

From Policy to Action: Addressing Racial and Ethnic Disparities at the Ground-Level

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Despite improvements in the overall health status of Americans, minorities continue to lag behind whites in health status and access to care. Since the 2002 release of the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, a significant amount of analytic work has enhanced our understanding of the scope and causes of disparities in health and health care. It is now time to move beyond documenting disparities and to focus our efforts on actionable steps to eliminate them.

A comprehensive, multi-stakeholder strategy is needed to reduce racial and ethnic disparities in health care delivery. Progress in this area requires the engagement of the entire health care stakeholder community — purchasers, managed care organizations, providers, consumers, and community-based organizations. This brief outlines innovative, practical strategies that states and Medicaid managed care organizations nationally are implementing to address documented gaps in care. They include:

- Strengthening and standardizing efforts to collect information on the race and ethnicity of enrollees, either directly or indirectly;
- Incorporating disparities reduction goals and objectives into health plan and provider contracts;
- Linking monetary incentives to initiatives to reduce disparities in health care;
- Analyzing utilization and performance data by race and ethnicity to identify disparities and target patient and provider interventions;
- Increasing access to culturally and linguistically appropriate care; and
- Developing community-based strategies to reach out to minority members.

Introduction

Recent advances in medicine and public health have led to significant improvements in the overall health status of Americans, yet members of racial and ethnic minority groups continue to lag behind whites in health status and access to care. Minorities in general encounter more barriers to care, greater incidence of chronic disease, lower quality of care, and higher mortality than white Americans. These racial and ethnic disparities are present across all dimensions of health care access and quality, as well as a wide range of clinical conditions, care settings, and types of care. Consider that:

- Hispanics are less likely to receive recommended care for diabetes and are twice as likely to die from the disease as non-Hispanic whites.
- African-Americans who undergo surgery are significantly more likely to develop postoperative complications than whites.¹

These and many other documented disparities in health care are both pervasive and disturbing. Further, the existence of these disparities in care raise important quality and patient safety issues. It means certain subgroups of Americans are not receiving care at the level of the rest of Americans who, incidentally, only receive proper care 50 percent of the time.

Health care disparities can impose a tremendous burden on individuals and communities, and account for considerable costs to our society as a whole. This brief, drawing from efforts supported by The Commonwealth Fund and the Robert Wood Johnson Foundation, outlines practical strategies to address documented gaps in care.

Disparities in health and health care can impose a tremendous burden on individuals and communities, and account for considerable costs to our society as a whole. Disparities in access to high quality preventive services could be contributing to increasing health care costs through unnecessary utilization, avoidable hospital stays, and emergency room visits. For example, in response to a request from members of the National Health Plan Collaborative, staff from the Center for Health Care Strategies and RAND Corporation used existing data to produce a “back-of-the-envelope” assessment of the fiscal implications of racial disparities in diabetes care. This preliminary analysis suggested that the cost to the U.S. health care system of these diabetes disparities could be as much as \$4 billion per year.

With escalating health care costs impacting federal, state, and employer budgets, the financial and economic consequences of disparities could be a key driver to effecting change and improving the quality of care for minority populations. Initiatives to reduce health disparities and improve care, particularly in the areas of diagnosis and prevention of hospitalizations among high risk patients, are likely, over time, to yield improved outcomes that may result in long-term cost savings and reduced premiums. The savings generated could then be used to sustain or develop new programs to reduce disparities in care.

There are ample opportunities within the health care system to foster and guide quality improvement efforts that address disparities. The Medicaid program is an ideal venue for addressing disparities in care and outcomes given its role in the health care financing and delivery system. As many as half of Medicaid’s 52 million beneficiaries are members of racial and ethnic minority subgroups.²

I. The Purchaser/Policymakers’ Role in Addressing Disparities

Medicaid is the largest provider of health insurance for minority populations in America, covering at least one in five non-elderly Hispanics and African Americans compared to one in 10 whites.⁴ As a purchaser of care for a large proportion of minority Americans, the Medicaid program has a vested interest in reducing racial disparities in health care delivery. Racially and ethnically diverse Medicaid consumers, due to language or cultural differences, may face increased barriers to and disparities in health care. States should be concerned that the care they are paying for is inadequate, or in certain cases inappropriate, for their Medicaid beneficiaries.

