



**NATIONAL  
HEALTH PLAN  
COLLABORATIVE**

*Reducing Racial and Ethnic Disparities &  
Improving Quality of Health Care*

**NATIONAL HEALTH  
PLAN COLLABORATIVE:  
PHASE ONE SUMMARY REPORT**

November 2006

## Table of Contents

The National Health Plan Collaborative and its Mission.....	1
The First Phase of the Collaborative’s Work.....	3
What the Collaborative Has Learned.....	5
Next Steps.....	7
Conclusion.....	8
Appendix: Overviews of the Collaborative Members’ Activities and Interventions.....	9

## The National Health Plan Collaborative and its Mission

### About the Collaborative

The National Health Plan Collaborative (NHPC) is a groundbreaking effort by nine major health insurers, in partnership with public and private funders and investigators, aimed at reducing racial and ethnic disparities and improving the overall quality of care in the U.S. health care system. Established in December 2004, it is the first national effort of its kind to move beyond research and actively test possible solutions to inequalities in health care service delivery.

The Collaborative's member health plans—Aetna, CIGNA, Harvard Pilgrim Health Care, HealthPartners, Highmark Inc., Kaiser Permanente, Molina Healthcare, UnitedHealth Group (UnitedHealthcare, Ovation and AmeriChoice), and WellPoint, Inc.—reach more than 76 million Americans. The Collaborative's activities are sponsored by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation (RWJF), with coordination and support to participating plans provided by the Center for Health Care Strategies (CHCS) and the RAND Corporation and assistance from the Institute for Healthcare Improvement (IHI).

### Why and How the Collaborative Was Formed

For more than 20 years, research has documented gaps in health care quality that disproportionately affect Americans from specific racial and ethnic backgrounds. African Americans and Hispanics, for example, are less likely than whites to have private health insurance. Many live in neighborhoods lacking high-quality health services and providers. Our nation's legacy of inequality along lines of race, national origin, language, income, employment, education and housing perpetuate these gaps.<sup>i</sup>

More troubling still, an expansive body of research shows that racial and ethnic minorities are less likely than whites to receive health care of comparable quality *regardless of their income or health care coverage status*. For example, between 2000 and 2002, the quality of diabetes care among Hispanic adults declined by 6 percent while the quality of diabetes care among white adults increased by 5 percent.<sup>ii</sup> In some instances, racially and ethnically diverse populations have experienced as much as 50 percent more diabetes-related complications and deaths than the total population.<sup>iii</sup>

The National Academy of Science's Institute of Medicine (IOM) highlighted such findings in its seminal 2002 report, "*Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care*."<sup>iv</sup> The scientists and doctors who prepared the report concluded not only that the gaps are real, but they contribute to higher death rates among minorities. They specifically called on health insurance companies to collect, report and monitor patient-care data to build a foundation for solutions to the problem of racial and ethnic disparities in care. Their work has been corroborated and elaborated upon in a subsequent annual series of national health care disparity reports by AHRQ. In response to these and other reports, leaders from several large health plans decided it was time to take action. After a series of preliminary meetings in 2002 and 2003 between plan leaders and other stakeholders, AHRQ and RWJF formally agreed to co-sponsor a health plan "learning collaborative" on disparities. Over the next several months, they began recruiting the Collaborative's nine members and contracted with RAND, CHCS and IHI for the provision of data analysis and other support services. The Collaborative held its first meeting in September 2004, its second in March 2005 and its third in June 2006.

Since coming together, the Collaborative’s members have made major strides toward achieving a key goal, namely, making efforts to reduce disparities a core business practice. “That’s the kind of change we are hoping to inspire,” notes Dr. Carolyn Clancy, M.D., director of AHRQ. “We are emphasizing the evolution from pilot project to core corporate strategy.”

Perhaps most importantly, by studying data and acting accordingly, the Collaborative is beginning to make a difference. Its members have developed and tested new approaches for quickly estimating race and ethnicity that they can use to begin acting on disparities now while they complete the longer process of collecting race and ethnicity information directly from their members. They are also developing novel strategies and tools, such as interactive mapping tools, to help them efficiently and effectively target interventions to address disparities. More generally, they have embarked on cultural competency training for their own staffs and provider networks and are testing a variety of strategies to educate and reach out to underserved racial and ethnic populations. Members are pilot testing interventions designed to reduce disparities in care, and they are sharing their findings with each other and with the broader health care community. In these respects, the Collaborative is emerging as a unique national laboratory to develop and test practical approaches to addressing disparities in managed care settings.

