

Reducing Racial and Ethnic Disparities: A Quality Improvement Initiative in Medicaid Managed Care

toolkit



Funded by the Robert Wood Johnson Foundation and The Commonwealth Fund.

CHCS
Center for
Health Care Strategies, Inc.

Reducing Racial and Ethnic Disparities: A Quality Improvement Initiative in Medicaid Managed Care



About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed care for people with chronic health needs, the elderly, and racially and ethnically diverse populations. CHCS works with state and federal agencies, health plans, providers, and consumers to design programs that better serve high-need and high-cost populations. Its program priorities are: improving quality, reducing racial and ethnic disparities, and integrating care.

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January 2007

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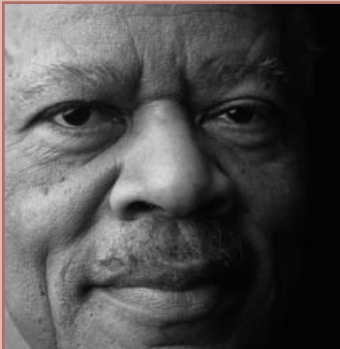
 CHCS National Activities to Improve Health Quality for Racially
 and Ethnically Diverse Populations.45

Acknowledgements

The *Improving Health Care Quality for Racially and Ethnically Diverse Populations* toolkit would not have been possible without the dedication and expertise of several individuals. First and foremost, the Center for Health Care Strategies extends its gratitude to Rhonda Johnson, MD, MPH, medical consultant and medical director at Highmark, Inc., for her guidance, inspiration, and leadership throughout the initiative. We also extend thanks to David Nerenz, PhD, acting director and senior staff investigator for the Center for Health Services Research at the Henry Ford Health System, for imparting his expertise to assist participating organizations in designing their improvement projects. CHCS gratefully acknowledges the core funding from the Robert Wood Johnson Foundation and The Commonwealth Fund that made this initiative possible. Above all, CHCS salutes the representatives of the Medicaid managed care organizations who took part in this pioneering effort. They have exhibited an unwavering commitment to addressing disparities in care.

FOREWORD:

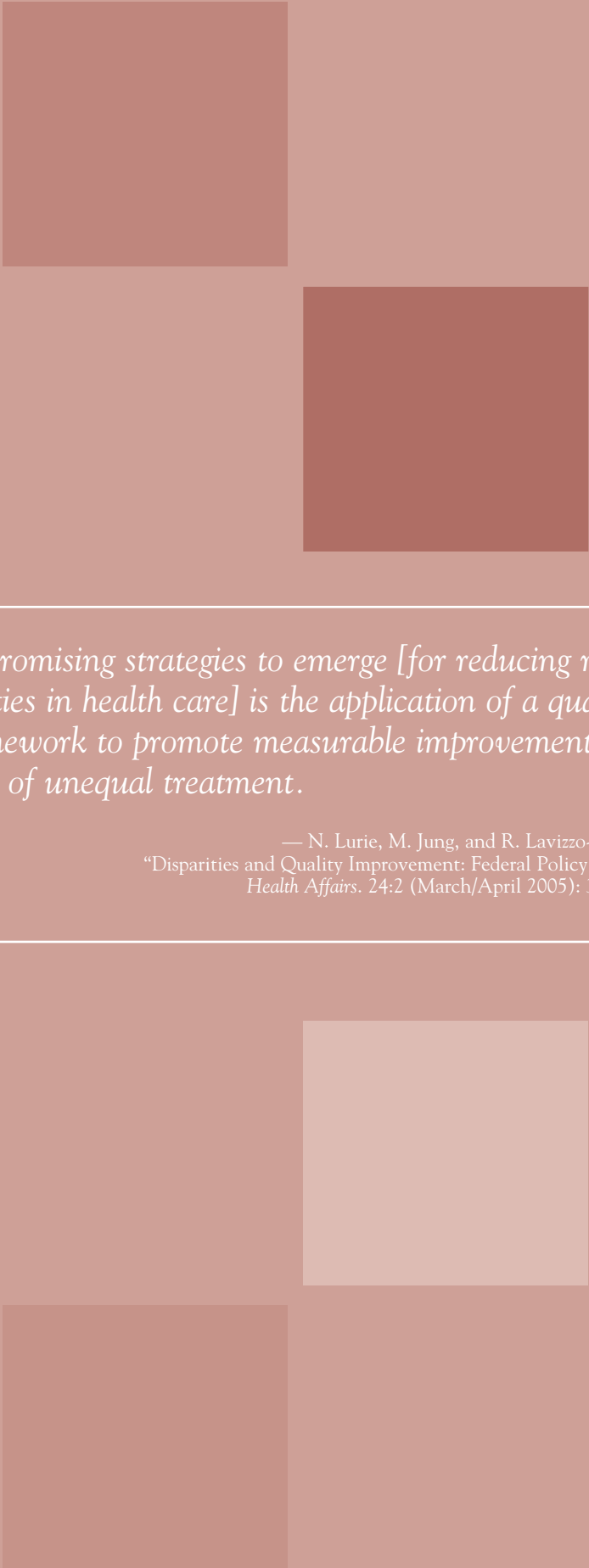
ADDRESSING DISPARITIES THROUGH QUALITY IMPROVEMENT IN MEDICAID MANAGED CARE



As the nation moves from merely documenting racial and ethnic disparities in health care to actually addressing these issues, it becomes important to identify the appropriate leverage points for change. Medicaid, especially Medicaid managed care, is an ideal venue for addressing and remediating disparities in care and outcomes. Many racial and ethnic minorities are disproportionately more likely than whites to rely on Medicaid to access the health care system — the program affords coverage to roughly one in five non-elderly Hispanics, African Americans, American Indians and Alaskan Natives, and to about one in 10 non-elderly Asian Americans. Medicaid and its contractors have for some time recognized the importance of the provision of culturally and linguistically appropriate care. Medicaid, by virtue of the eligibility determination process in many states, has ready access to data on the race and ethnicity of its enrollees, which is critical for any quality improvement activity.

This toolkit presents promising approaches and tools for addressing disparities as well as improving the quality of care. The case studies in this document explore the challenges encountered and the lessons learned, in the hope that these experiences will inspire as well as support other health plans in addressing racial and ethnic disparities in care. While these health plans cannot by themselves solve the complex issue of racial and ethnic health care disparities, this toolkit provides the evidence that managed care plans can be an important part of the strategy.

Rhonda Johnson, MD, MPH
Medical Director, Integrated Clinical Services, Highmark, Inc.



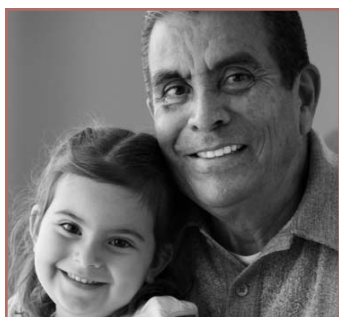
One of the most promising strategies to emerge [for reducing racial and ethnic disparities in health care] is the application of a quality improvement framework to promote measurable improvement on persistent patterns of unequal treatment.

— N. Lurie, M. Jung, and R. Lavizzo-Mourey.
“Disparities and Quality Improvement: Federal Policy Levers.”
Health Affairs. 24:2 (March/April 2005): 354-364.

Introduction: Closing the Gap and Improving Health Quality for All

Members of racial and ethnic subgroups encounter more barriers to care, greater incidence of chronic disease, lower quality of care, and higher mortality than white Americans. Racially and ethnically diverse Americans are less likely than whites to receive most kinds of care, including evidence-based practices like blood lipid monitoring and annual eye testing among diabetics. They receive fewer diagnostic tests and treatments for cancer and have less access to state-of-the-art treatment for HIV.¹ Black children are about three times more likely than white children to be hospitalized for asthma,² and diabetes rates are more than 30% higher among Native Americans and Hispanics than among whites.³

As many as half of Medicaid's 52 million beneficiaries are members of racial and ethnic minority subgroups and over 60% of all beneficiaries are enrolled in managed care.^{4,5} By virtue of the diverse populations enrolled, Medicaid health plans are uniquely positioned to identify and address disparities in health care utilization and outcomes.



This toolkit details the experiences of a collaborative workgroup of Medicaid managed care organizations, *Improving Health Care Quality for Racially and Ethnically Diverse Populations*, which was designed by the Center for Health Care Strategies (CHCS). This workgroup, supported by the Robert Wood Johnson Foundation and the Commonwealth Fund, included 11 Medicaid health plans and one state primary care case management program. The 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, and to explore ways to improve health care quality.

The workgroup members designed innovative strategies to uncover and address disparities in three targeted areas: birth outcomes and immunizations, asthma care, and diabetes care. Ultimately, the workgroup members were joined by a common belief — that improving the care of racially and ethnically diverse Medicaid enrollees can drive important advances in quality of care for all Medicaid participants.

¹ Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Institute of Medicine, 2002.

² *National Healthcare Disparities Report*, 2004.

³ Addressing Racial and Ethnic Health Care Disparities: Where do we go from here? Institute of Medicine, http://www.iom.edu/Object.File/Master/33/249/BROCHURE_disparities.pdf. Accessed June 27, 2006.

⁴ Centers for Medicare and Medicaid Services, "Fiscal Year 2003 National MSIS Tables," <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MSISTables2003.pdf>

⁵ Ibid.

How this Toolkit is Organized

Managed care organizations and state agencies can use this toolkit to spur new quality improvement approaches to address disparities. The first section discusses lessons from the workgroup in three key areas:

- Using data to identify and stratify health care disparities;
- Developing patient-centered approaches to care; and
- Collaborating with key stakeholders to reduce disparities.

Case studies detailing the successes and obstacles faced by health plans in the workgroup comprise the bulk of the toolkit. The health plans used the Best Clinical and Administrative Practices (BCAP®) Quality Framework, a continuous quality improvement approach developed by CHCS, to identify, stratify, and address disparities to improve birth outcomes, child immunizations, asthma management, and diabetes care.⁶ The resource section of the toolkit lists sample tools (available online) created by the participants to help managed care organizations develop effective approaches to reducing disparities in care.

Improving Health Care Quality for Racially and Ethnically Diverse Populations Workgroup		
Health Plan/PCCM	State	Participants
Blue Cross of California	California	Rose Taylor Calhoun, RN* Margot Lisa Miglins, PhD David Moroney, MD Thi T. Montalvo, MHA
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UPMC for You	Pennsylvania	Michael J. Culyba, MD Terri L. Rosen*

* No longer with the health plan.

⁶ For more information about the Best Clinical and Administrative Practices (BCAP®) quality improvement methodology, including case studies, resources, and toolkits, visit www.chcs.org.

Key Lessons in Addressing Disparities



Collecting and Analyzing Data

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.⁷ Successful efforts at the federal, state, health plan, or provider level to reduce and eliminate these disparities depend largely on the availability of reliable data.

Data Collection

While there are a number of ways that Medicaid managed care plans can ascertain the race and ethnicity of enrollees, data collection and analysis aimed at racial and ethnic populations generally fall into one of two categories:

- Data obtained indirectly either from external sources such as the state; or
- Data obtained directly from enrollees.

Collecting Racial and Ethnic Data from External Sources

Medicaid plans routinely obtain racial and ethnic data about beneficiaries from state Medicaid agencies. Since 2003, the Centers for Medicare and Medicaid Services (CMS) has required Medicaid programs to make racial and ethnic data available to plans to support quality improvement activities related to disparities, or to develop culturally and linguistically appropriate services. Because CMS does not specify uniform data collection in terms of race, ethnicity, primary language, or country of origin, the extent to which data in eligibility files is accurate, and whether it is transferred to plans, varies greatly from state to state.