Medicaid can be an important catalyst for efforts to eliminate racial and ethnic disparities. States can use their regulatory and purchasing influence to engage managed care organizations and providers in identifying and actively addressing racial and ethnic disparities in care. Following are three strategies for state Medicaid programs to leverage their extensive purchasing power:

- Strengthen and standardize efforts to collect information on the race and ethnicity of enrollees, either directly or indirectly;
- Incorporate disparities reduction goals and objectives into health plan and provider contracts; and
- Link monetary incentives to initiatives to reduce disparities in health care.

Establishing Standards for the Collection of Race, Ethnicity, and Language Data

Efforts to eliminate racial and ethnic disparities in health care must begin with valid and reliable data on race, ethnicity, and language preference. While collecting such data alone cannot reduce or eliminate disparities, gathering these data is a necessary first step in identifying disparities and targeting strategies to address inequalities in care.⁵ These data are important to understanding the health care needs of specific populations, and planning customized programs and interventions. Without such data, health care organizations cannot effectively define the problem or devise targeted, meaningful solutions.

Despite growing recognition of the need for accurate and timely data on race and ethnicity, the collection of this information is neither widely practiced nor accepted by the health care industry. No standardized requirements exist for the collection, categorization, or use of data on race and ethnicity. The Office of Management and Budget (OMB), supported by the Department of Health and Human Services (DHHS), published recommendations in 1997, but implementation has never been mandated.⁶ As a result, there are vast inconsistencies in the reporting of race, ethnicity, primary language, or country of origin.

In the Medicaid arena, managed care organizations can often obtain race, ethnicity, and, in some cases, language information from their state Medicaid agencies. However, missing and incomplete data are often a problem because states and counties collect this information on a voluntary, rather than mandatory, basis. In addition, data sources and frequency of collection vary significantly across states. For example, some states collect as few as two basic categories of race and ethnicity data, others gather up to seven outlined by OMB, and others go further to define specific subgroups reflecting the race, ethnicity, and primary language of people within a state.

Nationally accepted standards for primary data collection are needed to facilitate identification of disparities at all levels of care — from the practice site, to hospitals and health plans. As a regulator and the nation's largest purchaser of health care, the federal Centers for Medicare and Medicaid Services should exercise its influence and lead the effort to standardize the collection of race and ethnicity data. Without a mandate, considerable variability in methods for collecting race and ethnicity data will continue to exist, and will severely limit the health system's ability to generate comparable information on health status and quality for all racial and ethnic groups. Establishing standards to guide states and health care organizations in collecting direct race and ethnicity data would be a substantial step forward for the entire health care industry.

Although there is no standardized requirement for collecting race and ethnicity data, the Health Research and Educational Trust (HRET) has developed a uniform framework for collecting and reporting this information in hospitals. HRET's framework includes standards and recommendations on the appropriate sources of race and ethnicity data, the timing of data collection, and an approach for categorizing race and ethnicity for analytical and reporting purposes.^{7,8} It also addresses appropriate uses for the data and a mechanism for guaranteeing confidentiality and preventing misuse, as well as a communication strategy for addressing patients' concerns regarding race and ethnicity data collection. To ensure consistency, efforts to develop an industry standard in managed care could build on HRET's framework, which is currently being implemented in many, though not all, hospitals across the country.

Collecting Race and Ethnicity Data for Commercial Members

In the commercial sector, Verizon requires health plans attending contract renewal meetings to provide information regarding awareness of racial and ethnic disparities in care and activities to reduce disparities. Consequently, these plans must either use indirect methods to gather these data, or collect the information directly from members, providers, or employers with whom they contract. Aetna is one of a few health plans leading the effort to voluntarily collect race and ethnicity data from its members. In 2002, Aetna began asking members to self-report such information through electronic and paper enrollment forms in 13 states and the District of Columbia. It has since expanded this effort and now collects race and ethnicity data through additional methods, including the use of its member Web site. To date, Aetna has collected race and ethnicity information for more than five million members, and is using the data to target members who are likely to benefit from its special programs and services. Aetna is also working with nine other major health plans with a total of 87 million members in the National Health Plan Collaborative to establish standards for the collection and use of race and ethnicity data.⁹ While the leadership of health plans such as those participating in the National Health Plan Collaborative will advance the direct collection of race and ethnicity data, there is substantial need for a system-wide approach.