“We still don’t have a clear idea of what the magic bullet intervention is,” says Dr. Lisa A. Latts, M.D., M.B.A., vice president of Programs in Clinical Excellence at WellPoint. “So we are all trying. And that’s the beauty of the collaborative. We are learning from each other.”

## The First Phase of the Collaborative's Work

As first steps, the Collaborative members agreed to:

- Analyze existing data on racial and ethnic disparities in care and acknowledge the feasibility of using primary, member-reported information over proxy measures
- Evaluate how such data could be used for quality-improvement interventions
- Focus on chronic conditions, most notably diabetes
- Develop and pilot test interventions aimed at improving health care quality and share findings with health care decision makers and leaders, including other health plans

Collaborative members agreed to involve some of their senior leaders in this effort in order to send a clear message to their own organizations and the broader health care community about their commitment to reducing disparities. They also agreed to concentrate initially on reducing health care disparities among their members with diabetes.

The diagnosis and treatment of diabetes is not the only area in which racial and ethnic gaps in health care have been documented, but it is a good starting point. First, diabetes is common, and it is well documented that African Americans and Hispanics are less likely than whites to receive proper treatment for the disease—even when patient characteristics such as age, gender, income, health coverage status, morbidity and disease severity are similar.

Second, the opportunity to make a real difference in the disparities that exist in diabetes treatment is particularly strong:

- There is compelling evidence of racial and ethnic disparities in the treatment of diabetes.
- The recommended standard of care for diabetes is clear.
- The measurement tools to determine whether patients are receiving the recommended standard of care for diabetes have already been developed and tested.

### Developing Insights into Disparities

During the Collaborative's first year, its members concentrated mainly on developing insights into disparities within their own organizations. Two plans had already begun collecting or were in the process of collecting their members' self-reported racial and ethnic data. RAND assisted the others with geocoding and surname analysis to help them learn more about disparities in care among their members.<sup>v</sup>

Although preparing and analyzing this data took longer than expected, the results were beneficial. The analyses often yielded immediately valuable insights about disparities, and even when they did not the Collaborative members learned from the experience. They shared their results with their organization's leaders, which helped raise understanding about disparities and mobilize resources to address them within their organization.

### Developing and Implementing Quality-Improvement Interventions

Once Collaborative members had the data in hand, they began to develop and implement provider-, member-, and community-targeted quality-improvement initiatives.



Many of these pilot projects built on the organizations' prior quality-improvement work with their overall memberships or targeted populations. Some of these pilots are ongoing and their outcomes are not yet known. The interventions are described in greater depth in the appendix to this report.

Examples of the Collaborative's quality-improvement interventions to date include:

- **Aetna** is testing an outreach strategy to providers and nurses to improve diabetes screenings for African-American members. As part of the project, Aetna has developed a cultural sensitivity training module available to all staff and a nursing education program.
- **CIGNA** has conducted an extensive analysis of its members with diabetes and is testing a disease management program focusing on medication use and compliance. Based on the management program results, CIGNA is developing specific internal and community outreach strategies to improve the care diabetic members receive.
- **Harvard Pilgrim Health Care** is testing community-based, provider-focused and member-directed intervention programs designed to ensure diabetic Hispanics receive timely eye exam screenings.
- **HealthPartners** is developing a Web-based data collection program to gather members' information. Community outreach efforts include working with minority media to educate the public on the issue and creating a speaker's bureau to share knowledge with the business community.
- **Highmark Inc.** has analyzed multiple data sources to identify health disparities in its membership. Based on this analysis, education programs and collaboration with physician practices were initiated in communities where diabetes disparities exist.
- **Kaiser Permanente** is developing a culturally appropriate outreach model for delivering a proven cardiovascular risk reduction program to its minority members with diabetes.
- **Molina Healthcare** has expanded its diabetes management program with members by providing 24/7 access to Spanish- and English-speaking nurses and staff who have been qualified in cultural congruency.
- **UnitedHealth Group** used geocoded data to evaluate the impact on sharing health care outcomes with physicians. United has designed a pilot that uses a free Web-based patient registry to help physicians manage patients with diabetes and cardiovascular disease.
- **WellPoint, Inc.** is also using geocoded data to identify physicians and members in areas with documented disparities. Physicians in pilot regions will receive cultural competency toolkits, as well as culturally and linguistically adapted patient education materials. Members with eligible chronic disease conditions in identified regions with documented disparities will receive enhanced disease management outreach efforts and programs.

