

Performance Improvement

The National Health Plan Collaborative to Reduce Disparities and Improve Quality

Nicole Lurie, M.D., M.S.P.H.; Allen Fremont, M.D., Ph.D.; Stephen A. Somers, Ph.D.; Kathryn Coltin, M.P.H.; Andrea Gelzer, M.D.; Rhonda Johnson, M.D.; Wayne Rawlins, M.D.; Grace Ting; Winston Wong, M.D.; Donna Zimmerman, M.P.H.

Despite numerous initiatives, progress in reducing racial/ethnic disparities in health care has been slow.¹⁻⁵ In this article, we describe an innovative effort to overcome some of the considerable challenges to progress. The National Health Plan Collaborative (NHPC) to Reduce Disparities and Improve Quality is a novel partnership between nine health plans and public- and private-sector entities that have come together to address racial/ethnic disparities in care. We describe the genesis of the NHPC, its progress to date, and lessons learned.

Genesis of the NHPC

While the origins of the NHPC can be traced to early U.S. Department of Health and Human Services (HHS) efforts in the late 1990s to engage the health care delivery sector in identifying and addressing disparities,⁶ the Institute of Medicine's seminal report, *Unequal Treatment*,⁷ was an important catalyst. Several health plan leaders, meeting informally, determined that, competition notwithstanding, it was time for collective action to address disparities. At their request, in Spring 2003 the California Endowment supported two of us [N.L., A.F.] to explore the feasibility of collaboration. Numerous health plan representatives and government officials were interviewed as part of the planning process, confirming significant health plan interest in addressing disparities and identifying industry actions already underway that added to the momentum. These actions included Aetna's widely publicized initiative to collect self-reported racial/ethnic data, large employers' (for example, Verizon) desire to address health disparities among their employees, and Kaiser Permanente's cultural competency initiatives.

However, some fundamental barriers were also recognized. First, although Medicare (and Medicaid) plans had a means to obtain race/ethnicity information about their beneficiaries, commercial plans, which covered the majority of enrollees, had virtually no race/ethnicity data and did not have the capacity to obtain it in a rapid time frame. For example, Aetna discovered that the actual process of collection of self-reported race/ethnic-

Article-at-a-Glance

Background: Despite numerous reports and initiatives, progress in reducing racial/ethnic disparities in health care has been slow. The National Health Plan Collaborative (NHPC), a novel public-private partnership between nine health plans covering approximately 95 million lives, leading learning and research organizations, the Agency for Healthcare Research and Quality, and the Robert Wood Johnson Foundation, was established in December 2004 to address these disparities.

Progress to Date: The health plans were able to overcome initial challenges in obtaining information on race/ethnicity of their enrollees and examined their diabetes performance measure to assess disparities in care. By February 2006, the initial nine plans that had joined the NHPC progressed from focusing solely on data collection and management issues and were engaged in outreach activities to members, providers, or community or had completed capacity development for disparities work. Five plans had implemented one or more pilot interventions. Plans also addressed unanticipated challenges, such as sorting through large amounts of data to target disparities.

Challenges and Lessons Learned: Because many of the plans are complex national entities with varying regional and departmental structures, simply achieving coordination of disparities activities across the organization has been a major challenge and, in many cases, a major breakthrough.

Conclusions: The NHPC represents a model of shared learning and innovation through which health plans are tackling racial/ethnic disparities. Now that most of the plans have some data on their enrollees with diabetes and have begun targeting disparities, they want to capitalize on their collective industry strength to influence policy on issues related to disparities.

Table 1. Selected Characteristics of the National Health Plan Collaborative (NHPC)*

| Plan | Plan Types | Number of Enrollees |
|--|--------------------------------|---------------------|
| Aetna | HMO, PPO, Medicare, Medicaid | 15 million |
| CIGNA | HMO, PPO | 13 million |
| Harvard Pilgrim Health Care | HMO, PPO, Medicare | 900,000 |
| Health Partners | HMO, PPO, Medicare | 630,000 |
| Highmark, Inc. | HMO, POS, PPO, Medicare, SCHIP | 4.6 million |
| Kaiser Permanente | HMO | 8.5 million |
| Molina Healthcare | Medicaid, SCHIP | 1 million |
| UnitedHealth Group (United Healthcare, Ovation, AmeriChoice) | PPO, Medicare, Medicaid | 18 million |
| WellPoint, Inc. | HMO, PPO, Medicare, Medicaid | 34 million |

* HMO, health maintenance organization; PPO, preferred provider organization; POS, provider of services; SCHIP, State Children's Health Insurance Program.

ity data can take years to complete in the current environment. Second, although recent reports clarified the legality of collecting race/ethnic data on members,⁸ some plan representatives remained concerned that obtaining such data could expose them to liability risk, even if the data were used to improve quality. Finally, some were concerned that working together could violate antitrust laws or be perceived as inappropriate by some patient groups.