Integrating Racial/Ethnic Disparities Reduction Activities into Managed Care Contracts

Contract negotiations provide an opportunity for purchasers to address racial and ethnic disparities. States can insist that health plans and providers integrate quality improvement activities aimed at reducing racial disparities into their managed care contracts. For example, several states have required Medicaid health plans to provide interpreter services and translated materials to Limited English Proficient (LEP) members.

In Missouri, health plans with more than 200 members or five percent of its membership (whichever is less) whose common primary language is not English must make materials, such as member handbooks, available in that language. In Massachusetts, the state's Division of Medical Assistance requires health plans to ensure that its providers are responsive to the cultural and linguistic needs of minorities. The state requires health plans to maintain an updated database on the cultural and linguistic abilities of its providers. In California, the state's Medi-Cal managed care contract requires plans to provide 24-hour access to interpreter services for LEP members at key points of contact. Plans must also assess the cultural and linguistic needs of plan members and report to the state's Department of Health Services on plans to address these needs.

Other strategies include stipulating that plans maintain a network of providers that reflect the demographic make-up of its membership, ensuring that provider networks are easily accessible to areas with large minority populations, and requiring plans to examine utilization data by race and ethnicity. Most state Medicaid agencies are dominant purchasers in their marketplace, and can exercise leverage in setting these standards for health plans with whom they contract.

Incorporating Disparities Reduction into Business Practice

In the commercial sector, Verizon requires health plans to provide information regarding awareness of racial and ethnic disparities in care and activities to reduce disparities at contract renewal meetings. The company's human resource manager asks the health plans to describe cultural components of disease management programs and how communication materials specifically address cultural concerns. Verizon then incorporates this information into the company's decision-making process for renewing contracts with specific plans.¹⁰

Using Performance Incentives to Reduce Disparities

Performance incentives are increasingly being used in the Medicaid, Medicare, and commercial arenas as a strategy for improving quality of health care for enrollees. By aligning payment for health benefits with accountability and performance, purchasers can increase the efficiency with which health services are delivered and save money. Incentives have traditionally focused on performance measures such as well-child visits, preventive health care screenings, and appropriate asthma medication, but they could be used in targeted ways to improve the health care of minorities.

Specifically, the Massachusetts health care reform law established a Medicaid pay-for-performance plan for hospitals that is partly linked to disparities. The reduction of racial and ethnic disparities is among the specified quality standards and performance benchmarks that hospitals are required to meet by fiscal year 2009. Another approach uses performance incentives to reward health plans that attain higher Health Plan Employer Data and Information Set (HEDIS) scores in areas where racial and ethnic disparities in health care are commonly found. Diseases such as diabetes, high blood pressure, and heart disease, for example, are more prevalent in minority populations and are often underdiagnosed. Focusing on these clinical conditions is likely to help close the disparities gap. Alternatively, purchasers can provide performance incentives for providing more culturally competent care. This can be achieved by tying incentives to surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), that measure patients' satisfaction with their physicians' communication and patients' trust in their physicians.

While the use of performance incentives to reduce disparities offers promise, purchasers considering the adoption of such arrangements should incorporate strategies to minimize unintended consequences. Such strategies may include the appropriate use of risk adjustment, rewarding both quality scores and improvement over time, as well as rewarding both overall quality and reduction in disparities.¹¹

II. The Role of Managed Care Organizations in Addressing Disparities

While states and other health care purchasers are significant forces in moving the disparities agenda, the effective implementation of activities to reduce disparities in care ultimately rests with providers. Managed care organizations can do a number of things to support them. As the focal point of many quality improvement activities, managed care organizations can be critical players in efforts to eliminate disparities and improve the quality of care provided to minority beneficiaries. Health plans have the capacity to create systems that better coordinate care, reach out to members in need of preventive care services, provide health education, and support physicians in their networks. Furthermore, managed care organizations that are paid on a capitated basis have real business incentives to implement quality initiatives to eliminate health disparities.