Most Medicaid agencies collect data on race and ethnicity through eligibility and enrollment processes, and obtain additional information from claims and payment data, beneficiary satisfaction and complaint data, clinical data from medical record reviews, service authorization data, and provider-related data. The majority of states collect self-reported data on race and ethnicity from beneficiaries on a voluntary basis. Missing and incomplete data are a common result. Plans using state records as a primary collection method need to be wary of the validity of the data and the percent of the population that is categorized as “other.” Another operational problem is the monthly tape from the state, which usually overwrites current identifiers at the health plan even when the health plan’s data are more accurate.

Other external sources of race and ethnicity data include vital statistics and birth records, which have long been used to collect information such as the socioeconomic status of parents (in birth records) or ancestors (in death certificates) and can be used to make inferences. For example, SoonerCare, Oklahoma’s Medicaid managed care program, is working with multiple state agencies including the Department of Health, the Department of Human Services, and the Department of Mental Health, to develop a multi-system-linked database that includes vital statistics and other external data resources. The accuracy of this type of data should be verified by comparing it and testing it against other data sources.

⁷ N. Lurie et al. “Disparities and Quality Improvement: Federal Policy Levers.” *Health Affairs*. 24:2 (March/April 2005): 354-364.

Check One: Black, White, Hispanic, or None of the Above?

Unfortunately, there are no uniform standards for collecting data on race and ethnicity. Some organizations ask for three categories while others use up to 16. Ideally, categories should reflect the race, ethnicity, and primary language of the groups within the plan's covered population, and also recognize multiple racial or ethnic backgrounds. To make comparisons between states or service areas, plans can include the major US Census categories — White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Hispanic or Latino, and Not Hispanic or Latino — in addition to any relevant subcategories. Plans that rely on Medicaid agencies as their primary sources of information on race and ethnicity are affected by the state's sophistication in categorizing data. Despite a 1997 Office of Management and Budget directive requiring federal agencies to use a minimum of five racial and two ethnic categories, state data collection practices vary considerably, and range from a few basic racial categories to a broad array of specific racial, ethnic, and language subgroups.

Seeking Information from Enrollees

Plans most often collect racial and ethnic data directly from enrollees. In general, self-reported data are preferred since they are more accurate than when race and ethnicity are assigned by the state or the enrollment broker. Many Medicaid managed care plans collect race, ethnicity and primary-language information directly from members through their outreach and enrollment processes; some also collect data through enrollee satisfaction surveys. The Consumer Assessment of Health Plans Study (CAHPS), a standardized survey instrument designed by the Agency for Healthcare Research and Quality and the National Committee for Quality Assurance, contains questions about race and ethnicity, and is frequently used by Medicaid managed care plans to measure disparities. Molina Healthcare of Michigan, a Medicaid managed care plan, is collaborating with the Michigan Department of Community Health to merge claims and CAHPS data as an initial step in addressing lower rates of childhood immunization among African Americans than among whites.

Challenges and Barriers to Collecting and Using Data

There are a number of challenges and barriers to the collection and use of data on race and ethnicity to address health disparities. The accuracy of the data is generally the most significant problem. While self-reporting might produce more accurate results than assignment, it is usually voluntary, and the data are often sparse. While data on race and ethnicity can be assigned, assignment is subjective, and based on indicators such as surname, geographic location, or physical appearance, which can result in inaccuracies. Subjective assignment of multi-race or multi-ethnicity can also skew results and conclusions.



Another barrier to the collection and use of data on race and ethnicity in Medicaid programs is the misperception that the collection of such data is either illegal or objectionable to consumers and managed care organizations' (MCO) staff.⁸ In fact, there are no federal statutes prohibiting the collection of these data. Title VI of the Civil Rights Act of 1964, which prohibits intentional discrimination on the basis of race or national origin in the provision of services supported by federal funds, is considered the broadest mandate the federal government has to *require* collection and reporting of data on race and ethnicity.⁹ The majority of states place no restrictions on data collection. Of the four states that have established restrictions – California, Maryland, New Hampshire, and New Jersey — none have done so across the board. Instead, these states have prohibited the collection of data on race and ethnicity in certain contracts, generally dependent upon when the data are collected, as opposed to whether they are collected at all.¹⁰ Reluctance to collect racial and ethnic data could also stem from the erroneous belief that people object to being categorized in these terms. According to a Robert Wood Johnson Foundation poll, when they were told that the information would be used to improve the quality of their health care, respondents were significantly more likely to support these types of data collection.¹¹

Using Data to Reduce Health Disparities

Medicaid managed care plans use racial and ethnic data in a variety of ways to address health care quality. Plans can use data on race and ethnicity 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. More general uses of data on race and ethnicity to reduce health care disparities include program planning and priority setting, achieving more nuanced understanding of the health needs of specific populations, assigning appropriate primary care physicians, determining translation and interpretation needs, and identifying and explaining performance differences among plans or within plans.

⁸ S. Rosenbaum et al, "The Legality of Collecting and Disclosing Patient Race and Ethnicity Data." The George Washington University School of Public Health and Health Services, June 2006.

⁹ R.T. Perot and M. Youdelman, "Racial, Ethnic, and Primary Language Data Collection in the Health Care System: an Assessment of Federal Policies and Practices," *The Commonwealth Fund*, September 2001, www.cmf.org/usr_doc/perot_raceethnic_492.pdf.

¹⁰ E. Berry et al, "Assessment of State Laws, Regulations, and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans," American Association of Health Plans Annual Meeting, April 2001.

¹¹ R. Lavizzo-Mourey and M. Jung, "Improving the Quality of Health Care for All Americans," *Grantmakers In Health (GIH)*, May 16, 2005, www.gih.org/usr_doc/Views5-16-05.pdf.

Unique Data Issues for Commercial Health Plans

Health plans wanting to reduce health care disparities for their Medicaid populations can often receive race, ethnicity, and sometimes language information from their Medicaid agencies. Health plans focusing on disparities among their commercial and Medicare members, however, usually need to use indirect methods to gather race and ethnicity data.

Geocoding and surname analysis are the most prevalent approaches used by health plans. Geocoding allows analysts to approximate the likelihood of a member's race or ethnic background based on the member's residence. This technique is used primarily to identify enrollees who are likely to be African American. Surname analysis is used to identify persons of Hispanic or 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 belonging to someone from the specified racial or ethnic group. These techniques, matched with Health Plan Employer Data and Information Set (HEDIS) or other quality metrics, can be powerful tools for identifying disparities and targeting quality improvement efforts.¹²

Although neither of these indirect methods provides precise information on an individual's race or ethnicity, they can provide an accurate estimate of the racial/ethnic differences in quality when analyzed at the population or group level. It is encouraging that some commercial health plans are now collecting direct race and ethnicity data from their members. Aetna has been a leader in this area, with the development of a web portal in which members can provide the health plan with information on a voluntary basis. The health plan has collected race and ethnicity data on more than two million members through this online data collection tool. As a member of the National Health Plan Collaborative, Aetna is working with the nation's leading health insurers to develop recommendations on the collection and standardization of direct race and ethnicity data. Establishing national standards to guide other health plans in collecting direct race and ethnicity data will be a substantial move forward for the entire industry.

Using Data to Target Interventions

Managed care organizations were selected to participate in the *Improving Health Care Quality for Racially and Ethnically Diverse Populations* workgroup based on their demonstrated capacity to match race and ethnicity data to quality targets and to use this information to stratify membership. Most organizations received these data from their state Medicaid agencies. Several participating health plans implemented strategies aimed at improving the completeness and accuracy of data by creating health risks assessments that captured this information, as well as working closely with physicians, health clinics, and community-based organizations. Some organizations used data to identify disparities in care and to pinpoint the focus of their quality improvement pilots. The majority of participants based their pilots on improving a particular indicator, such as the number of Hispanic members with diabetes receiving eye exams. Plans also stratified providers for a particular target group of members by looking at performance on similar HEDIS metrics. The following examples detail how two plans stratified and focused their pilot initiatives:

¹² A. Fremont et al, "Use of Geocoding in Managed Care Settings to Identify Quality Disparities." *Health Affairs*. 24:2 (2005): 516-526.

Healthfirst

Healthfirst, a Medicaid plan based in New York, sought to increase its HEDIS rates for HbA1c testing, eye exams, LDL-C screening and nephropathy monitoring among African American and Hispanic members with diabetes. The plan's goal was to reach the National Committee on Quality Assurance (NCQA) 75th percentile for this set of comprehensive diabetes measures. Healthfirst used a four-step process to identify the target population:

1. Using HEDIS 2005 technical specifications, Healthfirst identified 5,563 members who were eligible for the comprehensive diabetes measure.
2. The list of members who were eligible for the comprehensive diabetes measure was sent to the New York State Bureau of Quality Management and Outcomes Research to obtain information on enrollees' race and ethnicity.
3. Upon receiving information on race and ethnicity, Healthfirst identified the target population of 3,043 African American and Hispanic members eligible for the comprehensive diabetes measure.
4. An analysis of the target population was used to identify the 1,369 primary care providers providing care to the targeted members, and to determine which members were not receiving care according to the comprehensive diabetes measure guideline.

Helix Family Choice

Since Maryland does not supply data on race and ethnicity to all Maryland Medicaid plans, Helix Family Care worked closely with the state to obtain the data it needed. Since January 2005, Helix has received electronic files that include ethnicity information for newly enrolled members from the state on a weekly basis. This file is separate from the standard eligibility file. Modifications were made to allow Helix to identify new members who were pregnant and members who changed their enrollment category to one associated with pregnancy. The state file has consistently contained less than 5% "unknown" race and ethnicity information.

CHCS Disparity Index: A Tool to Measure the Gap

Disparity is the quantity that separates a group from a reference point on a particular measure of health that is expressed in terms of a rate, proportion, mean, or some other quantitative measure.

— Healthy People 2010¹³

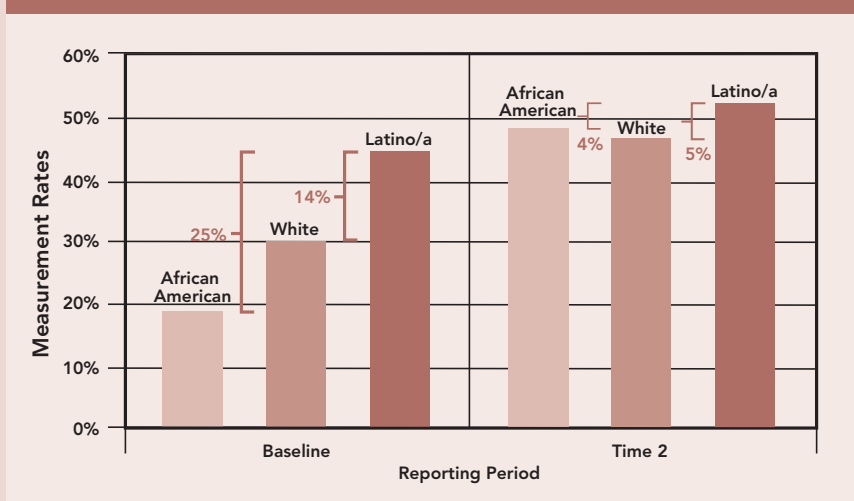
Working with the participants in the *Improving Health Care Quality for Racially and Ethnically Diverse Population* workgroup, CHCS developed a new tool to measure health care disparities within Medicaid populations. While many health plans use member surveys to assess disparities in care and guide quality improvement activities, plans' efforts are rarely focused on reducing disparities across the health plan. Standardizing disparity and related quality-of-care measures would give managed care plans, states, and physicians a clearer picture of how well organizations are doing in reducing disparities and improving quality. Standardization would also help pinpoint where initiatives are having a positive impact on all ethnic groups, as well as improving the quality of care within specific clinical areas.

How does the Disparity Index work?

The Disparity Index identifies the average disparity in the quality of care experienced by members of racial and ethnic minority groups within the health plan membership. The index combines measures of disparity across several clinical measures; it is not specific to any one clinical condition. If calculated on a regular basis, the index can indicate whether disparities in quality are decreasing, increasing, or remaining constant in the plan's population.