Nevertheless, plan leaders recognized that they could have more impact collectively than alone. In addition, progress in indirect approaches to estimating race/ethnicity, based on geocoding and surname analysis techniques,^{9,10} offered a practical means of quickly obtaining sufficiently accurate race/ethnicity information to identify potential disparities. Although not a replacement for self-reported data, indirect data could help bridge the gap until plans could collect it. Finally, the Agency for Healthcare Research and Quality (AHRQ)'s willingness to serve as convener helped mitigate the antitrust concerns.

During planning meetings in December 2003 and July 2004 with AHRQ and other organizations, the plans agreed that disparities would be addressed as a problem in quality of care, that they would share information with one another, and that they would not use information derived through the NHPC's work to compete with or disparage one another. They also agreed to obtain data on race/ethnicity of their enrollees, using either direct or indirect methods, and to work together on at least one health condition, diabetes, which caused significant morbidity and mortality for minority populations.

AHRQ and the Robert Wood Johnson Foundation (RWJF) then agreed to cosponsor activities of the group, which became

known as the National Health Plan Collaborative to Reduce Disparities and Improve Quality (NHPC). AHRQ supported RAND to provide necessary infrastructure and assistance (for example, conducting geocoding/surname analysis to estimate race/ethnicity, providing analytic support and consultation on the design of potential pilot interventions), and RWJF contracted with the Center for Health Care Strategies (CHCS) and the Institute for Healthcare Improvement (IHI) to help facilitate shared learning and quality improvement (QI) activities. Participating plans and their respective enrollment and characteristics are shown in Table 1 (above).

Design of the NHPC

The NHPC's design was heavily influenced by plans, which wanted considerable flexibility in the scale, measurement, and types of activities that plans could pursue as part of their participation while receiving technical assistance and sharing lessons learned. Plan leaders and their teams participate in advisory or work groups around some commonly shared but challenging issues, such as selecting common data elements and reporting. In addition, plans worked to overcome organizational barriers to reducing disparities and improving quality. Because participating plans are competitors in many markets, early technical assistance provided to individual plans came with the promise of confidentiality to encourage a level of candor and problem solving that could not be attained until participants built trust with one another. As plans became more comfortable in the collaborative and shared common problems, it was hoped that plans would be more willing to share ideas and solutions.

Steps to Addressing Disparities



Figure 1. Activities rest on a foundation of having data on enrollee race/ethnicity with which to examine disparities. The figure depicts the additional steps involved, with the arrows referring to collaborations with the array of partner activities necessary to support plan efforts at reducing disparities. QI, quality improvement; IT, information technology.

Progress to Date

One central goal of the NHPC has been for plans to move from a point at which most had little, if any, race/ethnicity data to routinely monitoring their populations for disparities in quality of care and acting on those they observed. Although the participating plans began at different points with respect to race/ethnicity data, by Fall 2006—the end of the two years—all the plans were involved in designing and testing interventions to address disparities. In Figure 1 (above) and the following sections, we describe the basic steps that plans took and highlight some of their key activities.

OBTAINING RACE/ETHNICITY DATA

Plans had the option of obtaining race/ethnicity data either directly (for example, self-report or from the Centers for Medicare & Medicaid Services [CMS]) or indirectly (using indirect estimation algorithms based on geocoding/surname analysis developed by RAND).⁶ Aetna had already begun large-scale efforts to collect race/ethnicity data from members before the NHPC's start, and Molina Healthcare, which primarily serves Medicaid patients, received race/ethnicity data from the states it serves. UnitedHealthcare and WellPoint, Inc., had also obtained some racial/ethnic data (either directly or indirectly) on a subset of their members as part of earlier research projects. Most of the plans initially opted to use indirect estimates as their primary source of race/ethnicity.^{10,11}

IDENTIFYING DISPARITIES

Plans then linked their members' race/ethnicity data to

already-collected data on diabetes quality and conducted analyses stratified by race/ethnicity. Quality measures included National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures for diabetes, including glycosylated hemoglobin (A1C) and lipid testing, retinal eye exam, and treatment with an angiotensin-converting enzyme (ACE) inhibitor and lipid-lowering agent. Some plans also examined glucose and lipid control.