The following sections detail ways that health plans can help reduce disparities in care, including:

- Analyzing utilization and performance data by race and ethnicity to identify disparities and target patient and provider interventions;
- Increasing access to culturally and linguistically appropriate care; and
- Developing community-based strategies to reach out to minority members.

Using Race and Ethnicity Data to Identify Disparities and Target Interventions

Managed care organizations are increasingly collecting data on enrollees' race and ethnicity and using this information to address health care quality. Those that have data on race and ethnicity can use it to identify differences in health status and service use and to develop, implement, and monitor intervention programs aimed at reducing and eliminating gaps in care. Data on race and ethnicity can also be used to plan programs and set priorities, achieve a more nuanced understanding of the health needs of specific populations, assign appropriate primary care physicians, determine translation and interpretation needs, and identify and explain performance differences among providers within plans.

In its *Improving Health Care Quality for Racially and Ethnically Diverse Populations* initiative, the Center for Health Care Strategies (CHCS) worked with 11 Medicaid health plans and one state primary case management program to develop strategies to identify members of racial and ethnic subgroups, measure the gaps in care, and improve health care quality. The workgroup focused on three clinical areas where disparities in care have been documented — birth outcomes and immunizations, asthma, and diabetes — and used quality improvement approaches ranging from case management to forming partnerships with community organizations.

Targeting Disparities Versus Targeting Conditions

Strategies to incorporate disparities reduction into quality improvement (QI) activities generally take the form of: (1) conducting QI with the explicit goal of reducing disparities; or (2) targeting conditions that are known to disproportionately affect minorities, and for which there are known disparities. Each strategy has advantages and disadvantages associated with it, and the considerations for taking one approach over the other vary. The best strategy is likely to combine elements of both.

Using QI to reduce the disparities gap involves stratifying quality measures by race and ethnicity to identify disparities, then focusing on interventions to narrow identified gaps in quality. Measuring progress involves comparing the difference between each racial and ethnic subgroup's rate on a measure and the "best" performing subgroup's rate for the same measure. This can be difficult for organizations that do not have accurate or complete information on their members to identify and stratify quality measures by race and ethnicity. Plans that have this information, however, can use this approach to monitor areas in which disparities are increasing or decreasing and focus efforts accordingly. To the extent that organizations can stratify individuals into subgroups with enough specificity, this strategy also allows organizations to tailor interventions and develop more culturally or linguistically appropriate programs. Focusing only on closing the gap, however, does not take into account the overall level of care that is being delivered. This is an important consideration, particularly in circumstances when even the "best" performing subgroup is receiving poor care. It should also be noted that it is possible to demonstrate a reduction in the disparities gap while at the same time lowering the quality of care (i.e., by lowering scores for the "best" performing subgroup). Pay-for-performance initiatives targeting disparities reduction should therefore be structured to support strategies aimed at both closing the gap and raising quality for all.

Another approach is to conduct QI activities that target clinical conditions that disproportionately affect members of racial and ethnic minority groups. The goal would be to improve the overall quality of care and services for everyone suffering from the targeted clinical conditions. This could be a particularly attractive option for health plans dealing mostly with commercial members, for whom race and ethnicity data are not readily available. However, using this approach, an overall improvement in performance measures does not necessarily indicate a reduction in disparities. It would be difficult to gauge improvements in care for particular racial and ethnic subgroups, and it may allow disparities to continue to exist.