## What the Collaborative Has Learned

Over the past two years, the Collaborative's members have developed a deep understanding of the barriers they must overcome to begin closing racial and ethnic gaps in health care and have launched initiatives to surmount those obstacles. They have learned about both the advantages and challenges posed by their size, the vital importance of data collection and analysis and the value of working together. The following is a summary of some of the overarching lessons that the plans have learned thus far.

### *1. The member companies' scale is both an advantage and a challenge.*

History shows that health plans can be powerful partners in improving health outcomes for underserved populations. The Collaborative's member plans touch millions of lives and a large proportion of providers across the country. Through their collective voice, they are raising awareness of this problem within the government, the health care community and the public at large.

However, the Collaborative's members have learned that reorienting enterprises as large and diverse as theirs and developing institution-wide "buy-in" to disparities reduction will take time. They recognize that their success will depend on making disparities reduction a core business strategy.

Dr. Andrea Gelzer, M.D., M.S., F.A.C.P., senior vice president of clinical public affairs at CIGNA, notes that her firm delayed implementation of two pilot interventions in order to build in time to educate all stakeholders. CIGNA has "a very diverse group of individuals with a very diverse understanding of what racial and ethnic disparities constitute," she says. "We had to educate them and some outside vendors as well about the value of certain interventions, and that took quite some time."

### *2. The collection of plan members' racial and ethnic data is politically sensitive but essential and feasible.*

Companywide education efforts must also extend to the potentially sensitive task of collecting health plan members' racial and ethnic data. Donna Zimmerman, M.P.H., vice president of government and community relations at HealthPartners, observes that patients and plan members might not agree to share such information without some assurance of how the information will be used. Staff members, too, might not fully support asking patients about their race until they understand that disparities exist and that data collection is key to helping reduce them.

"As you can imagine, this is no small task," Zimmerman says. "It involves training, the buy-in and support from the very top of the organization, and our support to that frontline staff person who is going to be asking those questions."

Dr. Winston F. Wong, M.D., M.S., medical director, community benefit disparities improvement and quality initiatives at Kaiser Permanente, echoes those sentiments. "Its implementation entails building human relationships and buy-in. It's a real operational and logistical challenge," he says. "How do you build that vision of why this is important and translate that into something that's functional? That's the real challenge."

Aetna has forged ahead and started collecting such primary racial and ethnic data from its members on a voluntary basis, and it has suffered no ill consequences to date for having done so. The Collaborative is

obviously heartened by that outcome. In the meantime, many of the Collaborative's other members are now relying on proxy measures of disparities yielded from geocoding and surname data analysis.

Data collection and analysis are central to efforts to end racial and ethnic disparities in health care. Yet the health care industry as a whole lags behind others in this regard, in no small part because the federal government has yet to issue comprehensive, definitive guidelines for the collection and disclosure of race and ethnicity data in health care quality improvement. Although there is no federal regulation or law that prohibits the collection of racial and ethnic data, regulations that clearly authorize such data gathering and set uniform standards for the scope of information to be gathered, the points at which it may be collected, and methods of analysis and reporting would greatly advance efforts to encourage effective data collection.

### *3. Collective action is a key to progress.*

As time goes on, the value of collective action has become more and more apparent to the Collaborative's members. Their participation in the Collaborative has raised understanding of disparities within their companies. They have begun learning from each other's efforts and have established important benchmarks for measuring their activities against emerging national practice. They are learning more about disparities, what causes them, how to measure them and how to reduce them. And they are also learning the limitations of acting independently.

Kathryn Coltin, M.P.H, director of external quality data initiatives at Harvard Pilgrim Health Care, observes that the return on a community-based intervention depends heavily on its health plan sponsor's market share in the community. For example, the proportion of Harvard Pilgrim members who are Hispanic, have diabetes and attended free eye exam screening events developed as part of the firm's participation in the Collaborative mirrored Harvard Pilgrim's limited market share in the targeted communities. The lesson, Coltin says, is that "we need collaboration among local health plans in markets like Boston to make sure such interventions are cost-effective for the individual plans."