Through this process, each plan identified disparities in one or more clinical measures, and some conducted additional analyses to further understand their disparities. For example, the process of geocoding enabled plans to estimate the income and educational level of their enrollees using additional census demographic data.¹² Some plans examined the degree to which racial/ethnic disparities persisted once these factors were controlled and found that they could not make the disparities “go away.” Others linked data on A1C or lipid control to their pharmacy data and estimated medication adherence. Others constructed Pareto charts, arraying in ascending or descending order geographic locations of patients or providers' offices that were associated with nonreceipt of recommended care. For example, Harvard Pilgrim Health Care learned that three communities contained 60% of its Hispanic diabetic enrollees who had not received an eye exam and then determined that there was limited access to eye care providers in one of those communities. Such analyses helped the plans to focus on specific aims and populations in designing and implementing interventions (Sidebar 1, page 259).

Sidebar 1. Harvard Pilgrim Health Care

Harvard Pilgrim has also initiated a series of data-related actions. It has undertaken a systematic examination of all of the points at which members interface with the organization (for example, enrollment, claims adjudication, Internet) and is determining which of those interfaces are appropriate points to ask patients to provide race/ethnicity and language preference information.

The organization has also pilot tested several interventions. First, it provided a large provider group with information about its level of disparities in diabetes care. This, in turn, led the provider group to obtain race/ethnicity information directly from its patients. Using a Pareto chart, Harvard Pilgrim noted that members with diabetes in six communities accounted for nearly 60% of the deficiency in retinal examinations for Hispanics with diabetes. It piloted a community-based screening program to increase the rate of these examinations, partnering with a local supermarket chain to provide free in-store fundus photography and other diabetes-related services in two of these communities. Subsequently, Harvard Pilgrim, in cooperation with a local optometry chain, provided a co-pay waiver coupon for an eye exam to members living in these and other such communities. In both interventions, multilingual communications regarding the programs were sent to these members by mail, along with information about the importance of eye exams for people with diabetes. Harvard Pilgrim learned about the need to partner with others, including community-based organizations and other insurers with market share, when implementing a community-based intervention. Only 2.5% of members needing exams attended the screening event, and only a small fraction of those who did were Harvard Pilgrim members. Similarly, use of the co-pay waiver coupons was extremely low. Harvard Pilgrim staff felt that community organizations could have provided guidance regarding effective communication channels and helped to increase participation in such programs. However, the organization did obtain experience with what is required to conduct interventions outside the health care setting.

In response to Massachusetts' mandate of the collection of race/ethnicity data in the hospital setting, Harvard Pilgrim is examining the possibilities for obtaining that information because there is currently no requirement that the hospitals share such information with health plans. It is also piloting the collection of race/ethnicity data during telephone outreach calls to members. Harvard Pilgrim recognizes that once that information becomes available, it needs to be integrated into its data system in a way that it is readily accessed and can be merged with data on clinical performance.

TARGETING AND TESTING INTERVENTIONS

The NHPC adopted a four-level framework for considering interventions, which could be aimed at the patient, provider, organizational, or community level. To be successful in the long run, interventions at all levels are probably important. At the time of this writing, plans are in different stages of development

and pilot testing interventions (Table 2, page 260). However, all plans have identified an intervention that they want to test and have interventions under way; others have completed some pilot interventions and are trying others.