Disparity Index measures are self-defined by the organization using the tool. Improvements in quality are assessed by variance from an established quality benchmark rate (e.g., HEDIS) for each measure. The index, which uses measures based on either HEDIS or Healthy People 2010 objectives, consists of three or more clinical measures in one clinical area or topic (e.g., diabetes, asthma, child health) and allows comparison to a national quality benchmark. The index 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 the Medicaid HEDIS 75th percentile (Figure 1). 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.

Figure 1. Disparity in Annual HbA1c Test Rates for Persons With Diabetes



Testing the Disparity Index within Medicaid Health Plans

To date, the 12 organizations in the workgroup have submitted baseline Disparity Index data on nine HEDIS measures in four clinical areas: adolescent immunization status, asthma care, diabetes care, and prenatal care. The Disparity Index has considerable potential as a tool to measure both disparities and quality of care, and to help health plans and states target clinical quality improvement programs for specific subgroups of their populations.

¹³ K. G. Keppel, J. N. Pearcy and R.J. Klein, "Measuring Progress in Healthy People 2010" *Healthy People 2010 Statistical Notes*, no. 25, September 2005, <http://www.cdc.gov/nchs/data/statnt/statnt25>.



Designing Patient-Centered and Culturally-Sensitive Care

Designing health care services to meet the individual and cultural needs of plan enrollees can vastly improve the quality of care. Engaging members in self-management regimens is critical to quality improvement. Health plans have opportunities to potentially improve quality by designing member materials to reach diverse audiences, promoting cultural competency among providers and their staffs, and encouraging best practices through incentives. Case management and member education programs are other approaches to providing appropriate services to members most in need.

The plans participating in the workgroup on *Improving Health Care Quality for Racially and Ethnically Diverse Populations* tested patient-centered care approaches aimed at meeting the needs of specific populations. Strategies included:

- 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 appropriate health education materials.

Several participants in the workgroup implemented successful patient-centered care projects. New York's Monroe Plan for Medical Care built on the success of its Healthy Beginnings Program, which engages the local BabyLove program to provide outreach to high-risk pregnant teens. The program added an outreach worker to manage up to 30 pregnant African American teens under age 18 throughout their pregnancies and for their infants' first six months of life. The outreach worker was an African American woman who had herself become a mother while in her teens. With her encouragement and support, these teens were more likely to keep their prenatal care appointments and to deliver healthier infants.

Consumer Experience – Monroe Plan for Medical Care

Sixteen-year-old Tiffany was referred to the Baby Love program by the social worker at her prenatal care provider's office for assistance with school, transportation, and supportive home visits. At the time she was enrolled, Tiffany was not attending school. With the help of her outreach worker Tiffany enrolled in the Young Mother's Program, an alternative school for pregnant teens. Tiffany began attending school regularly, and excelled academically. Baby Love helped Tiffany gather infant supplies and a bed for herself. When Tiffany's family was seeking a new place to live, her outreach worker identified an apartment. With the help of transportation from her outreach worker, Tiffany received regular prenatal care. She delivered a full-term, healthy son in August 2005. Tiffany breastfed her baby and kept all pediatric check-up appointments in the first year. She returned to school in the fall of 2005 and continues to live with her mother.

HealthFirst, also in New York, sought to improve physician-patient relationships by assigning “culturally congruent” provider representatives to the primary care providers (PCPs) 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. A post-survey of providers revealed improved physician satisfaction.

Neighborhood Health Plan of Rhode Island implemented the Teach with Stories program, which was aimed at improving health-seeking behavior among pregnant Hispanic women. The health plan partnered with Providence Community Health Center to produce a series of informal interactive group education sessions using photo novellas.

Member Experience – Neighborhood Health Plan of Rhode Island

During a July 2005 session, the photo novel being discussed was *1st Week Home with Baby*. This discussion focused on depression, anxiety, and the stress of having a new baby at home. One participant, who was six months pregnant, identified with many of the issues that were discussed during this session. She did not feel comfortable discussing her feelings in an open forum, but contacted the facilitator two days later. The participant explained that she was experiencing a lot of stress, depression, that she had trouble sleeping and had suicidal thoughts.

The facilitator asked for permission to contact Beacon Health Strategies (behavioral health partners for NHPRI members) to arrange an immediate intervention. The facilitator contacted Beacon and served as an interpreter during the initial screening interview. Beacon assessed the patient and immediately contacted Rhode Island Hospital and arranged for the patient to be transported to the hospital by taxi. Beacon personnel and the facilitator stayed on the line with the member until her cab arrived.

The member was treated at the hospital and released. As she spoke limited English, the member took the photo novella with her to the hospital to help her explain what she was experiencing. She was prescribed appropriate medication. A family therapist from Beacon met with the member at her home, and enrolled her in the Day Program at Women and Infants Hospital.

Encouraging Collaboration to Reduce Disparities

Health plans in the workgroup that went beyond their own corporate confines to build creative relationships in their communities were able to reach members more effectively. Among the plans that used collaboration were UPMC for You in Pittsburgh, Pennsylvania, which worked with school districts, hospitals, and community-based organizations; Medica, which teamed with the American Lung Association of Minnesota; and Blue Cross of California, which partnered with local pharmacies.

Through a partnership with local hospitals and community leaders, UPMC for You increased the number of women entering prenatal care in the first trimester of pregnancy and improved birth outcomes. Through the collaborative program, the health plan moved from primarily telephone outreach for pregnant members to using a community-based health plan representative. 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. UPMC for You achieved a steady improvement in first-trimester identification though 2005 for the pilot's target population.

The American Lung Association of Minnesota (ALAMN) helped Medica clinics identify disparities in pediatric asthma care, and also helped clinics comply with the Lung Association's Asthma Clinics Systems Change program and practice guidelines. In addition to helping generate accurate race and ethnicity data, ALAMN:

- Documented whether there was an asthma action plan in the patient's medical record;
- Tracked asthma education sessions conducted by certified asthma educators; and
- Tracked the patients with asthma who were seen in the participating clinics.

This pilot was implemented in four high-volume practice sites serving African American members aged five to nine who had persistent asthma. ALAMN's monthly data showed that implementation of the Asthma Clinic Systems Change Program had a positive effect on the severity ratings for African American children with asthma who were seen in the clinics, as well as the percent of children with asthma who were treated with anti-inflammatory medications, had up-to-date asthma action plans in their medical records, and were treated with spirometry.

Blue Cross of California collaborated with community pharmacies to help patients manage their asthma more effectively. The plan's Asthma Pharmacy Consultation Program (APCP) provides point-of-service prompting and reimbursement for asthma pharmacy consultation through a computerized pharmacy data entry and claims system. The information focuses on the importance of creating and using a personalized asthma management plan with the help of the member's physician. The pharmacists also remind patients how to minimize the risk of an asthma attack by reducing or eliminating exposure to indoor and outdoor environmental asthma triggers. APCP gives members the opportunity to ask the pharmacist questions about asthma and medications that they might be reluctant to ask their physicians. Through this community-based intervention, the asthma pharmacy consultation rate for African American members at the eight targeted non-chain pharmacies rose from 0% to 15% from 2004 to 2006. HEDIS rates for appropriate use of controller medication also rose during this time period from 68.6% to 84.6% for African Americans. These rates also increased in similar fashion for Hispanics and whites.

Blue Cross found that the rate of these pharmacy consultations was lower for African American members than other ethnic groups. The plan also found that African American members who received pharmacy consultations demonstrated the greatest increase in controller medication use. Delving deeper into administrative data on pharmacy consultations, Blue Cross identified eight pharmacies with a high incidence of "missed opportunities" to educate African American members with asthma. The plan targeted these pharmacies for face-to-face outreach and within a short amount of time increased the number of pharmacy consultations from 0% to 15%.

Future Directions

There are ample opportunities within Medicaid managed care to guide quality improvement efforts that address disparities in care. Critical factors in the success of quality improvement interventions include well-designed, culturally-competent approaches and creative partnerships with community stakeholders. Above all, these activities rely on ready access to reliable data, which depends on the commitment, participation, and collaboration of state Medicaid agencies and managed care organizations to support health plans in four key initiatives:

- Obtaining information on the race and ethnicity of enrollees, either directly or indirectly through the enrollment process and/or state Medicaid agencies;
- Using data to generate reports stratified by race and ethnicity to identify disparities;
- Incorporating a focus on health care disparities into existing quality improvement projects; and
- Organizing additional quality improvement or other projects specifically designed to reduce or eliminate disparities in health care.

CHCS efforts to promote continuous quality improvement, through Best Clinical and Administrative Practices (BCAP) and other, similar, approaches are all guided by the recognition that a managed care organization — whether not-for-profit or for-profit — is a business. Recognizing, and documenting, the value of targeted investments in prevention, outreach, cultural competency, and primary care are essential to gaining corporate buy-in for quality improvement efforts. The first critical steps for establishing a business case for a quality improvement activity are to identify a target population, for instance of Hispanics at risk for diabetes, and to stratify within the targeted population to identify those at the highest risk of exacerbation of disease and use of high-cost services. Once a managed care organization has taken these steps, it can test the cost effectiveness of targeted outreach and interventions. The 12 participants in this disparities collaborative have all made significant progress in using data to identify and stratify the health risks of racially and ethnically diverse members and targeting their investments to improve care.

The richly diverse mix of Americans served through publicly financed care will undoubtedly grow even more diverse in the next few decades. By determining methods that can consistently identify gaps in care, and by documenting the value of targeted quality improvement efforts to close these gaps, the 12 health plans in this toolkit — and others across the country — can make the case for undertaking comprehensive efforts to reduce disparities in care.

Case Studies in Identifying and Reducing Disparities



The 12 managed care organizations that participated in the *Improving Health Care Quality for Racially and Ethnically Diverse Populations* workgroup focused their efforts to reduce disparities on improving birth outcomes and immunizations, improving asthma care, and improving diabetes care. Following are brief case studies that summarize what these plans were able to accomplish, as well as some roadblocks that they encountered.

IMPROVING BIRTH OUTCOMES AND IMMUNIZATIONS

Although birth outcomes and rates of immunization have steadily improved in the United States over the past several decades, racial and ethnic variations persist. African Americans and other minority populations are at two to three times greater risk for poor pregnancy outcomes, compared to white Americans. For instance, the prevalence of low birth weight among African Americans (13.1%) is more than double that of whites (6.4%), and of Hispanics (6.5%).¹⁴ Similarly, in the first few years of life, children in minority subgroups are more likely to miss recommended preventive care. One out of four African American children aged 19-35 months did not receive recommended vaccinations in 1999.

A subset of the health plans in the workgroup sought to improve birth outcomes for Hispanic and African American pregnant women. Molina Healthcare worked with both plan members and the local health department to improve rates of child and adolescent immunizations.

¹⁴ Child Health USA 2003. US Department of Health and Human Services. Health Research and Services Administration. Health Status of Infants Fact Sheet.



Monroe Plan for Medical Care Healthy Beginnings for African American Pregnant Teens

Monroe Plan for Medical Care Inc. is a physician-organized and -governed non-profit health management organization with more than 4,000 providers. Monroe, in partnership with Excellus BlueCross BlueShield, provides health care services to more than 94,000 Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries in seven counties surrounding Rochester, New York.

The Monroe Plan set a goal of addressing high neonatal intensive care unit (NICU) utilization and low prenatal care rates among African American pregnant teenagers and their babies. Through its Healthy Beginnings Program, the Monroe Plan demonstrated significant improvements in prenatal care. NICU admission rates decreased from 108 per 1,000 births in 1998 to 35 per 1,000 births in 2004. Despite these overall improvements, rates of NICU use for babies of African American teens remained higher than rates for babies of white teens. Monroe sought to reduce the gap in NICU admission rates between these two groups by at least 50%.