In addition, health plans routinely assess their performance on dimensions of care and service using measures such as HEDIS or CAHPS. Plans could report many or all of the HEDIS and CAHPS measures by race and ethnicity to identify gaps in care. In a demonstration project supported by The Commonwealth Fund and the Health Resources and Services Administration, state Medicaid agencies partnered with health plans to match race data with quality indicators to identify and address areas of disparity in health care utilization and outcomes. Plans were able to generate reports on HEDIS and CAHPS measures stratified by race and ethnicity, and examine disparities in clinical processes and patient experiences of care.¹²

Medicaid health insurance plans, by virtue of the eligibility determination process in many states, have ready access to data on the race and ethnicity of its enrollees. Medicare and commercial plans, however, must turn to other methods to obtain such information. For plans that do not have race and ethnicity data and are not ready to initiate data collection, indirect methods such as geocoding and surname analysis provide potential methods for obtaining such information.

Geocoding is a technique used to infer the characteristics of a person (e.g., race and/or ethnic background) based on the characteristics of the area or neighborhood where he or she lives. This technique is used primarily to identify enrollees who are likely to be African-American. Surname analysis, on the other hand, is used to identify members of Hispanic and Asian heritage. The most common approach compares a person's last name to a long list of names known to have a high probability of linkage to a specified racial or ethnic group.

Neither is an exact science. These techniques cannot provide precise information on an individual's race or ethnicity. They can, however, provide an accurate estimate of the racial/ethnic differences in quality when analyzed at the population or group level. They are potential tools that health plans can use to identify geographic areas and/or particular ethnic groups that plans should target for quality improvement interventions. For Medicare and commercial insurers, where racial and ethnic data are more difficult to collect, geocoding and surname analysis may provide a rough marker of a person's racial and ethnic characteristics.

Collecting Primary Language Information

In addition to race and ethnicity data, some plans are also collecting information on members' and providers' primary language. Language barriers can compromise the quality of care delivered, and collecting language information can help plans match patients with providers who speak the same non-English language or arrange for interpreter services. California is leading the field in making access to language services a priority for health care organizations. The state is now requiring health plans to assess the linguistic needs of their enrollee population and to provide for translation and interpretation for medical services when certain language thresholds are met.

Increasing Access to Culturally and Linguistically Competent Care

As the U.S. population becomes more diverse, health care providers are interacting with patients and consumers from many different cultural and linguistic backgrounds. Culture and language are critical factors in the delivery and receipt of health care services. Provider-patient differences in language and culture may lead to miscommunication of critical health care information and lack of compliance with prescribed treatment or medication regimen. Given the influence of culture and language on communications and clinical decision-making, it is important that health care providers and other staff respond with sensitivity to the needs and preferences of patients with diverse backgrounds. The provision of culturally and linguistically competent care has the potential to improve health care access, quality and outcomes, and reduce disparities in care.

Standards for Culturally and Linguistically Appropriate Services (CLAS)

In December 2000, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) released national standards for culturally and linguistically appropriate services (CLAS) in health care. These standards encompass three main themes — culturally competent care, language access services, and organizational supports for cultural and linguistic competence — and provide a consistent and comprehensive approach to addressing the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. More details on the standards can be found on the OMC website at <http://omhrc.gov>.

Health plans have implemented programs to address the cultural, ethnic, and linguistic needs of members in various ways. Kaiser Permanente's Institute for Culturally Competent Care established a number of "Centers of Excellence," with innovative clinical models designed to respond to the health needs of specific populations. One Center of Excellence in Los Angeles, which targets the African-American population, focuses on diagnosing, treating, and managing conditions that are prevalent among African Americans, such as heart disease. A center in San Francisco provides care in Spanish, Chinese, and other languages that are frequently spoken by members in the surrounding community.

Some health plans are working to increase the number of racial and ethnically diverse providers in their networks. There is some evidence that underrepresented minority providers are more likely to practice in underserved communities, thereby increasing access to care for those living in these communities. Racial and ethnic concordance between the patient and provider is also likely to enhance communication and understanding and provide opportunities for building trust.

Other promising strategies include providing interpreter services, hiring and training bilingual workers, using community health workers to provide outreach, and providing cultural competency training to health care providers and staff who are in direct contact with patients. HealthFirst, a Medicaid plan in New York, sought to improve physician-patient relationships by assigning “culturally congruent” provider representatives to the primary care providers caring for a high-risk subset of African American and Hispanic members with diabetes. These provider representatives sought to improve how physicians related to their patients by providing insights about the health beliefs of particular cultures.