## Next Steps

The Collaborative's goals for its second phase revolve around four major themes: collecting primary data, enhancing access for non-English speakers, supporting investment in disparities reduction, and disseminating what member plans have learned.

### Collecting Primary Data

Collaborative members will work together to identify or develop uniform approaches to collecting their members' self-reported information about their race and ethnicity. They will also seek opportunities to work together nationally or in specific markets with plan members, providers and employers to test approaches to primary data collection.

The Collaborative will seek the development of national guidelines for the collection and use of primary data in health care quality-improvement efforts. These guidelines should spell out both the appropriate and inappropriate uses of such data. If necessary, member plans will develop and propose such guidelines themselves. Plans have recognized that the successful collection of primary data will take several years. In the meantime, they will continue to use indirect measures to guide their work, with the aim of transitioning to primary data as quickly as possible.

### Enhancing Access for Non-English Speakers

Interventions with plan members lacking fluency in English have highlighted the importance of language translation services. Accordingly, the Collaborative will create and test a language translation services model that can be replicated by others in the industry. The member plans will work together at the national level to raise awareness of this issue and will pursue other member- and provider-targeted initiatives in this area, either individually or collectively.

### Supporting Investment in Disparities Reduction

As was noted earlier, data collection is essential to addressing racial and ethnic disparities in health care. Data collection is also feasible to undertake. In addition to investing in staff-, provider- and patient-education efforts around data collection, the Collaborative will continue to explore technologies that can help gather, analyze and put such data to work.

Toward that end, the Collaborative's members will work with CHCS to explain in greater depth, both to their own organizations and their industry as a whole, why data collection is critical to closing racial and ethnic gaps in care and that data collection efforts are a sound investment and a wise policy.

### Sharing Lessons Learned

The member plans and supporting partners came together to learn from one another. Their knowledge about disparities, their roots, how to measure them, and how to measure gaps in care and outcomes to begin closing these gaps has grown considerably during the past two years. In the coming months, the member plans will expand their efforts to share information among themselves and others interested in their work through meetings, telephone conference calls, and Internet-based communication tools. They will report their progress to one another on a regular basis. More broadly, they will advance knowledge of their work through joint issue briefs and possibly through articles in major health policy journals.



## Conclusion

By forming the Collaborative, these health plans are doing their part to solve the problem. But they cannot solve it alone. It will take everyone—researchers, policy-makers, health care insurance providers, doctors, nurses and communities—to improve the quality of health care that racially and ethnically diverse patient populations receive. Patients, too, must take a more active role in their own care, and the Collaborative is seeking ways to help them better understand their conditions and treatment options and to act on them.

Health care inequalities are an affront to the nation’s promise of equal opportunity for all and reducing them benefits us all. Healthier Americans of all races and backgrounds make our economy stronger. They stem rising health care costs because healthier Americans need fewer and less costly medical services. They make America a better place through their increased capacity to contribute to the common good in our nation’s communities and neighborhoods. By learning how to improve care for racially and ethnically diverse populations, we can potentially improve the delivery of vital health care services to all Americans.

## Appendix: Overviews of the Collaborative Members' Activities and Interventions

### Aetna

Aetna has been collecting its members' racial and ethnic data on a voluntary basis since 2002, largely through the firm's member self-service Web site. Close to 4 million plan members have shared their racial and ethnic information with the firm. Aetna has been putting the data to work in its breast care management program, African-American pre-term delivery program and other pilot initiatives.

For the Collaborative, Aetna launched a diabetes disease-management pilot program targeting more than 500 African-American and Hispanic members. Its goal was to increase LDL cholesterol and HbA1c screenings among non-adherents. Aetna intensified outreach to the targeted members and their physicians, developed a cultural sensitivity training module available to all staff, and implemented a nursing education program.

Preliminary results show that 38 percent of non-adherents obtained HbA1c screening after the intervention and another 38 percent obtained LDL cholesterol screening. Diabetics in the intervention group also had better HbA1c control than those in the comparison group. Aetna continues to review the results of this successful pilot.

**Health Plan:**

Aetna

**Web Site:**

[www.aetna.com](http://www.aetna.com)

**Program Contact:**

Troy Brennan, M.D., J.D.,  
M.P.H.