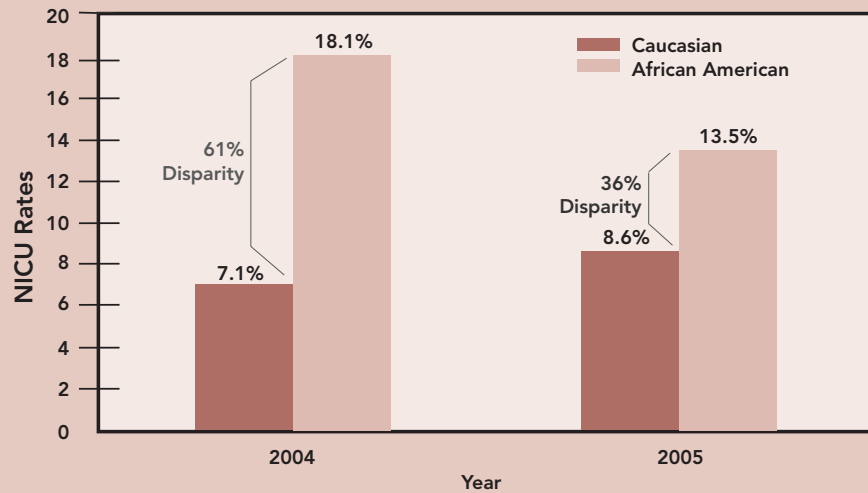
Program

Healthy Beginnings provides outreach to high-risk pregnant women in the Monroe Plan. To improve birth outcomes for babies of African American teens, Monroe Plan hired one additional outreach worker and one part-time social worker to manage up to 30 pregnant African American teenagers under age 18 through their pregnancies and during the postpartum period, until their infants reached six months. By January 2006, 38 African American teens were enrolled in the program (exceeding the initial target of 30). All program participants stayed in the program. The outreach worker was an African American woman who had been a teen mother herself. She was able to have a significant influence on the teens because of her background and similar life experiences. This targeted outreach provided high-risk teen mothers with education and support, particularly related to family planning and preventive health. The program also offered home visits, facilitation of transportation to services (either by arrangement or direct transport), and opportunities for health education.

Results

Since implementing this outreach effort in 2005, the Monroe Plan has documented a decrease in NICU admission rates for the babies of the targeted population. The initial goal was to decrease the difference in NICU admission rates between African American and white teenagers by at least 50%. The intervention contributed to a decrease from 11% to 4.9% in the disparity between rates of NICU admissions among babies of African American teen mothers and babies of white teen mothers in 2005 (Figure 2). A portion of the decrease in the disparity was attributable to an increase in NICU admissions among babies of white teenagers.

Figure 2. 2004-2005 Monroe Plan NICU Admission Rates, by Race



SOURCE: Monroe Plan

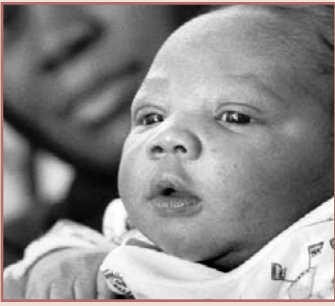
Lessons

Key lessons from this project are:

- Programs targeted at an ethnic or racial subgroup must be culturally competent. Monroe's outreach workers were from the same community and shared many of the same experiences as the pregnant teens with whom they were working. This commonality enhanced the probability of the program's success.
- Earning the trust and respect of teenagers is critical. Monroe made a concerted effort to help each teen feel respected and valued. When their trust was earned, these young women were more likely to seek help to comply with recommended prenatal visits and preventive care.
- Family planning is an important issue that needs to be addressed and should be a component of interventions aimed at pregnant teens.

Sustainability

The Monroe Plan earmarked \$75,000 annually for the pilot program, resources that came from the New York State Department of Health's Quality Incentive Program. Based on its performance against New York State's award criteria, the Monroe Plan received the maximum allowable award of a 3% additional premium, which during 2005-2006 amounted to over \$3 million. The Monroe Plan's experience with its Healthy Beginnings Program demonstrated a positive financial return on investment. Through 2004, each dollar spent on the program returned \$2.86, making a strong business case for the continuation of the program.



Helix Family Choice ***Addressing Critical Outcomes for African American Newborns in Maryland***

Helix Family Choice serves 22,000 Medicaid enrollees in Baltimore, Maryland. Helix set an overall goal of improving prenatal care for its African American members, measured by the percent of newborns with complex medical problems, NICU admission, NICU length of stay, and low birth weight. The plan had not previously had access to information on members' race or ethnicity. Through participation in the workgroup, Helix worked with the state of Maryland to obtain electronic files including race and ethnicity data for newly enrolled members, updated weekly.

Based on its HEDIS 2004 data, Helix identified a racial disparity between the proportion of African American women who completed more than 80% of the recommended prenatal and post partum visits and the percent of white women who did so. Recognizing that African American babies in Maryland are at greater risk for premature birth and low birth weight, Helix sought to achieve four improvements in outcomes for babies of African American mothers:

- Decrease the percent of “complex” newborns, as defined by HEDIS, by 5%.
- Decrease the average length of stay for complex newborns by two hospital days.
- Decrease the frequency of NICU admissions by 5%.
- Decrease the percent of low birth weight babies by 5%.

Program

As a first step, Helix invited African American mothers to participate in “Momma & Me,” the plan’s prenatal incentive program, which provides \$10 gift certificates for each prenatal visit, for each educational class attended, for each dental visit, and for infants’ first well-child visits. Educational materials were mailed to each member when she entered the program and when her baby was delivered.

Helix sought to identify African American women as early as possible during pregnancy and enroll them in the incentive program. A “Momma & Me” educational flyer was developed to highlight birth-outcome disparities between African Americans and white women. These flyers, which included information about available transportation to prenatal visits, were sent to pregnant African American women.

Results

Helix increased the percent of pregnant African American women who completed more than 80% of the recommended prenatal visits, but did not reach the goal of 75%. Moreover, while the African American prenatal visit rate increased from 59.3% in 2004 to 69.1% in 2006, the white prenatal visit rate increased from 74.3% to 87.6% in the same time period, widening the gap.

Table 1: HEDIS Frequency of Prenatal Visits >80% by Race

	2004	2005	2006
Overall	68%	70%	81%
African American	59%	67%	69%
White	74%	71%	88%
Disparity	15%	14%	19%

Helix intends to continue to focus attention on the disparities within its membership. The intervention was not in full effect until the second quarter of calendar year 2005 and so the data do not reflect the complete impact of the program. For example, African American women who were enrolled in “Momma & Me” in November or December of 2005 might not have delivered their babies until the latter half of 2006.

Sustainability

The process of identifying pregnant members’ race and ethnicity through state-supplied enrollment data was incorporated into Helix’s routine procedures. The plan also identified the need to address racial and ethnic health care disparities as a priority in its quality plan for 2006. Moreover, MedStar Health, the integrated delivery system to which Helix belongs, instituted a system-wide commitment to collecting data on race and ethnicity data in order to focus activities on reducing disparities.

UPMC for You

A Community Effort to Improve Birth Outcomes

UPMC for You, a network-model health maintenance organization, had 98,651 Medicaid enrollees in 2004, 25% of whom were African American. The network, an affiliate of the UPMC Health Plan, covered 18 counties in western Pennsylvania. In the 11 ZIP codes comprising UPMC Braddock Hospital's primary service area, almost 28% of UPMC's members are Medicaid enrollees and 59% are African Americans. UPMC for You members had a low birth weight of 12%. In the UPMC Braddock hospital service area, the rate was 19% among African American births.

Program

UPMC set a project goal of decreasing low birth weight rates among African American members residing in the UPMC Braddock service area. To achieve its goal, UPMC created an integrated clinical team that included representatives from the UPMC for You Maternity Program, UPMC Braddock Hospital, Magee-Women's Hospital, area providers, and community agencies. The team intended to identify and have a positive impact on the individual issues leading to poor birth outcomes. The initiative was part of a larger project led by UPMC Braddock Hospital.

In the summer of 2004, UPMC conducted focus groups with Braddock residents to identify gaps, barriers, and opportunities for improvement in prenatal care. Barriers identified included obstetrical offices not submitting the Obstetrical Needs Assessment form, or submitting it late; members seeking care late; women not obtaining coverage early in their pregnancies; women not recognizing that they were pregnant; and a general lack of knowledge about the maternity program. UPMC planned to determine the existing rate of member identification by trimester and race; identify current and potential methods of member identification; identify and meet with key providers in the target communities; identify and meet with key community agencies that might interact with pregnant women; and implement strategies to increase community awareness of the maternity program.

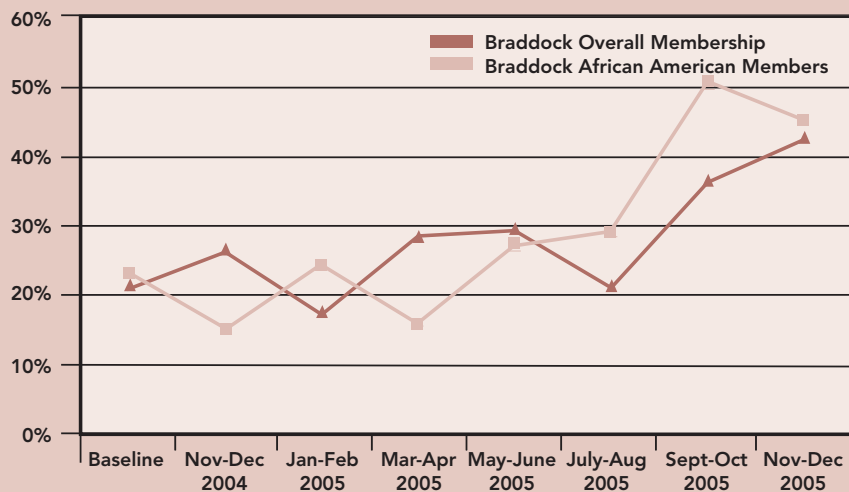
UPMC improved community awareness of the maternity program by using posters throughout the community. A mobile outreach representative was hired to locate women who could not be reached by telephone. In August 2006, the plan introduced the Birth Circle Program, which uses doulas to help improve birth outcomes.

Results

Through its piloted work in the Braddock community, UPMC was successful in identifying women earlier in their pregnancies. The plan reported an increase in first-trimester identification from about 20% at baseline (2004) to more than 40% in 2005 (Figure 3). The plan also reported a decline in low birth weight deliveries for African American women, from more than 20% in 2004 to 0% in 2005, and a decline from more than 20% to about 8% among all women in the Braddock area (Figure 4).

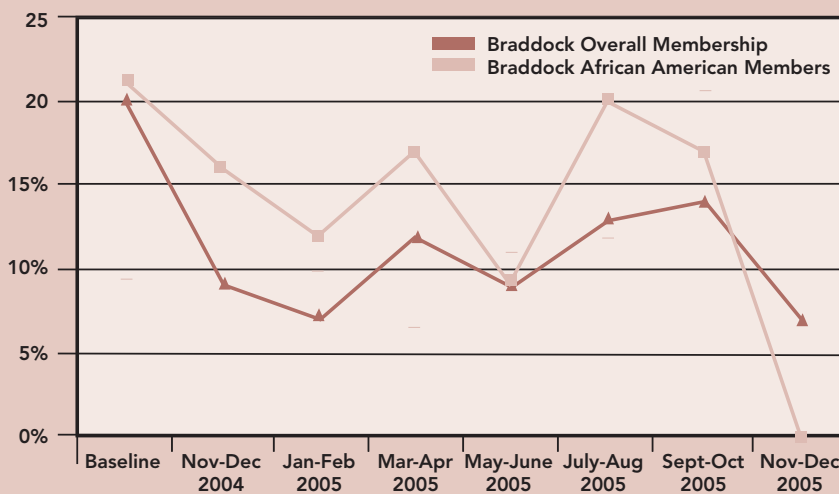


Figure 3. Percent of Pregnant Women Identified During the First Trimester of Pregnancy, 2004-2005



SOURCE: UPMC

Figure 4. Rates of Low Birth Weight Births, 2004-2005



SOURCE: UPMC

Neighborhood Health Plan of Rhode Island Using Stories to Improve Birth Outcomes

Neighborhood Health Plan of Rhode Island (NHPRI) is a nonprofit statewide health maintenance organization. NHPRI had approximately 73,000 members in 2005, primarily enrollees in the state's RItE Care Program, Rhode Island's mandatory Medicaid managed care program. Approximately 25% of NHPRI's membership identified themselves as Hispanic.