Some plans have taken steps to assure that disparities reduction has an ongoing and prominent role in health plan operations. For example, Highmark, Inc., has established a high-level committee focused on planning and implementing the organization's activities to reduce disparities, and Highmark's corporate giving strategy has a focus on addressing disparities. (Sidebar 2, page 262). United Healthcare, through its corporate foundation, is supporting community health "centers of excellence" in diverse communities in which it operates to help ensure sustainability of its efforts. Aetna has an internal reporting process for its disparities activities and uses an external advisory committee, to whom it reports on progress semi-annually. Harvard Pilgrim Health Care has worked with its Foundation's Institute for Linguistic and Cultural Skills to ensure that appropriate services are available to diverse communities and providers serving these populations. Kaiser Permanente's Institute for Culturally Appropriate Care has three Centers of Excellence, each with a specific focus: black populations in Los Angeles, Hispanic populations in Colorado, and linguistic services in San Francisco. Each center represents a response to serving the needs of its local community, and each serves as a model and origin for best practices for other Kaiser Permanente programs and regions. Molina Healthcare's Institute for Cultural Competency supports its efforts to address cultural issues and disparities among its membership.

Challenges and Lessons Learned

Despite the commitment from senior leadership, all the plans have faced challenges in moving their disparities initiatives forward. Table 3 (page 262) lists some additional challenges and critical success factors.

Organizational Engagement: Leadership and Alignment of Business and Corporate Strategy. Many of the plans are complex national entities with varying regional and departmental structures. Simply achieving coordination of disparities activities across the organization has been a major challenge, and in many cases, a major breakthrough. For example, some plans have had to coordinate different information systems that serve different regions and different, largely autonomous brands; others have sought to bring departments that address quality of care, marketing, and human resources together to address disparities. Many, if not most, plans faced challenges relating to organizational change. For example, approximately a year into

Table 2. Plan Disparity Reduction Activities*

| Plan | Method of Obtaining Data | NHPC Pilot Interventions | Other Activities |
|-----------------------------|--|--|---|
| Aetna | Direct, voluntary collection from members (have data on approximately four 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 data and primary language spoken, on a voluntary basis, through health risk assessments and through all <i>Well Aware</i> disease management programs | In-depth data 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 | Member intervention to reduce disparities in colorectal cancer (CRC) screening Quality improvement grants to provider groups for disparities reduction initiatives in diabetes care and CRC screening Coordination with Harvard Pilgrim Foundation programs that fund disparities reduction efforts by community-based groups |
| HealthPartners | Direct collection at practice group level | 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 speakers' bureau has reached more than 5,000 people in 2006 |
| Highmark, Inc. | Indirect and direct methods | Provider education in practices with higher than average minorities 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 | Nurse advice line offers 24-hour access to bilingual nurses, which increased outreach to members by direct telephonic contact in member-preferred language. The diabetes disease management program provides both language- and culturally-appropriate telephonic counseling. | 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. Distributed a cultural resource manual about language, culture, and religious sensitivity and understanding |
| 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 | Multi-Cultural Organizational Assessment completed to promote the alignment of resources to meet the overall needs of the member population Community Health Center "Centers of Excellence" initiative |
| 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 resource responsibilities |

* NHPC, National Health Plan Collaborative; CMS, Centers for Medicare & Medicaid Services.

the collaborative, WellPoint and Anthem merged, resulting in new leadership, new operational processes, and new information systems. Kaiser Permanente has been in the process of phasing in its electronic medical record (EMR) nationwide, a process that has required a huge companywide effort, effectively delaying interventions in some sites until the EMR is in place. UnitedHealth Group had planned a major intervention in the Gulf States but had to change plans after Hurricanes Katrina and Rita. Other plans have undergone smaller-scale organizational or personnel changes that have affected their time lines.

Several plans identified preexisting organizational structures that could be aligned with disparities efforts, such as human resource and marketing departments and QI efforts, while others identified organizational champions from different regions of the country and brought them together. Such processes have led increasingly toward alignment of disparities reduction with the business case.

Provider Engagement: Challenges in Implementing Interventions at the Provider Group Level. Although some plan participants initially contemplated interventions at the provider group level, network model plans recognized that they typically exert only limited influence over providers in some markets because the providers with which they contract also have contracts with multiple other plans. WellPoint, Inc., confronted this issue when it wanted to begin a cultural competence initiative in one of its markets and rapidly received feedback from physician groups that they were already bombarded with information from multiple plans. On the basis of its experience in providing cultural competency training for its entire clinical staff, Aetna decided to provide cultural competency training for any network physician who submitted a claim to Aetna beginning in 2007. Group-model plans have more easily been able to implement some provider-focused interventions. Kaiser and HealthPartners have provided cultural competency material and training, respectively, to providers. HealthPartners, which is geographically confined, has also been able to work with each of its provider groups to directly collect information about race/ethnicity from members.

