Toolkit to
Reduce Racial & Ethnic
Disparities in Health Care

**NATIONAL
HEALTH PLAN
COLLABORATIVE**

Contents

Section 1: Introduction

Importance of Reducing Disparities

For more than 20 years, research has documented the persistent gaps in health care quality that disproportionately affect Americans from specific racial and ethnic backgrounds. Many who experience disparate care live in neighborhoods lacking high-quality health services and providers. Our country's legacy of inequality along lines of race, national origin, language, income, employment, education and housing perpetuate these gaps.[1] More troubling still, research shows that racial and ethnic minorities are less likely than Caucasians to receive heath care of comparable quality *regardless of their incomes or health care coverage statuses*.[2]

Despite longstanding research documenting disparities in health care, the overall disparities in quality and access for minority groups and poor populations have not been reduced. For example, comparisons of 2000/2001 data with 2004/2005 data from the 2007 National Healthcare Disparities Report (NHDR) show that many health care measures have gotten significantly worse or have remained unchanged for African Americans, Hispanics, American Indians and Alaska Natives, Asians, and poor populations.

The Agency for Healthcare Research and Quality states that some of the most significant disparities that continue to exist include[3]:

---

[1] Lavizzo-Mourey R, Richardson W, Ross R, et al "A Tale of Two Cities." *Health Affairs*, 24(2): 313-315, March/April 2005. (http://content.healthaffairs.org/cgi/reprint/24/2/313)

[2] Smedley BD, Stith AY and Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: The Institute of Medicine, 2003. (http://www.nap.edu/catalog.php?record_id=10260#orgs)

[3] *2007 National Health Quality and National Healthcare Disparities Report*. Washington: The Agency for Healthcare Research and Quality, 2007. (http://www.ahrq.gov/qual/qrdr07.htm)

Asian adults age 65 and older are 50 percent more likely than Caucasians to lack immunization against pneumonia.

African-American children are hospitalized due to asthma at an almost four-times-higher rate than Caucasian children.

New AIDS cases are 10 times more prevalent among African Americans than Caucasians.

American Indians and Alaska Natives are twice as likely to lack prenatal care in the first trimester compared with Caucasians.

American Indians and Alaska Natives are nearly twice as likely to report poor communication with their health care providers

Data released by the Dartmouth Atlas Project show that African Americans were *four times* more likely than Caucasians to develop diabetes complications requiring leg amputations.[4] Further, between 2000 and 2002, the quality of diabetes care among Hispanic adults declined by 6 percent, whereas the quality of diabetes care among Caucasian adults increased by 5 percent.[5]

These and many other documented disparities in health care and outcomes are both pervasive and disturbing. Health care inequalities are an affront to the country's promise of equal opportunity for all, and they impose a tremendous burden on individuals and communities. 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. Initiatives to reduce disparities and improve care are likely, over time, to yield improved outcomes that may result in long-term cost savings. With escalating health care costs affecting federal, state and employer budgets, it is increasingly important to address disparities and eliminate the financial and economic costs that result from them.

Racial and ethnic disparities in health and health care are caused by a number of complex factors. Therefore, solutions require a comprehensive, multi-level strategy involving everyone in the health care delivery system—including

---

[4] Fisher ES, Goodman DC, Chandra A, et al. *Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project.* Princeton: Robert Wood Johnson Foundation, 2008. (http://www.rwjf.org/pr/product.jsp?id=31251)

[5] *2005 National Health Quality and National Healthcare Disparities Report*. Washington: The Agency for Healthcare Research and Quality, 2005. (http://www.ahrq.gov/qual/nhqr05/nhqr05.htm)

health insurance companies. As a focal point of many quality improvement programs, health insurance companies are in a unique and important position to influence the quality of care that their members receive, including members from diverse racial and ethnic backgrounds. In its seminal 2002 report, *Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care* the Institute of Medicine specifically identified the need for health insurance companies to collect, report and monitor patient care data as one solution to eliminating racial and ethnic disparities in care.[6]

In response to the well-documented and persistent racial and ethnic disparities in our country's health care system, 11 leading health insurance companies combined forces to form the National Health Plan Collaborative (NHPC) to seek out and test best practices to address the issue. The NHPC represents a collective effort by health insurance companies to do their parts to address this serious problem.

In this respect, the NHPC is emerging as a unique national laboratory to develop and test practical approaches to addressing disparities in managed care settings.

Introduction to the National Health Plan Collaborative

The National Health Plan Collaborative (NHPC) is a groundbreaking effort bringing together 11 major health insurance plans, in partnership with organizations from the public and private sectors, to identify ways to improve the quality of health care for racially and ethnically diverse populations. Together, member health plans reach more than 87 million Americans.

Members of the NHPC include Aetna, Boston Medical Center HealthNet Plan, CIGNA, Harvard Pilgrim Health Care, HealthPartners, Highmark Inc., Humana, Kaiser Permanente, Molina Healthcare, UnitedHealth Group and WellPoint, Inc.

The NHPC has received management support and technical assistance from the Center for Health Care Strategies and the RAND Corporation, with funding and leadership support provided by the U.S Department of Health and Human Services Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation.

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

---

[6] Smedley BD, Stith AY and Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: The Institute of Medicine, 2003. http://www.nap.edu/catalog/10260.html

Spurred by the Institute of Medicine's *Unequal Treatment* report, the health plans came together to find ways to reduce racial and ethnic health disparities in care. They determined that, competition notwithstanding, it was time for collective action to address disparities in care. Although others in the health care system—purchasers, patients and providers—also have critical roles to play, this collaboration provides health plans with a unique opportunity to address this critical issue.

During the initial phase of the Collaborative, which began in 2004, the plans agreed to share information about their activities to reduce disparities, not to use the information to compete, and to obtain race and ethnicity data on their members—using either direct or indirect methods. They also embarked on developing and testing interventions targeting diabetes, which is a significant cause of morbidity and mortality among minority populations.[7]

Currently, the member health plans are evaluating provider-, member- and community-targeted approaches that use race, ethnicity and language data to determine the effectiveness of these strategies in reducing gaps in care and improving the quality of care that racial and ethnic populations receive. More specifically, the Collaborative is:

National Health Plan Collaborative Members:

Aetna

Boston Medical Center HealthNet Plan

CIGNA

Harvard Pilgrim Health Care
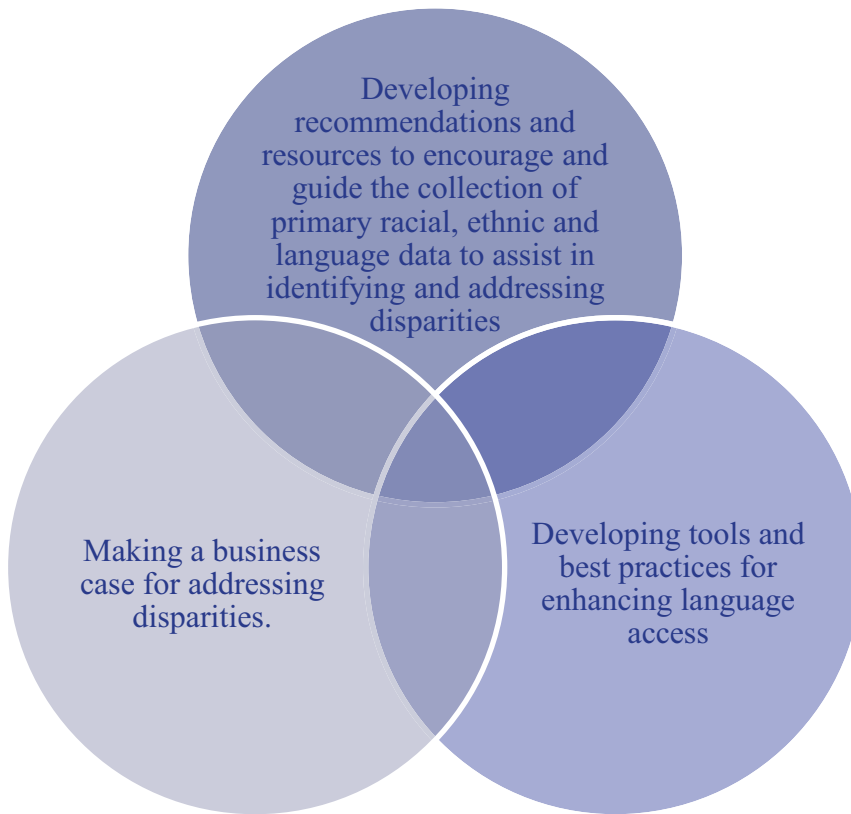
HealthPartners

Highmark Inc.

Humana

Kaiser Permanente

Molina Healthcare

UnitedHealth Group

WellPoint, Inc.

---

[7] Lurie N, Fremont AM, et al. "The National Health Plan Collaborative to Reduce Disparities and Improve Quality." *The Joint Commission Journal on Quality and Patient Safety*, 34 (5): 256-265, 2008.

Building on the spirit of collaboration, this toolkit was designed to share the lessons learned, best practices and tools developed from the efforts of these 11 plans. These resources are available to health plans throughout the country to recognize and understand the disparities within their own plans and to apply these tools and lessons to reduce racial and ethnic disparities in health and health care within their memberships.

Introduction to the Toolkit

The National Health Plan Collaborative has created this toolkit of resources, lessons, best practices and case studies to help other health plans join the effort to reduce disparities. The toolkit shares what the Collaborative's members have done to develop and test new methods of measuring and addressing racial and ethnic disparities so that other health care decision-makers and leaders can learn from this work, implement these best practices and make the case for addressing the unacceptable differences in health care and health outcomes for health plan members throughout the country.

Useful resources featured in this toolkit include:

- Health plan case studies;

- Sample tools, forms, policies and resources for implementation;

- Videos of experts talking about the importance of reducing disparities and about firsthand experiences in developing and implementing interventions; and

- A compilation of resources in this field.

Descriptions of each chapter are below:

Introduction:
- Answers to why disparities in health and health care should be addressed and a description of the National Health Plan Collaborative.

Data Collection:
- A summary of national and local policies on data collection; a description of why it is important to collect primary race, ethnicity and language data; and methods the health plans have used for collecting race, ethnicity and language data.

Language Access:
- A discussion of why patient-provider communication is important; state and federal policies that affect language assistance in health care; how to plan for language services; how to implement interpretation services; how to provide materials in different languages; and how to ensure the quality of language access services.

Business Case:
- Tools and information for making the business case for improving quality and addressing disparities in your health plan.

Section 2: Data Collection

Why Collect Race, Ethnicity and Language Data

Efforts to eliminate racial and ethnic disparities in health care must begin with valid and reliable data on race, ethnicity and language preference. Although collecting such data alone cannot reduce or eliminate disparities, gathering these data is a necessary first step in identifying disparities and the health care needs of specific populations and planning customized interventions to address inequalities in care.[8] Without such data, health plans cannot effectively define the problem or devise targeted, meaningful solutions.

Current National and Local Policies on Data Collection

The disparities agenda continues to exist as a high priority issue for public and private stakeholders that is intricately linked to the overall quality agenda. Although the majority of disparities-related activities has revolved around developing targeted interventions for various racial and ethnic populations, significantly less attention has been paid to the collection and accessibility of race and ethnicity data on which to base these efforts.

To some degree, this discrepancy may reflect the fragmentation of data collection efforts among various entities. Current national health-related data collection and reporting activities primarily reflect the efforts of the U.S. Department of Health and Human Services (HHS), with virtually all of its health-related divisions collecting race and ethnicity data.[9] However, despite the individual efforts of HHS and other government entities, federal laws, policies and practices governing racial, ethnic and primary language data collection remain unclear and are often inconsistent.[10]

The Office of Management and Budget's (OMB) standards for the Classification of Federal Data on Race and Ethnicity, which were originally developed to support the enforcement and monitoring of civil rights laws, are currently mandated for use by specific federal agencies such as the

Top Tips:

Gathering data is a necessary first step in identifying disparities and the health care needs of specific populations, and to plan customized interventions to address inequalities in care.

Did you know?

Virtually all of the U.S. Department of Health and Human Services' health-related divisions collect race and ethnicity data.

---

[8] Lurie N, Jung M, Lavizzo-Mourey R. "Disparities and Quality Improvement: Federal Policy Levers." *Health Affairs.* 24(4): 354-364, March/April 2005.

[9] Perot RT and Youdelman M. *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*. New York: The Commonwealth Fund, 2001.

[10] Perot and Youdelman.

Bureau of the Census. However, mandates of these standards have not been expanded into the health sector despite already being one of the most pervasively utilized race/ethnicity classification approaches in the field. OMB standards are certainly not without their own limitations. Originally developed for the purposes of reporting information for civil rights enforcement and monitoring, the OMB categories do not contain more granular race and ethnicity information that health care organizations need for more targeted outreach effort. With no mandated requirements existing for the collection and categorization of race and ethnicity data (OMB or otherwise), the collection of race, ethnicity and language data is not universally practiced by the health care industry.[11]

Policymakers, health plans and other entities are increasingly recognizing the value of and need for accurate and timely data on race, ethnicity and language as evidenced by the broad array of mandates or recommendations that exist at a local level. Several states have been proactive in moving the race and ethnicity data collection agenda forward.

> *Top Tips*
>
> *The collection of race and ethnicity data falls within health plans' legal purview.*

---

[11] *Federal Register.* 62(210): 58782, October 30, 1997.

State Activities

Several states have been proactive in moving the race and ethnicity data collection agenda forward:

California:

- The state mandates that all California health plans provide language assistance services to their enrollees with limited English proficiency.
- Plans must identify the languages that are likely to be encountered among enrollees and outline the data collection methods used to estimate the number of limited English proficiency (LEP) enrollees and their language needs.
- A survey to collect data on each individual enrollee's language needs must also be conducted. Mandates for these activities, however, do not include guidance on important specifics such as the classification of race and ethnicity data. (California's 2003 Senate Bill 853)

Organizations such as the California Association of Health Plans (CAHP) have convened important stakeholders to discuss and come to consensus on such issues; however, without formal incorporation of these points in the legislation these positions only remain recommendations.

Massachusetts:

- The state has a requirement that all acute care hospitals in the city and state collect race and ethnicity data from all members with an in-member hospitalization, an observation unit stay or an emergency department visit. (Regulations passed by the Boston Public Health Commission (BPHC) and the Massachusetts Division of Health Care Finance and Policy (MDHCFP) via the 2006 Massachusetts Health Care Reform Bill)

Legislation in Massachusetts is similarly lacking the specificity needed to ensure alignment of race and ethnicity data aggregation efforts locally, let alone at a broader level.

The activities of these states, though to be lauded, again highlight the fact that even among these and other local entities currently collecting race and

ethnicity information, variations exist in the types of information being collected, the classification of the data being collected, as well as the manner in which the data are collected.

Resources such as the Health Research and Educational Trust's (HRET) *Disparities Toolkit* and America's Health Insurance Plans' *Tools to Address Disparities in Health: Data as Building Blocks for Change,* along with other important syntheses serve as important caches of information on race and ethnicity data collection; however, the continued growth in disparities-related activities and the associated proliferation of recommendations has highlighted the need to identify a uniform framework for collecting race and ethnicity data.

Communicating the Importance of Collecting Primary Race, Ethnicity and Language Data

Sensitivities around the collection of race, ethnicity and language information necessitate the careful crafting of communication messages that convey the need to acquire this important data.

In the last several years, health plans have become more aware that the collection of race and ethnicity data is an activity that falls within their legal purview. A 2006 policy analysis supported by the Robert Wood Johnson Foundation (RWJF) and conducted by The George Washington University School of Public Health and Health Services (GWU) set out to expound on the legality of data collection at a time when many were still unclear about the legal implications of doing so and the potential liability created by the collection and use of such data.[12]

Top Tips

When communicating about collecting data on race and ethnicity, remember the concerns of multiple beneficiaries including providers, staff, employer groups and other stakeholders.

---

[12] Rosenbaum S, Burke T, Nath SW, et al. *The Legality of Collecting and Disclosing Patient Race and Ethnicity Data.* Washington: The George Washington University School of Public Health and Health Services Department of Health Policy, 2006.

> ### *Did You Know*
>
> *The collection and disclosure of member data by race and ethnicity in a quality improvement context advances the purposes of Title VI of the Civil Rights Act:*
>
> *"...Title VI of the 1964 Civil Rights Act (which prohibits discrimination on the basis of race or national origin by recipients of federal assistance) creates no legal liability for health care providers who collect and report health care quality data by race and ethnicity, when such an effort is undertaken as part of an overall program of quality improvement and not as a subterfuge for an impermissible purpose under the law. Experts in quality improvement – including the federal government – consider the evaluation of member quality by race and ethnicity as an essential element of overall health care quality improvement. For this reason, the collection and disclosure of member data by race and ethnicity in a quality improvement context advances the purposes of Title VI. Such practices would be entirely consistent with the regulations and would operate as evidence of compliance with the law rather than as a violation of it."*

The analysis not only clearly affirms that it is legal to collect and report health quality data by member race and ethnicity, but appeals for government guidelines to further encourage and shape the practice.[13]

Health plans are attuned to the need to address the health care needs of their increasingly diverse membership. However other stakeholders such as employers and health service providers, question the importance of collecting race, ethnicity and language information. Because opportunities to collect data exist at multiple levels, communication strategies need to reflect not only the concerns of beneficiaries but other potential sources or acquirers of data including providers, staff and employer groups.

---

[13] Rosenbaum et al. *The Legality of Collection and Disclosing Patient Race and Ethnicity Data.*

Beneficiaries

In a 2003-2004 survey of its members, America's Health Insurance Plans asked plans about the extent to which they collect and use enrollee race and ethnicity data. Virtually all health plans noted that enrollees' perception about the use of this information was of significant concern.[14] Research by Baker et al on members' attitudes toward health care providers' collection of information on race and ethnicity indicated that despite relatively high levels of comfort about sharing this information, over half of the participants in their study were somewhat or very concerned that this information could be used to discriminate against members.[15] Interestingly, when members were offered different rationales as to the purpose of collecting this information, individuals were most comforted by the justification that race and ethnicity data would be used for quality monitoring purposes for all members.

Given what is known about people's attitudes regarding sharing this type of information, it is important for health plans and health care providers to include several key elements when devising messaging for beneficiaries, regardless of the method chosen to collect information. These elements include assuring members that:

1. The information is **voluntary**;

2. The information is **confidential;**

3. The information will be used to **improve quality of care** for its members; and

4. The information will **NOT be used to determine coverage, paying of claims or discriminate** in any other way.

Several National Health Plan Collaborative plans have integrated these key principles into a variety of their data collection methods. For example, Aetna's member Web portal includes a dialog box soliciting beneficiary race, ethnicity and language information and addresses concerns that members may have about the data use. Other examples of scripts soliciting beneficiary

> *Did You Know?*
>
> *Members want to know that race and ethnicity data is used for quality monitoring purposes for all members.*

---

[14] *Collection and Use of Racial and Ethnic Data by Health Plans to Address Disparities: A Final Summary Report.* America's Health Insurance Plans and the Robert Wood Johnson Foundation, 2004.

[15] Baker DW, Kenzie A, Cameron, et al. "Members' Attitudes Toward Health Care Providers Collecting Information About Their Race and Ethnicity." *Journal of General Internal Medicine,* 20(10): 895–900, 2005.

race, ethnicity or language information include the Highmark Inc. member survey and the HealthPartners clinic form.

Health Plan and Provider Group Staff

Although health plans may decide at an organizational/leadership level to pursue the collection of race and ethnicity data for disparities reduction efforts, the successful execution of these activities depends on high level support and buy-in of internal health plans and provider group leadership and staff. Health plan staff represent the operational means of acquiring the data (whether via customer service representatives, office support staff, clinical staff, ancillary staff or providers). It is important to communicate to them the disparities agenda and their important role in successfully implementing data collection efforts. Most importantly, health plans should describe how accessing this information will support staff in providing better care for their members. In its Tools to Address Disparities in Health: Data as Building Blocks for Change toolkit, America's Health Insurance Plans outlines a case for why the collection of race, ethnicity and language access data is important for staff and providers.

Staff access to race, ethnicity and language data can:[16]

- Strengthen the member-provider relationship and communications;

- Improve cross cultural education and skills;

- Increase member compliance and adherence to medication;

- Reduce potential for misdiagnosis of medical conditions due to language barriers;

- Identify need for interpreter and translation services; and

- Increase the representation of racial and ethnic minorities in health professions.

