set of lessons learned. Each respondent stressed the criticality of establishing of the existence of health disparities within the health plan's member population. Half noted the importance of developing a deep understanding the specific characteristics and needs of the Hispanic population(s) that the plan serves or is seeking to serve -- and acquiring resources with the appropriate skills and experience to meet those needs. An equal number of respondents cautioned health plans to avoid making the erroneous assumptions that all Hispanics are the same, and that Hispanics will respond to the same messages and methods as non-Hispanic populations.

Several participants exhorted other plans to do something – to start small, to demonstrate value relatively quickly, and then to scale up their efforts. Two respondents

specifically mentioned that diabetes may not be the right place to start building a business case for addressing health disparities, given the length of time required to demonstrate true cost savings. Other lessons included securing senior executive buy-in for organizational support and visibility; engaging in internal and external partnerships to add momentum and resources to the effort and to leverage knowledge from and synergies with others; and to be patient – tackling health disparities is a long-term initiative.

Finally, any discussion of this topic would be incomplete without addressing the new (Obama) administration and the potential impacts of health care reform on racial and ethnic health disparities. President Obama has been clear and consistent about the need for health care reform, and has promised to take definitive action by the end of 2009. At the time of this writing (March 2009), no legislation had been passed, but a white paper entitled *Call to Action: Health Reform 2009* had been published by Senate Finance Committee Chairman Max Baucus (D-Montana) in November of 2008, and a stimulus bill positioned as a “downpayment on health care reform” had been recently proposed by President Obama.

The reduction of disparities is not called out as a specific goal by the administration, in the stimulus package, or in the white paper -- and is unlikely to be, given the current state of the economy. Nor are any of the federal policy levers that Lurie *et al.* suggest are needed specifically addressed. (These include requiring the collection of racial and ethnic identifiers for patient populations; setting standards for the usage and collection of such standards; and ensuring that culturally diverse populations receive appropriate health care through the enforcement and dissemination of CLAS standards and best practices.)<sup>44</sup> However, there are key elements of both the stimulus package and Senator Baucus’ plan that can potentially aid in the reduction of disparities.

The first is improved affordability and access to coverage (such as individual mandates, employer “pay to play” requirements, guaranteed issue, restrictions on premium

rate adjustments for health status, and subsidies for small employers and individuals). Such provisions can help reduce access-related drivers of disparities. There is also an increased focus on, and funding for, prevention and wellness to fight preventable diseases and conditions with evidence-based strategies. Type 2 diabetes is certainly a preventable disease, and support for evidence-based strategies may increase the focus on care that results in demonstrably improved outcomes.

In addition, the stimulus package provides for funding for the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and the Health and Human Services (HHS) Office of the Secretary to evaluate the relative effectiveness of different health care services and treatment options may lead to the provision of more individualized care – which a growing body of research indicates is effective in improving quality of care and outcomes, particularly for racial and ethnic minorities.

Both the Baucus plan and the stimulus package call for investments and incentives (through Medicare and Medicaid) to ensure widespread adoption and use of interoperable health information technology, which can serve to jump-start efforts to increase the use of useful technologies such as electronic medical records and electronic prescribing in physicians' offices, hospitals and other medical facilities. Such technologies can help with the direct collection of race and ethnicity data (as is the experience of the integrated health delivery systems examined in this study), and with medication adherence, for example. Electronic medical records can also help reduce linguistic barriers in the clinical encounter, as the information that they provide to physicians will reduce the reliance on the patient to understand and communicate his or her health history and status to care providers.<sup>s</sup>

Another provision of the stimulus bill includes a potential expansion of the security and privacy elements of the Health Insurance Portability and Accountability Act (HIPAA).

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<sup>s</sup> From an interview with Harry L. Reynolds, Chairman of the National Committee on Vital and Health Statistics, March 24, 2009.

While a detailed discussion of that is beyond the scope of this project, one potential impact to efforts to reduce health disparities is that it may restrict or deny access to such critical data elements as race/ethnicity indicators for entities like health insurers and other payers.