Member Engagement: Challenges in Implementing Interventions at the Patient Level. Indirect estimates of race/ethnicity generally provided plans with reasonably accurate estimates at the group (or population) level but they were not well suited to identifying the race/ethnicity of individuals. Thus, although plans relying on indirect measures were able to identify disparities within specific groups or areas and persuade leadership of the need for action, they still needed to obtain member-level

race/ethnicity data if they wanted to implement direct-to-patient interventions. Health plans that directly collected information about members' race or ethnicity used the data for member-directed interventions. For example, Aetna has been working on enrolling black and Hispanic members with diabetes in culturally tailored disease management programs. Molina Healthcare has focused on the development of a live-answer, around-the-clock bilingual/bicultural nurse advice line and has promoted it to Spanish-speaking members through individual, provider, and community channels.

CIGNA negotiated with its disease management vendor to begin routinely collecting and retaining self-reported race/ethnicity information from at-risk members after indirect measures revealed significant disparities in diabetes care. WellPoint, Inc., is also developing member-level interventions that take advantage of existing disease management infrastructure, again by directly collecting race/ethnicity information about members within a disease management program, as well as through health assessment surveys on its secure online member portal (Sidebar 3, page 264).

Community Engagement: Challenges Implementing Interventions at the Community Level. Community-level interventions to improve clinical quality metrics were new to many plans. Harvard Pilgrim Health Care, through its initiative to provide eye care, identified and addressed several challenges in community-level interventions:

- How to identify community thought leaders around the targeted problem
- How to identify appropriate venues in a community
- Understanding the cultural norms in a community
- In markets where a plan is not dominant, the need for collaboration with other payers in order to improve the return on investment on the planned intervention

Harvard Pilgrim Health Care also identified the potential to align with related public health efforts at a state and local level or to induce cooperation from public health entities in an area it may not have targeted but noted that there are likely bureaucratic delays associated with doing so.

QI and Information System Capacity: Challenges Related to Data and Analysis. Although all NHPC plans obtained race/ethnicity information on a subset of their members and had extensive QI infrastructure in place, the process of interpreting and communicating the results for key decision makers was far from straightforward. A major challenge has been to find ways to efficiently translate those data into actionable knowledge. Plans employed several approaches, such as presenting disparities data in Pareto charts to highlight instances in

Sidebar 2. Highmark, Inc.

Highmark, Inc., has initiated active programming both with regard to data collection and activities at the provider group, member, and community levels. The insurer began its efforts by analyzing data provided from the Centers for Medicare & Medicaid Services and data obtained by other indirect methods. Highmark has also been collecting race/ethnicity data directly from members for direct-to-member interventions. It mailed questionnaires with letters and fact sheets to more than 1 million members, asking them to provide information about race/ethnicity data and language preference, and had a response rate of approximately 30%. Although on a different scale, this rate is comparable to what Aetna had achieved when it asked members to self-report race/ethnicity on enrollment or through its Web portal.

Highmark has undertaken several other member interventions to reduce gaps in care, especially diabetes care. The insurer provided member education regarding language support and translation services and published member newsletter articles to increase awareness about health care disparities in diabetes care. Members who self-identified as needing additional diabetes support because of their cultural background were sent educational letters that included information on where to turn for additional support.

Highmark also worked with physicians on a mailing of educational letters on physician letterhead with laboratory work order forms to members of practices with greater than average numbers of minority members who have identified gaps in diabetes care. The insurer also published provider newsletter articles to increase awareness about health disparities and disparities in diabetes care and how to bill appropriately for reimbursement of in-office diabetes education and organized focused discussion groups with practitioners from across Pennsylvania to address potential barriers to care for minority patients.

Highmark has made its community involvement activities a business strategy and has translated its mission into operational goals. Highmark supports a number of outreach programs that address the diverse needs of the communities it serves. The goals of the community-based initiatives to address disparities are to support activities that narrow disparities in health outcomes, support programs that encourage individuals and families to participate competently in their health care and/or pursue and sustain evidence-based health promotion behaviors, foster stronger community and institutional collaborations that improve health and well-being, and monitor progress in reducing and eliminating disparities in health outcomes.

which a relatively small number of geographic areas or markets accounted for the vast majority of minority members in a region not receiving care.