> ***Top Tips***
>
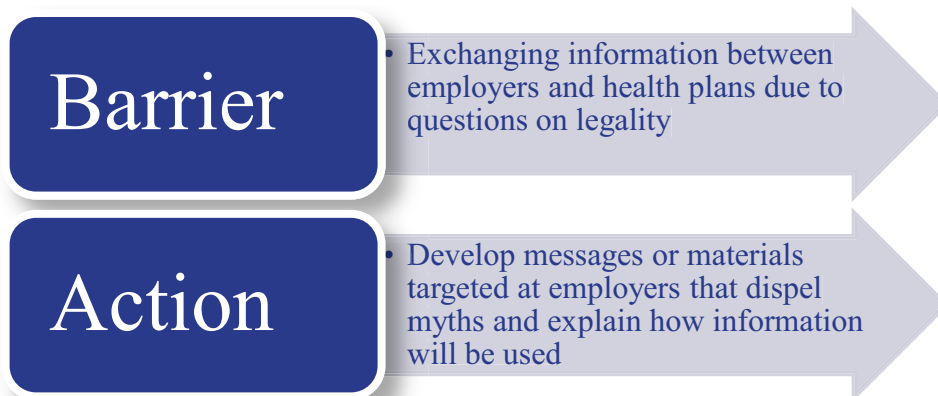> *Staff buy-in is essential for data collection. To achieve buy-in:*
>
> *1. Communicate why data collection can reduce disparities and show the importance of the staff role in successfully implementing data collection efforts.*
> *2. Communicate that information on race and ethnicity will help staff provide better care for members.*

Employers

Employers represent another potential source of race, ethnicity and language data given that they routinely collect this information for Equal Employment Opportunity (EEO) related purposes. Through means such as specific

---

[16] *Tools to Address Disparities in Health: Data as Building Blocks for Change*. Washington: America's Health Insurance Plans, 2005.

requests to their plans or via more standardized means such as the National Business Coalition on Health's Evalue8 RFI, employers have more information on how their contracted health plans are addressing disparities.

Some plans have developed materials specifically geared to respond to the growing number of inquiries on disparities related activities from their clientele. For example, Highmark Inc. focused one issue of its group customer newsletter on how the plan is working to close the disparities in health care quality.

Despite interest of both health plans and employers to examine disparities, there are a number of barriers which have prevented the exchange of information between employers and health plans from being a more customary practice. The issue which appears to be one of the most prominent among employers is the concern over the legality of sharing employee data. Messages or materials targeted at employers should address these looming legal concerns, dispelling inaccurate perceptions around the permissibility of doing so and fully informing employers of the ways in which the information will be used.

<table>
<tr><td>Barrier</td><td>• Exchanging information between employers and health plans due to questions on legality</td></tr>
<tr><td>Action</td><td>• Develop messages or materials targeted at employers that dispel myths and explain how information will be used</td></tr>
</table>

The George Washington University recently produced a brief addressing the legal concerns of employers regarding the use of race and ethnicity for quality improvement activities.

The brief, entitled *The Legal Context for Employer Health Care Quality Improvement Initiatives That Collect and Report Information by Member Race and Ethnicity,* ultimately concludes that "employer participation in workplace or community quality improvement projects that use race/ethnicity data to examine health care quality and report results are not only consistent with federal civil rights law but actually advance the central goal of Title

VII."[17] This brief provides a legal basis for encouraging employers and health plans to partner in using available race, ethnicity and language data for quality improvement purposes.

What Categories of Race/Ethnicity to Use?

A critical issue in race and ethnicity data collection is how many categories of race and ethnicity to include. Having every possible racial and ethnic category available in a data collection tool may be quite cumbersome and require sophisticated information technology. On the other hand, collecting data using very broad categories may not be useful for organizations serving very diverse populations. For example, the Asian category includes individuals from India, China, Korea and other countries with significantly different cultures and beliefs.

Use of a Separate Ethnicity Question

One of the unresolved questions in the collection of race and ethnicity data is how to collect information on Latino ethnicity. To address this, the Office of Management and Budget collects information on race and ethnicity using two separates questions. However, recent studies have found that many Latinos do not see themselves as having a race separate from their ethnicity.[18] Indeed, a large proportion of individuals who respond to the ethnicity question tend to leave the race question blank.[19] The Health Research Educational Trust recommends using a single race and ethnicity question that includes a Hispanic or Latino option.

---

[17] Burke T, Stewart A, Harty ME, et al. "The Legal Context for Employer Health Care Quality Improvement Initiatives That Collect and Report Information by Member Race and Ethnicity." *BNA's Health Care Policy Report,* 16(25), 2008.

[18] Baker DW, Cameron KA, Feinglass J, et al. "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity." *American Journal of Public Health,* 96(3): 532-537, 2006.

[19] Kenefick HW and Flaherty K. *Results of Pilot Study: Race, Ethnicity and Education Data Collection in Partners HealthCare System.* 2005.

Table 1: Race and Ethnicity Categories by Organization

ORGANIZATION	CATEGORIES INCLUDED
U.S. Office Management and Budget	Question I, Ethnicity (*asked before the race question*): • Hispanic or Latino • Not Hispanic or Latino Question 2, Race: • American Indian or Alaska Native • Asian • Black or African American • Native Hawaiian or Other Pacific Islander • White *Allow each person to give as many answers as needed.*
Health Research and Educational Trust	• African American/Black • Asian • Caucasian/White • Hispanic/Latino/White • Hispanic/Latino/Black • Hispanic/Latino/Declined • Native American • Native Hawaiian/Pacific Islander • Multiracial • Declined • Unavailable/Unknown *This format is helpful if the organization's data system will only allow for the collection of one race/ethnicity category per person*

Race and Ethnicity Categories

In its 2004 report, *Eliminating Health Disparities: Measurement and Data Needs*, the National Research Council of the National Academies recommended that health care organizations collect standardized data on race and ethnicity using the Office of Management and Budget (OMB) standards as a base minimum.[20] The Health Research and Educational Trust (HRET) recommends that when possible, organizations should collect granular data

---

[20] *Eliminating Health Disparities: Measurement and Data Needs.* Washington: National Research Council of the National Academies, 2004.

on race and ethnicity that can be aggregated into the broader OMB categories. Specifically, the U.S. Centers for Disease Control and Prevention (CDC) have prepared a hierarchical code set that can support this approach. The CDC code set is based on current federal standards for classifying data on race and ethnicity, specifically the minimum race and ethnicity categories defined by the OMB and a more detailed set of race and ethnicity categories maintained by the U.S. Bureau of the Census.

The code set consists of two tables: (1) Race and (2) Ethnicity. Concepts in the Race and Ethnicity tables include the OMB minimum categories—five races and two ethnicities—along with a sixth race category—Other race— and a more detailed set of race and ethnicity categories used by the Census. Within the table, each race and ethnicity concept is assigned a unique identifier, which can be used in electronic interchange of race and ethnicity data. The hierarchical code is an alphanumeric code that places each discrete concept in a hierarchical position with reference to other related concepts. For example, Costa Rican, Guatemalan and Honduran are all ethnicity concepts whose hierarchical codes place them at the same level relative to the concept Central American, which is the same hierarchical level as Spaniard within the broader concept Hispanic or Latino. In contrast to the unique identifier, the hierarchical code can change over time to accommodate the insertion of new concepts.

Plan Methods for Collecting Race, Ethnicity and Language Data

Health plans can employ multiple methods for collecting data on members' races, ethnicities and primary languages. Strategies for obtaining data fall into two broad categories: direct data collection methods and indirect data collection methods. Table 2 outlines the strategies for data collection.

Table 2: Strategies for Data Collection

TYPE	DEFINITION	PRIMARY SOURCE
Direct	Direct request for member to supply his or her race, ethnicity or language information	• *Primary source*: data derived from health plan-specific interactions or encounters • *Secondary source*: data directly collected from an individual by an entity external to the health plan (e.g., Centers for Medicare & Medicaid Services, state Medicaid agencies and employers)
Indirect	Estimation of members' likely races, ethnicities or preferred languages from other related information such as the neighborhoods they live in or their last names	• Geocoding from census information • Surname analysis

A single best practice or method for collecting race, ethnicity and language data may not be the most effective way to conceptualize data collection methods since real world experience suggests that no single method is sufficient for obtaining these data for a plan's entire membership. Indeed, the experience of plans participating in the National Health Plan Collaborative (NHPC) indicates that combined methods are needed to obtain complete and accurate information in the current environment. Ideally, the barriers to obtaining race, ethnicity and language data, and the need for plans to draw on so many diverse sources, will rapidly diminish as local and national efforts to establish consistent standards and rules for data collection and related information technology infrastructure improve. Table 3 illustrates the various methods that NHPC members are using or are considering using in the near future to collect race, ethnicity and language data.

Table 3: NHPC Plan Methods for Collecting Race, Ethnicity and Language Data – Direct Methods, Primary Sources

	Aetna	BMC HealthNet	CIGNA	Harvard Pilgrim	HealthPartners	Highmark Inc.	Humana	Kaiser Permanente	Molina Healthcare	UnitedHealth Group	WellPoint, Inc.
Direct Data Collection Methods											
Primary Sources											
Enrollment	◉			□		○	○	○		○	□
Disease management programs	□	□	◉	○	□	□	○	□	□	□	◉
Health risk assessments	□	□	◉	□	□	□	□	□	□	◉	◉
Encounter (office, hospital, etc.)		○		□	◉			◉	□		
Health plan direct outreach		○		□			○		□		○
Member Web portal	◉		○	□	□	○	○			□	□
Member surveys	□			□		◉	○	□	□	□	◉
Member-initiated contact	□				□		○		□		□

LEGEND

◉ Primary source of race, ethnicity and language data
□ Additional source of race, ethnicity and language data
○ Considering use of this data source

Table 4: NHPC Plan Methods for Collecting Race, Ethnicity and Language Data – Direct Methods, Secondary Sources

	Aetna	BMC HealthNet	CIGNA	Harvard Pilgrim	HealthPartners	Highmark Inc.	Humana	Kaiser Permanente	Molina Healthcare	UnitedHealth Group	WellPoint, Inc.
Direct Data Collection Methods											
Secondary Sources											
CMS (Medicare)	□		◉	□	□	□	◉	□		◉	□
State (Medicaid)	□	◉		□			○		◉	□	◉
Insurance broker	□										
Employer	◉		□							○	○

LEGEND

◉ Primary source of race, ethnicity and language data
□ Additional source of race, ethnicity and language data
○ Considering use of this data source

Table 5: NHPC Plan Methods for Collecting Race, Ethnicity and Language Data – Indirect Methods

	Aetna	BMC HealthNet	CIGNA	Harvard Pilgrim	HealthPartners	Highmark Inc.	Humana	Kaiser Permanente	Molina Healthcare	UnitedHealth Group	WellPoint, Inc.
Indirect Data Collection Methods											
Third- generation methods (Bayesian)	□			◉		○	○		○		◉
Combined geocoding/surname analysis			□	□		□		□		□	◉
Geocoding or surname analysis alone			□		□		□		□		

LEGEND

◉ Primary source of race, ethnicity and language data
□ Additional source of race, ethnicity and language data
○ Considering use of this data source

Each method has various advantages and disadvantages. Health plan contextual factors, such as infrastructure capacity and overall strategy, play an important role in determining the ideal method or mix of methods for collecting race, ethnicity and language information. For example, plans such as Kaiser Permanente and HealthPartners—which feature integrated delivery systems in which they own clinics and employ the staff—may be well-positioned to have physicians or clinic staff obtain race, ethnicity and language data when they encounter members at office visits. In contrast, network model HMOs, even if large, such as WellPoint, Inc. or UnitedHealth Group, may have a harder time compelling contracted providers to routinely obtain race, ethnicity and language data during encounters since most of those providers contract with numerous other plans which may not encourage this data collection.

Table 6: Health Plan Characteristics

HEALTH PLAN CHARACTERISTICS	EXAMPLES	PLAN EXPERIENCE
• Integrated delivery system • Health plan owned clinics • Health plan staff	• Kaiser Permanente • HealthPartners	Easier for staff to obtain race, ethnicity, and language data when they encounter enrollees at office visits
• Network HMOs • Network providers	• Aetna • BMC HealthNet • CIGNA • Harvard Pilgrim Health Care • Highmark Inc. • Humana • Molina Healthcare • WellPoint, Inc. • UnitedHealth Group	Harder to compel network providers to routinely obtain race, ethnicity, and language data during encounters due to different health plan contracts

The following section outlines the various data collection methods and describes associated advantages and disadvantages to consider when contemplating the combination of strategies that may be most suitable. For a comparison table of the various methods of data collection, including advantages, disadvantages and reliability of the various methods, please see the Appendix.

Primary Sources of Race, Ethnicity and Language Data

Health Insurance Plan Enrollment

In 2003-2004, America's Health Insurance Plans collaborated with the Robert Wood Johnson Foundation to conduct a survey and follow-up research to assess whether health plans and insurers collect racial and ethnic data on their enrollees and how this data is used to improve patient care. Their findings, highlighted in the *Collection of Race and Ethnicity and Primary Language to Address Health Care Disparities* brief, indicate that the most common method used to collect race, ethnicity and primary language information is via the enrollment process.[21] The enrollees self-report these data, which have been found to be fairly accurate. Information collected at the time of enrollment has the advantage of being integrated into the health plan's central data system. The primary concern about collecting data during enrollment involves the potential for members to perceive that race and ethnicity data might be used to deny coverage. As mentioned previously, it may be important to include messages within the enrollment form that inform members about the use of the race, ethnicity and language data.

> ***Did You Know?***
>
> *The enrollment process is an easy way to collect race, ethnicity and primary language information.*

Disease Management

Disease management programs are another avenue for health plans to collect race, ethnicity and primary language information from their members. Data can be collected not only during enrollment in these targeted programs, but during any one of the frequent contacts that the disease management entity has with the member. Program participants self-report these data, so they are therefore likely to be accurate. This method may reach some of the plans' most vulnerable members. However, this method will capture only those individuals who participate in disease management programs, and will not provide race, ethnicity and language data across the majority of the plan membership. Also, race, ethnicity and language data collected through disease management programs may reside within a contracted disease management organization and are not necessarily transmitted to the health plan.

> ***Top Tips:***
>
> *Data collection through disease management programs captures only a fraction of members. It may be helpful to supplement this with other data.*

---

[21] *Collection and Use of Racial and Ethnic Data by Health Plans to Address Disparities: A Final Summary Report.* America's Health Insurance Plans and the Robert Wood Johnson Foundation, 2004.

Health Risk Assessment

Health plans use health risk assessments (HRAs) to identify the future care needs of their members and to determine those individuals who would benefit from specific disease management or other health promotion programs. HRAs typically collect members' demographic information, including data on race, ethnicity and primary language. As in the case of data collected via disease management programs, health risk assessments may realistically capture only a limited fraction of all members.

Encounter

Many medical groups, physicians' offices, hospitals and clinics collect information on the patient during his or her intake process. This includes information on the member's demographic characteristics, initial health condition and symptoms, and services and treatments received. Health plans can potentially obtain race, ethnicity and language data collected by providers through a data transfer. This is the primary method of data collection used by plans that are part of an integrated delivery system (IDS), such as HealthPartners and Kaiser Permanente. In these cases, shared systems and data infrastructure allow for the easy transfer of data from providers to the health plan. However, plans that are not part of an IDS may need to both negotiate access to these data and reconcile the data to ensure that the data categories used by providers match those used by the plan. An advantage of collecting data during an encounter is that members have the opportunity to ask questions about why data are being collected and what data will be used for. If staffs are properly trained, this method can be quite effective in collecting data. However, without proper education, providers may be hesitant to ask these questions of members, fearing exposure to litigation. Furthermore, providers who do not ask members to self-identify may note members' data incorrectly.

Top Tips:

Staff education is essential for collecting data through the intake process. Without education and training, staff may incorrectly assess a member's race or ethnicity. It is also important to train staff to communicate why they are asking for race and ethnicity information.

Member Web Portal

Health plans are increasingly using Web portals to help members manage their health care. These Web portals offer information about enrollees' benefits, decision support tools and claims information. Health plans can use the member Web portal as a vehicle for collecting members' background information, such as race, ethnicity and preferred language. Aetna, HealthPartners and UnitedHealth Group are among the National Health Plan Collaborative plans employing this method.

As mentioned earlier, the efficiency and appropriateness of specific methods may vary based on substantial differences in the rate of use of a plan's Web portal by enrollees in different markets and regions and/or those served by different plans in same area. The member Web portal can be an efficient method of data capture for Internet users. For example, Aetna found the use of the Web portal to be very efficient and effective for its membership. Other plans may not find the Web portal as effective, particularly those whose members are not likely to access the Internet. In addition, even if a relatively large proportion of enrollees uses the Web portal and is willing to provide race, ethnicity and language information, there still can be substantial differences within a given plan. For example, some groups of members may be more or less likely to use the Web portal than others. Health plans should be aware of these potential biases and attempt to use strategies that facilitate the collection of data from the widest range of their diverse membership.

Aetna: Voluntary Race, Ethnicity and Language Data Collection Program

Aetna first began collecting race and ethnicity data in 2002 via electronic and paper enrollment forms. Over time, data collection efforts have significantly expanded and multiple mechanisms are used to capture accurate race and ethnicity data. Race/ethnicity and language preference data can be updated at any point of contact, including paper and electronic enrollment forms, online benefits information and health risk assessment, and via the phone with customer service or member management representatives. The electronic system tracks when a member declines to give race/ethnicity or language data, alerting staff not to ask again.

Key Milestones in Aetna's Data Collection Efforts

- **2002**: Aetna begins voluntary collection of data via electronic and paper enrollment forms in targeted states.

- **2003**: Aetna integrates race/ethnicity data captured in HRAs into member management systems.

- **2004**: Members who access their personal benefits information on the Aetna Navigator portal are prompted to voluntarily provide race/ethnicity information. This enhancement significantly increases the amount of data available for Aetna to

create targeted programs and services to decrease disparities in health care. To ensure that race/ ethnicity data continue to remain protected, additional policies and procedures were introduced to define appropriate and inappropriate uses

- **2005:** Aetna expands data collection efforts to 47 states and Washington, D.C. Aetna modifies its system to allow members to enter up to two races to identify themselves.

- **2006:** Race/ethnicity and language preference information may be updated at any point of contact when members talk with customer service and member management representatives. Aetna prioritizes the use of customer service interactions and the Web portal in collecting self-reported race/ethnicity and language data.

Aetna Navigator

Aetna collects member race, ethnicity and language data through several mechanisms. Beginning in 2006, Aetna prioritized collection of this information through its member Web portal, the Aetna Navigator. Members who access their personal benefits information online are prompted to voluntarily provide race/ethnicity and language information. The Aetna Navigator affords multiple occasions to reach members, thereby enhancing Aetna's ability to collect this data. The Aetna Navigator also eliminated significant challenges associated with collecting the data through paper enrollment forms, allowing Aetna to collect the data at a more granular level. More important, since the data are being collected after member enrollment, there is much less suspicion about using the information to deny coverage.

Results

Since 2002, more than 60 million Aetna members have provided race/ ethnicity and or primary language information. In 2008, Aetna collected this information from more than 5 million members, representing approximately 30 percent of its actively enrolled medical and/or dental membership. By using these data and combining them with health care data for these members, Aetna has identified differences in quality of care measures across racial/ethnic groups and developed culturally appropriate initiatives to address health issues prevalent among racial/ethnic minorities. For example, Aetna's blood glucose monitoring program uses Spanish-language services and materials to better serve and empower Spanish-speaking

members with diabetes. In addition, the company launched the *African American with Hypertension* study which demonstrated that a culturally competent disease management program improved blood pressure control and medication adherence.

The most significant advantage of collecting race/ethnicity data through the member Web portal is that it allows health plans to collect the information at a more granular level. Plans can include more race, ethnicity and language options through drop-down menus, eliminating the space constraints associated with paper forms. The availability of this information could also populate other databases—removing the need for multiple data entry.