It is certainly too early to predict what will happen with current efforts at health care reform and the resultant impacts on racial and ethnic health disparities. However, there is a renewed focus at the federal level to address many of the problems with our current health care system that affect all Americans -- affordability, access, cost, and demonstrable quality and effectiveness of care. In many instances, our nation's racial and ethnic minorities feel those gaps more acutely than those who do not experience the additional barriers to care that those cultural and linguistic differences present. While a direct focus on reducing racial and ethnic disparities may not be in our nation's immediate future from a federal policy standpoint, many elements of proposed health care reform may provide an indirect benefit.

## **CHAPTER 7: Conclusions**

There is a role for private payers to play in reducing the incidence of type 2 diabetes among Hispanics in the United States. However, given the barriers to reducing or eliminating racial and ethnic health disparities in general that health plans currently face, successfully filling that role is a long-term proposition – one that must be preceded by much foundational work by all stakeholders in the health care system. In the meantime, there is a more critical and immediate role that all private payers should play, if they have not begun to do so already – and that is to join the fight to reduce racial and ethnic disparities in health and health care. Broader industry action will raise the level of the quality of care delivered to racial and ethnic minorities in general; improve the overall health of those populations; create additional momentum for necessary federal policy changes; enhance industry knowledge and expertise in addressing health disparities; increase the evidence base for program outcomes; and reduce the time it will take to solve this serious problem.

Currently, more than thirty health plans in the United States are engaged in visible and public efforts to reduce racial and ethnic health disparities, both as individual plans and as part of collaborative arrangements with other health plans, agencies and foundations. Many of those efforts are focused on Hispanic and African American populations, given their relative size and the known cultural and linguistic barriers that their members face in the health care system. A number of programs aimed at reducing gaps in care between population groups are focused on diabetes, given its prevalence, the billions of dollars that it costs the health care system each year, and its toll on the quality of life for those who suffer from the disease.

The activities and programs to reduce racial and ethnic health disparities in diabetes, however, are primarily focused on managing the disease and improving care for it, consistent with traditional health plan disease management approaches. No programs are currently focused on reducing the incidence of diabetes among Hispanics. Health plans are struggling to overcome the lack of accurate, comprehensive and reliable race, ethnicity and language preference data for their members, a costly and complex problem to solve. That issue, combined with the absence of both federal guidelines for the collection and disclosure of race and ethnicity data in health care quality improvement and disparity guidelines or measures, leaves health plans severely hampered in their efforts to move beyond their current state. Without such data, health plans cannot identify differences in health status and utilization across racial and ethnic groups, nor can they develop, implement and monitor intervention programs aimed at reducing and eliminating gaps in care. Such data is also needed to help health plans set priorities, design programs, better understand the health needs of specific populations, evaluate performance differences among and within plans, geographic areas, physician groups, etc., and provide the foundation for rewarding good performance.

As result, many health plans that are moving forward to address racial and ethnic health disparities most commonly employ member interventions (such as screening reminders) and process measures (such as HEDIS screening rates for diabetes). Notable exceptions are the integrated delivery systems, which have control over more aspects of the delivery process, including provider performance measures, salaries and incentives. The relative uniformity of systems and processes between the health plans and providers also makes investments in helpful technologies such as electronic medical records and disease/patient registries less risky and less complex. Such tools can greatly facilitate the exchange of data and information, such as member race and ethnicity, care alerts,

treatment algorithms, etc. The organizational umbrella also promotes shared goals among a wider range of stakeholders, and may explain the higher frequency of multi-factorial interventions in integrated delivery systems.

Despite these challenges, there are a few success stories resulting from the efforts of health plans, agencies and foundations to reduce racial and ethnic health disparities, particularly in diabetes. Outcomes range from increased adherence rates for screening and treatment protocols to improved glycemic control. Due to the nascence of many of the programs focused on diabetes, and the length of time required to produce valid and meaningful outcome results for a complex and chronic disease like diabetes, no programs as of yet have reported solid outcomes, such as reduced morbidity, mortality or medical expenses.