Another health plan, L.A. Care, sought to improve medication adherence for members with persistent moderate to severe asthma by equipping community pharmacists with tools to overcome language barriers and communicate more effectively with members. The intervention focused specifically on Cantonese-, Armenian-, and Spanish-speaking members with asthma in particular communities. L.A. Care developed health education materials in the target members’ languages, as well as tools to help pharmacists assess patients’ symptoms and medication regimens and to document counseling. L.A. Care also provided pharmacists with access to free telephone interpretation services, which were paid for by the health plan.

Cultural and linguistic competence is fundamental to providing high quality health care, particularly for diverse patient populations. Adopting activities to enhance patients’ access to culturally and linguistically appropriate services is essential for reducing disparities and reaching the ultimate goal of building a health care system that delivers the highest quality of care to every patient, regardless of race, ethnicity, culture, or language.

Supporting Innovations in Cultural Competency

To encourage the development of culturally competent approaches to health care, the National Committee for Quality Assurance (NCQA), supported by The California Endowment, developed the *Recognizing Innovation in Multicultural Health Care* award program. This award program provides a forum for recognizing health plans’ efforts in promoting cultural competence and addressing racial and ethnic disparities in health care. The awards program also helps to identify and disseminate best practice models that are replicable in other settings. Several health plans that participated in the National Health Plan Collaborative and in the CHCS Medicaid-based initiative aimed at reducing racial and ethnic disparities have been named as recipients of the NCQA award, including Aetna, Blue Cross of California, HealthPartners, Kaiser Permanente, L.A. Care Health Plan, and Molina Healthcare of Michigan.

Involving the Community to Address Disparities

Experience demonstrates that barriers to care and solutions to eliminating inequities in care vary widely by region and culture. There is no one-size-fits-all solution that works across all communities. Rather, interventions must be tailored to the community’s specific needs, and must reflect the community’s demographic and socioeconomic make up, cultural values, as well as existing infrastructure and supports. Strategies to effectively reduce disparities in care must engage the broader public through community-based activities and programs. Indeed, a health plan that goes beyond its own corporate confines to build creative relationships in its communities is likely to be more successful in reaching its members.

For example, through a partnership with local hospitals and community leaders in Pittsburgh Pennsylvania, *UPMC for You* increased women’s prenatal care, and improved birth outcomes. The health plan used this collaboration to move from primarily telephone outreach for pregnant members to using community-based health plan representatives to serve as health coaches. The program engaged community outreach representatives at UPMC Braddock Hospital and Magee-Women’s Hospital, as well as local social service agencies and the largest school districts in the target communities. Since these health coaches were from the local community, they had a greater understanding of the social and physical issues facing the women enrolled in the program.

In Southbridge, Massachusetts, Network Health implemented a strategy to increase asthma awareness and education in the community. The health plan partnered with representatives from the Hispanic community, community organizations, the local hospital, local government, youth organizations, and churches to support community events promoting asthma education.

Another Medicaid plan, Blue Cross of California, collaborated with community pharmacies to help patients manage their asthma more effectively. The plan conducted face-to-face outreach to small non-chain pharmacies, during which Blue Cross staff reviewed educational outreach materials and asthma consultation content with pharmacists. The health plan encouraged the pharmacists to talk with members about reducing exposure to environmental triggers and to refer members to primary care physicians for the development of asthma action plans. As a result of the outreach, Blue Cross increased the asthma pharmacy consultation rate for African-American members at the targeted pharmacies.

Community-based approaches that take into account the social, cultural, and environmental factors affecting the health of community members go a long way toward raising awareness and engaging members, particularly the underserved minority populations. Such a strategy requires strong, committed leadership within the health plan and broader community. When implemented well, managed care organizations partnering with community-based organizations and health workers gain the ability to effectively reach populations that would otherwise be underserved.