Health Plan Direct Outreach

Health plans frequently conduct outreach as part of efforts to educate members about existing programs, encourage preventive screenings or help members better understand their benefits. Race, ethnicity and language data collection can be incorporated into these outreach efforts. Harvard Pilgrim Health Care (HPHC) initiated the collection of race and ethnicity data through interactive voice response (IVR) outreach calls to educate members about colorectal cancer screening. A major advantage of this method is that since plans are already conducting outreach for other purposes, the cost of adding race, ethnicity and language data collection to the outreach is often minimal.

Did You Know?

Web portals allow data collection at a more granular level (e.g., more race, ethnicity and language options can be provided).

Did You Know?

The cost of adding race, ethnicity and language data collection to outreach is often minimal.

Harvard Pilgrim Health Care: Pilot Test of IVR Outreach Calls as a Mechanism for Collecting Race and Ethnicity Data

Background

Harvard Pilgrim Health Care (HPHC) has been using Interactive Voice Response (IVR) technology since 2003 to generate educational outreach calls to members who have not received necessary preventive or chronic care services within the recommended time period. Calls initially focused on flu reminders, but HPHC has since expanded outreach calls to include colorectal cancer screening, asthma and cardiovascular disease. HPHC generates more than 200,000 IVR calls in connection with clinical outreach projects. IVR technology is also used for other member communications.

IVR as a Vehicle for Collecting Race and Ethnicity Data

In June 2007, HPHC piloted the collection of race and ethnicity data in the context of IVR outreach calls to educate and encourage members to be screened for colorectal cancer. The calls began with questions about members' screening history and plans, delivered information about screening options, and then asked about barriers to screening. After covering these items, IVR call recipients who remained on the line were then asked to describe their race and ethnicity.

> **Sample Script for Obtaining Race and Ethnicity Information Through Computer-Generated Outreach Calls**
>
> - Please tell me, yes or no, are you of Hispanic or Latino origin (such as Puerto Rican, Latin American, Mexican American or Cuban)? [IF NO]
>
> - Now I'm going to read from a list of other categories, including white, black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, or multiracial. Please say, "yes" after the option you feel best fits you or you can just say "please move on."
>
> - OK. Are you white? Black or African American? Asian? Native Hawaiian or other Pacific Islander? American Indian or Alaska Native? Multiracial? Another race that was not mentioned?

HPHC initially targeted 50,000 members for colorectal cancer screening outreach. After removing individuals who appeared in multiple call lists and accounting for individuals who could not be reached, HPHC was able to contact 22,000 individuals. Of the 20,000 members who accepted the CRC screening outreach call, 27 percent were still on the line when the query about race/ethnicity was made, representing 13 percent of the initial target population.

Results

Almost 96 percent of those who were queried about their race and ethnicity readily volunteered information for an overall yield of 11.5 percent of targeted members. Furthermore, no complaints were received from the members who were asked to provide the information. Although the percentage of members queried about their race/ethnicity could be increased by moving this query earlier in the call, the primary purpose of the call was to determine whether members had been screened and to convey important clinical messages to those who hadn't been screened (i.e., you should be

screened for colorectal cancer; there are several acceptable tests; speak with your doctor about the right test for you; etc.). These messages were viewed as needing to be delivered first.

Despite the seemingly low response rate, there are several factors that still make the use of IVR for race/ethnicity data collection attractive. First, the cost of adding the race/ethnicity query to an existing IVR call is marginal since there is a one-time development cost and essentially no operational cost. There is also no cost associated with data entry, since the IVR responses are captured in electronic form. Lastly, it may be that when race/ethnicity queries are added to IVR calls that focus on less unpleasant topics or with more brief messages, a higher response rate is likely to result.

Members initially targeted for CRC outreach

50,000 — Excluded because members appeared in multiple call lists → 4,400

Eligible to receive CRC outreach calls

45,600 — Invalid phone numbers → 4,600

Members with valid, working phone numbers

41,000 — Unreachable/ no answer → 19,000

Members actually reached

22,000 — Refused to continue call after initial introduction → 2,000

Allowed IVR message to continue

20,000

Lessons Learned

There are several benefits associated with the use of IVR technology.

- IVR provides an opportunity to educate members as well as probe on their self-management behaviors.

- The use of a toll-free number allows members to hear the information at a time that is more convenient for them.

- Spoken messages may be more effective when dealing with individuals with low literacy, especially since members can ask to have statements and questions repeated as often as necessary.

- Advances in IVR technology have also enabled calls to be conducted in Spanish.

- Computer-generated messages may be perceived as less threatening than a personal discussion.[22]

- Previous IVR initiatives suggest that information reported by members through IVR is as reliable as that obtained through structured clinical interviews.[23]

HPHC has learned several lessons in conducting the IVR colorectal screening pilot. The topic of colorectal screening is more unpleasant than many other issues and a larger number of members do not complete the entire call. The call is also longer than most as it asks a series of questions on CRC screening, plans for future screening and barriers to getting screened, explains all of the screening options, and provides information about the importance of screening. Regarding the sensitivity of indirect data collection methods, some members who self-identified as Hispanic or Latino were not correctly identified as such by geocoding and surname coding. Lastly, experience in reaching members who had been called the previous year and who had not been screened in the interim suggests that these individuals may require stronger messages and different questions to secure participation.

---

[22] Piette JD. "Interactive Voice Response Systems in the Diagnosis and Management of Chronic Disease." *The American Journal of Managed Care,* 6(7): 817-827, 2000.

[23] Piette JD. "Interactive Voice Response Systems in the Diagnosis and Management of Chronic Disease."

Member Survey

Health plans can integrate race, ethnicity and language questions into member surveys that are intended for other topic areas. Alternatively, plans can conduct a survey for the specific purpose of collecting race, ethnicity and language information from members. The use of member surveys always raises the important concern of ensuring adequate response rates. Highmark Inc. developed a paper-based questionnaire asking members for their race and ethnicity, language spoken at home, language preference for communications with Highmark Inc. and whether a member or family member needs or wants an interpreter to communicate with a health care provider.

Highmark Inc.: Obtaining Race, Ethnicity and Language Preference Through a Member Survey

Overview

The key to Highmark Inc.'s disparities reduction efforts is the solicitation of members' self-identified race, ethnicity and language preference data via a member survey. Highmark Inc.'s member survey is a brief paper-based questionnaire that is mailed to insured members. This voluntary questionnaire asks for race and ethnicity, language spoken at home, language preference for communications from Highmark Inc., and whether a member or family member needs or wants an interpreter to communicate with a health care provider.

In 2006, Highmark Inc. mailed 1.5 million surveys to its members. Highmark Inc. notified members about the survey by sending out information in advance through various communication channels including member newsletters. Members were told that the information would be used to improve communication with members and for quality improvement activities. Employer groups were also notified about the request to members and were asked to encourage their employees to provide the information.

Response Rate

Highmark Inc. observed a 30 percent overall response rate. Of the respondents, 94 percent were Caucasian, 2 percent were African American, 2 percent were Hispanic, 1.5 percent were Asian and 0.5 percent were multiracial. Ninety-nine percent of the respondents indicated that they prefer to receive information from Highmark Inc. in English and that they speak English at home. One percent of the respondents identified themselves as speaking a non-English language at home and requiring interpreter services during a provider

encounter. A subsequent wave of mail surveys targeting new commercial members occurred in the fall of 2007.

Lessons Learned

Highmark Inc. has gained important insights as it continues to use surveys as the primary method for collecting race, ethnicity and language data from its members. First, the low percentage of racial and ethnic minorities among survey respondents leads Highmark Inc. to suspect that the African-American response rate does not accurately reflect the true distribution of the population in the region. Additional work may be needed to identify potential barriers that influence the likelihood of African Americans participating in such consumer surveys.

Highmark Inc. also discovered that some members were very sensitive about the use of health plan resources to accommodate members with additional language needs. Explaining the benefit did not lower the sensitivity. In response to this, in future correspondence Highmark Inc. plans to incorporate information about the regulatory requirements of providing access to language services.

In addition to internally developed member surveys, health plans may use existing standardized instruments. A common survey administered by plans is the Consumer Assessment of Health Providers and Systems (CAHPS). This survey evaluates the quality of services provided to health plan enrollees and contains a question on member race and ethnicity. However, the CAHPS usually captures a relatively small sample of members. Although a plan can make inferences and estimates about the composition and extent of disparities throughout its entire membership, health plans need to be aware of the potential selection bias associated with those more and less likely to respond to surveys.

Did You Know?

Selection bias can be common in member surveys.

Member-Initiated Contact

Members initiate contact with their health plan for numerous reasons. These points of contact may include benefit questions, administrative or billing inquiries, as well as complaints or grievances. During these points of contact, health plans can ask members at the end of the call to "update" their information. Updated information could include the member's race, ethnicity or preferred language. For example, Molina Healthcare asks members who call into its nurse advice line about their language preferences and includes this information in the member's records. As is the case with several of the

other data collection methods, data would be collected only for the subset of members who contact the health plan. Additionally, customers calling with grievances or complaints may be less likely to cooperate with requests for race, ethnicity and language information.

Secondary Sources of Race, Ethnicity and Language Data

Health plans that serve Medicare and Medicaid populations can link their enrollee data to race/ethnicity data collected in the course of program administration, and there are numerous examples of this practice. The accuracy of Medicare's race/ethnicity data has been steadily improving. The accuracy of race/ethnicity data in Medicaid programs varies both by state and by eligibility category. Those states and categories that rely on an enrollee-completed application form are likely to have the most accurate data.[24]

Centers for Medicare & Medicaid Services (CMS)

Medicare's databases provide a rich source of information about the program's 43 million beneficiaries. The program maintains beneficiary race and ethnicity data, which are derived from Social Security's administrative records. Plans that have a Medicare product can obtain these data from CMS, although the usefulness of these data may be limited. Specifically, most Medicare data on race and ethnicity only have four fields—white, black, other and unknown. In addition, the Social Security Administration does not maintain separate fields for race and ethnicity. As a result, the lack of specificity does not allow for accurate estimation of Asians, Hispanics and American Indians. To overcome this limitation, some health plans—such as Humana—are using surname analysis to estimate members' ethnicity and are combining this with Medicare data on race.

Top Tips:

Due to the lack of specificity in Medicare data, some plans use surname analysis to estimate ethnicity and compare with Medicare date on race.

State Medicaid Agencies

Medicaid plans have an advantage over commercial plans in obtaining race, ethnicity and language information since this information is collected by states during eligibility determination or enrollment into a health plan. Since 2002, CMS has required state quality strategies to include "procedures that identify the race, ethnicity, and primary language of each Medicaid enrollee" for the managed care organization or prepaid in member health plan at the time of enrollment. However, it should be noted that although all state Medicaid agencies collect some form of data on race and ethnicity, data

---

[24] Lurie N and Fremont AM. "Looking Forward: Crosscutting Issues in Race/ethnicity Data Collection." *Health Services Research*, 41(4 Pt 1):1519-33, 2006.

sources and frequency of collection vary significantly across states. For example, Molina Healthcare, which serves a significant number of Medicaid enrollees in California, receives information from the state that is accurate enough to use for strategic planning purposes. In contrast, Massachusetts-based Boston Medical Center HealthNet Plan receives data that are only about 30 percent complete. Some states implement additional processes to evaluate data accuracy, such as matching with other types of state data (e.g., vital statistics and immunization registries), matching with administrative or claims data, or comparing data with self-reported race/ethnicity from other sources such as CAHPS.

Employers

As noted previously, employers are increasingly engaging with health plans on disparities issues, particularly as they relate to their employees. Indeed, plans report that more employers are asking about their efforts to address disparities and are doing so in a more systematic fashion through the use of the eValue8™ Common Request for Information (RFI) developed by the National Business Coalition on Health (NBCH).

Many employers already collect race, ethnicity and language data for Equal Employment Opportunity purposes, which presents another opportunity for plans to obtain this information. As an example, CIGNA has partnered with one of its major employer accounts to examine health care utilization and quality for its employees—stratified by race and ethnicity. For this analysis, employers supplied information on members' race and ethnicity.

> *Did You Know?*
>
> *EValue8 is a tool used annually by health care purchasers to compare the quality and efficiency of America's health plans.*

CIGNA: Collecting Race and Ethnicity Data Through a Collaborative Clinical Initiative with a Major Employer

Background

Although health plans often make very deliberate efforts to engage their major employer groups on a variety of issues, health plans may also be in a position to seize unexpected opportunities that arise. During an eValue8 meeting of local business coalitions, CIGNA was approached by a fellow participant—also one of CIGNA's major employer accounts—and was asked about its interest in jointly addressing an issue that had been identified through client-specific reports. The invitation to collaborate on a clinical initiative with one of its major employer groups opened the door to examining race/ethnicity member data that was already in the hands of the employer. Given the

volume of members represented by this employer, CIGNA recognized that this could ultimately be a significant opportunity to affect overall HEDIS rates.

The employer indicated the rising medical costs for breast cancer treatments was a major concern. Breast cancer is the most commonly diagnosed cancer and the leading cause of cancer death among Hispanic/Latina women.[25] African-American women have the highest breast cancer mortality rates among all other women. Despite recent increases in screening rates, breast cancer still tends to be diagnosed at a later stage (for these populations) when treatment options are more limited.[26] Preliminary examination of the data revealed that the employer group's breast cancer screening rates lagged behind CIGNA's overall rates as well as statewide rates.

CIGNA's Collaborative Clinical Initiative

CIGNA and the employer group set out to conduct a more in-depth analysis to better understand the potential influence of various member demographics on the breast cancer screening. Based on the results, they hoped to develop a scalable program that would improve screening rates, increase early detection and ultimately improve breast cancer outcomes. In this case, the collection of race and ethnicity data was not necessarily the primary impetus for this partnership. Rather, CIGNA's ability to gain access to this information reflected the fact that race/ethnicity might be a possible source of the observed disparity in breast cancer screening rates. Race and ethnicity information was therefore examined as one of several factors of interest. They included:

- Race/ethnicity

- Job type

- Job function

- Home zip code

The employer provided CIGNA with a password-protected Excel file containing member data. This file included unique member identifiers that allowed CIGNA to link the data to its own member file. The file

---

[25] *Cancer Facts & Figures for Hispanics 2006-2008*. Atlanta: American Cancer Society, 2006.

[26] *Breast Cancer Facts & Figures 2007-2008*. Atlanta: American Cancer Society, 2007.

merge resulted in 4,270 matches with fewer than 100 cases falling out. In order to ensure a level of member anonymity, CIGNA limited segmentation of data to 50 or more members.

Findings

CIGNA's analysis of the data revealed several unexpected findings. First, among the members analyzed, race/ethnicity did not appear to account for differences in breast screening compliance. Rather, job type and job function were the two factors that were significantly associated with likelihood of screening compliance. The analysis also revealed that older women were less likely to have received appropriate breast cancer screening.

The findings related to job function and job type allowed further exploration of the specific strategies that could be employed to remove any barriers associated with these factors. A lack of a significant association observed with regard to race/ethnicity was also informative as it allowed both CIGNA and the employer to appropriately prioritize where to direct limited resources with regard to racial/ethnic disparity efforts.

As a result of the project, various interventions were implemented:

- Employer-specific mailings addressing benefit questions

- Onsite health education

- Articles in employee newsletter

- Provider contracting to address specific employer accessibility and convenience issues

- Identification and training of Peer Health Champions

- Employer exploration of opportunities to decrease disparities

Lessons Learned

CIGNA's experience provided valuable insight into several factors that should be considered when partnering with an employer group. Foremost, parties should be realistic and allow sufficient time for planning and execution of activities. Despite being a seemingly simple data analysis, the timeline to accomplish the activities for this partnership took approximately six months. More complex undertakings may require even longer timelines. In particular the size of the organization may sometimes dictate the speed at which the

project is able to move forward.

Additionally because multiple departments within the organization are likely to be pulled into the project, it is important to involve matrix partners early. In this case, CIGNA's Information Technology Department and Analytic Department were all critical players in executing the analysis. Although not included from the onset, CIGNA recognized that the Contracting Department could have played an important role as well.

Plans should also be aware that employers often receive client-specific reports from other entities that are based on differing methodologies. Being clear upfront regarding the specifications used for the analysis may help plans prevent potential confusion around the interpretation of the data.

In this case, CIGNA is the only health care choice offered to the employees of this group, thereby giving the plan more leverage than if there were multiple plans involved. Plans may need to consider the influence they possess and the relative value of engaging the specific employer group.

Perhaps, one of the most valuable lessons learned in this partnership was that although interests may vary between the employer group and managed care organization, agreeing to tackle a common issue opens the door to other opportunities for both entities. CIGNA may not have necessarily been looking to examine breast cancer screening rates, but in doing so it learned that the employer group was willing and able to share race and ethnicity information. Although the analysis focused on a subset of members, CIGNA expressed optimism about the employer's willingness to share additional race and ethnicity data for more broad-based efforts.

Indirect Data Collection Methods

When directly obtained sources of race, ethnicity and language data, such as from self-reports, are unavailable or impractical to obtain quickly, health plans and providers can use a variety of indirect methods to estimate their members' likely race, ethnicity and language preferences. The two most commonly used indirect methods are geocoding and surname analysis.[27]

---

[27] Fiscella K and Fremont AM. "Use of Geocoding and Surname Analysis to Estimate Race and Ethnicity." *Health Services Research,* 41(4 Pt 1):1482-500, 2006.

Either approach can be used alone, but various types of combined approaches are increasingly used to improve accuracy.[28]

When and Why Should Health Plans Consider Using Indirect Data Methods?

The most obvious answer is that most plans still lack race, ethnicity and language data on most or all of their member population, and the process of obtaining the data through self-reported data can be lengthy and expensive. For example, with significant company leadership and a system in place for data capture, Aetna has data on one-quarter of its active enrollees at any point of time. Although a few smaller regional plans that followed Aetna's lead have obtained a similar proportion of self-reported data in less time, collecting data on an increased percentage of members will likely take several more years. Though not a replacement for self-reported data, indirect methods of obtaining race, ethnicity and language data can help plans and providers quickly begin assessing disparities at relatively little cost.

The majority of the plans participating in the NHPC began their efforts with indirect estimates of race and ethnicity.[29] Indirect data demonstrated to plan leadership and other internal stakeholders that there were disparities in care and illustrated some of the ways race, ethnicity and language data could be used to target resources to member populations with apparent disparities. At the same time, some plans (e.g., HealthPartners and Highmark Inc.) recognized the need and urgency of obtaining self-reported data because of the uncertainty of the precision of indirect estimates for determining the race and ethnicity of a single member (vs. a group of members) and directly targeting interventions to the individual member based on this information. Other plans, such as WellPoint, Inc., concluded that continued refinements to indirect methods and improved accuracy made the indirect approach a viable interim strategy for effectively targeting their efforts. They were also reluctant to rapidly scale up collection of self-reported data across their system until health information technology and data coding standards, including race/ethnicity coding, were standardized nationally.

> **Top Tips:**
>
> *Plans should use indirect methods of data collection to:*
>
> - *Provide a quick, though less reliable, method of assessing disparities*
> - *Demonstrate the existence of disparities among plan members to health plan leadership and stakeholders*
> - *Supplement direct methods of data collection (e.g., indirect data on total plan membership can supplement direct data on a subset of membership)*

[28] Elliott M, Fremont AM, Lurie N, et al "As New Method for Estimating Racial/Ethnic Disparities where Administrative Records Lack Self reported Race/Ethnicity." *Health Services Research,* 2008.

[29] Lurie N, Fremont AM, et al. "The National Health Plan Collaborative to Reduce Disparities and Improve Quality." *The Joint Commission Journal on Quality and Patient Safety*, 34 (5): 256-265, 2008.

Indirect data collection methods can supplement missing data and be useful to assess disparities. Health plans should devise methods to validate the indirect methods with direct methods. Health plans can cross-check direct race, ethnicity and language data from a sample of members with indirect method estimates of their entire membership. Indirect methods can also be used to increase accuracy of some types of direct data where misclassification occurs. For example, despite significant improvements in overall accuracy of CMS Medicare race and ethnicity data, a substantial proportion of Hispanics are classified as "white" or "other," preventing more targeted analysis of disparities among Hispanics. The indirect method of surname analysis using Hispanic surname dictionaries can be used to reclassify most of those individuals.[30]

In the sections that follow, you will find brief descriptions of two of the most common approaches health plans have used for indirect estimation of race/ethnicity—geocoding and surname analysis—as well as some newer methodologies that are substantially improving the accuracy and reliability of these approaches.[31] You will also find ways indirect approaches can be used to estimate other member characteristics, such as language or socioeconomic status.