In conjunction with health plan efforts, researchers continue to seek evidence of the efficacy of different intervention types and approaches in eliminating or reducing gaps in care between racial and ethnic groups. Their findings indicate that quality improvement programs, extended and broadened to include multi-factorial and culturally tailored approaches, show great promise as weapons in the fight to reduce racial and ethnic health disparities, particularly for Hispanics with diabetes. In addition, a number of case studies and projects aimed at improving care for Hispanics have produced helpful lessons and guidelines on how to successfully integrate cultural components specific to the Hispanic population into quality improvement programs to enhance their effectiveness. At the same time, health plans are increasingly realizing the criticality and value of understanding and meeting the specific needs of their minority populations, and are conducting focus groups and other research to better test intervention methods, messages and delivery vehicles to improve their effectiveness.

Finally, questions persist about the business case for reducing health disparities in diabetes care and outcomes for Hispanics – and there are no clear answers yet. Health plans need more clarity about what types of interventions are most valuable and most important for Hispanics with diabetes, and what the return on investment is for these interventions. Without more experience, better data on both member race and ethnicity and the costs and benefits of interventions, it is not yet possible to produce a solid business case for reducing racial and ethnic disparities in diabetes among Hispanics.

However, thanks to the efforts of the National Health Plan Collaborative, The Center for Health Care Strategies, the Agency for Healthcare Research and Quality, individual health plans, health researchers, and the support of community-level initiatives by organizations like the Robert Wood Johnson Foundation, there is mounting – and promising – evidence that interventions aimed at reducing or eliminating gaps in care between Hispanics with diabetes and other groups are beginning to chip away at the problem.

What is certain is that successful resolution of the overall problem of racial and ethnic health disparities, regardless of the target population or the target disease, will require the involvement of and action by all health care system stakeholders – payers, providers, members, communities, the government, agencies, and foundations. Health plans are in a unique position to influence the majority of these players, through advocacy, strategies, interventions, incentives, partnerships, policies, and programs. The more organizations that join the effort and take informed, targeted action, the sooner the problem of health disparities will recede into our nation’s past. As Nicole Lurie put it, “Health disparities – less talk, more action.”

### ***Limitations of This Research***

Limitations to this study include both those that are general to document review and key informant interview methods, as well as several that are specific to this study. For the key informant interviews, the relatively small sample size, the sampling methodology and participation introduced selection bias. This limitation was partially addressed through purposeful inclusion of at least two organizations in each of the sampling categories described in this study's methods section (Chapter 3). The categories included geographic coverage, organization type and delivery system type.

General limitations of the key informant interviews include the fact that this component of the study relied heavily on the knowledge and expertise of the key informants interviewed. Limitations were also introduced by the lack of availability of documentation or information in some instances on specific interventions, programs, and results. Several respondents either refused to provide specific facts at certain points in the interviews, or asked that such information not be disclosed in the study. These details are considered confidential or proprietary trade secrets, and are therefore cannot be made publicly accessible, but their absence does leave data gaps in the study.

The non-participation of seven of the fifteen health plans reduced the amount of data collected. This factor undoubtedly narrowed the breadth and depth of observations produced by this study. Given the almost equal distribution of the geography and organization type categorical variables between the participating and non-participating groups, it is unlikely that any significant bias was introduced in these areas. In addition, the inclusion of both integrated delivery systems allowed for more robust comparison of the two types of delivery systems included in the study. A review of the publicly available information on the interventions employed by the non-participating plans revealed no discernible patterns between the two groups (participating and non-participating) that would

indicate a common reason for refusal that would bias these results. Instead, it appears that non-participation was generally based more on an individual representative's time available to be interviewed, and his or her competing priorities, willingness or interest in participating. (The exception to this conclusion is the one health plan that cited legal reasons for its refusal to participate.)

Key informants undoubtedly – and in most cases, unintentionally – injected bias into their responses, either due to presence of the researcher or to the respondents' role in the program being evaluated. A specific limitation to this study is the researcher's dual role as a student and as a health plan employee, which was fully disclosed to all participants in the initial invitation. This factor introduced both selection and response bias – for example, at least one organization declined to participate in the key informant interviews for this reason. It was apparent on a few occasions during interviews that this fact made it difficult or uncomfortable for subjects to respond to certain questions or probes for information.

There was also a natural and expected variability in the respondents' abilities to perceive the full extent and intention of the question(s), and to effectively communicate all of the information requested by the researcher. Finally, for the key informant interviews, there was likely a tendency to underemphasize or omit information regarding failed programs or interventions, although the researcher found no evidence that this was the case.