**Intervention:**

- Training diabetes disease-management staff in cultural competency
- Sending mailings to targeted members

## CIGNA

CIGNA has begun to collect members' racial, ethnic and primary-language data on a voluntary basis through its health risk assessments and disease management programs.

For the Collaborative, CIGNA is focusing on disparities among Hispanics and African Americans related to diabetes and cardiac care as determined by HEDIS effectiveness of care measures. It is looking at LDL cholesterol and HbA1c levels, and the use of and compliance with ACE inhibitors, statins, oral hypoglycemics and insulin in the African-American and Hispanic populations.

CIGNA has implemented cultural competency training with its formal disease management nurse coaches and is equipping its disease management clinical staff with tools to communicate effectively with a diverse population. The cultural competency training for disease management nurses began in the first quarter of 2006 and concluded at the end of May 2006. It is hoped that the training will lead to increased understanding about why members do not take their medications.

CIGNA is also focusing on improving health literacy, in part through a \$100,000 CIGNA Foundation grant to the Methodist Healthcare Foundation of Memphis to help educate Tennesseans with poor health literacy who have congestive heart failure and diabetes.

**Health Plan:**

CIGNA

**Web Site:**

www.CIGNA.com

**Program Contact:**

Andrea Gelzer, M.D., M.S.,  
F.A.C.P.

**Intervention:**

- Training call center nurses in culturally appropriate ways to encourage appropriate medication use
- Improving health literacy among heart and diabetes patients

## Harvard Pilgrim Health Care

Harvard Pilgrim has established a formal planning process for the systematic collection of data on members' race, ethnicity and language preference. It is currently transitioning to a new data administration system and has defined the ability to capture and store members' racial, ethnic and language-preference data as a core business requirement. Harvard Pilgrim has also been geocoding and surname coding member data as an interim step toward identifying potential disparities in care.

With respect to diabetes, Harvard Pilgrim eliminated its referral requirement for diabetic retinal screening for its members. It also launched a pilot community-based intervention based on its finding that Hispanic and Latino members who resided in just six communities accounted for more than 30 percent of missed retinal screening opportunities. Harvard Pilgrim held four free screening events in two of these communities, both of which had a shortage of community-based eye care providers. A local grocery and pharmacy chain with stores in the communities co-sponsored and helped to promote the events.

The pilot's results were mixed. On one hand, only 2.5 percent of Harvard Pilgrim members invited to the screening events actually attended, and only 20 percent of those who obtained a screening at the events were Harvard Pilgrim members. On the other hand, 31 percent of Harvard Pilgrim members who received an outreach mailing did obtain an eye exam, compared with 26.5 percent of those in a control group.

Harvard Pilgrim is following up its diabetic retinal screening effort by launching a member-directed incentive program in the fall of 2006. It is also planning interventions on medication management for pediatric asthma and colorectal cancer screening.

Harvard Pilgrim has sent practice-site-level performance reports by race and ethnicity to its largest medical group, and that group has since engaged both in the collection of race and ethnicity data from its patients and in efforts to reduce disparities in diabetes care. Harvard Pilgrim has awarded grants to two other physician groups in Massachusetts, one for a project to reduce disparities in diabetic retinal exams and another for a project on colorectal cancer screening.

**Health Plan:**

Harvard Pilgrim Health Care

**Web Site:**

[www.harvardpilgrim.org](http://www.harvardpilgrim.org)

**Program Contact:**

Kathryn Coltin, M.P.H.

**Intervention:**

- Providing community-based intervention to increase retinal screenings
- Providing co-pay waiver coupons to high-risk members to increase retinal screenings

## HealthPartners

In 2004, HealthPartners' clinics began collecting data on patients' language preference, race and country of origin on a voluntary basis through its electronic medical record. A year later, it began collecting this same data on a voluntary basis through a secure members' Web site. The firm estimates that it now has such primary data on more than 20 percent of its overall membership. Data collection has been so successful that clinics now report on selected quality measures and patient satisfaction by race. The company is evaluating the data and determining appropriate next steps.