Challenges in Targeting and Testing Interventions. A major challenge faced by most plans has been determining where and how to most effectively target and design interventions. This

Table 3. Factors That Facilitated or Hindered Plans' Efforts

Factors That Facilitated Effectiveness

- Active involvement and commitment of plan leads
- Ability to influence internal plan organization
- Senior health plan leadership setting disparities a companywide priority
- Availability of appropriate health plan resources (e.g., financial, information services, etc.) for implementation
- Involvement of public and private sector

Factors That Hindered Effectiveness

- Plan reorganizations
- Competing organizational priorities
- Lack of information about interventions that work and could be replicated
- Lack of dedicated plan resources to the initiative
- Significant investment to existing information technology

reflects, in part, the fact that there is still a paucity of data about what works, as well as the need to analyze scalability of promising interventions, alignment with other analytic and QI initiatives, and sequencing of program and communications initiatives. Although some interventions have been shown to be effective in specific situations, these findings are not always generalizable to or easily implemented in very large organizations, such as the health plans in the NHPC.¹³

Because indirect methods of estimating race/ethnicity are not robust enough to support direct-to-member interventions, most plans have chosen to pilot organizational- or community-level interventions. Most plans have also shied away from interventions directed at providers who normally have contracts with numerous different insurers in which any single plan's influence may be quite limited. Regardless of the approach chosen, each plan has recognized that it is expensive and impractical to implement pilot strategies everywhere but has been challenged in deciding where to focus. Although this challenge has been particularly acute for large, national plans, so too is the need to advance, as these organizations in aggregate represent a sizeable share of the commercial marketplace.

One particularly promising strategy emerging from NHPC efforts to respond to these challenges is the development of interactive mapping and analysis tools. These tools, which became possible because of the use of geocoding to derive estimates of race/ethnicity, help plans quickly identify geographic

Percent Hispanic Diabetic Members by Census Tract in Plan Service Area

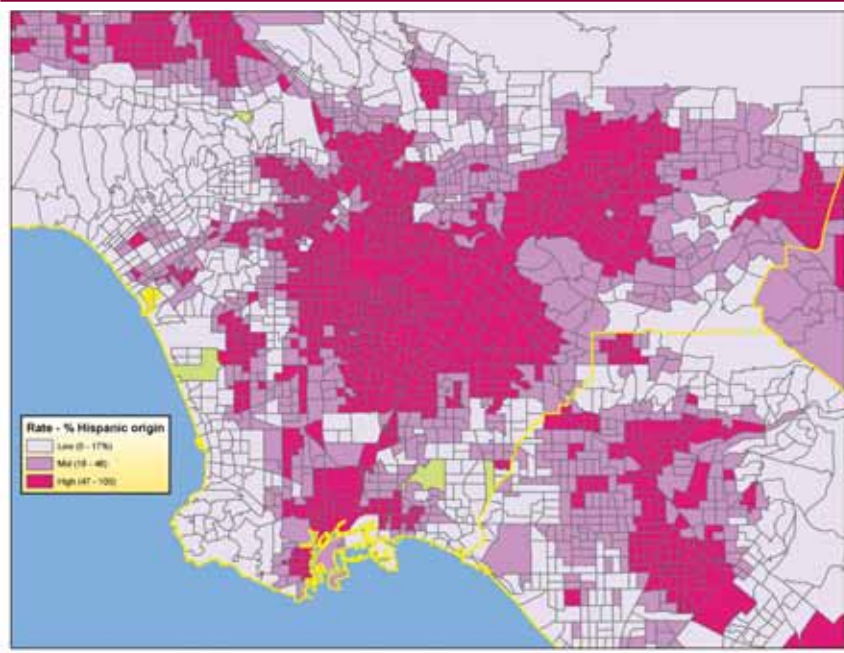


Figure 2. Highlighted census tracts are those with high numbers of Hispanic members with diabetes who have not had their low density lipoprotein checked in the prior year.