For the document review, several sources with inherent bias were used. Examples include press releases and reports published by the same party or parties that participated in or sponsored the event, program or initiative. For such reports, it was not always clear whether or by whom the information had been edited or reviewed. In those cases, any outcomes or results were clearly stated to have been self-reported, allowing the reader to draw his or her own conclusions as to their validity (based on the information and the source). In addition, there were limitations in the document review introduced by the

information quality. For example, some documents may have contained inaccurate or incomplete information. In a limitation similar to that of the key informant interviews, there may also be under-reporting of failed programs or initiatives, or those that produced no interesting or relevant results.

Unless otherwise stated, study limitations were addressed primarily through validation techniques. For example, information from the key informant interviews was triangulated with publicly available sources of information. In several cases, key informants were asked to affirm or clarify their responses, both during the interview and in subsequent correspondence.

## **CHAPTER 8: A PLAN FOR CHANGE**

The findings of this study – both of the document review and the experiences of the health plans interviewed -- suggest that the execution of a health plan's role in reducing racial and ethnic health disparities will entail a multi-phased, incremental process. These findings also suggest that, in order to quickly and effectively establish a business case for reducing disparities – a critical step in acquiring funding, resources and ongoing organizational support -- health plans should not start with diabetes.

As outlined earlier, expanding the number of payer organizations engaged in addressing racial and ethnic health disparities will provide multiple benefits; it will improve both the quality of care delivered to racial and ethnic minorities in general and the health of those populations, create additional momentum for federal policy changes, enhance industry knowledge and expertise in health disparities, increase the evidence base for program outcomes, and reduce the time it will take to solve this serious problem.

The purpose of this plan for change, then, is to help increase the number of health plans actively addressing racial and ethnic health disparities by providing them with a series of beginning steps. In other words, its purpose is to help move the industry beyond dialogue to action, heeding the exhortations of several observers and participants in this study.

An individual health plan's starting point in tackling the problem of racial and ethnic health disparities will depend on a variety of factors. These factors include the demographics and specific needs of its member population; the availability of member race and ethnicity data; organizational priorities; and the availability of the human and capital

resources necessary to undertake a program or programs to reduce racial and ethnic health disparities.

### ***Promising Practices***

Regardless of the specific target population or disease/condition chosen, the following steps are presented as a set of promising practices to guide organizations wishing to begin to address racial and ethnic health disparities through their first project or initiative. They are based on this study's literature review, document review, and key informant interviews,

#### **Step 1: Form an internal workgroup.**

The goals of the workgroup should be to: educate themselves and the organization on racial and ethnic health disparities in general; stay abreast of emerging issues and trends in health disparities; create a preliminary business case for organizational action against health disparities; recruit an executive sponsor to promote the visibility of the issue; coordinate and oversee organizational efforts to reduce disparities; set goals for such efforts; monitor and report on progress against those goals; and seek and develop the necessary external partnerships that serve to further the organization's disparity reduction goals.

Accordingly, the workgroup should include key stakeholders that do or should have a role in organizational efforts to reduce racial and ethnic health disparities. The list of participants will be specific to each organization, but considerations should include areas that have responsibility for functions such as quality improvement, informatics, marketing, community relations, professional and institutional networks, diversity, human resources,

and customer service. In addition, the health plan's community foundation, if one exists, should be included in the workgroup.

Members of the workgroup should leverage the wealth of information, tools and other resources published by:

- The National Health Plan Collaborative ([www.nationalhealthplancollaborative.org](http://www.nationalhealthplancollaborative.org))
- The Agency for Health Care Quality and Research ([www.ahrq.gov](http://www.ahrq.gov))
- The Center for Health Care Strategies' *Racial and Ethnic Heath Disparities* issue area ([http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=16310](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=16310)), which provides links to a number of studies and toolkits to reduce racial and ethnic health disparities
- The Center for Health Care Strategies' *Best Clinical and Administrative Practices* resource center at:  
[http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=16518](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=16518)
- The Robert Wood Johnson Foundation *Quality/Equality* program area (<http://www.rwjf.org/qualityequality/>)

Using this information, the workgroup can develop a proposal and preliminary business case to establish awareness of the issue of racial and ethnic health disparities within the health plan population and to recruit an executive sponsor. Excellent resources for building a business case, including journal articles, case studies, calculators, data sets, templates and other technical assistance can be found on the Center for Health Care Strategies' website at [http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=15791](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=15791).