Program

NHPRI set a goal of improving pregnant Hispanic women's understanding of their pregnancies, assuming that improved understanding would enable them to navigate more easily through health care services. Teach with Stories, a photo novella approach, was used to provide prenatal education to NHPRI members from Hispanic communities. Teaching with stories, using the *De Madre a Madre* photo novellas, is a unique way to teach prenatal care information. Instead of giving the information to passive listeners, this approach engages participants in a focused discussion, drawing out and weaving in relevant health messages in the process. New information learned in context and connected to what the participants already know is more likely to be understood, remembered, and used by learners than facts disseminated in a pamphlet or a lecture. This is especially true for poor readers and nonreaders. Education was provided in informal settings to generate conversation among group members about their individual experiences.

Results

As of September 2005, 42 of 48 women in the target population (85%) had attended at least one educational intervention class. Preliminary reports showed that women were very receptive to the information provided in the photo novella format and appreciated the personal approach (see story, page 16). The members who received the Teach with Stories intervention had higher rates of optimal prenatal care (receiving more than 81% of expected care) than NHPRI's overall prenatal population (Figure 5). Since Teach with Stories targeted women who were already identified as pregnant, the program did not impact timeliness-of-care measures; the women in the program did, however, have a slightly higher rate of kept post partum appointments (Figure 6).



Figure 5. HEDIS 2006: Frequency of Ongoing Prenatal Care

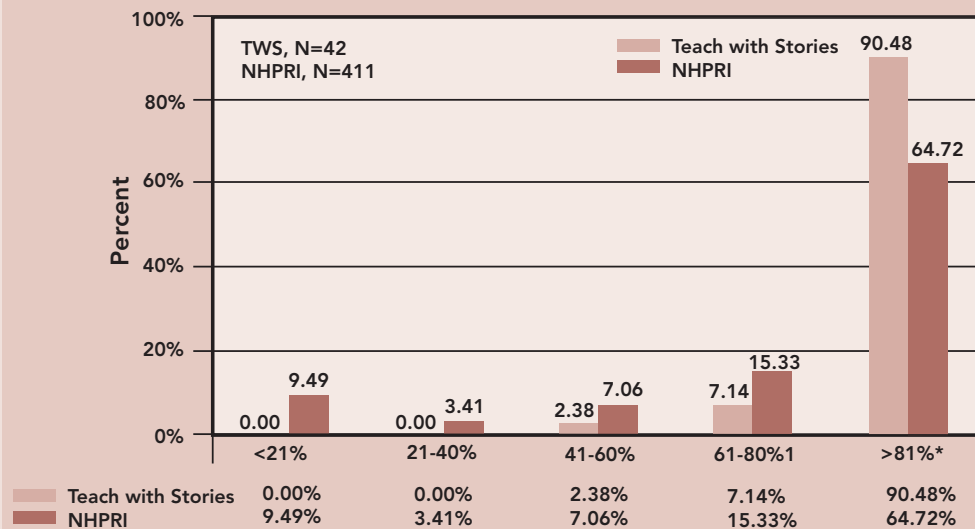
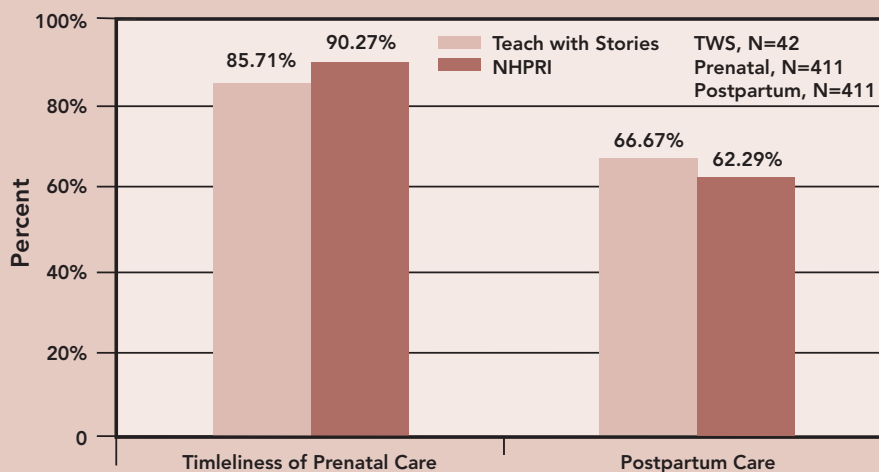


Figure 6. Results for NHPRI's Teach with Stories Program





Molina Healthcare of Michigan ***Shots for Shorties – Increasing Immunizations among African American Children and Adolescents in Michigan***

Molina Healthcare of Michigan is a for-profit Medicaid managed care organization serving more than 150,000 members. Molina's provider network includes community physicians, local rural health clinics, and hospitals throughout Michigan.

Program

Molina reviewed its 2004 HEDIS rates by ethnicity and determined that childhood and adolescent immunizations were the areas of greatest disparity between African Americans and whites. Molina Healthcare used existing race and ethnicity information provided by the Michigan Department of Community Health (MDCH) to identify the high-risk group. The pilot program was implemented in Southeast Michigan because of the large concentration of African American members living in that area. The plan added a field to store the pertinent data in the plan's internal immunization database. Molina Healthcare is now able to determine whether the targeted children have completed their immunization series.

Molina surveyed the parents of children age 12-24 months and 12-13 years who were overdue for immunizations to identify barriers to getting timely immunizations. The surveys revealed that parents were unaware of transportation services; felt immunizations could not be given if the child had a cold or minor illness; felt the immunization might make the child ill; and, in some cases, were not aware of the location of the child's medical provider. In a reminder letter sent to parents, the plan provided easy-to-understand immunization information that included the purpose of each shot and stated that the shots could be given even if the child had a minor illness, such as a cold. The child's medical provider's address and phone number were included in the reminder letter, as well as the transportation phone number to help parents who needed a ride to the provider's office.

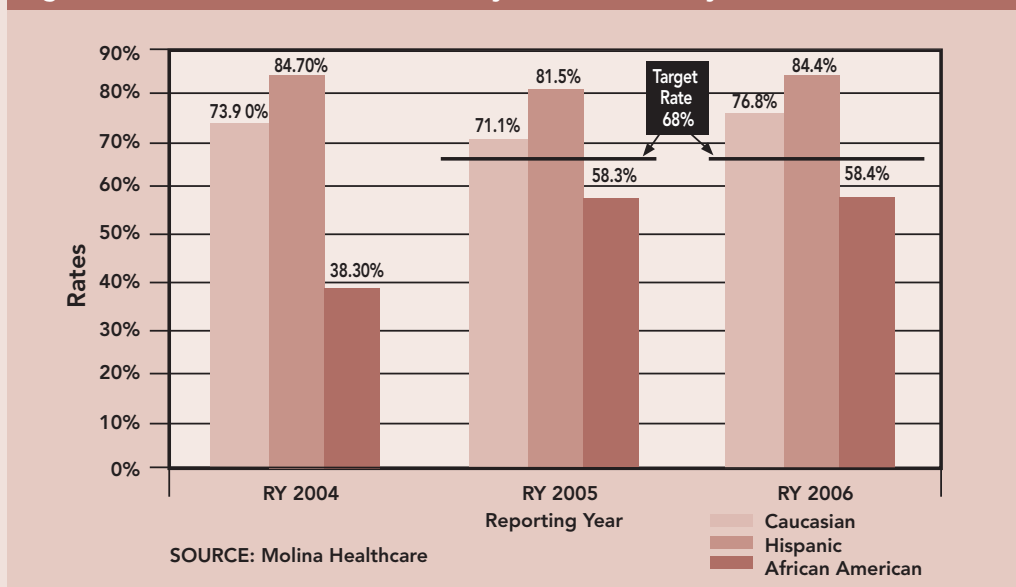
Molina notified the provider sites about children who were due or overdue for immunizations, and encouraged sites to implement a reminder system. The plan also told provider practices about training available through MDCH on managing vaccine inventory, creating patient reminders, monitoring immunization rates, and using an immunization registry to schedule well visits that coincide with immunizations. The plan also provided sites with a toll free number that members could use to arrange for a free ride to their medical appointments.

Molina reviewed the medical records at the pilot provider site and updated the Michigan Care Improvement Registry (MCIR), a state registry managed by MDCH. The practitioners were given reminder cards that were pre-stamped and addressed to the targeted group of toddlers and young adolescents, to help doctors get parents to bring their children in for immunizations.

Results

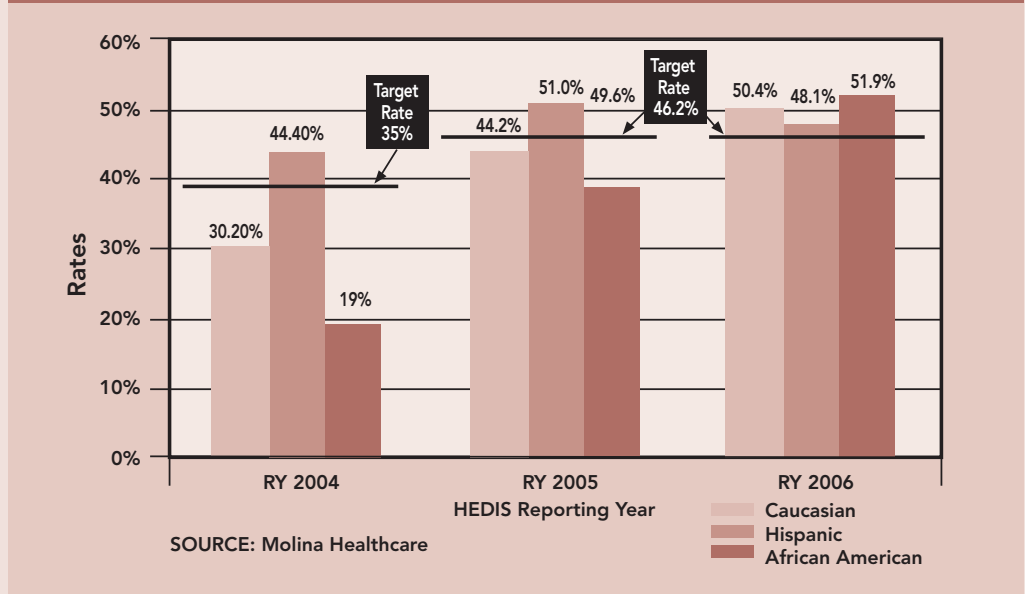
The childhood immunization rate for African American members increased from 38.3% in 2004 to 58.4% in 2006. Despite the increase, the plan has still not reached its goal of 68% and a disparity still exists: Molina’s immunization rate for African American children is below the 76.8% for whites and the 84.4% for Hispanics in 2006 (Figure 7). Nonetheless, the intervention increased the childhood immunization rates in six of the eight pilot sites.