Geocoding

Strictly speaking, "geocoding" refers to the process of assigning a geographic identifier to a person or object located in a given area, such as converting an address into a census code designating a census area (e.g., a specific census tract) or geographic coordinates (e.g., latitude and longitude). However, for our purposes, geocoding is a method in which information about the social characteristics of the neighborhood or community a person lives in is used to infer information about them. In these respects, geocoded measures are best viewed as reflecting the characteristics of the community or neighborhood individuals live in rather than being a direct proxy for that person's characteristics. For example, knowing that a person lives in a neighborhood where eight of 10 residents are African-American provides useful information for estimating that

> ### Top Tips:
>
> *Though indirect estimates of race, ethnicity and language for individual members should be performed at the block group (or census tract) level, it is fine to aggregate the member estimates to a higher geographic level such as ZIP code or county as needed for reporting or mapping patterns of care.*

> ### Geocoding:
>
> *A method in which information about the social characteristics of the neighborhood or community a person lives in is used to infer information about them.*

---

[30] *Morgan RO, Wei II, Virnig BA. "*Improving Identification of Hispanic Males in Medicare: Use of Surname Matching*." Medical Care,* 42(8):810-816, 2004.

[31] Lurie N, Fremont AM, et al. "The National Health Plan Collaborative to Reduce Disparities and Improve Quality." *The Joint Commission Journal on Quality and Patient Safety*, 34 (5): 256-265, 2008.

individual's race. Similarly, knowing that a member lives in a neighborhood where less than 1 percent of the residents live below the poverty level and housing values are high can be useful in determining the member's probable socioeconomic status. The initial step of geocoding involves converting members' addresses to a geographic identifier such as a census tract code. This step is a straightforward process that can be done easily using commercially available software or vendors. Keep in mind that cost and accuracy vary depending on the software or vendor.

Steps in Geocoding:

- *Convert members' addresses to a geographic identifier such as a census tract code*

    - *Need commercially available software or vendors—do some comparison shopping for cost and accuracy*

    - *Can also obtain data on members' area from the U.S. Census Bureau (staff need basic programming skills)*

- *Determine geographic level of information for the indirect estimates of estimates of race, ethnicity or language*

    - *Census block groups provide best level of detail and homogenization for making inferences (area = small neighborhoods)*

    - *Census tracts are larger areas than census blocks but smaller than zip codes (area = 4,000 residents)*

    - *Zip codes are least preferable due to large area included in zip codes; limited ability to make inferences (area = >10,000 residents)*

A related step is deciding what geographic level of information the indirect estimates will be based on. For example, a common mistake is to use ZIP code level information (e.g., average income level) as a proxy for an individual's socioeconomic standard. ZIP codes generally include relatively large areas containing tens of thousands of people, often with widely varying racial/ethnic characteristics. Geocoding to the census tract level is a much better approach since these areas average only about 4,000 residents and are

designed to demarcate populations with relatively homogeneous social characteristics. However, it is not uncommon for a given census tract to include both pockets of poverty and influence. Therefore, when possible, indirect estimates of race, ethnicity or language should be based on information obtained at the census block groups level.

These areas roughly correspond to small neighborhoods with 1,000 residents or fewer.[32]

---

[32] Fiscella K and Fremont AM. "Use of Geocoding and Surname Analysis to Estimate Race and Ethnicity." *Health Services Research,* 41(4 Pt 1):1482-500, 2006.

WellPoint, Inc.'s Georgia Telemedicine Diabetes Education Project (GPTH): Using Proxy Methodologies to Locate High Opportunity Areas

Background

Minority populations in Georgia carry a heavier burden related to diabetes, as evidenced by the higher prevalence of diabetes and diabetic complications such as amputations, retinopathy and neuropathy. With the Hispanic population representing more than 5 percent and African Americans comprising approximately 30 percent of the state's population, addressing racial and ethnic disparities in diabetes represents a health priority. Additionally, unlike their urban counterparts, 108 of Georgia's 150 counties are rural. Rural counties typically have half as many physicians and dramatic shortages of nurses, therapists and nutritionists, straining the capacity of the health care delivery system to reach the residents that need care.

Project Goals

The primary goal of the initiative is to link rural residents with a Certified Diabetes Educator (CDE) who can offer culturally appropriate diabetes education tailored to the needs of African-American and Hispanic members in rural, underserved counties. Individuals take part in multiple one-on-one diabetes counseling sessions to support lifestyle changes and improve disease self-management.

Identifying High-Opportunity Areas

Proxy race and ethnicity data methodologies were used to estimate demographic information for WellPoint, Inc.'s diabetic members. Estimated race and ethnicity data were then used to identify rural regions with high proportions of minorities and low diabetes-related performance scores. For example, Figure 1 is a map of the percentage of African-American members with diabetes who had good HbA1c control, by county. The darkest shaded areas represent counties where ≥ 90 percent of members have poor control and therefore are regions of high opportunity for outreach interventions like the GPTH's telemedicine network.

Figure 1. High-Opportunity Regions for GPTH Outreach

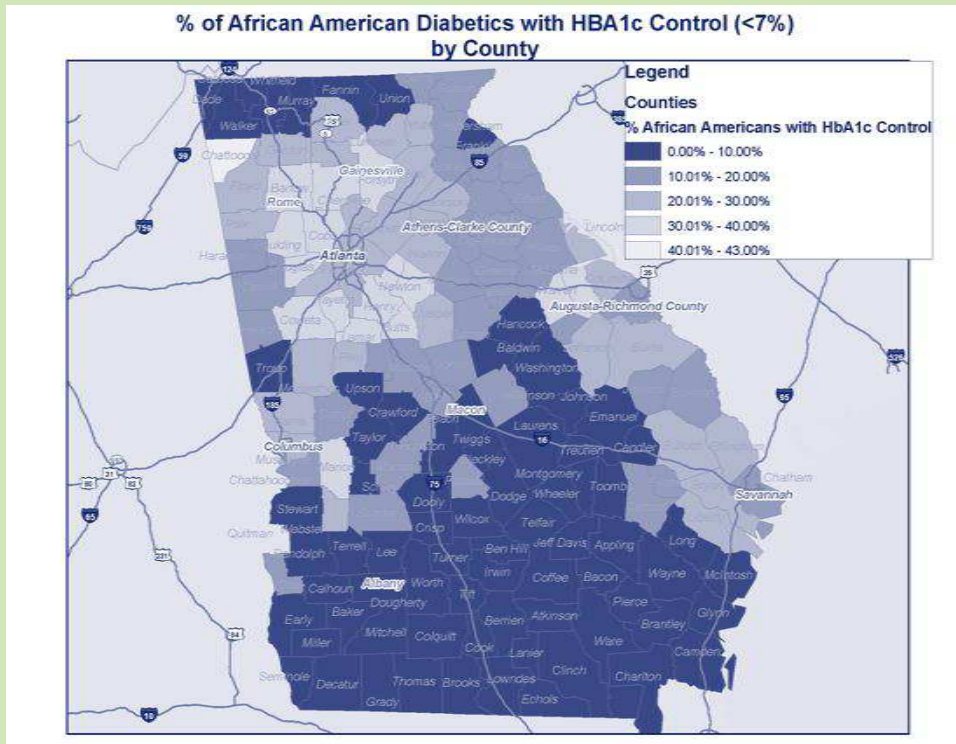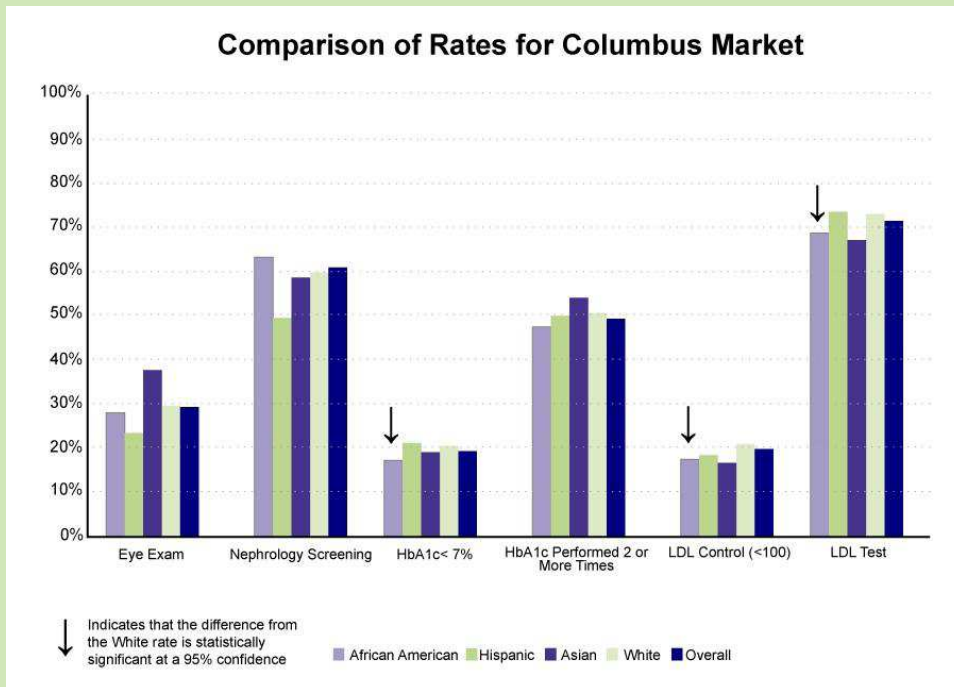% of African American Diabetics with HBA1c Control (<7%) by County

Figure 2 also demonstrates the ability to examine specific measures by racial/ethnic group by county to determine the greatest priorities for those areas. For example, in the Columbus market, the greatest opportunities for improving disparities lie in increasing African Americans' rates of good HbA1c and LDL control.

Figure 2. Rates of Selected Diabetes Measures by Race for the Columbus Market

Comparison of Rates for Columbus Market

↓ Indicates that the difference from the White rate is statistically significant at a 95% confidence

African American | Hispanic | Asian | White | Overall

Results

Since 2006, GPTH has begun to facilitate diabetes education for rural residents within approximately 30 miles of their homes by linking them with CDEs at a major medical center. After only a few months of implementation, the program is already at capacity with a lengthy waiting list.

WellPoint, Inc.'s Blue Cross Blue Shield of Georgia (BCBSGa) unit is seeking grant funding to partner with GPTH to expand the program and evaluate the efficacy of diabetes health education delivered through GPTH's telemedicine network. Because government-sponsored health plans are the largest payers of telemedicine diabetic education services, recruiting CDEs who can provide bilingual or bicultural services to rural minorities appears to represent a very viable strategy for outreach. WellPoint, Inc. continues to consider opportunities for collaboration with public health centers and large rural employers with large minority populations (e.g., agriculture) to promote services.

Surname Analysis

Surname analysis uses a person's last name to estimate the likelihood that they belong to a particular racial or ethnic group. For example, a person whose last name is Lopez has a reasonably high likelihood of being Hispanic, whereas it is a reasonable bet that a person whose last name is Chang is Asian. Based on this logic, researchers have developed a number of surname dictionaries that include names that have relatively high probability of belonging to a specified racial or ethnic group. The most widely used dictionaries focus on Hispanic or Asian surnames; separate surname lists have been generated for Chinese, Indian, Japanese, Korean, Filipino and Vietnamese Americans. Experimental dictionaries for identifying Arab Americans are under development.[33] More recently, the U.S. Census Bureau released a new surname list that includes nearly 90 percent of all surnames in the U.S. Census, including predictive probabilities that individuals with a given surname belonged to each of six racial/ethnic categories (white, black, API, Asian, 2+Race and Hispanic).[34] Although use outside of the U.S. Census Bureau is still limited, it offers numerous advantages compared to prior lists—in terms of accuracy and flexibility—and it could become the industry standard.

Studies assessing the accuracy of surname analysis using older surname lists confirm the approach is reasonably accurate, at least for identifying persons likely to be Hispanic or Asian, respectively. Most validation studies, for example, show that surname lists can correctly classify about eight of every 10 Hispanic members and seven of 10 Asians. However, the accuracy can vary considerably depending on the concentration or prevalence of a given racial/ethnic group in an area or region. For instance, individuals with "Lee" as a surname are much more likely to truly be Asian if they live in San Francisco where the proportion of Asians is relatively high versus individuals with the same last name living in Atlanta, where there are proportionately fewer Asians and Lee is a surname more commonly used by non-Asians. This sort of variation can be largely overcome by employing Bayesian methods that adjust estimates based on the prevalence of different racial/ethnic groups in the area. Plans and providers considering using

> ### Did You Know?
>
> *The U.S. Census Bureau released a new surname list that includes nearly 90 percent of all surnames in the U.S. Census; this list could become the industry standard.*

> ### Did You Know?
>
> *Surname analysis is best used for identifying persons likely to be Hispanic or Asian.*

---

[33] Elliott M, Fremont AM, Lurie N, et al "As New Method for Estimating Racial/Ethnic Disparities where Administrative Records Lack Self reported Race/Ethnicity." *Health Services Research,* 2008.

[34] U.S. Census Bureau. Demographic Aspects of Surnames. Available at: http://www.census.gov/genealogy/www/surnames.pdf, 2008.

surname analysis should remember that this approach, by itself, is generally not very useful for identifying African Americans or Caucasians since these groups tend to have less distinctive surnames than Hispanic or Asian individuals.

Combined Approaches: Geocoding and Surname Analysis

The advantages and limitations of geocoding and surname analysis complement each other, making combined use an attractive means for inferring race/ethnicity among health plan members. Geocoding is more reliable for inferring race whereas surname analysis is better for inferring Hispanic or Asian ethnicity. Furthermore, geocoding provides estimates of the racial/ethnic composition of the area where surnames are applied. When the two methods are applied to the same geographic area (e.g., census tract, block group, or block), overall accuracy can improve. For example, a combined approach can improve the accuracy of geocoding of non-Hispanic African Americans and Caucasians. To verify numbers of non-Hispanic, African Americans or Caucasians:

1. Use geocoding to infer Caucasian or African-American race.

2. Use surname analysis to infer Hispanic or Asian ethnicity.

3. Remove names of Hispanic or Asian ethnicity (determined from surname analysis) to refine the list of names of the non-Hispanic Caucasian or African-American population. Incorrect assignment of minorities to the majority Caucasian population will have relatively little effect in most instances because of much higher numbers of Caucasian, non-Hispanics.[35]

Bayesian Approaches

As noted earlier, the accuracy of indirect methods can vary depending on the prevalence (e.g., actual proportion of local population that are Hispanic) of different racial/ethnic groups in a given area. In general, accuracy of indirect estimates drops when prevalence of a group is low and improves when it is high. This problem can be partly overcome by applying an approach similar to those used in medical decision making based on Bayes Theory. For instance, though a commonly used diagnostic test to detect a blood clot in a member's lung, a V-Q scan, is reasonably accurate, it still may misclassify

---

[35] Fiscella K and Fremont AM. "Use of Geocoding and Surname Analysis to Estimate Race and Ethnicity." *Health Services Research,* 41(4 Pt 1):1482-500, 2006.

Did You Know?

Geocoding and surname analysis are the most commonly used indirect methods of race, ethnicity and language data collection. Approaches that employ both methods are preferred because of increased accuracy.

Top Tips:

Use geocoding for inferring race; use surname analysis for inferring Hispanic or Asian ethnicity.

Did You Know?

Accuracy of indirect estimates drops when prevalence of a group is low and improves when it is high.

20 percent or more of the cases. Based on Bayes Theory, doctors have learned that the likelihood that a positive test result is correct depends, in part, on whether the doctor thought that the likelihood the member had a clot was low or high prior to the test, based on the patient's clinical symptoms. For instance, if the doctor felt the patient was at high risk, even a weakly positive test may warrant treatment. Conversely, if the doctor felt there was little risk of a clot based on the members' symptoms, then it was reasonable to not take into account even a moderately positive test. In a similar way, one can use prior knowledge about the plan member, such as the percentage of Asian Americans living in their neighborhood, to refine the final estimate of the likelihood that one is Asian or not based on the surname. Hence, we would be more confident that someone with a name on an Asian surname list was truly Asian if they lived in a neighborhood that census data indicated was predominantly Asian versus if only about 1 percent of the residents were Asian. Using this approach, RAND researchers have been able to markedly improve estimates obtained with the combined geocoding and surname approach described earlier.[36]

Common Challenge to Using Indirectly Estimated Data

Health care disparities are throughout the health care system. Each NHPC health plan has used data on the race, ethnicity or language preference of their members as a critical decision-making tool to target quality improvement programs in the effort to reduce disparities. As highlighted in the case study below, plans have used various methods such as geographic information system (GIS) mapping and decision tools to inform their efforts to reduce disparities.

> **Top Tips:**
>
> *Remember that accuracy can vary considerably in surname analysis depending on the concentration or prevalence of residents belonging to given racial/ethnic group in an area or region— Bayesian methods that adjust estimates based on the prevalence of different R/E groups in the area can improve accuracy.*

The Use of GIS Mapping and Decision Tools to Address Disparities

One particularly promising strategy emerging from NHPC efforts to address disparities is the development of interactive mapping and analysis tools. These tools help plans quickly identify geographic areas with characteristics that signify good opportunities for interventions. For example, software tools and algorithms, such as those developed by RAND for the NHPC, enable plans to highlight census tracts that have a high volume of members with diabetes from

---

[36] Elliott M, Fremont AM, Lurie N, et al "As New Method for Estimating Racial/Ethnic Disparities where Administrative Records Lack Self reported Race/Ethnicity." *Health Services Research,* 2008.

a given race/ethnic group who have not received one or more recommended elements of care. Figure 1A shows such a map of a health plan's market area, and Figure 1B provides more detail on this area. These maps serve, in some fashion, as a "geographic Pareto chart," and a plan can use this information to focus more efficiently on a variety of interventions, ranging from targeted mailings to providers in this area to community-wide education.

The effectiveness of displaying complex data through maps, such as those shown in Figures 1A and 1B, rests on a number of general principles, including making large data sets coherent and encouraging the viewer to make comparisons by region and race/ethnicity[37]. For example, Figure 1A shows that the Hispanic diabetic members in one plan who are not receiving LDL tests tend to be clustered in a relatively small number of areas. The Pareto chart in Figure 1B shows that four of the clusters account for a significant proportion of disparities observed in that market; clusters (C, E, F and A) account for 80 percent of the Hispanic diabetics in that market not receiving LDL tests. This type of information has helped plans focus more efficiently on where they may want to implement an intervention.

[37] Lurie N, Fremont AM, et al. "The National Health Plan Collaborative to Reduce Disparities and Improve Quality." *The Joint Commission Journal on Quality and Patient Safety*, 34 (5): 256-265, 2008.