**Step 2: Recruit an executive sponsor.**

The best individual for this role will vary by the size, structure and politics of the organization. In selecting the sponsor, members of the workgroup should seek to strike an optimal balance between the individual's formal role, visibility and status in the organization, his or her passion for and interest in the issue, and the political capital that he or she will bring to bear. Likely candidates for consideration include the Chief Medical Officer and Chief Executive Officer. Most of the health plans included in this study had recruited their organization's Chief Medical Officer, as their programs are primarily extensions of their quality improvement programs. To the extent that this effort may align with the enterprise's overall strategy, the C-level officer who has responsibility for strategic development and execution should be considered.

**Step 3: Develop an ongoing communications plan.**

Identify all impacted internal and external stakeholders, such as health plan employees, key executives, members, providers, employer groups and the community at large. Determine the relevant messages, media and timing for each group. For example, specific recommended messages regarding the collection and use of member race/ethnicity and language preference data are addressed in Step 4 below. In addition, as noted earlier, employer groups are showing growing levels of interest in what health plans are doing to address health disparities, as evidenced by the increase in the number of requests for proposal (RFPs) that include questions related to this topic (as cited by several plans participating in the key informant interviews).

**Step 4: Choose a target population for evaluation of the presence of health disparities, and determine the race and ethnicity of that population.**

There are various methods and approaches to accomplish this step, as highlighted by the experiences of the health plans participating in the key informant interviews and the members of the National Health Plan Collaborative. If an organization collects EEOC data on employees, it may be able to leverage that data for analysis. If that is not an option, there are several organizations that specialize in imputing race and ethnicity data, using techniques such as geo-coding and first name and surname analysis. More information on this topic can be found on the Robert Wood Johnson Foundation website at <http://www.rwjf.org/qualityequality/product.jsp?id=34022> or at the RAND Corporation website ([www.rand.org](http://www.rand.org)) by performing a search using the term “geo-coding.”

In addition to being critical to the reduction or elimination of health disparities and the overall improvement of care quality, the collection and use of member race, ethnicity and language preference data can provide important marketing and customer service benefits to health plans. Such data can help health plans determine the presence and size of various racial and ethnic groups in their overall population, providing important insights into potential product offerings and targeted marketing and education campaigns for certain groups. It can also help health plans make informed decisions about the necessity and type of culturally and linguistically appropriate customer service.

Several sources stress the importance of addressing enrollee, employee and provider concerns about the collection and use of member race and ethnicity data.<sup>41, 98, 99</sup> When asked to provide such information, members must be told that it will be used to improve the quality of care for its members. They must also be given assurances that the information will not be used to determine coverage, claims payment (or to discriminate in any way), and that it is both voluntary and confidential.

Health plan employees and provider group staff are critical both in the collection and successful use of member race/ethnicity and language preference data to reduce health

disparities, and thus must fully support it. Key messages to these stakeholders include that access to such information can help them provide better care to members by strengthening the member-provider and member-payer relationship and communications; improve cross-cultural education and skills; increase member compliance and adherence to treatment and medication; reduce the potential for misdiagnosis or non-diagnosis of medical conditions due to language barriers; identify the need for interpreter and translation services; and increase the representation of racial and ethnic minorities in health professions.<sup>41, 100</sup>