Figure 7. Childhood Immunization Rates by Race and Ethnicity for Pilot Sites, 2004-2006



The 2005 adolescent immunization rate of 49.6% among African Americans was higher than the 44.2% rate among whites, but slightly lower than the 51.0% rate among Hispanic adolescents. Following the pilot program, the adolescent immunization rate of 51.9% among African Americans was higher than the 44.2% rate among whites, and higher than the 48.1% rate among Hispanics, indicating that what the plan perceived as a disparity was actually a data collection problem in which the providers were not recording immunizations properly in the state database (Figure 8).

Figure 8. Adolescent Immunization Rates by Race and Ethnicity, 2004-2006



Lessons

The immunization record assessment identified provider offices that were not consistently entering immunizations into the MCIR. The office staff was given feedback and recommendations for improving documentation. Focus group findings suggested that members recognized the importance of immunization, but did not realize the need to have their children fully immunized by 24 months. Many members were unaware of the free transportation provided to medical appointments, and members were having difficulty scheduling appointments. Some clinics had eliminated week-end hours, making it more difficult to obtain services. Most participants relied on reminders from their providers to make or keep their appointments.

Next Steps

Molina’s next efforts to increase childhood immunization rates will focus on 4,200 children under two and 3,900 12- and 13-year olds, at 120 provider sites in Oakland and Wayne counties. Planned interventions include working with the MCIR and Vaccine for Children staffs, increasing immunization assessments performed by MDCH, offering an incentive if immunizations are complete by the second birthday, and follow-up with members needing only one additional vaccination.



IMPROVING ASTHMA CARE

Racially and ethnically diverse populations have long been identified as having higher prevalence rates of asthma, as well as higher asthma-related rates of hospitalization and emergency department visits. In the United States, asthma prevalence is highest among Puerto Rican Americans (13.1%), followed by Native Americans (9.9%), and non-Hispanic blacks (9.5%). These case studies describe how four health plans addressed asthma care for African American and Hispanic populations. The plans implemented a range of strategies that included partnerships with pharmacists, physician practices, and community-based organizations.



Blue Cross of California State Sponsored Business Improving Asthma Care through Effective Pharmacy Education

Blue Cross of California State Sponsored Business (“Blue Cross”) serves more than one million enrollees in California. Blue Cross designed a Comprehensive Asthma Intervention Program that includes the Asthma Pharmacy Consultation Program (APCP), which provides point-of-service prompting and reimbursement for asthma pharmacy consultation through the computerized pharmacy data entry and claims system.

Program

Blue Cross set a goal of increasing the rate of pharmacy consultations among eligible African American members with asthma from 45% to 52% through targeted pharmacy and member interventions.

APCP, an existing Blue Cross program, provides personalized pharmacy education for members upon receipt of asthma medication. APCP includes information on the importance of creating and using a personalized asthma management plan and information on how to minimize the risk of asthma attacks by reducing or eliminating exposure to indoor and outdoor environmental asthma triggers. An evaluation of APCP in 2003 demonstrated an increase in the overall number of members who received asthma consultations from pharmacists over the pre-APCP baseline. It demonstrated a greater increase in the use of controller medications over time among members who received consultations than among those who did not, with the highest increase found among African American members (Table 3).

Table 3. Percent of Members with Three or More Controller Medications Filled in the 180 Days Before and After Eligible Consultation Date, by Race and Ethnicity

Ethnicity	Given Consult				No Consult			
	N	Pre %	Post %	Change %	N	Pre %	Post %	Change %
White	572	3.1	14.9	11.8	536	3.4	10.6	7.3
Hispanic	1,234	2.4	10.3	7.9	1,713	1.7	4.3	2.6
African American	365	2.2	16.7	14.5	453	3.1	6.8	3.8
Asian/Pacific Islander	665	2.7	15.3	12.6	973	2.1	6.1	4.0
Other	101	5.0	16.8	11.9	92	5.4	10.9	5.4

Yet, despite the increase in the number of African American members receiving controller medication, the rate of pharmacy consultations among this group was lower than the rate among the other ethnic groups. Blue Cross sought to identify the cause of the disparity in pharmacy consultation for eligible members by race and ethnicity, in particular the percent of African American members who were eligible for, but did not receive, consultations. Using administrative data on pharmacy consultations, Blue Cross was able to identify:

- Members who did not receive consultations;
- Members who refused consultations; and
- Pharmacies with high numbers of missed opportunities to educate minority patients.

To increase the number of pharmacy consultations among African American members, Blue Cross targeted eight non-chain pharmacies for outreach visits and 4,119 African American members for additional educational mailings. Blue Cross staff reviewed educational outreach materials and asthma consultation content with pharmacists during pharmacy outreach visits. Pharmacists were encouraged 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. Blue Cross staff also pointed out to pharmacists the positive impact of asthma pharmacy consultation, especially for African American members, who demonstrated the greatest increase in controller medication use following pharmacy asthma consultations.

Results

The asthma pharmacy consultation rate for African American members at the eight targeted non-chain pharmacies rose from 0% to 15% following outreach visits.

HEDIS rates for Use of Appropriate Asthma Controller Medications increased from 68% for African American members in 2004 to 85% in 2006. Caution must be exercised when comparing 2006 Asthma HEDIS rates to those of earlier years, because the 2006 asthma HEDIS sample inclusion criteria were more restrictive and generally included a population that was more seriously affected by asthma. HEDIS rates among ethnic groups was quite similar and consistent over time, regardless of the higher rates in the 2006 reporting year.

Lessons

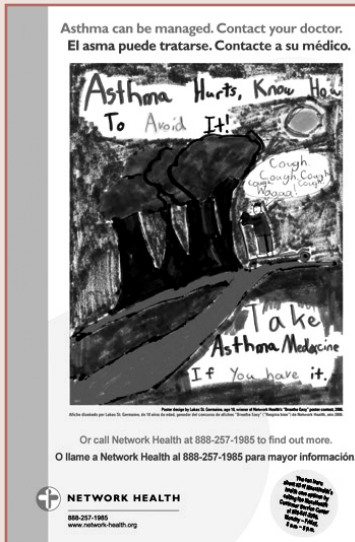
Face-to-face outreach to small pharmacies was an effective way to reach pharmacists and reaffirm the importance of the pharmacist's role in asthma management and patient education. The visits encouraged increased pharmacy asthma consultation services for all members, regardless of ethnic background. Pharmacists thanked outreach staff for visiting them and for supplying them with information and resources.

Network Health Addressing Asthma Care Among Hispanics in Southbridge, Massachusetts

Network Health serves more than 82,000 Medicaid and State Children's Health Insurance Program (SCHIP) enrollees in Massachusetts. Network Health employed a multi-pronged approach to target providers, members, and the community to reduce disparities in asthma care as measured by rates of controller medication use between white members and identified Hispanics with persistent asthma in Southbridge, Massachusetts.

Program

The project was organized into an initial identification phase, followed by three parallel strategies that focused on members, health care providers, and the community. The initial phase involved use of the asthma registry to identify Hispanic members who were enrolled in provider practices in Southbridge. These provider practices were narrowed down to the 10 practice sites that served the highest volume of members in the target group. Network Health provided the practices with member lists stratified by Hispanic ethnicity, persistent asthma, and non-persistent asthma. Providers were asked to verify and/or complete race and ethnicity information for members included on the lists, as well as to edit the accuracy of data with respect to asthma severity and inclusion in (and exclusion from) the provider panel. Network Health's member strategy comprised an outreach initiative focused on improvement in asthma self-management. The plan contacted members through a series of three asthma education and self management information mailings, which occurred successively, approximately one month apart. Materials, in both English and Spanish, included information on disease management, medication use (including the role of controller medications), and environmental factors influencing asthma symptoms and management. There were 249 mailings sent, of which 13 were returned.



Network Health's provider strategy involved engaging practices via individual meetings with providers and their office staffs. These meetings involved Network Health quality staff, an asthma case manager, and the medical director. A review of the BCAP Health Disparities Project along with practice-specific controller medication data were offered at the meeting. There were 10 practices identified for participation, of which seven chose to be engaged. Engagement was defined as holding more than one meeting, by phone or in person, with the physician and office staff, and enlisting their participation in one or two of the goals of the project. The first goal for participating providers was to review and edit the data on their patients for accuracy regarding ethnic/cultural information and also for correct identification of asthma diagnosis and severity, and controller medication use. Providers and their staffs were also given an updated pocket-sized asthma management guide, which included the Network Health formulary for asthma-related medications. The second goal involved providers and/or staff agreeing to participate in community-based events sponsored by community agencies participating in the pilot. These events included, but were not limited to, Hispanic radio and television spots, community health fairs, and an asthma poster contest.

Network Health's community strategy had an initial goal of increasing racially- and culturally-appropriate asthma awareness and education in the community. Participants included representatives from the Hispanic community, community organizations, the local hospital, local government, youth organizations, and churches. A secondary goal involved the formation of a community-based action committee to support community health education.

Results

Network Health measured disparities in asthma care using relative rates of appropriate controller medication as the proxy measure for asthma care. The disparity measure was initially based on the absolute difference in appropriate controller medication between the Hispanics and non-Hispanics.

Lessons

A major barrier was the lack of a reliable system to accurately identify member race and ethnicity. Inaccuracy and inadequacy in both the state-supplied and internal member data resulted in difficulty defining the Hispanic population. This was further complicated by members who answered "other." The most successful strategy to identify race and ethnicity was through the provider.

Continuous member turnover presented another challenge to compiling reliably comparable data from month to month. The health plan analyzed the experience of a continuously-enrolled cohort but the sample size of this cohort was significantly smaller than any of the other samples. The ability to draw conclusions was limited by the small sample size.

Sustainability

Network Health will include race/ethnic/language data fields in member demographic databases and in disease registries. Network Health recognized the need to devote more resources and attention to the area of obtaining accurate member ethnicity and race data, as well as increased focus on provider collaboration, which is an important key to improving care to Network Health members.



Medica *Improving Asthma Controller Medication Use Among African-American Children*

Medica is a Minnesota-based health plan with 1.3 million members. The Minnesota Department of Human Services provides Medica with ethnicity and preferred language self-reported member data. Medica sought to reduce the disparity in the appropriate use of asthma controller medications between African American and white members with persistent asthma, age five to nine years. Review of plan performance on HEDIS scores revealed that African American children were less likely to receive asthma controller medications than white children. The plan targeted children in the Minneapolis/St. Paul metropolitan area.

Program

Medica met with leaders from the Minnesota Department of Human Services, the Minnesota Department of Health, and the Minnesota branch of the American Lung Association (ALAMN) to discuss existing asthma-related interventions that Medica could use to reduce the identified disparity. ALAMN's intervention, the Asthma Clinic Systems Change Program, was adopted as the platform for collaboration between Medica and ALAMN. The Asthma Clinic Systems Change Program consists of a cluster of interventions targeted at clinics that provide care to people with asthma.

HEDIS specifications were used to identify members with persistent asthma. Using Medica member enrollment information, children age five to nine who were identified as having persistent asthma were selected by ZIP code and ethnicity. Medica's 2005 HEDIS data indicated that 67.4% of the identified target population of 126 members had received appropriate asthma medications, compared to 73.8% of the 183 whites.

Medica used claims data to link the identified members with primary providers at area clinics. In particular, the plan identified clinics in the Minneapolis/St. Paul area that were seeing the highest number of the high-risk African American children in the target population. ALAMN and Medica recruited the clinics identified in the stratification process to participate in the Asthma Clinic Systems Change Program. Six clinics agreed to participate. The Medica Foundation provided partial funding to implement the clinic-based pilot. The program included:

- Requiring an asthma action plan in the patient's medical record;
- Tracking asthma education sessions conducted by certified asthma educators; and
- Tracking the patients with asthma who were seen in the participating clinics.

ALAMN requested that the participating clinics submit monthly tracking data. Initial data showed that the program had a positive impact, increasing provider adherence to asthma practice guidelines.