Figure 1A. Clusters of Census Tracts with High Numbers of Hispanic Diabetic Members in the Plan Service Area Who Have Not Received LDL Tests
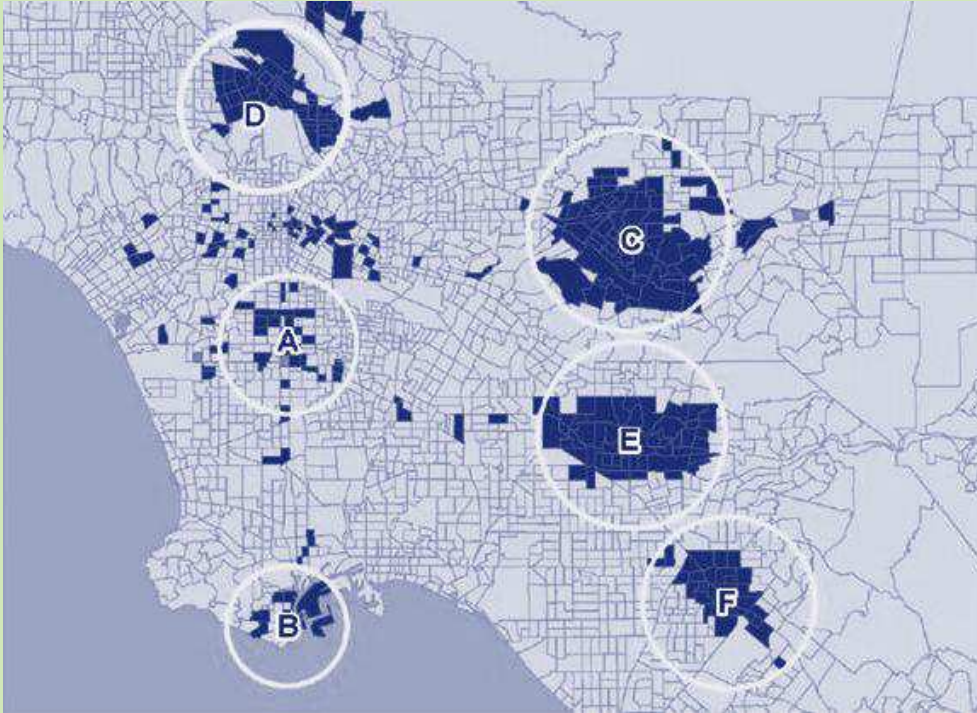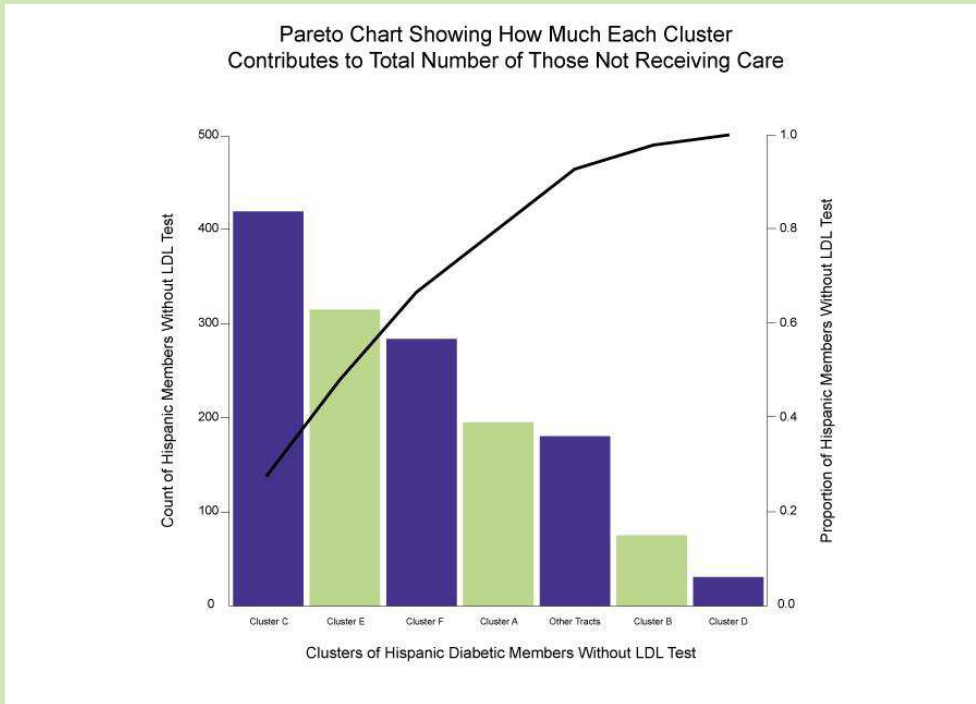
Figure 1B. Pareto Chart Showing Count and Proportion of all Diabetic Members in Clusters Not Receiving LDL Tests
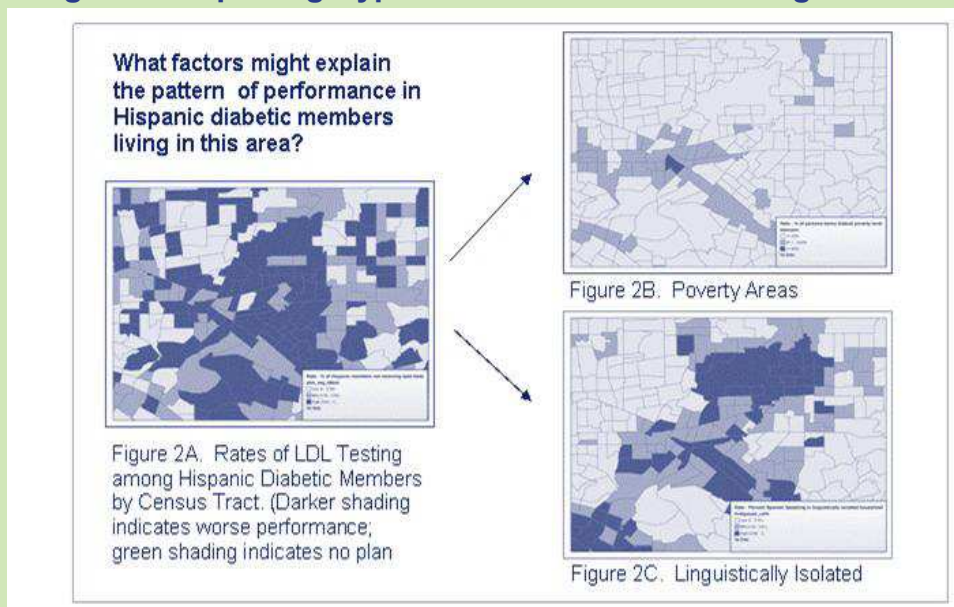

Pareto Chart Showing How Much Each Cluster
Contributes to Total Number of Those Not Receiving Care

Several plans now use these tools to target and develop interventions and have noted that the tools provide a way to focus resources, enabling interventions that would have otherwise been cost-prohibitive. As plans have grown more sophisticated about the possibilities for assessing and acting on disparities, they have also noted the need for measures of other types of information that may contribute to disparities.

GIS tools make it easy for plans to begin to assess these potential contributing factors. For instance, Figure 2 highlights how GIS tools can help different stakeholders and decision-makers test their working hypotheses about factors that may explain the observed pattern. Figure 2 shows an enlarged view of a portion of Cluster C, a predominantly Hispanic Area (>90 percent of residents are Hispanic) with relatively high rates of health plan diabetic members who had not received LDL tests. At the local level shown, it is apparent that the patterns of care are not as homogenous across census tracts as one might assume based on the overall low performance rate for the cluster.

When plan decision-makers are initially presented with such maps and asked to speculate why they think Hispanic members living in some census tracts tend to receive worse care (as indicated by the darker shading) than Hispanic members living in nearby census tracts, the most common answer is that Hispanic members in the areas receiving worse care tend to be poorer than those receiving better care. However, upon closer examination of Figures 2B and 2C, decision-makers could easily see that poverty levels do not appear to play a large role in the observed care patterns shown in Figure 2A. Rather, levels of linguistic isolation appear to have a much larger role. Indeed, showing the data on maps such as these helped convince decision-makers that linguistic isolation is an important consideration in any intervention they might devise and helped plans identify specific census tracts or neighborhoods where they might want to target their efforts. Though not shown in this example, the map data generally is presented in combination with other types of information (e.g., summary tables of subgroup characteristics and statistical associations) to further clarify the observed patterns.

Figure 2. Exploring Hypotheses about Contributing Factors

What factors might explain the pattern of performance in Hispanic diabetic members living in this area?

Figure 2A. Rates of LDL Testing among Hispanic Diabetic Members by Census Tract. (Darker shading indicates worse performance; green shading indicates no plan

Figure 2B. Poverty Areas

Figure 2C. Linguistically Isolated

Prior to seeing this type of information mapped, decision-makers with quality improvement backgrounds tended to assume that when aggregate data (e.g., within a member service area or region) showed a consistent disparity between the receipt of indicated care by African-American or Hispanic members versus Caucasian members, their strategy should simply be to target all members belonging to the disadvantaged racial/ethnic group. Based on that logic, for example,

one health plan's initial strategy to address an observed disparity in LDL test rates between diabetic Hispanics (60 percent) and Caucasians (70 percent) was to develop and mail new member education materials about diabetes to all members residing in predominantly Hispanic census tracts. However, maps highlighted local variation in quality of care between neighboring census tracts (all of which were predominantly Hispanic), leading the plan to modify its approach, resulting in a better-targeted, less costly intervention.

Section 3: Language Access

The Importance of Patient-Provider Communications in Ensuring High-Quality Care

Patient-provider communication is critical to ensuring high-quality health care and patient safety. Poor communication can contribute to misdiagnosis and misunderstanding of treatment regimens and can lead to adverse events. Understanding and processing medical treatment information is already challenging, and for those who have limited English proficiency, it can be nearly impossible. Several studies have documented the adverse impacts of language barriers across many dimensions of access to and quality of care. For example, limited English proficiency (LEP) patients are more likely than others to receive poor medical care, defer needed care or have drug complications. They are also less likely to have a usual source of care.[38]

Language access is an issue that must be addressed if medicine is to effectively serve patients. The U.S. Census forecasts a dramatic increase in foreign-born and non-English-speaking populations during the next 20-to-40 years. Currently, as many as one in five people in the United States speaks a language other than English in the home, and this number is likely to increase.[39] Moreover, approximately 50 million U.S. residents do not speak the same language as their health care providers.[40] As we become an increasingly diverse nation, reducing language barriers should be an important component of efforts to improve health care quality.

State and Federal Policies Affecting Language Assistance in Health Care Settings

Several laws exist around the provision of language services in health care. Title VI of the Civil Rights Act of 1964 prohibits the use of federal funding to support providers who discriminate on the basis of race, color or national

---

[38] Flores G, Abreu M, Olivar MA, et al. "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics and Adolescent Medicine* 152(11): 1119-1125, 1998.; Weinick R and Krauss N. "Racial/Ethnic Difference in Children's Access to Care." *American Journal of Public Health,* 90(11), 2000.

[39] U. S. Census Bureau. *American FactFinder.* Retrieved June 2008, from http://www.factfinder.census.gov.

[40] "Office of Civil Rights Title VI, CLAS." Washington: Department of Health and Human Services, 2006.

Did You Know?

Patients with limited English proficiency are more likely to receive poor medical care, defer needed care or have drug complications.

Did You Know?

One in five people in the United States speaks a language other than English in the home.

Did You Know?

Federal law obligates health care providers receiving federal funding to ensure that LEP patients have meaningful access to their programs and services.

origin. This has been interpreted by the U.S. Department of Health and Human Services (HHS) and the courts to include individuals who are limited English proficient (LEP). Federal law thus obligates health care providers receiving federal funding to ensure that LEP patients have meaningful access to their programs and services. Executive Order 13166 was issued in 2000 and requires every federal agency that provides financial assistance to non-federal entities to publish guidance on how their recipients can provide meaningful access to LEP persons and comply with Title VI regulations. HHS issued its final guidance in 2003, which covered Medicare, Medicaid and the State Children's Health Insurance Program, as well as state agencies, managed care plans, hospitals, physician practices, community clinics, nursing homes and pharmacies. In addition, the HHS Office of Minority Health developed standards for Culturally and Linguistically Appropriate Services (CLAS) in health care, which set forth certain mandates around access to and quality of language services.

**Standards for Culturally and Linguistically Appropriate Services
Related to Language Access**

CLAS Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

CLAS Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

CLAS Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

CLAS Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Did You Know?

All states have enacted statutes or regulations that clarify or expand the federal requirements for language access.

In addition to the federal laws, all states have enacted statutes or regulations that clarify or expand the federal requirements. The National Health Law Program's publication, *Summary of State Law Requirements Addressing Language Needs in Health Care*, cites and briefly describes each state's statutes and regulations regarding services to LEP persons in health care settings. State laws vary from being comprehensive to addressing specific health care providers or patient groups.

Planning for Language Services

Many health plans already support the provision of culturally and linguistically appropriate services. Health plans that are just starting to provide language services sometimes do so ad hoc, without having developed a consistent, comprehensive approach. In developing a plan's capacity to provide language services, it is critical to first conduct an assessment of the

plan's language needs and resources, and then develop a written policy outlining an approach for addressing the language needs of its members. This section briefly describes these activities and provides references to resources that offer more detailed implementation guidance.

Assessing the Health Plan's Language Needs and Resources

Planning for Language Services:

Step 1: Conduct an assessment of your plan's language needs and resources.

> *Step 1.1: Examine the number and proportion of LEP members served.*

> *Step 1.2: Examine the frequency and type of contact with members to identify priorities for interpretation and translation services.*

> *Step 1.3 Determine priorities by examining the nature and importance of services that members need at various points of contact with the plan.*

Step 2: Develop a written policy with an approach for addressing the language needs of your members

> *Should include:*

> - *How to identify patients needing language services*
> - *Points of contact within the plan for which language services are available*
> - *How to notify LEP members about their rights to language assistance services*
> - *Types of services available (e.g., in-person interpreter, telephonic interpretation, etc.)*
> - *Process for maintaining, monitoring and improving language access services*
> - *The need to assess grade level of consumer education products and publications.*

The first step in implementing language services within any organization starts with an assessment of the language needs of the population it serves.

This involves collecting information about the plan's LEP members, such as preferred language for oral and written communications, as well as needs for an interpreter. The data collection section of this toolkit describes various methods employed by health plans to collect this information from its members.

> ### *Top Tips: Resources*
>
> *Tool to evaluate accurate and timely language services:*
>
> - *The National Council on Interpreting in Health Care's* Linguistically Appropriate Access and Services: An Evaluation and Review for Health Care Organizations *(Link to http://www.ncihc.org/mc/page.do)*
> - *How-to guide from ARHC and CMS for identifying linguistic needs of membership and assessing capabilities of the health plan:*
> - Providing Oral Linguistic Services: A Guide for Managed Care Plans *(Link to http://www.ahrq.gov/about/cods/oralling.htm)*

With preferred language information, health plans can examine the number and proportion of LEP members they serve, as well as the frequency and type of member contact. This evaluation will identify priorities for interpretation and translation services. Health plans will want to consider which services are more critical, by examining the nature and importance of services that members need at various points of contact with the plan.

Developing a Written Policy for Language Services

After a plan has completed an assessment of its members' language needs, it is important to develop written policies and procedures outlining how and when to use available language services. A written policy on the provision of culturally and linguistically appropriate services can help to focus a health plan's commitment and efforts to serve diverse communities. It serves as a guide to ensure the implementation of consistent and appropriate approaches, procedures and practices in communicating with LEP members. The written policy is often helpful for training, administration and budgeting purposes. It can also provide clear guidelines for staff and providers regarding what they should do when serving a member with specific cultural or language needs.

In general, effective policies are those that clearly identify the following elements:

- How to identify members needing language services

- Points of contact within the plan for which language services are available

- How to notify LEP members about their rights to language assistance services

- Types of services available (e.g., in-person interpreter, telephonic interpretation, etc.)

- Process for maintaining, monitoring and improving language access services

- The need to assess grade level of consumer education products and publications.

More guidance and resources on how to develop and implement effective language services policies are provided in the Office of Minority Health *Health Care Language Services Implementation Guide*. HealthPartners provides an example of how a health plan has developed a language assistance plan for spoken and sign language services, which are designed to formalize best practices in interpreter services for its health plan, medical group, clinics and hospital.

HealthPartners: Formalizing Organizational Best Practices for Language Services Through the Development of a Language Assistance Plan

Background

Demographic data suggest that there is a need for language assistance services in Minnesota communities. The number of immigrants doubled from 1999 to 2002, and the number of non-English speaking residents in Minnesota tripled from 1994 to 2003. The percentage of Minnesota residents identifying themselves as non-white, Hispanic or both grew from 6.3 percent in 1990 to 11.8 percent in 2000; Minnesota's Hispanic/Latino population grew 166 percent from 1990 to 2000. Overall, 11 percent of Minnesota's population identified themselves as non-white in the 2000 U.S. Census, and many of these are LEP individuals. There are now more than 100

different languages spoken in homes throughout the seven-county metro area.

Initiative

Recognizing the language needs of its members, HealthPartners invests heavily in providing interpretation and translation services to its LEP members, and the health plan has taken a proactive and strategic approach to addressing language access. In 2004, HealthPartners formed an Interpreter Services Workgroup to provide enterprise-wide leadership on the provision of safe, timely, effective, efficient, equitable and patient-centered spoken and American Sign Language services for LEP, deaf and hard-of-hearing patients and members.

In 2005, the workgroup developed a Language Assistance Plan for spoken and sign language services that formalizes best practices for the entire organization in interpreter services. The plan features a user's guide, which includes information on:

- How HealthPartners provides interpreter services

- How to arrange services

- How to use the Language Line

- How bilingual staff can best assist members who require language assistance

- How to respond to a patient who wants to use a family member or friend to interpret

- Where to get more information

The plan also includes a provider manual that defines:

- Quality and performance expectations for interpreter service vendors

- An oversight and delivery model for interpreter services

- A provider satisfaction survey to measure interpreter performance

- Procedures for appropriate third-party payer reimbursement of state public and program interpreter services

Impact

HealthPartners has invested a significant amount of resources to provide language assistance services for its patients and members. In 2006, the Minnesota Department of Human Services contracted with the Michigan Peer Review Organization to perform compliance and auditing functions for HealthPartners state public programs for 2005 activities, including the MCO Cultural Considerations Self-Assessment Survey. Based on this self-assessment, HealthPartners appeared to have met the National CLAS Standards as they relate to language access.

Implementing Interpretation Services

Health plans have several options for providing interpretation services to their members. One model of interpretation may not be enough to meet the language needs of a plan's members. Health plans often employ multiple strategies to accommodate several different language groups. Plans participating in the National Health Plan Collaborative have devised solutions that reflect the diversity of their members and their needs, as well as various operational and resource constraints. This section describes the models for interpretation that are commonly used by health plans, noting the various considerations associated with each strategy. Various organizations may categorize these alternatives differently, and in practice, these models may overlap and be combined.

Types of Interpretation Services:

- *Bilingual staff and clinicians*
- *Ad-hoc interpreters*
- *Professional interpreters*
- *Telephone interpretation lines*

Table 7: Types of Interpretation Services

TYPE OF INTERPRETATION SERVICE	DEFINITION	ADVANTAGES	DISADVANTAGES
Bilingual Staff and Clinicians	Staff or clinicians proficiently speak the same language as LEP members.	• Direct communication (no interpreters needed) • Best if staff is fluent at the level required for patient interaction • Shared cultural and linguistic background • Most economical if significant proportion of members speak particular language	• Bilingual staff may not be able to work with all language groups of members
Ad-hoc Interpreters	Individuals' primary jobs are not interpretation. Interpreters can include members' friends and family, clinic staff or even fellow members/patients; though usually involves bilingual staff employed in other positions.	• Useful for administrative contact with members or as back-up only when professional interpreters are unavailable	• Usually not trained in interpretation skills or ethics • May compromise the quality of the health care encounter • Inefficiencies in use of staff time; may interfere with staffs' primary duties

Table 8: Types of Interpretation Services – Professional Interpreters

TYPE OF INTERPRETATION SERVICE	DEFINITION	ADVANTAGES	DISADVANTAGES
Professional Interpreters			
Dedicated Staff Interpreters	Dedicated staff interpreters are employed full- or part-time at a plan for the sole purpose of providing interpretation services.	• Ideal when significant number or proportion of LEP members speak a particular language • Likely to be formally trained professional interpreters	• May not be economical if interpretation needs are across several languages
Contract Interpreters	Contract interpreters are not employed by the health plan, but are available on a per diem or on call basis.	• Likely to be formally trained • High incentives for continuing education • If demand is low, more cost-effective than dedicated staff	• Requires staff to coordinate screening, contracting, dispatching and payment of interpreters
Language Agencies	For-profit and nonprofit organizations that recruit, contract and dispatch interpreters on demand to health care organizations.	• Guarantee of competency and assessment • Good for lower demand of services • Monitoring of standards	• Interpreters usually need to be scheduled in advance • Can be more costly
Telephone Interpretation Lines	Includes remote telephone interpretation services or language lines and remote simultaneous interpretation.	• Lower cost for occasional demand • Available 24-7; invaluable for emergencies	• Not as appropriate when nonverbal communication is important, when interactions are complex, or when multiple people are in the examination room • Higher cost per minute

Bilingual Staff and Clinicians

Bilingual staff and clinicians can communicate directly with the LEP patient, without the need for interpreters. This model is considered the best form of communication if staff is fluent at the level required for patient interactions. When the patient and provider share the same cultural background, mutual

understanding of cultural beliefs and health care practices enable providers to address subtle cultural nuances that can influence health behaviors and attitudes. This model is most economical when a significant proportion of LEP patients speak a particular language. One limitation, however, is that bilingual staff and clinicians may not be able to work with all the language groups present in the LEP population.