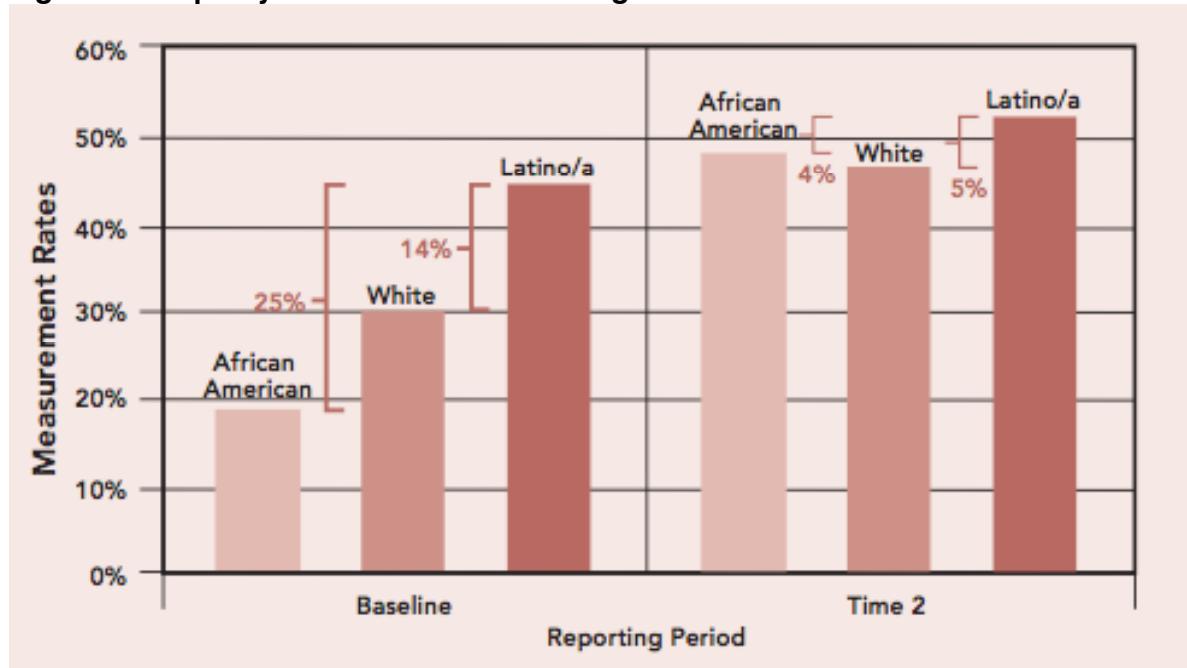
Finally, employer groups can be important partners in the collection of member race/ethnicity and language preference data, as they often collect it for purposes such as for the EEOC. However, employers often have concerns over the legality of sharing employee data; health plans need to develop and communicate messages to dispel those inaccurate perceptions and to assure employers of the intended uses of the data.<sup>41, 101</sup>

#### **Step 5: Establish that disparities exist in the member population.**

Using conditions like prenatal care, asthma, and diabetes, develop disparities indices for each disease and population. In general, a health disparities index (HDI) measures each health plan's progress toward eliminating disparities by comparing the difference between each racial and ethnic subgroup's rate on specific measures and the best-performing subgroup's rate for the same measure. The quality component of the index measures each subgroup's performance against an external norm, such as HEDIS measures. The index can be used for needs assessment, to identify overall patterns of disparities at the plan level, to evaluate ongoing disease management programs, and to determine whether racial and ethnic disparities are increasing or decreasing.<sup>38</sup> An example of a disparities index for HbA1c test rates for persons with diabetes is shown in Figure 7; a

step-by-step approach to targeting improvements in diabetic care, using a health disparities index, is outlined in Table 9.

**Figure 7. Disparity in Annual HbA1c Testing Rates for Persons with Diabetes<sup>38</sup>**



**Table 9: Analytic Steps to Target Improvements in Diabetic Care for Hispanics<sup>48</sup>**

<b>Step 1:</b> Select the population of Hispanic beneficiaries and a white reference group.
<b>Step 2:</b> From those pools, select beneficiaries with diabetes.
<b>Step 3:</b> Determine if beneficiaries have recommended diabetic care.
<b>Step 4:</b> Select geographic areas.
<b>Step 5:</b> Assign beneficiaries to geographic areas, such as counties.
<b>Step 6:</b> Create a disparities index (calculated as the percentage of Hispanic beneficiaries receiving the recommended care divided by the percentage of whites receiving the recommended care).
<b>Step 7:</b> Identify areas with large numbers of Hispanic diabetic beneficiaries and a large disparities index.
<b>Step 8:</b> Design and implement culturally sensitive, evidence-based intervention programs.