Conclusion

The need for multi-stakeholder strategies for addressing racial and ethnic disparities in care is evident. Much remains to be done to provide equal opportunities for high quality health care to all. Continued progress in this area requires the engagement of policymakers, purchasers, managed care organizations, providers, and local communities. To effectively reduce racial disparities in care, quality improvement interventions need to include well-designed, culturally-competent approaches and creative partnerships with community stakeholders. Above all, these activities rely on ready access to reliable data.

The richly diverse mix of Americans served by the nation's health care system will undoubtedly grow even more diverse in the next few decades. As such, eliminating disparities in care becomes more of an imperative. Reducing disparities, however, should be seen as a subset of all quality improvement activities, with the ultimate goal, not of reducing disparities for a few, but rather improving quality of care and services for all.

Endnotes

1. Agency for Healthcare Research and Quality. 2006 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; December 2006. AHRQ Pub. No. 07-0012.
2. Centers for Medicare and Medicaid Services, "FY 2003 National MSIS Tables," <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MSISTables2003.pdf>
3. Ibid.
4. Ibid.
5. N. Lurie et al. "Disparities and Quality Improvement: Federal Policy Levers." *Health Affairs*. 24:4 (March/April 2005): 354-364.
6. Federal Register, October 30, 1997 (vol. 62 no. 210) page 58782.
7. R. Hasnain-Wynia and D. Pierce. "A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients." HRET. February, 2005.
8. R. Hasnain-Wynia and D. Baker. "Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care." *Health Services Research*. 41(4): August, 2006.
9. For more information, visit <http://www.chcs.org/nationalhealthplancollaborative/index.html>
10. B. Weinstock (2003). *Why Companies are Making Health Disparities Their Business: The Business Case and Practical Strategies*. Washington, DC: National Business Group on Health.
11. L.P. Casalino and A. Elster. "Will Pay-for-Performance and Quality Reporting Affect Health Care Disparities?" *Health Affairs*, 2007; 26(3). w405-w414
12. D. Nerenz, V. Bonham, R. Green-Weir, C. Joseph, M. Gunter. "Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?" *Health Affairs*. May/June 2002; 21(3). 259-263.

CHCS Resources to Reduce Racial and Ethnic Disparities

Toolkit – Reducing Racial and Ethnic Disparities: Quality Improvement in Medicaid Managed Care

This toolkit details the experiences of a collaborative workgroup of Medicaid managed care organizations to reduce racial and ethnic disparities. *The Improving Health Care Quality for Racially and Ethnically Diverse Populations* workgroup, directed by CHCS and co-sponsored by the Robert Wood Johnson Foundation and The Commonwealth Fund, sought new ways to identify members of racial and ethnic subgroups in participating plans, measure gaps in their care, and to explore ways to reduce disparities and improve overall health care quality. The toolkit offers case studies, as well as “key lessons” on using data to identify disparities; developing patient-centered approaches to care; and collaborating with key stakeholders.

Brief – Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries

This CHCS issue brief provides practical examples from across the country to demonstrate how states are using data on race and ethnicity to improve the quality of care for Medicaid beneficiaries. Based on states’ experience with the CHCS Purchasing Institute, *Leveraging Data to Reduce Racial and Ethnic Health Disparities*, the brief covers strategies on how states can enhance data mining skills, build agency capacity, and create strategic plans for interventions aimed at reducing disparities.

National Health Plan Collaborative to Reduce Disparities and Improve Quality

This initiative, co-sponsored by the Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation, brings together 10 of the nation's largest health insurance plans serving commercial, Medicare, and Medicaid patients nationwide, which are committed to reducing racial and ethnic disparities and improving quality of care. The 10 plans are working together to test provider, member, and community targeted approaches to reduce gaps in care and improve the quality of care that patients with chronic illnesses receive.

For more information, visit www.chcs.org.

About the Center for Health Care Strategies

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 for people with chronic illnesses and disabilities, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs to better serve adults and children with complex and high cost health care needs. Its program priorities are: advancing regional quality improvement, reducing racial and ethnic disparities, and integrating care for people with complex and special needs. For more information, visit www.chcs.org.

This issue brief was made possible through support from The Commonwealth Fund.

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