HealthPartners has made a commitment to reducing health disparities and raising organization-wide cultural competence. In 2002, it formed a Cross Cultural Care and Service Task Force charged with developing strategies to improve cultural competence and reduce health disparities. In 2003, it conducted an organization-wide assessment of cultural competence to determine baseline capabilities, identify opportunities for improvement, and develop a multiyear plan. And in 2004, it initiated multiyear strategies in the areas of data collection, language access and staff education.

In 2005, HealthPartners developed a Language Assistance Plan for spoken and sign language services that addresses how its own and contracted providers work with interpretation services. It is also developing policies and procedures to make sure that such services are in place throughout the organization.

HealthPartners has also implemented a Web-based cross-cultural training program for its own employees and contracted providers and is working to identify best practices for the use of interpreters and cultural competence.

**Health Plan:**

HealthPartners

**Web Site:**

[www.healthpartners.com](http://www.healthpartners.com)

**Program Contact:**

Donna Zimmerman, M.P.H.

**Intervention:**

- Providing on-site and telephonic interpretation in 150 languages;
- Implemented Web-based cross-cultural training program for employees and contracted providers

## Highmark Inc.

Highmark Inc. has analyzed data from multiple sources to identify potential health disparities among its members. It has also launched an initiative to begin collecting members' racial, ethnic and language-preference data directly.

For the Collaborative, Highmark is focusing primarily on its diabetic membership. Data analysis allowed it to identify network physicians whose patients demonstrated greater than average disparities. It has launched an intervention in which physicians in 10 practices have sent letters to 446 diabetic patients reminding them to obtain needed testing. Although the pilot test is ongoing, physicians report that the intervention is bringing targeted patients into their offices.

Highmark has also launched an ethnic-tailored, interactive, voice-response telephone call campaign regarding barriers to diabetes care. For example, members are asked if they would like to receive additional information about the complications of diabetes. The company has placed more than 24,000 calls and received more than 4,000 positive responses. Some of the callers are being connected with health coaches and other interventions are being planned.

Highmark is also looking at ways to enhance patient support in smaller practices located in areas with higher rates of disparities.

Ongoing community-based interventions that reduce disparities and improve health include partnerships and programs with faith-based and advocacy groups, hospitals, community health centers, and general and minority media. Because diabetes is a growing epidemic that affects a disproportionate number of minorities and because health habits are developed early, Highmark's community commitment starts with children and includes a multifaceted partnership with schools and other organizations to educate families on the risks of childhood obesity.

Highmark reports that since joining the Collaborative, its disparities efforts have evolved from a focus on targeted quality-improvement pilots to enhancing overall strategic direction, which will not only identify and address potential disparities, but will help prevent them. It has embarked on widespread cultural competency training both internally and with its network providers.

**Health Plan:**

Highmark Inc.

**Web Site:**

[www.highmark.com](http://www.highmark.com)

**Program Contact:**

Rhonda M. Johnson, M.D.,  
M.P.H.

**Intervention:**

- Targeting office-based physician educational intervention on health care disparities and diabetes care
- Sending mail reminders to patients with diabetes and cardiac care conditions to encourage needed testing



## Kaiser Permanente

Kaiser Permanente is developing a culturally appropriate outreach model for delivering a proven cardiovascular risk reduction program that is focused on A.L.L. (Aspirin, Lisinopril, Lovastatin) to its Latino members with diabetes. It draws on Kaiser Permanente's unique population management system, which relies on robust data on clinician performance, clinical outcomes and patient adherence.

Utilizing a predictive modeling program, Kaiser Permanente is confident it can reduce the cardiovascular mortality of diabetic patients by nearly 50 percent by placing at-risk patients on three drugs: aspirin, a cholesterol lowering agent known as a statin and a cardioprotective drug known as an ACE inhibitor. The company knows from experience that if it manages these patients efficiently, it stands to save \$300 per patient per year while simultaneously dramatically reducing their mortality.

Kaiser Permanente launched a patient outreach program drawing from the bicultural and linguistic skills of the staff and physicians of its Latino Center of Excellence in Colorado. As a result, it has increased adherence to this therapeutic regimen by nearly 30 percent.

**Health Plan:**

Kaiser Permanente

**Web Site:**

[www.kaiserpermanente.org](http://www.kaiserpermanente.org)

**Program Contact:**

Winston Wong, M.D.