**Step 6: Stratify and prioritize disparity reduction opportunities.**

Based on the results of the index, determine which population(s) and disease(s) or condition(s) have the largest gaps in care. If possible, determine or extrapolate the direct costs of those gaps in care to your organization. The ROI resources on the CHCS website ([http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=16310](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=16310)) will be helpful in this step.

**Step 7: Pick a population and a condition, and determine program objectives.**

The population and condition chosen should allow for a fairly rapid establishment of the value of the intervention(s) and a platform on which the health plan can build a business case. A key consideration is the feasibility of designing and executing a valid evaluation instrument. Conditions with shorter intervals from intervention to measurement, such as prenatal care and asthma, are promising candidates. Plan to test small interventions at first.

**Step 8: Acquire the right resources to help plan, develop, execute and maintain the program.**

Determine the specific needs of, barriers to care faced by, and the most effective potential interventions methods for the target population. This can be accomplished by drawing on existing research and by conducting investigations (such as focus groups, in-depth interviews, and needs assessments). In doing so, acquire and utilize resources that are skilled, knowledgeable and experienced in the culture(s) and language(s) of the population in question.

An important component of this step is the determination and pursuit of the granularity of data required to design effective interventions. Data may include, for example, such elements as country of origin, language isolation, socioeconomic status, and

geography. This is particularly critical to ensure the adequate and appropriate integration and leveraging of cultural components specific to the target population.

**Step 9: Design the program.**

Based on the research conducted in Step 6, design the intervention(s) to meet the specific needs of the target population. Important additional design considerations include intervention types (member, provider, community and multi-factorial interventions, as well as program evaluation mechanisms. Finally, identify and pursue the internal and external partnerships that will be necessary in carrying out the program.

**Step 10: Based on the program objective(s) established in Step 5, determine the specific program metrics and design the program evaluation.**

Most health plans already have program evaluation teams and resources, as these are typically applied to monitor and measure the effectiveness of disease management, utilization management, quality improvement and other health-related programs. The types of inputs that will likely be required for program evaluation are claims data, financial data on programming costs, and process and outcome measures (such as HEDIS and CAHPS). Key design principles for program evaluation are simplicity and measurability.

For background on program evaluation, The Centers for Disease Control and Prevention's *Framework for Program Evaluation in Public Health*, produced and reviewed by hundreds of public health professionals, provides a summary of evaluation terms and concepts, as well as a step-by-step model for program evaluation. It can be found at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>.

**Step 11: Implement the program.**

**Step 12: Continuously evaluate program performance, make the necessary adjustments, and discuss and document lessons learned.**

Apply the program evaluation developed in Step 8. One potential outcome of the program evaluation is that the program is discontinued for nonperformance reasons.

Several key informants indicated that their health plan had been forced to make such a decision on at least one occasion; both pointed out that, as difficult as these decisions may be, they are necessary to both build trust in the disparities reduction effort and to preserve funding for future programming.

***Additional Considerations***

This list consists of other steps or practices for health plans to consider adopting that are not specifically related to a particular program or intervention, or are longer term in nature. These are also derived from the literature review, the document review, and key informant interviews.

**Build internal awareness of racial and ethnic health disparities through health disparities and cultural competence training and education for employees (at a minimum) and providers (ideally).**

Several of the organizations taking part in this study are using online cultural competence training tools such as Quality Interactions® (<http://www.qualityinteractions.org/>) for their employees and providers. Quality Interactions® is interactive and role-based, meaning that the scenarios presented vary by the participant's role. Others are using less costly static online content, which can often be developed in-house, to educate health plan employees about health disparities in general and to provide cultural competence training.

**Consider how and when to begin the direct collection of member race, ethnicity, country of origin, and language preference data.**

This is a time- and labor-intensive process, but it does produce high data accuracy rates. Such accuracy is necessary to: definitively evaluate and measure the impacts of disparities and efforts to reduce them; to set performance measures; and to hold participants accountable to those measures. This is a multi-year effort that can involve information systems, forms and process changes. One key consideration is the number of systems of record for members that the health plan uses; the more systems involved, the more costly and complex this will be to implement and maintain.