Clusters of Tracts with High Numbers of Hispanic Diabetic Members Without LDL Test in Plan Service

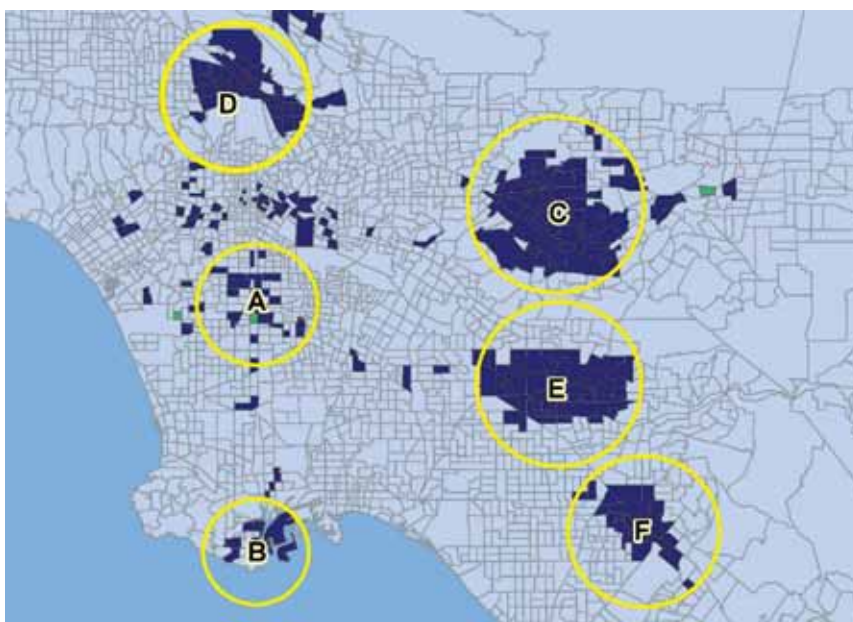


Figure 3. This figure provides more detail on the census tracts highlighted in Figure 2, underscoring the fact that these members are clustered in only a few census tracts that collectively account for a significant proportion of disparities observed in that market. LDL, low density lipoprotein.

areas with characteristics that signify good opportunities for interventions and engage senior leadership. For example, software tools and algorithms, such as those developed by RAND for the NHPC, enable plans to highlight census tracts that have a high volume of members with diabetes from a given race/ethnic group who have not received one or more recommended elements of care. Figure 2 (left) shows such a map of a health plan's market area, and Figure 3 (left) provides more detail on this area. These maps serve, in some fashion, as a "geographic Pareto chart," and a plan can use this information to focus more efficiently on a variety of interventions, ranging from targeted mailings to interventions with providers in this area to communitywide education.

The effectiveness of displaying complex data through maps such as those shown in Figures 2 and 3 rests on a number of general principles described elsewhere,¹⁴ including making large data sets coherent and encouraging the viewer to make comparisons by region and race/ethnicity.

Learning Collaborative Framework: Key Adaptations for Success: The NHPC learned early on that a Breakthrough Series-type QI collaborative¹⁵ required adaptations to meet the needs of the partners, both because of the need for population (versus practice-based) information and because the appropriate set of interventions was not well understood. Consequently, rather than being prescriptive, the collaborative embraced an approach that encouraged participating plans to characterize their populations and health disparities, identify factors that might contribute to observed disparities, and then design and test potential interventions that best leveraged their available resources. By February 2006, all the plans had progressed from focusing solely on measurement issues to initial action. Actions included outreach activities to members, community, or providers, or completion of organizational assessment/capacity development for disparities work (for example, cultural compe-

Sidebar 3. WellPoint, Inc.

WellPoint provides an example of a large national plan with numerous markets and brands. Its December 2004 merger with Anthem highlighted the challenges in combining data systems between different components of a company. While moving forward with self-reported data collection in its disease management programs and strengthening those programs through online health risk assessment surveys, the plan has also moved rapidly to take advantage of indirect data collection methods to identify geographic areas in which interventions are most likely to be congruent with the population need. Extensive deployment of indirect data strategies allows WellPoint to provide disparities analyses throughout its markets for business decisions without costly investments in enhancing legacy data systems scheduled to be retired. Using disparities mapping of Health Effectiveness Data and Information Set (National Committee for Quality Assurance, Washington, D.C.) quality measures and physician group profiles produced via indirect data methodologies, WellPoint has conducted physician quality improvement outreach with medical groups and independent practice associates in pilot geographies to facilitate discussion of health disparities issues and assess member education support needs at the patient-physician point-of-service level. In addition, it has reached out to develop partnerships with provider associations around the area of cultural competency by providing written educational material. It also identified disparities in care (unrelated to diabetes) in its own employee population and implemented changes in health benefit design, referrals channels into disease management programs, and workplace wellness programs to address the disparities gap. Its human resources department is addressing employee and supervisor awareness of health disparities issues. In 2007, WellPoint implemented clinical cultural competency training for all its physicians, nurses, and clinical associates with member contact.

tency training of providers). Five plans had implemented one or more pilot interventions (Table 2, page 260).