Results

Medica had originally planned to evaluate whether the implementation of the Asthma Clinic Systems Change Program decreased racial and ethnic disparities by comparing 2006 HEDIS data with 2005 HEDIS data. However, because the 2006 HEDIS asthma measure was modified and cannot be compared with the 2005 measure, Medica is exploring the feasibility of alternative evaluation methods. Medica and ALAMN will continue this project through at least two more measurement cycles. In addition, Medica and ALAMN are exploring the possibility of having participating clinics conduct race and ethnicity tracking and identify of asthma-related health care disparities.

L.A. Care Health Plan ***Reducing Health Disparities in Asthma Medication Management Program***

L.A. Care Health Plan is a public agency serving residents of Los Angeles County through a variety of programs including Medi-Cal, Healthy Families, and Healthy Kids. L.A. Care has more than 750,000 members; approximately 89% come from racially and ethnically diverse communities, and over half prefer to speak a language other than English.

Program

L.A. Care set a goal of improving medication adherence for members with persistent moderate to severe asthma (PMSA). The pilot was designed to equip community pharmacists with tools to overcome language barriers and communicate more effectively with members. L.A. Care identified 1,487 Cantonese-, Armenian-, and Spanish-speaking members with asthma in six target ZIP codes, 741 of whom had PMSA. The plan identified 34 independent community pharmacies caring for the identified members. The 25 independent pharmacies with the highest volume of PMSA members were targeted for the project.

The pilot intervention included a series of counseling sessions provided by pharmacists when members picked up asthma medications. Health education materials were developed in the target members' languages and tested for readability by focus groups. The key educational tool is a sheet (written in the three languages) that describes asthma medications and includes specific directions (e.g., take two puffs three times a day) that can be checked off by the pharmacist. Pharmacists were trained on what to include in the counseling sessions. A pharmacy note was developed, in collaboration with the Institute for Community Pharmacy and the University of Southern California School of Pharmacy, to help pharmacists assess patients' symptoms and medication regimens and to document counseling. Pharmacists could contact members' primary physicians with recommended changes to drug regimens, based on the assessment.

Pharmacists are provided with access to free telephone interpretation services paid for by L.A. Care. For the pilot, pharmacists were trained on how to effectively use interpretation services and were given dual-phone headset devices that allowed them to communicate via a telephone-based interpreter while maintaining eye contact with the patient. Notifications were sent to primary care physicians informing them of the counseling available at the pharmacies.

A major challenge was timing, due to the simultaneous implementation of Medicare Part D; participating pharmacists initially resisted the extra workload. The intervention was postponed to allow time for the Medicare Part D issues to subside.

Results

Thirteen participating pharmacies provided counseling services from April through September 2006. Several pharmacies proactively called members to schedule pharmacy visits. The project team also worked with the L.A. Care's financial department to ensure monthly consultation payments. In the first two months, the team made follow-up calls to all 13 pharmacies twice a month to address questions. Pharmacy site visits were conducted for eight of 13 pharmacies in May and June, 2006.

As of September 30, 2006, a total of 97 pharmacy notes had been received from four pharmacies. The notes documented first, second, and third consultations for 57 targeted PMSA members in their own languages. The plan verified members' eligibility information by comparing pharmacy notes with L.A. Care's asthma registry database before payments were made. An evaluation of the encounter data and patient-reported asthma control will be performed.

Next Steps

Based on lessons learned from the pilot, recommended next steps are:

- Solicit recommendations from the Institute for Community Pharmacy and the pharmacy focus group;
- Work with the plan's pharmacy benefit manager to develop an electronic reminder to pharmacists to provide counseling at the time of prescription pickup;
- Improve counseling quality, simplify the counseling process, and reduce the number of sessions from three to one;
- Develop an appropriate and attractive member incentive plan to increase participation;
- Distribute the patient medication education form to physicians' offices; and
- Include information about pharmacist counseling services in member-education materials.

Sustainability

The encounter data and degree of asthma control as reported by patients will be analyzed to monitor asthma medication use and to evaluate the effectiveness of the pharmacy consultation. If the results are positive, the intervention will be maintained and broadened to additional pharmacies and for additional conditions.



IMPROVING DIABETES CARE

Total health care and related spending for the treatment of diabetes is about \$132 billion annually. Diabetes can result in serious complications, including kidney disease, blindness and limb amputations. Diabetes is a major health problem among racially and ethnically diverse populations, especially Native Americans, African Americans, and Hispanics:

- 12.8% of American Indians and Alaska Natives aged 20 or older who received care from the Indian Health Service in 2003 had diagnoses of diabetes. An estimated 118,000 (15.1%) American Indians and Alaska Natives aged 20 or older have diabetes.
- 2.5 million, or 9.5%, of Hispanic Americans aged 20 or older were diagnosed with diabetes in 2002.
- In 1999, 11,927 African Americans died from diabetes, the sixth leading cause of death in this population. The age-adjusted African American death rate due to diabetes was more than twice that for white Americans.

This section includes case studies describing promising approaches for improving diabetes care among the Native American, Hispanic, and African American populations.



SoonerCare Choice

Oklahoma is home to 39 tribal governments and more than 380,000 American Indians. In 2005, almost 70,000 American Indians, representing 13% of the state's Medicaid population, were enrolled in SoonerCare, Oklahoma's Medicaid, or SoonerCare Choice, Oklahoma's primary care case management (PCCM) program.

SoonerCare Choice set a goal of improving care for adult American Indians with diabetes by improving the HEDIS 2006 screening scores for American Indian members age 18-75 years identified with diabetes as follows:

- Increase HbA1c screening from 20.2% to 28.2%;
- Increase LDL-C screening from 16.5% to 24.9%; and
- Increase eye exams from 2.1% to 11.9%.

Program

SoonerCare Choice used claims data to identify 1,020 eligible Native American enrollees with diabetes from January 2005 through September 2005. In addition, SoonerCare Choice ran queries to identify each enrollee's primary care provider. The plan educated Native American members with diabetes, and their providers, about benefits related to diabetes screening via letters, one-on-one outreach, and on-site clinic visits. Mailings to members explained the importance of screenings, diabetes management, and the benefits available. Nurses from the care management team contacted members to assess why screenings had been missed and to help schedule appointments and transportation for scheduled screenings. The plan also alerted providers about members in need of screening.

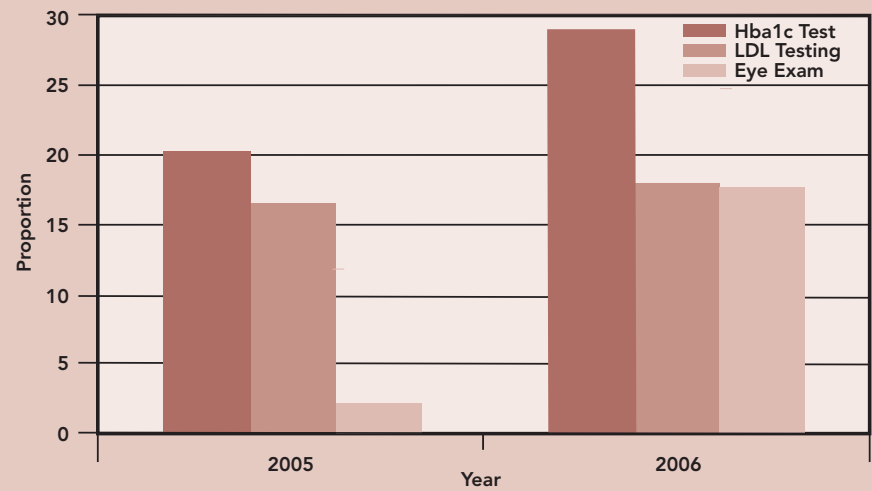
In addition, SoonerCare Choice evaluated the management of Native Americans with diabetes at four "high-performing" provider sites. Health plan staff interviewed medical teams to assess their approach to day-to-day diabetes care management: how they identified and registered patients, how they scheduled visits, how they organized care, and the level of personnel input. The results of the assessments guided the development of educational sessions at four "low-performing" practice sites.

Results

SoonerCare Choice met the project goals for two of the three measures (HbA1c and eye exam) and increased screening rates for all three measures (Figure 9). The overall HEDIS 2006 screening recommendation rates (administrative data only) for American Indian members aged 18-75 years identified with diabetes were increased:

- HbA1c screening from 20.2% to 28.9%;
- LDL-C screening from 16.5% to 17.9%; and
- Eye exam screening from 2.1% to 17.7%.

Figure 9. Proportion of SoonerCare Choice American Indian Members Who Had HEDIS-Recommended LDL, Hba1c and Annual Eye Exams



SOURCE: SoonerCare

Lessons

SoonerCare Choice identified several best practices that could be implemented at the provider, as well as the plan, level:

- Diabetes registry – A plan-level registry could track members with diabetes who move between different providers. A registry could automate reminder mailings to members and providers. Focused disease management for noncompliant members would also be facilitated by a registry.
- Provider tracking system – Information systems at many of the IHS facilities demonstrated efficient scheduling of screening appointments, reminder calls and notices, and follow-ups for missed appointments.
- “Tickler” sheets – Many providers developed medical record reminder notices that listed last dates of screenings and needed education to assist doctors in scheduling and tracking their diabetic members. Providers can use these tools to schedule future appointments for necessary screenings months ahead of their due dates.
- Diabetic Day – A number of the IHS facilities scheduled periodic one-day clinics to provide all diabetic screenings and education during one visit for diabetic members. While some members receive screenings, others receive nutritional education or information on how to use diabetic monitoring equipment, as needed.

Healthfirst ***Increasing Diabetes HEDIS Measures for African-American and Hispanic Members***

Healthfirst, with more than 400,000 members, is the largest Medicaid managed care organization in the state of New York. According to a 2002 survey by the New York City Department of Health, the prevalence of diabetes among African Americans (10.8%) and Hispanics (12.2%) is more than twice that of whites (5.0%).

Healthfirst set a goal of increasing HEDIS measure rates to the NCQA's 75th percentile for HbA1c testing, eye exam, LDL-C screening, and nephropathy monitoring for African American and Hispanic members with diabetes.

Program

To identify its target population, Healthfirst:

- Identified 6,537 members who were eligible for one or more of the interventions in the HEDIS comprehensive diabetes measures, according to 2005 technical specifications;
- Matched data from the New York State Bureau of Quality Management and Outcomes Research to obtain information on members' race and ethnicity;
- Stratified 3,055 members by race and ethnicity; and
- Analyzed the target population to identify the 986 primary care physicians providing care to these members as well as the 1,863 members who were noncompliant for the comprehensive diabetes measure.

The plan sent targeted mailings to identified African American and Hispanic members with diabetes who had had no HbA1c testing, eye exam, LDL screening, or monitoring of nephropathy. A mailing also went to the primary care providers (PCPs) for these members.

Outreach occurred in four cycles:

1. To members who were noncompliant for all comprehensive diabetes indicators.
2. To members who received mailings.
3. To the PCPs who were in the top 10 list of providers with noncompliant members. These PCPs received mailings with their noncompliant lists and phone calls from Healthfirst staff.
4. To all PCPs with members with a diagnosis of diabetes.

Healthfirst used multiple PCP and member outreach strategies, including:

- Registered nurses and quality improvement coordinators conducted telephone outreach to PCPs to provide information about diabetes HEDIS measures, the American Diabetes Association (ADA) standard of care, and proper encounter and claim coding and submission.
- PCPs were assigned culturally-appropriate provider representatives to improve communication between the provider and the plan.
- Members were offered a \$50 gift certificate if they completed HEDIS monitoring services (documented through a voucher completed by providers). The program was promoted online and through member outreach calls, provider outreach, and provider and member newsletters. Healthfirst had received 305 vouchers signed by providers that documented that the members had received all indicated interventions.

- A mailing was sent to targeted providers to remind them to provide ADA-recommended services. The mailing included a copy of the ADA’s standard of care for diabetics and a list of members who had not received diabetes services during the measurement year.
- Mostly-bilingual quality improvement staff called members to educate them on the ADA standards of care, to encourage them to make and keep medical appointments, and to inform them about the gift certificate program.