Direct data collection sources include the member enrollment process, disease management programs, health risk assessments (HRAs), clinical encounters, direct outreach to members, member web portals, member surveys, and member-initiated contact.

Other health plans currently engaged in member race and ethnicity data collection have found that combined methods (indirect and direct data collection) are required to obtain complete and accurate information. This is due to the aforementioned barriers presented by the lack of consistent standards and rules for data collection and the disparate information technology systems used by the various stakeholders collecting and using this data. The NHPC toolkit provides a wealth of information on the various methods for data collection and their inherent advantages and disadvantages. The toolkit can be downloaded from the Robert Wood Johnson Foundation site at:

<http://www.rwjf.org/qualityequality/product.jsp?id=33960>.

**Create or join existing external partnerships with other stakeholders to share knowledge and best practices, and to create critical mass for policy changes.**

Most of the key informants interviewed for this study pointed to the value of external partnerships, primarily the collaborative efforts developed by the CHCS and the Blue Cross and Blue Shield Association. As outlined earlier, the primary benefits of such partnerships (and thus health plan motivations to participate in them) center on sharing knowledge and lessons learned. Such partnerships are also serving to achieve greater industry alignment and mass to reduce racial and ethnic health disparities in general. In addition, groups like the NHPC are working together to advocate for the establishment of federal standards and guidelines for race and ethnicity data disclosure and collection, and health disparities guidelines or measures.

**Include member health improvement as part of corporate goals and employee incentive compensation programs.**

The indicators that underlie member health improvement can and should be tailored to the health plan's specific member population and its needs, and those indicators may or may not explicitly address the reduction of racial and ethnic health disparities. However, such a step accomplishes two things: it establishes a visible commitment on the part of the health plan to improving the health of its members; and, if designed, monitored and executed properly, it will put positive pressure on the health plan to reduce gaps in care for all members, regardless of the source of those gaps (race/ethnicity, socioeconomic status, health literacy, etc.).

## **APPENDIX A**

### **Key Informant Interview Guide**

#### Introduction

Thank you for agreeing to participate in this study. As you may know, Hispanics in the United States suffer from diabetes more than any other racial or ethnic group, and at twice the rate that white Americans do – a problem often referred to as a “health disparity” between Hispanics and other groups. The results of this study will be used to develop a deeper understanding of the mechanisms – both current and potential -- that health insurers and other organizations are using or may use to help address this problem.

The information collected in this study will be kept confidential. Your specific answers will not be attributed to you or your organization. It will be used in summary form to discuss the structure and effectiveness of diabetes intervention programs, and to form specific recommendations for organizations wishing to take action against this problem.

Your participation in this study is purely voluntary, and there are no consequences if you refuse to participate, or if you decide to discontinue the interview (which you may do at any time). Do you have any questions about the research or the interview?

I'd like to ask you a few questions about how your organization is addressing health disparities in the Hispanic community.

1. What was the original impetus for development of your program(s)? (Examples may include such things as service area demographics, claims experience, community awareness, corporate vision/mission, requests for community support through such mechanisms as charitable foundations, etc.)
2. Are there stated goals or objectives for the program(s)? If so, what are they?
3. What percentage of your customer base is Hispanic?

4. Do you capture race/ethnicity data on your members? If so, how is it used?
  5. When (month and year) did you implement your program?
  6. What functional area is accountable for development, implementation and evaluation of the program (e.g., Health Care, Operations, Marketing, etc.)?
  7. In general, how does the program work?
  8. Where are the points of intervention?
  9. What are the incentives for stakeholders to participate in the program? To comply with it?
10. What metrics, if any, have you established to measure its effectiveness? [Probe: Process measures (such as eye exams, foot exams), clinical outcome measures (such as HbA1C test results), functional outcome measures (SF-12 or other health status measures), cost avoidance measures (reduced hospitalizations), or other measures (increased productivity, presenteeism, etc.).]
11. What results or outcomes have you experienced to date? If there are no measurable outcomes to date, what early evidence do you have about the success of the program?
12. Do you have continual budget commitment? For how long?
13. How much has your organization spent to date to develop and implement your program?
14. Is there anything else that you think other organizations tackling this issue should know, either before they begin, during implementation, or while the program is in effect?

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