To facilitate patient-provider language concordance, several health plans now publish the language of their providers in their provider directories. For example, United HealthCare recently engaged in an effort to develop a directory listing the languages spoken by its networked Asian providers. The directory is accessible in print and online and is available in Chinese, Korean, Japanese and Vietnamese.

United HealthCare: Developing an Asian In-Language Provider Directory

Background

With more than 60 percent of Asian Americans born overseas and most speaking a language other than English, there is a profound need to address linguistic and cultural disparities in health care. According to the Commonwealth Fund 2001 Health Care Quality Survey, only 16 percent of Asian Americans whose primary language is not English said it is very easy to understand doctors' materials, compared with 47 percent of those who speak primarily English. The survey also found that less than one-half of Asian Americans (48 percent) strongly believe that their doctor understands their background and values, compared with 61 percent of Hispanics, 58 percent of Caucasians and 57 percent of African Americans. Although only 39 percent of Asian Americans have an Asian-American physician, in comparison 82 percent of Caucasians have a Caucasian doctor.

In light of these findings, United HealthCare set out to address the inconsistency in patient-practitioner racial, ethnic and language concordance by creating an interactive in-language Asian directory to help Asian members find physicians who meet their language and cultural needs.

Initiative Description

United HealthCare charged its Asian American Markets team, working collaboratively with internal partners, to develop a relevant, reliable and adequate provider directory that is accessible to targeted Asian

members. Core features of the directory include:

- **Content in Asian languages:** Though other health plans provide tools that members can use to identify physicians who speak languages other than English, few of these tools are offered in a native language format.

- **Relevant and reliable information:** A distinction is made between the language capability of physicians and their administrative or medical staff.

- **Practitioner network adequacy:** A systematic process was established to evaluate, identify and enhance practitioner networks.

- **Easy accessibility:** The goal of the initiative was not only to create the tool, but also to widely disseminate it to the target population. By matching patients to practitioners more successfully, the initiative provides for linguistically and culturally sensitive communication. Effective communication is integral to developing a relationship of trust between physicians and their patients and may encourage better health outcomes and reduce unequal treatment and medical error.

United HealthCare identified Chinese, Korean and Vietnamese members as priority groups based on population size, level of linguistic isolation and preference for in-language providers. A geographic analysis further revealed specific regions where the need for the directories was high. The project was designed to be implemented initially in California and Illinois, with the potential for expanding to other regions and including other Asian languages. Major activities of the project included:

- Enhancing United HealthCare's provider network by contracting with additional Asian-American providers, hospitals and major ethnic medical groups.

- Independently verifying individual providers' language capability.

- Enterprise-level provider language and ethnic-related data integrity validation.

- Verifying the accuracy of multilingual translations, with a particular emphasis on cultural sensitivity.

- Developing a Web-based provider directory that is functional, user-

friendly and presented in the target Asian languages.

- Increasing the awareness and use of the online provider directory through extensive advertising and communication efforts.

By late 2005 and early 2006, Chinese, Korean and Vietnamese versions of the provider directories were delivered and made available in California through multiple formats (print, PDF and online). The Illinois version of the provider directory was successfully completed late in 2006, with Japanese added as a fourth language.

Timeline and Key Milestones in United HealthCare's Efforts to Develop an Asian In-Language Provider Directory

- **2004:** Initial need assessment, marketing research and focus group study. Chinese version of the tool launched in the second half of the year for California.

- **2005:** Korean and Vietnamese version of the tool implemented and made available in the California market.

- **2006:** Chinese, Korean, Vietnamese and Japanese provider directories expanded to include the Illinois market with a focus on the Chicago metropolitan area.

- **2007:** Development for the Texas market is underway for a June completion target date. Feasibility study is ongoing for possible expansion of the tool to cover all 50 states.

- **2008:** Estimated completion date of the tool with national coverage.

Impact of the Initiative

United HealthCare employed a multidimensional and systematic approach for evaluating the impact of the initiative and identifying areas for further improvement. Periodic reports related to changes in provider composition in the regions enabled United HealthCare to assess the adequacy of the Asian patient-to-provider ratio in its network compared to the general market. In addition, data on member material requests and Web site traffic were used to track consumer demand for and use of the tool.

More than 7,500 Asian providers have been contacted and have individually verified their language capabilities since the beginning of this project. United HealthCare added an additional 900 Asian providers in the Los Angeles HMO market alone. Since the tool was made available to the general public, an estimated 91,250 in-language users have accessed the in-language directory online and printed directories.

Sustainability and Transferability

This initiative receives full corporate support and an internal assessment is underway to determine the feasibility of a national expansion, as well as adding other Asian languages. The Asian provider directory requires minimum resources for sustainability, and the reliability of this tool blends seamlessly with the ongoing network contracting and management efforts by United HealthCare.

For its behavioral care services, CIGNA collects information on languages spoken by practitioners. This information, along with other provider characteristics, is included in a Web-based directory that members can search in order to locate a provider.

CIGNA: Facilitating Cultural and Language Match in Behavioral Care

Background

In 1999, the U.S. Surgeon General declared that "even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services."[41] Racial and ethnic minorities have less access to and availability of care, receive generally poorer quality mental health services, and experience a greater disability burden from unmet mental health needs. The percentage of African Americans receiving needed care is only half that of non-Hispanic whites. Among Hispanic Americans with a mental disorder, fewer than one in 11 contact a mental health

---

[41] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

specialist, while fewer than one in five contact a general health care provider for assistance.[42]

The importance of a culturally tailored approach to providing mental health services cannot be overstated. Because providers have their own culture of shared beliefs, norms and values, they may view mental health, diagnosis and treatment in ways that may differ from the culture of the patient or client. CIGNA Behavioral Health's staff reported throughout the years that many individuals calling to access behavioral care have specific preferences in terms of the type of practitioner they would like to see. Members often request a practitioner of a particular race, religious faith, age, gender or language. Consequently, CIGNA Behavioral Health embarked on an effort to collect this information voluntarily from practitioners in order to facilitate a better cultural and linguistic match between patients and providers.

Initiative Description

CIGNA initiated the collection of cultural and demographic information from practitioners in 1999. Practitioners reported their gender, age, race/ethnicity, language spoken, sexual orientation, substance abuse recovery status, religion, veteran status and disability. In 2002, CIGNA implemented Web-based access, allowing members to select their own behavior care practitioners by searching for language, gender, ethnicity, age they treat and clinical specialty. Given the potential sensitivity of publicly posting information, details related to religion, sexual orientation, disability or recovery status were not included in the external Web search.

CIGNA conducted staff and provider training to expand and enhance the program. Staff were trained on how to do system searches and use translation services to match patients with providers. CIGNA also actively recruited diverse practitioners to become part of its network. Several communications were sent to behavioral practitioners to promote cultural awareness and encourage the provision of voluntary information.

---

[42] Ibid.

CIGNA Practitioner Search Screen

In December of 2004, the plan enhanced Web capabilities by implementing Provider Self-Introductions. This feature allows practitioners to include a photograph and a self-description of their practice in their Web-based profile. Based on this information, members are able to get a sense of the practitioner's style, treatment approach and practice setting. CIGNA actively promoted the Provider Self-Introduction, making outreach calls to encourage the completion of the self-introductions and submission of photos. CIGNA also held continuing education events for practitioners in several markets nationwide, where stations were set up for taking photographs and completing the self-introduction. In 2006, CIGNA began to require self-introduction for all practitioners upon their credentialing and contracting with the network.

CIGNA Provider Self-Introductions

Results and Impact

To monitor progress of the initiative, CIGNA conducted an annual assessment of the number of practitioners who voluntarily provided their race/ethnicity, languages spoken, religion and sexual orientation. Between 2001 and 2006, CIGNA nearly doubled the number of African-American and Spanish-speaking practitioners in its network. It also increased the number of Jewish and gay/lesbian practitioners by 36 percent and 68 percent, respectively.

CIGNA also monitors utilization of the Web-based practitioner search and online access. Between 2004 and 2006, the number of members using the practitioner search capability tripled from 3,043 to 9,174. The number of behavioral practitioners who submitted the provider self-introduction also showed dramatic improvement, from 1,282 in 2005 to 6,670 in 2006, reaching more than 8,500 practitioners to date.

In addition, an analysis of member satisfaction data indicated that from 2003 to 2006, African-American and other non-Caucasian respondents showed significant increases in satisfaction with urgent and routine access to care.

CIGNA Behavioral Health receives almost a million member initiated calls per year, many of which are related to selecting practitioners. By providing robust information on network practitioners available, members are better able to select a behavioral practitioner who meets their needs and preferences. This increased capability allows staff to respond to a request for an African-American male, a Christian counselor or a Spanish-speaking provider in the member's local area.

Implementation of these strategies has required a commitment to enhancing provider databases and Web capabilities. Staff time was required to recruit for the network, encourage the provision of voluntary information and self-introductions, and manage responses. Designing these steps across a number of years allowed CIGNA to plan its resources and incorporate changes sequentially. CIGNA and CIGNA Behavioral Health plan to continue these programs, enhancing them over time.

Another promising practice in promoting the use of bilingual staff and clinicians is Molina Healthcare's TeleSalud program, a 24-hour English/Spanish bilingual telephone service providing access to member services, medical advice from qualified nurses and interpreter services. TeleSalud is staffed by bilingual registered nurses who communicate directly with members seeking clinical advice.

Molina Healthcare's TeleSalud Program: Providing Direct Access to Language Services

Background

In 2002, Molina reviewed utilization of its outsourced nurse advice line and found that usage of Language Line Services by Spanish-speaking members (Latinos) was very low. Although 45 percent of the plan's

membership is Latino (primarily of Mexican origin) with a declared Spanish language preference, a Spanish interpreter had been requested in fewer than 2 percent of calls. This low utilization suggested a barrier for members in accessing nurse advice services.

Program Description

Molina Healthcare was one of 10 grantee of the *Hablamos Juntos* project, sponsored by the Robert Wood Johnson Foundation (RWJF). The TeleSalud project was established in 2004 as a separate department within Molina Healthcare of California. It offered direct accessibility for medical interpretation services to address the health and language needs of the underserved, limited English proficient Latino population living in the Inland Empire region of Southern California. The project was conceived to provide Molina Healthcare's members with service in their declared language of preference with 24-hour live and direct access to a registered nurse for advice and interpretation assistance.

Interpreter services are structured according to the Molina Healthcare Communication Model, in which bilingual registered nurses perform complex medical interpreting and education. The two-tiered model employs non-clinical staff to receive the intake calls and registered nurses to receive calls requiring interpretation, clinical assessment or intervention. Calls from Spanish-speaking members are answered in Spanish and routed to bilingual registered nurses for completion. If members find themselves in situations where no Spanish interpreter is available for a medical visit, emergency room or pharmacy encounter, Molina Healthcare's nurses are also available to interpret, educate and assist. The model empowers members to call for such assistance directly and at no cost to themselves or their health care providers.

The Molina Communication Model

SENSITIVITY

	NON-SENSITIVE	SENSITIVE
SIMPLE	**I** ➤ Access ➤ Prevention ➤ Incidental Needs	**II** ➤ Pregnancy ➤ Mental Health ➤ Procedures
COMPLEX	**III** ➤ Surgical Consent ➤ Abnormal Results ➤ Discharge Plans	**IV** ➤ Serious Illness ➤ Substance Abuse ➤ Life or Death

(CONTENT)

A centralized data system provides documentation capabilities and tracking for language needs. It is designed to support data security, integrity and confidentiality in compliance with the Health Insurance Portability and Accountability Act of 1996 requirements. All calls into the department are recorded as part of the Quality Improvement Program for monitoring purposes and coaching as indicated.

Registered nurses follow nationally recognized adult and pediatric protocols for nurse advice. The guidelines are based on scientifically valid and documented clinical principles and are appropriate for use by registered nurses. Physicians completely review the nurse advice protocol regularly and provide updates every six months.

Hiring and Staffing

The TeleSalud core staff includes an exchange operator who receives the call, the registered nurse providing interpretation services and advice, and management staff. The operators are responsible for live telephone access into the Clinical Telephone Services Department in accordance with defined policies and procedures. The registered nurses are licensed in the state in which clinical telephone nurse advice services are provided. Responsibilities include but are not limited to:

- Providing clinical telephone advice in accordance with approved protocols;

- Providing interpreter services for complex medical situations;

- Assisting the members in obtaining access at the appropriate level of care as directed by protocols; and

- Providing other health information to support member wellness.

Registered nurses must meet professional qualifications and minimum experience requirements. Bilingual fluency is also necessary. Interviews are conducted in Spanish by Molina Healthcare's language coaches, and test interactions (i.e., simulated advice call) are conducted in Spanish.

Training

Training includes a review of the California Healthcare Interpreter Standards, with a significant focus on confidentiality. Molina Healthcare tested bilingual dual-role staffs working in the clinical office setting and member services using the LISA tool presented by RWJF.

TeleSalud staffs complete orientation and training specific to their job functions, lasting up to 30 days, with an additional coaching and review period for RNs. Molina Healthcare has also established training program criteria using the California Healthcare Interpreting Association's (CHIA) Healthcare Interpreting Guidelines published by The California Endowment. Language coaches conduct ongoing quality monitoring by simultaneously listening to calls and reviewing call recordings. Inter-rater reviews are regularly conducted as well as regular meetings of TeleSalud nurses to discuss issues surrounding how to express certain concepts in Spanish to speakers from different countries of origin.

Results

Since initial implementation in April 2004, the TeleSalud program has grown tremendously, now serving Molina Healthcare members in nine states. Significant additions have been made to Molina Healthcare's infrastructure. There has been a substantial increase in bilingual capacity for nurse advice services at Molina Healthcare. Teams have been organized in each state and oriented to the project history, vision and implementation plan. Policies, procedures and individualized workflows that clearly demonstrate how the project functions have

resulted in replicable practices while serving specific needs.

Based on data collected during December 2004 through February 2005, Molina Healthcare's TeleSalud program produced a cost-savings of $2,448 per month during the pilot phase, totaling an extrapolated annual cost-savings of $29,000. Expansion of the program to cover all of Molina's members in all states yielded a savings ranging from $0.14 to $1.35 per member per year in calendar year 2005-2006, totaling more than $750,000 in cost-savings. The state with the greatest savings was California, where the greatest percentage of Spanish-speaking members resides.

Ad-Hoc Interpreters

Ad-hoc interpreters are individuals whose primary job function in the health care setting is something other than interpretation. Ad-hoc interpreters can include bilingual clinic staff or staff employed in other positions, patients' friends and family members, or even fellow patients. Individuals who have not received interpretation skills or ethics training can compromise the quality of the health care encounter. If competence is not assessed, use of bilingual staff to interpret may be most appropriate for administrative contact with patients, or as a backup when a professional interpreter is not available. Another area for consideration is how to balance staff's primary duties with interpreting, and the potential inefficiency of removing staff from their regular duties.

Professional Interpreters

Professional interpreters are those individuals whose sole function in the health care setting is to interpret. Health plans have employed a variety of strategies, including hiring interpreters, contracting for their services on a per diem, service basis and/or through a language agency.

Dedicated Staff Interpreters

Dedicated staff interpreters are employed full- or part-time at a plan for the sole purpose of providing interpretation services. This strategy is particularly economical in cases where a significant number or proportion of LEP patients speaks a particular language. It may not be the ideal solution if interpretation needs are diffused across several languages. Dedicated staff interpreters are likely to be formally trained, professional interpreters. However, plans also need to consider how to monitor quality, as well as provide ongoing training.

Contract Interpreters

Contract interpreters are not employed by the health plan, but are available on a per-diem or on- call basis. Contract interpreters are often formally trained, and have high incentives for continuing education. This model can be more cost-effective than the dedicated staff model when demand is low. This solution requires someone at the plan level to coordinate screening, contracting, dispatching and payment of interpreters.

Language Agencies (Interpreter Banks or Community Language Banks)

There are several for-profit or nonprofit organizations that recruit, contract and dispatch interpreters on demand to health care organizations. Agencies are usually paid per hour of interpreter services, and services typically need to be scheduled in advance. Competency is typically assessed and guaranteed by the agency, and health plans can monitor this by investigating the standards that an agency has set for its interpreters.

Telephone Interpretation Lines

There are two forms of telephone interpretation—remote telephone interpretation or language lines, and remote simultaneous interpretation.

- Using language lines, interpreters are accessed via a three-way conference call using regular telephone equipment.

- In remote simultaneous interpretation, interpretation happens simultaneously as individuals speak through wireless headsets. This service is typically more expensive when considered on a per-minute basis, although it can be cost-effective in situations where there is only occasional demand for a certain language.

These services are available in many languages on a 24-hours-per-day basis.

Providing Written Materials in Different Languages

Health plans often use written materials for multiple purposes, including educating members about available services, benefits, member rights and care. When done thoughtfully, the translation of certain documents can be a valuable means of communicating with LEP individuals.

Federal laws and some state laws (e.g., California and Texas) require federally funded health care organizations to translate vital documents for LEP patients. Specifically, the HHS Office of Civil Rights policy guidance

set forth the following guidelines for ensuring access to written materials and documents for LEP patients served by federally funded health care organizations:

- Translation of all written materials for each LEP language group that equals the lesser of 10 percent or 3,000 members;

- Translation of at least vital documents for each LEP language group that equals the lesser of 5 percent or 1,000 members; and

- Translation of notice of right to competent interpretation of written documents for LEP populations below the above thresholds.

Models for Translating Written Materials

Health plans vary in their capacity to provide translation services in-house. In many cases, health plans ask vendors and/or other organizations for translated materials and signage. This section describes the various methods that health plans can use to translate materials, noting the advantages and disadvantages associated with each method.

Bilingual Staff

A health plan can use its own bilingual staff to translate written materials. Under this model, translations may be performed as the primary responsibility of a language services staff member or on an ad-hoc basis by other bilingual staff. In cases where translation is not part of the staff member's job description, plans can offer additional compensation or incentives. A consideration for using this model is that it can be difficult to assure the quality of translations.

Clearinghouses and Other Web-based Resources

There are several clearinghouses and Web sites that host collections of translated materials, which are made available to the public. These materials are generally free, but in some cases some clearinghouses may charge a fee for use of their printed materials. The quality of materials is variable. Some materials might be formally translated and/or reviewed by competent translators but details about the process for translation and quality assurance are typically not available.

Community Collaborations

Health plans can sometimes tap into resources of community organizations to translate materials. These organizations often have professional translators to

> *Top Tips:*
>
> *Even if you do not have capacity for in-house translation or interpretation, there are many options for translating written materials:*
>
> - *Bilingual staff*
> - *Clearinghouses/Web-based resources*
> - *Community collaborations*
> - *Machine translation*
> - *Translation vendors*

help them serve their local community. Health plans can create partnerships with these organizations to share the costs of translating materials. One advantage of this strategy is that the local organization may have a good understanding of the literacy level of the community. Members of the community group may also be helpful in reviewing and assessing the appropriateness of translated materials.

Machine Translation

Increasingly, organizations are relying on computer programs to perform translation. The translation methods vary; some programs are "memory-based" and use previously translated phrases to increase accuracy. It is important to note that the machine performing the translation does not take into account context, so there is a need to have a professional translator review the target document. These programs are most useful when used as aids to human translators and can increase the efficiency of the translation process. A promising practice in this area is Molina Healthcare's use of "translation memory" resulting from this process to increase the consistency of its messages and reduce turnaround times and translation costs.

Molina Healthcare: Maximizing Linguistic Assets in Translation

Background

Driven by regulatory requirements and patient needs, health plans produce written materials that must be translated for their members, often in multiple languages. Every year, health plans spend a significant amount of resources translating into other languages materials, such as member manuals, explanation of benefits and health education pamphlets. Although translation services are widely used by health plans, very few understand the process and are therefore unable to identify ways to improve the accuracy and efficiency of translations.

The Translation Process

Health plans typically develop written materials in English for various purposes. The completed document is reviewed, approved and sent for translation. It then is returned to the plan in its target language, with the invoice.