Public-Private Partnerships. The NHPC represents a complex public-private partnership involving organizations with very different cultures and modes of operation. Although these differences presented some initial challenges, the partners developed an internal structure organized around key work groups with appropriate representation. This structure also served as one mechanism through which initial barriers could be successfully addressed and resolved.

Further, as the work of the NHPC has progressed, it has become evident that the perspective of each of the various parties has been critical. Each partner brings a different type of expertise and experience to the group, and this recognition has enabled all parties to commit to working together for another two years.

Next Steps

Beginning on October 1, 2006, the NHPC entered the second phase of its work to address disparities in care. Now that most of the plans have some data on their enrollees with diabetes and have begun targeting disparities, they want to capitalize on their collective industry strength to influence policy on issues related to disparities. Thus, in addition to continuing to target and test interventions to address disparities within their own plans, the plans are working collectively in the following areas:

■ **Primary data collection:** Plans are working together to identify and/or develop uniform approaches to primary race/ethnicity data collection, guidelines for appropriate (and inappropriate) use of such data, and opportunities to work together nationally/in specific markets with members, providers, and/or employers to test these approaches.

■ **Language access:** Plans are working together on the national level to promote availability and will work collectively in local markets to test specific approaches. Other joint efforts in member/provider education may also be developed with NHPC support.

■ **Business case:** Plans are exploring development of the “policy case” for reducing disparities in the health care industry and also will work on individual plan analysis of their own organizational business case.

Plans have also recognized the limitations of actions they can take on their own because they usually share market share with other plans in a given community. Their stated goal is to test interventions related to the core issues just described through local market collaboration, but they recognize that doing so will require considerable efforts to gain buy-in from each of the respective organizations.

Summary and Conclusions

The NHPC represents a novel public-private partnership in which health plans, a federal agency, and a foundation have joined together to address racial/ethnic disparities in health care. In its first two years, plans have made substantial progress both in examining their racial/ethnic disparities and in stimulating organizational changes to sustain efforts to address them. Although a number of pilot interventions are under way, it is too soon to know which have promise in reducing disparities. Whether the NHPC will ultimately be successful in meeting its goals, particularly those of producing measurable changes in health outcomes, remains to be seen. Although we are optimistic about the progress made thus far, an external evaluation of the NHPC processes is also under way and should provide additional lessons for future efforts.

Epilogue

In June and October 2007, Humana and Boston Medical Center HealthNet Plan, respectively, officially joined the NHPC and are participating in the second phase activities. ■

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Nicole Lurie, M.D., M.S.P.H., is Alcoa Professor and Director, Center for Population Health and Health Disparities, RAND Corporation, Arlington, Virginia. **Allen Fremont, M.D., Ph.D.**, is a Natural Scientist and Sociologist for RAND Corporation, Santa Monica, California. **Stephen A. Somers, Ph.D.**, is President and Chief Executive Officer, Center for Healthcare Strategies, Hamilton, New Jersey. **Kathryn Coltin, M.P.H.**, is Director, External Quality and Data Initiatives, Harvard Pilgrim Health Care, Wellesley, Massachusetts. **Andrea Gelzer, M.D.**, formerly Senior Vice President of Clinical Public Affairs, CIGNA Healthcare, Irving, Texas, is Chief Medical Officer, Boston Medical Center HealthNet Plan, Boston. **Rhonda Johnson, M.D.**, is Medical Director, Highmark, Inc., Pittsburgh. **Wayne Rawlins, M.D.**, is Medical Director, Aetna, Hartford, Connecticut. **Grace Ting** is Health Services Director, WellPoint Health Networks, Inc., Indianapolis. **Winston Wong, M.D.**, is Clinical Director of the Community Benefit, Kaiser Permanente, Washington, D.C. **Donna Zimmerman, M.P.H.**, is Vice President of Government and Community Relations, HealthPartners, Inc., Minneapolis. Please address correspondence to Nicole Lurie, M.D., M.S.P.H., lurie@rand.org.

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