**Intervention:**

- Developing a culturally appropriate outreach model for delivering a cardiovascular risk reduction program to its Latino members with diabetes and
- Educating Latino members in self management

## Molina Healthcare

Just prior to the Collaborative's formation, Molina Healthcare had begun implementing TeleSalud, a 24-hour English/Spanish bilingual telephone service providing access to member services, medical advice from qualified nurses and interpreter services.

At roughly the same time, Molina had begun implementing Healthy Living with Diabetes, a disease management, education and outreach program. To address health disparities among Latino members, Molina identified members with a stated preference for Spanish language and/or Hispanic ethnicity, and developed and distributed materials and conducted outreach specific to language and cultural norms. Through mailings and other outreach, members are invited to self-report information about their conditions, obtain booklets on care, enroll in diabetes education classes, schedule screenings or eye exams, and get help to quit smoking.

Molina has combined the two initiatives for its participation in the Collaborative. The joint project was specifically designed to address cultural barriers to improved care above and beyond those created by language differences.

Preliminary results indicate that members have experienced improvement in their disease management self-confidence and a coincident decrease in their program level of care requirements. Quality measures with respect to diabetes have improved.

**Health Plan:**

Molina Healthcare

**Web Site:**

[www.molinahealthcare.com](http://www.molinahealthcare.com)

**Program Contacts:**

Martha Bernadett, M.D.,  
M.B.A.

Kenneth E. Smith, M.D.,  
M.B.A.

**Intervention:**

- Implementing a 24-hour English/Spanish bilingual telephone service providing access to hospital services
- Involving consultation with providers to improve consistency of communications

## UnitedHealth Group

UnitedHealth Group has begun to develop the capability to directly collect members' primary data on a voluntary basis through its enrollment form.

Before joining the collaborative, UnitedHealth Group found significant differences in HEDIS measures among its African-American members with diabetes. With RAND's help since joining the collaborative, UnitedHealth Group has supplemented that earlier work by adding geocoding and surname analysis for Asian-American, African-American, and Hispanic populations.

Based upon these findings, UnitedHealth Group has designed a pilot that uses a Web-based patient registry, offered at no cost, to help physicians manage patients with diabetes and cardiovascular disease. The registry offers timely disease-specific patient data and includes patient-level race and ethnicity data. UnitedHealth Group is measuring disease-specific data on a quarterly basis for each physician practice participating in the pilot. Interventions are being tested with physicians, members, and the surrounding communities.

**Health Plan:**

UnitedHealth Group

**Web Site:**

[www.uhc.com](http://www.uhc.com)

**Program Contact:**

Jonathan Gavras, M.D.

**Intervention:**

- Providing information to practices through a Web-based patient registry and a planner with real-time, disease-specific patient information

## WellPoint, Inc.

Since joining the Collaborative, WellPoint, Inc. has begun collecting primary patient data on a voluntary basis through its disease management programs and health risk appraisals. It also plans to hold focus groups to develop a better understanding of barriers to care.

With RAND's help, WellPoint has used geocoding, surname analysis and geospatial mapping to identify disparity "hot zones" or "clusters." Pilot programs in place include sending cultural competency toolkits to providers practicing in highly disparate geographies, and enhancing culturally and linguistically adapted patient education materials. Other programs under development include using culturally and linguistically appropriate mailings and telephonic services to reach out to members in the zones, and sharing such materials with community and grassroots health advocacy groups.

**Health Plan:**

WellPoint, Inc.

**Web Site:**

www.wellpoint.com

**Program Contact:**

Lisa Latts, M.D., M.B.A.

**Intervention:**

- Sending pilot regions cultural competency tool kits and education materials and
- Involving staff and members in communication collaboration

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<sup>i</sup> "A Tale of Two Cities," Health Affairs. March/April 2005.

<sup>ii</sup> The Agency for Healthcare Research and Quality. (2005) 2005 National Healthcare Quality and Disparities Report.

<sup>iii</sup> Carter, J.S.; Pugh, J.A.; Monterrossa, A. (1996) "Non-insulin-dependent Diabetes Mellitus in Minorities in the United States." Annals of Internal Medicine.

<sup>iv</sup> <http://www.nap.edu/catalog/10260.html>

<sup>v</sup> These techniques are used to estimate racial and ethnic data that cannot be collected directly. Geocoding uses addresses and U.S. Census Bureau data and surname analysis uses last names to predict members' race and ethnicity