Many health plans are unaware of an interim process that translators use. When the translator receives a document, it is run through a machine translation process. Words that have been previously translated, often referred to as "leveraged" words, are automatically

translated in the current document. Words that have not been translated before are flagged and then manually translated by an individual. The translated content is stored in a database, referred to as translation memory, for future use. The customer's document is then reviewed, post-edited for content and returned to the customer.

Many plans do not know that translation memory is an asset that they own. If a plan uses a translation vendor consistently, that translation memory increases, which improves the quality of each translation, because the plans are leveraging their own words.

Leveraging Knowledge of the Translation Process to Achieve Efficiencies

In late 2006, Molina Healthcare embarked on a process to obtain its translation memory from its vendors. By late 2007, Molina Healthcare had pooled all of its translation memory data into a central repository. All of the data was then reviewed for a final quality check before being deposited into a permanent database. Molina Healthcare expects to leverage previously translated words from all departments and business units within the health plan. Much of the text that is translated across the organization or even across a single large document has a large amount of repetition. Using translation memory, Molina has begun to realize several benefits, including:

- **Consistency of Translations:** Because only new words are translated, the style, tone and usage of phrases and terminology will remain consistent with previously translated materials. It allows health plans to maintain a glossary of terms so that it can present certain messages to members in a standard language.

- **Faster Turnaround Times:** Translators do not have to re-translate "leveraged" words or sentences, reducing turnaround times.

- **Cost Savings:** Previously translated words and phrases are considered the health plans' assets and are charged at a significantly reduced rate.

Results

Molina Healthcare is now tracking and trending detailed translation cost data. Because the tracking period has recently begun in 2008, preliminary data are not yet available. Molina Healthcare expects to realize a significant savings using this process. Molina Healthcare plans to expand this process to encompass other threshold languages frequently used in translation. The savings achieved from harnessing

Translation Vendors

Many plans contract with translation vendors to meet their translation needs. In these cases, plans pay on a per-word basis, and the cost can vary depending on the language of the document. Translators are likely to have high proficiency and/or formal training, and some translators might be certified by the American Translators Association. In addition, the translation process usually includes a review of the document to ensure quality.

Table 9: Types of Translation Services

TYPE OF TRANSLATION SERVICE	DEFINITION	ADVANTAGES	DISADVANTAGES
Bilingual Staff and Clinicians	Translation done by health plan staff member.	• Little or no outside cost	• May be difficult to assess quality of translation, particularly if staff member is untrained or language and translation skills have not been evaluated
Clearinghouses and Other Web-based Resources	Clearinghouses and Web sites that host collections of translated materials.	• Usually free	• Quality of material may vary • Details about process for translation and quality assurance are typically not available
Community Collaborations	Collaborations with community organizations that provide translation or interpreters.	• Local knowledge and familiarity • Connection to the community • Can use for assessing materials	• May have an associated cost • Can be difficult to assure the quality of translations
Machine Translation		• Can increase efficiency of process	• No context for the translation

TYPE OF TRANSLATION SERVICE	DEFINITION	ADVANTAGES	DISADVANTAGES
		• Can build "translation memory" to reduce turnaround times and translation costs	• Need professional translator to review

Process for Checking Translations

Whether a health plan outsources its translation or conducts it in-house, it is critical to establish a process for reviewing the quality of translated materials. This section provides tools that health plans can use to ensure the quality of translated products. The first is a translation checklist outlining the various steps in the translation process, including identifying the target audience, determining the key health messages to be conveyed, and developing a budget and timeline for the translation. Staff who are conducting translation projects can use this checklist to ensure that all necessary steps are considered and completed.

The second tool, guidelines for in-house translation reviews, outlines the process that employees conducting internal reviews should follow. These guidelines can be used to ensure the quality of translated products and evaluate the performance of the translation vendor.

Finally, the translation quality assurance form is useful to reviewers when providing feedback on the quality of the translated document. It is a particularly useful tool when negotiating discrepancies with the translator. It addresses issues, such as accuracy, readability and appropriateness of the translated document.

Tools to Ensure Quality:

- *Translation checklist*
- *Guidelines for in-house translation Review*
- *Translation quality assurance form*

Top Tips:

Reviewing quality of translated material is essential.

Promising Practices in Interpreter Training and Competency Assessments

Health plans have improved the competency of bilingual staff who provide services and interpretation in languages other than English. Interpretation competency can be ensured through internal or external training. For example, Kaiser Permanente's Qualified Bilingual Staff (QBS) model provides internal assessments and trainings in an effort to increase the availability and use of bilingual staff. The goal of the QBS model is to

identify, qualify, educate/enhance, mobilize and monitor an internal workforce to improve health outcomes and eliminate health care disparities.

Kaiser Permanente also developed the Health Care Interpreter Certificate Program to address the dearth of qualified professional health care interpreters in the community. In partnership with City College of San Francisco, Kaiser Permanente designed a model Health Care Interpretation curriculum in 1996 and now has established multiple internship programs internally and externally, certified faculties, and disseminated the curriculum across the country. This innovative model has shown that partnerships between health care organizations and accredited academic institutions are sustainable and mutually beneficial. The collaborative efforts help promote a renewable balance of supply and demand by connecting the health care institutions that need professional health care interpreters with the academic institutions that train them.

Kaiser Permanente: Qualified Bilingual Staff Model

Background

To ensure access to linguistic services at every point of contact, health care organizations must address multiple unique encounters that span the patient and family health care experience. Each point of contact may be specialized and requires its own level of linguistic competency. Faced with increasing language service demand, and in the absence of adequate numbers of onsite qualified health care interpreters, health care organizations are turning to their own diverse workforce for practical solutions. To promote access to linguistic services, Kaiser Permanente developed the Qualified Bilingual Staff (QBS) model to *identify, qualify, educate/enhance, mobilize and monitor* an internal workforce as a key strategy to promote culturally competent care, improve health outcomes and reduce health care disparities.

Initiative Description

Kaiser Permanente established the QBS model to expand the ways it provides culturally and linguistically appropriate care services and training to its staff and providers serving LEP members. Specifically, the QBS model aims to:

- Identify workforce capacity;

- Qualify levels of linguistic competency;

- Enhance linguistic capabilities;

- Mobilize QBS within the care system; and

- Monitor the services provided to ensure continuous quality improvement and patient safety.

Three levels of staff training for the model include:

- Bilingual staff—language liaison

- Bilingual staff—language facilitator; and

- Designated interpreter.

The QBS model is complete with an internally developed training curriculum, resources and materials. It is open to all members of the Kaiser Permanente workforce who seek to enhance their linguistic competency. Currently, the model targets the plan's threshold languages including Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, Tagalog, Russian, Hmong, Punjabi and American Sign Language. The QBS model enhances bilingual communication within the staff's scope of practice or clinical specialty. QBS staff and clinicians can serve in dual roles where one role services a functional need, the other a linguistic need.

The model also promotes CLAS standards by embedding the standards as a core-element learning objective in each level of the curriculum. It provides a systematic approach to bridge health practice with health training by institutionalizing a skill enhancement process that internal workforce staff can use.

The development of the QBS Model required the participation of national, regional and local staff, project leads, executives, business managers, union leaders and community advocates. The QBS model introduced a fundamental change in organizational culture by investing in its internal expertise to meet the needs of linguistically diverse populations. The model was initiated in 2003 and has gained momentum as it is replicated within the organization in different regions. The model complies with the CLAS standards and federal and state mandates such as Title VI of the Civil Rights Act of 1964.

Results

The QBS model has been successfully implemented in Kaiser's Northern California, mid-Atlantic states, Georgia and Southern

California regions. Kaiser Permanente regions have been exceptionally successful in the implementation of the QBS model. The model has been recognized both internally (recipient of Kaiser Permanente's prestigious internal R.J. Erickson Award) as well as externally (recognition by patient rights leaders, advocates and community organizations). In 2006, the QBS model Program received the NCQA *Recognizing Innovation in Multicultural Health Care Award*.

In the Northern California region (covering 3.2 million members), particular achievements include:

- Implementation of the QBS model in 2003;

- Training of 75 level-one trainers and 50 level-two trainers;

- Implementation in 51 medical offices throughout Northern California;

- Completion of 6,173 assessments as of April 30, 2006;

- Assessment and training of 3,060 QBS staff with approximately 1,517 in level one and 1,543 in level two;

- Provision of more than 388 QBS level-one training and 119 level-two training sessions since the program's inception in 2003;

- Increased cultural and linguistic capacity for Spanish, Chinese, Vietnamese, Russian, American Sign Language, Tagalog, Hmong, and Punjabi speaking staff; and

- Collaboration with four main labor unions.

In the mid-Atlantic states region, which includes Washington, D.C., Virginia and Maryland (covering 500,000 members), accomplishments include:

 Implementation of the QBS program in 2004;

- Training of eight certified facilitators;

- Implementation in 22 facilities;

- Training of 102 QBS staff with approximately 15 in level one and 87 in level two; and

- Increased cultural and linguistic capacity for Spanish-, Chinese-

and Vietnamese-speaking staff.

Lessons Learned and Next Steps

Kaiser Permanente plans to add additional languages into the QBS model depending on patient demand. The model continues to flourish in an environment of strong organizational commitment and continues to gain momentum in regions that recognize potential program benefits. The model will continue to succeed as a viable and cost-effective solution to meet the needs of Kaiser Permanente's diverse multilingual and multicultural population and reduce the need to outsource services while maintaining the health plan's standards. Leadership at the various Kaiser Permanente regions throughout the country, coupled with collaboration and agreements with partnering labor unions, reinforce the effort to develop the linguistic competency of internal staff. Regional and labor union partnerships also provide monetary rewards as recognition for the provision of QBS services.

A fully developed curriculum and related program support material allow the model to be replicated across the organization. Policies and procedures are in place to govern and monitor the standards for on-going assessments and training. These guide delivery and expansion of the QBS model.

Kaiser Permanente: Health Care Interpreter Certificate Program

Background

In 1995, Kaiser Permanente performed a national environmental scan of existing interpreter programs that found: 1) No private or public accreditation program existed for professional health care interpretation and, 2) Interpreters provided by external agencies often lacked sufficient training and demonstrated an inconsistent quality in their interpretation. In addition, there were no existing interpretation accreditation or performance standards. Recognizing the lack of formally trained Health Care Interpreters, related training programs and certification standards, Kaiser Permanente in 1996 designed a model Health Care Interpretation curriculum. In 2000, Kaiser Permanente formed a collaboration with the City College of San Francisco (CCSF) to offer the curriculum as a formal 15 credit unit Health Care Interpreter Certificate Program (HCICP), making CCSF the first educational institution in the Western United States to offer

Health Care Interpreter training at the college level.

Initiative Description

The innovative partnership between Kaiser Permanente and CCSF provides a cost-effective and practical solution to training health care interpreters. The goal of the HCICP grassroots curriculum is to develop the cultural and linguistic competency of Health Care Interpreter students and prepare them to work effectively and efficiently in health care settings. Through academic preparation, practical skills training, guest lectures by Kaiser Permanente and non-Kaiser Permanente clinicians and field experience in various Kaiser Permanente and non-Kaiser Permanente facilities, HCICP students gain additional hands-on experience and real-time practical skills and knowledge to successfully complete their training program.

Success of the HCIP project requires five key resources:

- **Personnel:** Coordinators/instructors from each partnering academic and health care institution, language lab coaches and volunteer lecturers such as physicians and nurses

- **Financial:** Kaiser Permanente pays for the initial instructor training and provides class materials and space. Grants or other sources of funding help support training and education program.

- **Training:** The Health Care Interpreter Instructor Training Institute trains faculty at partnering academic institutions and improves skills of existing faculty.

- **Support:** Continuous technical support is provided to academic institutions and partner health care institutions.

- **Technology:** A dedicated Web site for HCICP ([www.kphci.org)](www.kphci.org) was developed and continues to be maintained.

Results

Since developing the HCICP, Kaiser Permanente has:

- Established six internship programs at Kaiser Permanente facilities and hospitals.

- Partnered with *Hablamos Juntos*, a project of RWJF, to establish 10 additional program sites throughout the country.

- Trained and certified more than 100 college-level instructors and

staff at Kaiser Permanente's HCI Instructor Institute.

- Graduated more than 900 students from HCICP at partnering colleges with a 90 percent successful completion rate.

- Enhanced HCICP students' marketability and readiness for employment in health care while building community capacity to serve limited English populations. Languages spoken by graduates include Arabic, Cantonese, Farsi, Japanese, Khmer, Korean, Laotian, Mandarin, Portuguese, Russian, Spanish, Tagalog and Vietnamese.

- Increased internal Kaiser Permanente workforce capacity by improving health care interpretation skills among employed staff.

Based on a Kaiser Permanente-funded research study, providers who used trained health care interpreters overwhelmingly preferred them to untrained health care interpreters (family members and bilingual staff). The same study found that members were able to differentiate between trained and untrained health care interpreters and favor trained health care interpreters significantly. In addition, the HCICP graduates fulfill cultural and linguistic health service needs, contribute to Kaiser Permanente's overarching mission to reduce health disparities and aid in compliance with federal and state mandates such as Title VI of the Civil Rights Act of 1964.

Sustainability

The success of the HCICP throughout the years and its ongoing expansion to 15 additional geographic areas have shown that partnerships between health care organizations and accredited academic institutions are sustainable and mutually beneficial. Collaborative efforts meet a mutual need by joining the health institutions in need of professional health care interpreters and the academic institutions that train them. Kaiser Permanente encourages and implements ongoing HCICP partnerships outside its service area. The HCICP is a national model with regional and local applicability. It is easily transferable to other health care and academic organizations committed to implementing this partnership training program model.

Section 4: Making the Business Case

Making the Business Case for Improving Quality and Addressing Disparities

The Institute of Medicine's seminal report, *Crossing the Quality Chasm,* articulated six quality aims for the U.S. health care system: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. Essential to achieving the equity aim are efforts to reduce racial/ethnic or socioeconomic disparities in health care and health outcomes.

A key component of the equity aim is to increase accountability by monitoring and improving the quality of clinical care for individual patients and populations. Health plans contemplating whether or how to address disparities often assess the "business case" for allocation of resources. Specifically, these plans may want to know whether the investment in a given intervention will produce the desired outcome, which may range from improving the ability of the organization to optimally provide services in the future, to save money in future health care costs, or to increase market share. Organizations seeking to reduce disparities in quality of care may need to financially justify the investments required to achieve these goals. For example, health plans face numerous competing resource demands, allocation of limited personnel time, care management supports, other intervention resources and the need to justify the opportunity cost of focusing on disparities reduction. Indeed, some medical or quality directors working within health plans seeking to address disparities need to project a positive return on investment (ROI) to gain institutional support for their efforts.

> *Did You Know?*
>
> *Creating a business case for reducing disparities can help plans determine how to prioritize and allocate limited resources.*

Challenges to Making a Business Case for Addressing Disparities

There are several potential challenges to making a business case for addressing disparities. First, returns (whether financial or otherwise) might not be realized for many years after the investment is made. This applies particularly to chronic diseases such as diabetes, for which some utilization-based savings do not accrue until several years after the intervention has been implemented. Health care utilization improvements for many interventions occur in the long-term and any returns might not go to the investors but instead might be realized years later by other health plans.

Another major challenge arises when assessing the ROI for interventions. Until recently, the lack of data on race/ethnicity in the health system has

precluded routine detection of disparities in quality of care and accountability for reducing them. In this context, persuading decision-makers to invest in obtaining data on race and ethnicity—a prerequisite to considering the business case—can be challenging because many still assume that no significant disparities in care exist within their systems. The Catch-22 is that these decision-makers have no real way to find out about disparities or optimal ways to address them until such data have been obtained and analyzed and different strategies have been tested. This conundrum can, unfortunately, focus the discussion on the business case for obtaining data, thereby disconnecting it from the broader goals of achieving equity and addressing disparities. Understandably, many health plans will question the value proposition for obtaining data alone, particularly when obtaining self-reported data for large proportions of a population can take years and may require changes to an already complex information technology infrastructure.

Considerations for Demonstrating the Business Case

Despite the challenges outlined above, a growing number of health plans have begun to look at the ROI and business case for implementing various initiatives. The National Health Plan Collaborative piloted several tools to aid in the assessment of the business case for identified initiatives. These tools include a prospective forecasting tool to analyze the ROI potential of proposed quality initiatives and an ROI evaluation tool to assess the return on quality initiatives after they have been implemented. A number of health plans, including Highmark Inc., Harvard Pilgrim Health Care and Kaiser Permanente, helped refine these tools to determine their value in testing and demonstrating the business case for specific initiatives to reduce disparities. Based on these preliminary efforts, several observations can be made regarding efforts to demonstrate the business case for reducing disparities:

- **Access to Data:** Analysis requires substantial access to financial data—including program costs required to develop, implement and operate initiatives—and health care claims to assess changes in utilization patterns over time. These data are often challenging to obtain.

- **Intervention Timeframe:** Analysis is best suited toward interventions and outcomes that are measurable in a reasonably short time frame. Short time frame is necessary due to membership churn, near-term financial priorities and pressures, and ability to accurately forecast effects.

- **Evaluation Design:** A strong evaluation design is essential for isolating intervention effects associated with the business case. In the absence of

> ### Challenges to making a business case:
>
> - *Length of time to realize returns*
> - *Limited data to determine disparities*
> - *Limitations in the breadth of evidence of positive return*

> ### Did You Know?
>
> *The following aspects should be considered when building a business case:*
>
> - *Access to data*
> - *Intervention timeframe*
> - *Evaluation design*
> - *Involvement of multiple stakeholders*

valid design and comparison groups, it may be difficult to isolate true financial savings from artifact—caused by factors such as selection bias and regression to the mean.

- **Involvement of Multiple Stakeholders:** Multiple stakeholders should be included in business case analyses in order to understand the full spectrum of financial impacts associated with interventions and to identify any misalignments that may serve as disincentives to reducing disparities.

Tools for Calculating ROI to Support the Business Case

ROI Templates

The *ROI Templates[43]* comprise an Excel-based, back-end tool designed to capture data on the costs of implementing quality improvement initiatives, as well as the savings associated with changes in patient utilization that result from these initiatives. The ROI calculations are derived from three main inputs:

- **Baseline Costs:** Users identify expenditures prior to starting the intervention by category of service.

- **Post-intervention Costs:** Users enter expenditures by category of service after implementing the quality improvement initiative.

- **Program Costs:** Users capture the costs of implementing the quality improvement initiative, such as allocated staff time, equipment and technology purchases.

> *Top Tips:*
>
> *Use the ROI templates and ROI forecasting calculator when determining ROI for disparities-focused interventions.*

ROI Forecasting Calculator

To help health care organizations assess and demonstrate the ROI from proposed initiatives to improve the quality of care, the Center for Health Care Strategies developed the *ROI Forecasting Calculator for Quality Initiatives.* The ROI Forecasting Calculator is a Web-based, front-end planning tool that includes four primary components:

- **Target Population:** Users identify the target population (e.g., high-risk diabetics) for a proposed quality initiative (e.g., HbA1c testing, group education visits).

---

[43] http://www.chcs.org/publications3960/publications_show.htm?doc_id=702936

- **Program Costs:** Users estimate the costs of program design and implementation (e.g., staff training, information technology systems implementation).

- **Utilization Changes:** Users predict changes in utilization patterns that are likely to result from the quality initiative (e.g., decrease in hospital admissions, increase in pharmacy costs).

- **Sensitivity Analyses:** Users account for uncertainty in forecast parameters, enabling the calculation of upper and lower bounds for ROI estimates.

The *ROI Forecasting Calculator for Quality Initiatives* may be useful to health plans in numerous ways. First, the tool can be used to predict the financial implications of proposed quality initiatives. Users specify key program attributes, such as target population size and projected utilization changes, and calculate the expected ROI based on these assumptions. By varying one or more of these assumptions, users can assess the impact of changes in program design, implementation costs or patient outcomes on expected financial returns.

Alternatively, users of the tool can start with a targeted ROI and work backward, employing the tool to identify program attributes that will be required to generate a desired return. To do this, users of the tool could assess the magnitude of reduction in utilization that would be necessary for a particular quality initiative to cover its implementation costs, holding all other assumptions constant. Similarly, users could identify the minimum size of the population that must be reached by the intervention, the maximum threshold for program-related costs, or the timeframe within which utilization changes must occur in order to achieve breakeven or another targeted ROI.