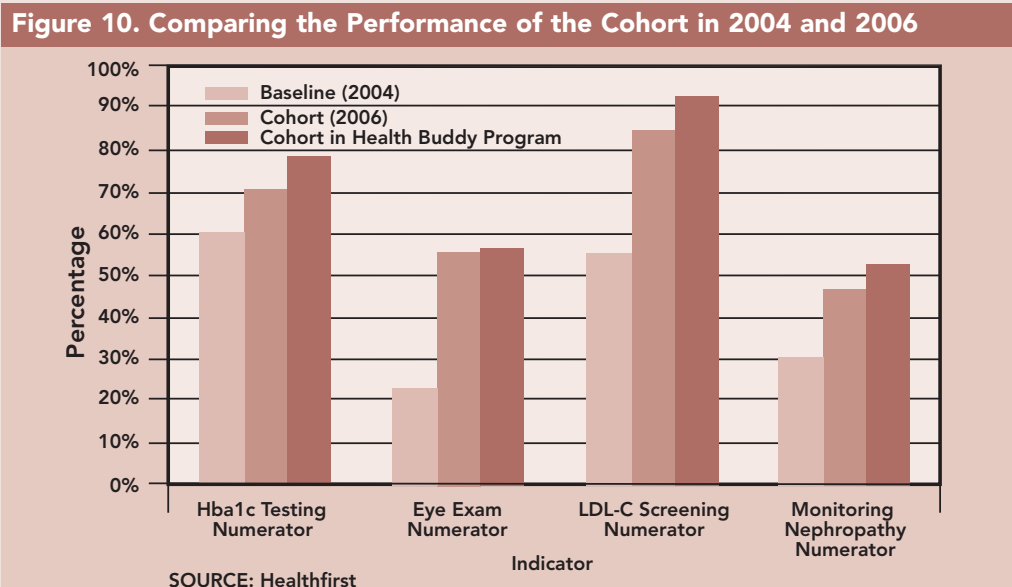
Healthfirst also provided intensive case management for members with diabetes who had had two or more emergency room visits per year. Case management took one of two approaches:

- High-risk members were provided with a comprehensive assessment and offered membership in Health Buddy, a program that uses an electronic, interactive machine that reminds members to perform self-monitoring such as blood glucose testing, and to document the results by entering data into the Health Buddy. If certain actions were not performed within a specified period, or if a high self-monitoring blood glucose level was noted, the member was called. More than 50 members were enrolled in the Health Buddy Program.
- High-risk members who declined to use the Health Buddy were encouraged to join the Diabetes Control Network, which provided periodic mailings of information regarding the importance of annual dilated retinal exams, foot exams, physical exams, and regular doctor visits. Healthfirst enrolled 148 members in this program.

Results

Direct member outreach was the most effective strategy to improve diabetes care. By 2006, the plan had reached 61% of its target population or a total of 3,995 members.

Healthfirst’s preliminary analysis showed that the Health Buddy Program was successful. Figure 10 compares performance on recommended monitoring measures at baseline, for the cohort and among those who participated in the Health Buddy Program.



Oregon Collaborative

Cross-Plan Collaboration to Improve Care for Hispanic Members with Diabetes

CareOregon, FamilyCare Inc., and Providence Health Plans collectively enroll about 120,000 (49%) of the 242,000 enrollees in the Oregon Health Plan, the state's Medicaid managed care program. The three fully-capitated health plans collaborated to improve their rates of preventive services and to reduce emergency department use among Hispanic members diagnosed with diabetes.

Program

To identify Hispanic members with diabetes, Oregon extracted race and ethnicity data from member eligibility files obtained from the Office of Medical Assistance Programs. These members' diabetes diagnoses were established through health plan claims data, using HEDIS definitions.

The identified population was stratified into high- and low-risk groups. High risk was defined as those who had received no HbA1c test or LDL tests in the past 12 months. Low risk was defined as those who had undergone all recommended preventive tests in the previous 12 months. Both the Spanish-speaking and English-speaking populations were stratified.

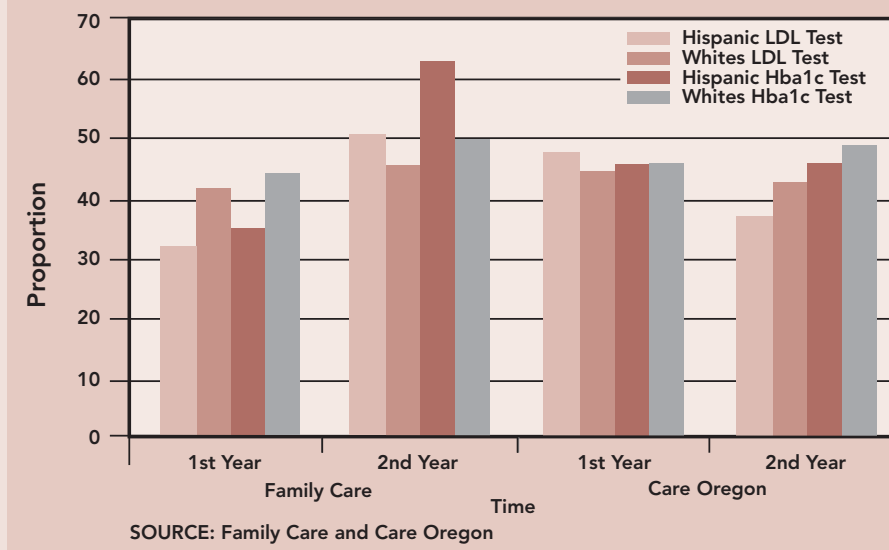
High-risk Hispanics were contacted by care coordinators by telephone and mail at FamilyCare and Providence, and through the mail at CareOregon. The care coordinators provided diabetes education and reminders about ongoing testing and disease management. CareOregon sent reports to primary care providers indicating which Hispanic patients had not had relevant tests in the previous 12 months. At FamilyCare and Providence, education sheets sent out to patients were used to track patient outreach.

Results

Each of the strategies yielded slightly different results. FamilyCare's HbA1c testing rates for Hispanic members with diabetes improved by 80%, from 35% to 63%. Rates among whites increased by 13%, from 44% to 50%. Rates of LDL testing among Hispanics increased by almost 60%, from 32% to 51%; and rates among whites improved about 10%, from 42% to 46%.

CareOregon results were mixed. Rates of HbA1c testing among Hispanics were stable at 46% over both years, while rates of testing for whites improved by only about 6%, from 46% to 49%. Rates of LDL testing declined by about 5% among both groups, from 48% to 37% among Hispanics, and from 45% to 43% among whites. At Providence Health Plans, LDL and HbA1c testing improved by 30% among Hispanic members.

Figure 11. Increases in Diabetes Preventive Care Services



Lessons

Not all health plans identified disparities at the beginning of the project; FamilyCare did, CareOregon did not. There were several reasons for this. Many individuals lose Medicaid coverage for some period of time, and then regain eligibility, so that they rotate into and back out of the program — referred to as “churning.” Those who lose their coverage, and are at greater risk of having unmet health care needs, are not captured in analyses that use Medicaid enrollment files. Hispanics might be less likely to have continuous enrollment than whites, and the resulting analyses would compare only minorities who have maintained continuous enrollment with continuously-enrolled whites, undercounting Hispanics. Another important consideration is that rates of testing for both Hispanics and whites were low, indicating that improvement is needed for all members, regardless of race.

Despite the limitations inherent in measuring disparities in populations characterized by unstable Medicaid coverage, a major lesson learned by the Oregon collaborative was that integrating race, ethnicity and language into usual HEDIS reporting is both possible and desirable. Typical quality improvement activities track HEDIS measures and develop interventions to improve preventive care. In each of the participating plans, the typical HEDIS measures were simply stratified by race and risk, and quality improvement staff were able to track disparities in care as part of their usual activities, without adding additional burdens. This approach not only allowed for the regular assessment of disparities, but also provided more information that could be used by quality improvement staff for developing culturally and linguistically appropriate interventions.

FamilyCare identified disparities in care and developed a protocol to provide Spanish-language education and case management to Hispanic diabetics, which resulted in a reduction in racial disparities in diabetes care. Their experience suggests that a data-driven quality improvement project focused on disparities reduction can be integrated into health plan activities, and can be successful.

Resources

Online Resources

The following resources are available, along with a downloadable copy of this toolkit, at www.chcs.org. We thank the health plans, states, and other stakeholders willing to share innovations to help other organizations identify and reduce racial and ethnic health disparities.

1. Workgroup Contact List

2. L.A. Care Health Plan Pharmacy Ancillary Labels – The pharmacy ancillary labels provide appropriate dosage information in the preferred language of the member.

- a. English
- b. Armenian
- c. Chinese
- d. Farsi
- e. Khmer
- f. Korean
- g. Russian
- h. Spanish
- i. Tagalog
- j. Vietnamese

3. Monroe Health Plan’s Healthy Beginnings Prenatal Registration Form – The health plan enhanced its existing prenatal registration form with race and ethnicity fields.

4. Neighborhood Health Plan’s Teach with Stories Pre- and Post-Test – To assess the impact of the Teach with Stories program, NHPRI developed this pre- and post-test for Hispanic women participating in the pilot.

5. Medica and American Lung Association’s (ALA) Survey for Determining Sustainability of Clinic Based Systems Change Efforts – This survey is being used with Medica’s providers to ensure that the changes implemented through the ALA Clinic Systems Change program are sustained.

6. Disparities Quality Summit Materials – Presentation for the December 2006 Disparities Quality Summit in Miami.

CHCS National Activities to Improve Health Quality for Racially and Ethnically Diverse Populations

In addition to the Medicaid-focused *Improving Health Care Quality for Racially and Ethnically Diverse Populations* workgroup, additional CHCS initiatives to address health care disparities include:

Purchasing Institute: Leveraging Data to Reduce Racial and Ethnic Health Disparities

With funding from the Robert Wood Johnson Foundation and The Commonwealth Fund, CHCS conducted a Purchasing Institute in November 2004 for 12 state Medicaid agencies. The Purchasing Institute provided guidance to states on data analysis techniques and contracting strategies that support statewide quality improvement initiatives for a group of racially and ethnically diverse beneficiaries. States attending the Purchasing Institute worked on developing strategic plans for addressing disparities within the Medicaid program through effective partnerships with other agencies and contracted health plans. As a result of the Purchasing Institute, states are now:

- Using enhanced data sets to conduct analyses and identify disparities.
- Establishing statewide health care collaboratives to implement a set of protocols and codes to ensure the standardization of racial, ethnic and language data.
- Integrating health care disparities into chronic disease management programs.
- Establishing performance measures for contracted health plans to work on addressing disparities in care.

For more information, visit www.chcs.org and download “Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries,” a CHCS Issue Brief published in June 2006.

National Health Plan Collaborative to Reduce Disparities and Improve Quality

Nine of the nation’s largest commercial health plans are participating in a four-year collaborative aimed at improving their capacity to collect and analyze data on race and ethnicity, developing quality improvement interventions to close gaps in care, and producing results that can be replicated by plans serving commercial, Medicare, and Medicaid populations nationally. The second phase of this work, which runs through September 2008, will focus on developing recommendations on standardization of primary race and ethnicity data collection; standards for language access lines; and building the business case for reducing racial and ethnic health care disparities.

The collaborative is coordinated and managed by CHCS, with technical assistance provided by the RAND Corporation and the Institute for Healthcare Improvement. Funding and leadership is provided from the US Department of Health and Human Services’ Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation.

For more information, visit the National Health Plan Collaborative website at www.chcs.org/nationalhealthplancollaborative/index.html and download the “National Health Plan Collaborative: Phase One Summary Report,” published in November 2006.

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