ROI Evidence Base

Accurate prediction of changes in utilization patterns is among the more challenging aspects of forecasting ROI for quality improvement efforts. To assist in this process, CHCS incorporated an "Evidence Base" dataset feature into the *ROI Forecasting Calculator for Quality Initiatives* that allows users to automatically populate forecast assumptions from comparable initiatives to improve quality. With the *ROI Evidence Base*, users may browse and select from the results of published studies, as well as from the results of similar interventions by other states or health plans.

The Evidence Base currently includes a selection of studies for clinical topics and conditions that are of high priority to Medicaid stakeholders, including asthma, congestive heart failure, depression, diabetes and high-risk pregnancy. These clinical conditions are also ones that disproportionately affect members of racial and ethnic minority groups. Studies are categorized: (1) by clinical condition and (2) by whether reported outcomes indicate decreases or increases in cost and utilization. Users may browse the *ROI Evidence Base* to assess the relevance of included studies based on intervention strategies, target population characteristics, intervention settings and overall study quality.

Top Tips:

When forecasting ROI, the ROI Evidence Base can be used to help predict utilization patterns.

Appendix

Tools

- Highmark Inc. Member Survey, Cover Letter and Fact Sheet

- HealthPartners Clinic Form

- Highmark Inc. Customer Newsletter

- Health Plan Data Collection Chart

- HealthPartners Language Assistance Plan

- HealthPartners "Your Guide to Interpreter Services"

- HealthPartners Interpreter Administration Program Policy

- Translation Checklist

- Guidelines for Translation Reviews

- Translation Quality Assurance Form

National Health Plan Collaborative Health Plan Descriptions

Resource List

Please share your language, race and ethnicity
information with Highmark.
It's voluntary and <u>confidential</u>.
It will help us improve our communications with you.

Dear Member:

Highmark wants to help you and all our members live longer, healthier lives. That's why we're asking you to tell us more about yourself and your family members who are covered under your health insurance.

The information you provide will be protected.
We value our members' privacy. Highmark is committed to protecting member data and handling it with respect and integrity. Also, what you tell us won't affect your insurance coverage, how much you pay or how we pay your claims.

We're working to help everyone get equal health care.
Did you know that racial and ethnic minorities may not receive equal health care even when they have the same access and insurance and their age and health conditions are similar? (See the fact sheet on the reverse for specific examples.) Highmark is committed to improving the quality of care that all of our members receive. We also know that today more of our members would prefer to receive information in a language other than English.

We need your help!
You can help us by providing information about your race, your ethnic background and language preference. We're counting on you and all our members to provide this valuable information. Please take a few minutes to complete the enclosed questionnaire. Then use the enclosed, postage-paid envelope to return it today to Highmark Blue Shield, Return Development, PO Box 890062, Camp Hill PA 17001-9886. If you have questions, you can call the number on your identification card. Thank you for your prompt attention to this request.

Sincerely,

Rhonda Moore Johnson, M.D.
Medical Director

Please complete either the English or Spanish version of this survey.

Member Questionnaire

Please fill in the circles completely to indicate your answers.

Shade Circles Like This--> ●
Not Like This-->⊠ ⊘

1. **How would you classify yourself and your dependents listed below who are covered under your <u>Highmark medical insurance plan</u>? (You can choose up to <u>two</u> answers for each person.)**

By race:						
American Indian or Alaska Native	○	○	○	○	○	○
Asian	○	○	○	○	○	○
Black or African American	○	○	○	○	○	○
Native Hawaiian or Other Pacific Islander	○	○	○	○	○	○
White	○	○	○	○	○	○
Some Other Race - Please Specify: _____	○	○	○	○	○	○
Unknown	○	○	○	○	○	○
Choose not to answer	○	○	○	○	○	○
By ethnic background: (choose only <u>one</u>)						
Hispanic or Latino*	○	○	○	○	○	○
Not Hispanic or Latino	○	○	○	○	○	○
Unknown	○	○	○	○	○	○
Choose not to answer	○	○	○	○	○	○

Please complete either the English or Spanish version of this survey.

*Individuals who trace their origin to Mexico, Puerto Rico, Cuba, Central or South America or other Spanish cultures.

HIGHMARK
BLUE SHIELD
An Independent Licensee of the Blue Cross and Blue Shield Association

2. **What language do you speak most of the time at home?**
    (Please choose only <u>one</u> answer per member.)

Shade Circles Like This-- > ●
Not Like This-- > ⊠ ⊘

English	○	○	○	○	○	○
Spanish	○	○	○	○	○	○
Other - Please specify: _____	○	○	○	○	○	○
Choose not to answer	○	○	○	○	○	○

3. **In what language would you prefer to receive communications from Highmark?**

○ English   ○ Spanish   ○ Other _____   ○ Choose not to answer

4. **Do you and the family members on your coverage need or want an interpreter to communicate with a doctor or health care practitioner? (Please choose only <u>one</u> answer per member.)**

Yes	○	○	○	○	○	○
No	○	○	○	○	○	○
Choose not to answer	○	○	○	○	○	○

**Please use the enclosed postage-paid envelope
to return your completed survey to:**
Highmark Blue Shield
PO Box 890089
Camp Hill PA 17001-9902
Thank you.

Please complete either the English or Spanish version of this survey.

Why is Highmark conducting this survey?

Experts say race or ethnic background can affect the health care you receive.
In 2002, the Institute of Medicine, a nonprofit organization that provides independent, objective, evidence-based advice to policymakers, health professionals and the public, issued a report showing that racial and ethnic minorities:

- Have a higher incidence of certain diseases
- Have worse health outcomes
- Have poorer quality of health care - even when they have the same access and insurance as non-minorities.

Getting quality care is difficult for patients who don't understand English.
A number of studies have shown that one key to quality health care is clear communications between health care providers and their patients. Understanding complicated medical terms can be challenging for many people, but especially for those who don't speak English as their primary language. The federal government recognizes this and requires health insurers like Highmark to provide interpretation and translation services so that all of our members - those who speak English and those who don't - have access to quality health care. That's one reason we're distributing this survey in both English and Spanish, which is now the primary language for a growing number of Highmark members.

National statistics prove race and ethnicity can affect health care.

- African Americans have:
  - 35% higher cancer mortality rates
  - Higher infant mortality rates - early two and a half times higher than that of white infants
  - More complications from diabetes. They're seven times more likely to develop kidney failure or need amputations than other diabetics.

  Former Surgeon General Dr. David Satcher, M.D. believes that nearly 84,000 deaths could be prevented each year if gaps in mortality between black and white Americans were eliminated.
- Vietnamese women living in the United States have a cervical cancer rate that's five times higher than other women.
- Non-English-speaking patients are less likely to understand medication instructions and to use primary and preventive care. They are also more likely to use emergency rooms, and, at the emergency room, they receive far fewer services than English-speaking patients.

Highmark sees similar issues with our own members!
In collecting data to report on the percentage of our members who received preventive care screenings and appropriate care for chronic conditions, Highmark found that in 2005:

- Our African American members with asthma were 24% *less* likely to use appropriate medications for their condition.
- Our Hispanic members with diabetes were 11% *less* likely to receive recommended tests.
- Our female African American members were 7% *less* likely to receive annual mammograms.

**Help us eliminate these differences
so that all of our members can live longer, healthier lives.**

Complete and return this important questionnaire today.

HealthPartners Clinic

We want to ask you about your race and country of origin. If you answer, you will help us provide the best care to all of our patients. We will use this information to help our doctors and nurses give you better care. We will keep your information private and confidential.

Race

Please tell me the race groups that describe you.

___ American Indian or Alaska Native

___ Black or African American

___ White

___ Choose not to answer

___ Asian

___ Hispanic or Latino

___ Some other race

Country of Origin

If you wish to have the country where you were born included in your medical record, please tell me the country you are from.

___ Bosnia-Herzegovina

___ Cambodia

___ Cameroon

___ Canada

___ China

___ El Salvador

___ Eritrea

___ Ethiopia

___ India

___ Kenya

___ Korea

___ Laos

___ Liberia

___ Mexico

___ Nigeria

___ Philippines

___ Russia

___ Somalia

___ South Africa

___ Thailand

___ United States

___ Vietnam

Other country, please specify: _____

___ Choose not to answer

Highmark Creates Multi-dimensional Approach to Address Health Care Disparities

I n 2002, the Institute Of Medicine (IOM) published "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," a report that concluded racial and ethnic minorities receive lower-quality health care than whites even when they are of similar age, at a similar income level and have the same access to health coverage and care.

Although the quality of health care is poor for many Americans, specific racial and ethnic groups continue to experience worse quality of care than their white counterparts. Evidence of these disparities in treatment is strongest for African-Americans and Hispanics in the U.S., but is also growing among Native Americans.

Highmark Blue Shield has formed a multi-dimensional approach to focus on health care disparities, and has been addressing this issue for more than five years through many activities, including data collection, focused interventions by its Integrated Clinical Services division, programs by its Community Affairs division, Highmark Foundation programs aimed at improving community health, and national initiatives that are designed to reduce disparities and improve the quality of care for all.

HIGHMARK® BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

A Comprehensive Strategy

"With strong support from senior management, Highmark is taking a comprehensive approach to address health care disparities," said Rhonda Moore Johnson, M.D., medical director of Integrated Clinical Services at Highmark. "Highmark takes its obligation seriously. We know we have opportunities to close some gaps in health care quality among our racial and minority group members. Our comprehensive strategy includes working with our providers, our health care systems, our members and our communities to improve health care quality and access. We want all of our members to live longer, healthier lives."

There are many possible reasons for these disparities, including access to high-quality care; cultural and language barriers; health literacy barriers; limited cultural competence of providers and health care organizations; biases; prejudices and stereotypes that may affect the way providers render care; and lack of trust by minority patients for the health care establishment.

Highmark Invests in Reducing Health Disparities

In 2006, Highmark formed a multi-disciplinary committee that oversees programs and practices that address the needs of an increasingly diverse population and marketplace.

Cultural competency training was completed by all Highmark medical directors and more than 1,000 Highmark clinical staff and customer service representatives. Also, nearly all of Highmark's 19,000 employees receive diversity and inclusion training on an ongoing basis.

Health Care Disparities

Through significant grant making, Highmark supports a number of outreach programs and local organizations throughout Pennsylvania, including the Children's Sickle Cell Foundation in Pittsburgh, the Latino Leadership Alliance of the Lehigh Valley and the Pennsylvania Immigrant & Refugee Women's Network. Highmark has also created special educational events: Partners for a Healthy Community, daylong events that offer free health screenings; and Fun, Fit and Fabulous! conferences for women and teens of color.

The Highmark Foundation, a charitable organization and private foundation funded solely by Highmark Inc., provided funding to the Capital Region Health System at Hamilton Health Center for their Healthy Outcomes program for diabetic patients and to Washington County Health Partners (WCHP) to help launch the Health Ministry Initiative, which is a program to identify and address the health issues of African-Americans in Washington County. The foundation has also provided several grants for dental and oral health programs across the state.

Information on Highmark preventive health support programs and other resources, as well as reminders for colorectal cancer screening, were mailed to thousands of minority members. Another initiative resulted in a 14 percent increase in flu vaccination rates among Highmark's African-American members from 2005 to 2006. Highmark continues to work with members to obtain self-identified race, ethnicity and language preference data through voluntary, confidential questionnaires and telephone outreach. To date, Highmark has received a 30 percent response rate.

Through Blues On Call℠, the 24/7 health information and decision support telephone and online service, Highmark addresses health disparities with customized outreach materials. Highmark's membership is segmented so that individuals receive direct mail with targeted messages based on clinical needs and socio-demographic variables such as age, geographic location, socio-economic status, literacy and race/ethnicity.

Highmark's comprehensive strategy includes working with our providers, our health care systems, our members and our communities to improve health care quality and access.

Highmark has worked with the SilverSneakers® program to improve access to fitness facilities for our Medicare members by adding three additional centers in Pittsburgh's East Liberty, Wilkinsburg and Hill District neighborhoods.

Highmark has been engaging practicing physicians through newsletters, focused discussion groups, quality management physician subcommittees and focused educational interventions. An external advisory panel was created in 2007 that includes physicians and local and national experts to provide guidance and recommendations to improve quality health care.

Highmark is one of 11 national health plans participating in the "National Health Plan Collaborative to Reduce Disparities and Improve Quality," funded by the Robert Wood Johnson Foundation and the Federal Agency for Health Care Research and Quality.

"Reducing health care disparities is important to Highmark as well as a key focus of the federal government and the U.S. Department of Health and Human Services' *Healthy People 2010* disease prevention and health promotion objectives," said Johnson. "Highmark will continue to take an active role in reducing racial and ethnic health care disparities. Developing and implementing strategies to reduce or eliminate disparities will require Highmark to develop more effective communication tools and strategies to interact with a diverse pool of members." ■

Figure A: Health Plan Data Collection Methods – Direct Primary Data Collection

METHODS	DESCRIPTION	ADVANTAGES	DISADVANTAGES
DIRECT PRIMARY			
Enrollment	Health plans can voluntarily collect race, ethnicity and preferred language information during the enrollment process.	• Data are self-reported and therefore fairly accurate. • Information collected at enrollment flows through to the rest of the data system.	• Potential members may perceive that race, ethnicity and preferred language data might be used to deny coverage. • Health plan staff are not available to encourage members to respond and provide assurances. • If this is the sole method, used, it provides only one opportunity to collect information from members.
Disease Management (DM) Programs	Health plans can collect race, ethnicity and primary language information from their members as they enroll in targeted disease management or as case managers conduct interviews or outreach to enrollees. Method can also reach most vulnerable populations.	• Data are self-reported and therefore fairly accurate. • Provides multiple opportunities for data collection through frequent contact with member.	• Data collected through DM programs may not necessarily be transmitted to other information systems within the health plan. • Data would be collected only for the subset of members who are in the DM program.
Health Risk Assessments	Health plans use health risk assessments (HRAs) to identify the future health care needs of their members. HRAs can collect data on race, ethnicity and primary language of a member.	• Data are self-reported and therefore fairly accurate.	• Data collected through HRAs may not necessarily be transmitted to other information systems within the health plan. • Only captures data for those who complete the HRA form.

METHODS	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Encounter – Office Visit, Hospital Visit, etc. *(May be considered a direct secondary source depending on the health plan.)*	Medical groups, physicians' offices, group practices and hospitals collect background information on patients during the admissions or intake process and these data may include race, ethnicity and preferred language.	• Members have the opportunity to ask questions about why data are being collected and what data will be used for. • If staff are properly trained, this method can be quite effective in collecting data. • If a health plan is an Integrated Delivery System, shared systems and data infrastructure allow for easy data transfer from providers.	• Data are typically not standardized or consistently collected by the different providers. • Providers or staff may be hesitant to ask these questions of patients, fearing litigation exposure. • Unless asking for self-identification, providers or staff noting/judging patient's race or ethnicity may do so incorrectly. • Data is collected only for the subset of members who have an office visit or are hospitalized. • For network based plans, transmission of data may be difficult since there is no field for this type of information in claims forms.
Health Plan Direct Contact	When a health plan sends an explanation of benefits to the members, it can include a survey or form asking for members' races, ethnicities and preferred languages. Health plans cans also use interactive voice response (IVR) outreach calls to educate members about a topic and ask for a members' race, ethnicity and preferred language.	• Data are self-reported and therefore fairly accurate. • For minimal cost, this method can be paired with existing contact or outreach. • No additional data entry is necessary if using IVR. • Telephone-based outreach may be effective to address low literacy concerns.	• Return rates for a survey or call completion of an IVR outreach call may be low. • Some types of outreach may not be an appropriate venue for collecting race/ethnicity and language data. Plans need to carefully consider the context for the outreach.

METHODS	DESCRIPTION	ADVANTAGES	DISADVANTAGES
Member Web Portal	Health plans can gather background information, such as race, ethnicity and preferred language, from members through their Web portals.	• Data are self-reported and therefore fairly accurate. • Allows for the collection of more granular data. • Eliminates the need for additional data entry. • Information would need to be collected only once.	• Data is collected only for the subset of members who use the portal. • Plans need to be aware of the potential biases that are associated with Internet use. The data may over-represent certain subgroups.
Member Satisfaction Surveys	Health plans can use satisfaction surveys to collect data on race, ethnicity, and primary language. (e.g., Consumer Assessment of Health Providers and Systems (CAHPS) survey developed by AHRQ and NCQA).	• Data are self-reported and therefore fairly accurate. • A system is needed for transferring race, ethnicity and preferred language information from member satisfaction surveys to member files.	• Data is collected only for the subset of members who respond to the survey. • Plans need to be aware of the potential biases that are associated with survey response. The data may over-represent certain subgroups.
Member Contact (e.g., complaint or grievance, questions on benefits, or other administrative issues)	At the end of the call, health plans can ask members to "update" their information. Information to be updated could include the member's race/ethnicity or preferred language.	• Data are self-reported and therefore fairly accurate.	• Not all types of member contact are an appropriate venue for collecting race/ethnicity and language information. Customers calling with grievances or complaints are less likely to cooperate. • Data are collected only for the subset of members who contact the health plan.

Figure B: Health Plan Data Collection Methods – Direct Secondary Data Collection

METHODS	DESCRIPTION	ADVANTAGES	DISADVANTAGES
DIRECT SECONDARY			
Centers for Medicare & Medicaid Services (CMS)	Plans that have a Medicare product can obtain these data from CMS. The Medicare program maintains beneficiary race and ethnicity data, derived from Social Security's administrative records.	• Usually easy to obtain from CMS.	• Accuracy of data may vary. • There are usually only four fields for data collection– white, black, other and unknown. • There are no separate fields for ethnicity. • Uses may be limited given lack of granularity.
State (Medicaid)	Information on an individual's race, ethnicity and preferred language is collected during eligibility determination or enrollment in a health plan. States are required by CMS to identify the race, ethnicity and primary language of each Medicaid enrollee.	• Data can usually be easily obtained from the state.	• Data sources, frequency of collection and accuracy vary significantly across states. • Need to establish a system for ensuring that monthly updates do not overwrite additional race/ethnicity and language information obtained by the plan.
Employer	Some employers collect race, ethnicity and language data for Equal Employment Opportunity purposes.	• The data often already exists through employer records. • Data are typically self-reported. • This method provides an opportunity for future collaboration between the health plan and employer.	• Negotiating partnerships with employers can be complicated. • Employers with third-party administrators must negotiate data stream to health plan. • Employers may not collect data on dependents.

Figure C: Health Plan Data Collection Methods – Indirect Data Collection

METHODS	DESCRIPTION	ADVANTAGES	DISADVANTAGES
		INDIRECT	
Third-Generation Methods (Bayesian)	Bayesian methods use prior knowledge to evaluate the likelihood a member belongs to a particular group.	• This method provides improved estimates from geocoding and surname analysis. • Can supplement direct data collection.	• Data are not self-reported and therefore, may be less accurate.
Combined Geocoding/ Surname Analysis	Geocoding provides estimates of the racial/ethnic composition of the surname area. Used in combination, these approaches can complement one another; geocoding can indicate race, and surname analysis can indicate ethnicity.	• This method provides improved estimates from geocoding or surname analysis alone. • Can supplement direct data collection.	• Data are not self-reported and therefore may be less accurate.
Geocoding or Surname Analysis Alone	Geocoding is a method in which information about the social characteristics of the neighborhood or community a person lives in is used to infer information about that person (such as race, ethnicity or preferred language). Surname analysis uses a person's last name to estimate the likelihood that he or she belongs to a particular racial or ethnic group.	• This method can be can be a good place to start to supplement direct data collection.	• Data is not self-reported and therefore, may be less accurate.

HealthPartners ®

Language Assistance Plan
For Spoken and Sign Language Services

Call to Best Practice: Goals and Rationale

Goal

Our goal is to provide high quality spoken and sign language assistance services to support the Six Aims and decrease health care disparities. This includes:
- To provide language assistance services;
- To use trained interpreters consistently and appropriately; and,
- To create a HealthPartners culture of knowledge and expectation about the use of trained interpreters.

The Six Aims

The HealthPartners family of organizations is committed to providing services to persons with limited English proficiency (LEP) or who are deaf or hard-of-hearing that support the six aims of safety, timeliness, equity, efficiency, effectiveness, and patient/member-centeredness.

Language barriers negatively affect access, quality of care, patient and member satisfaction, and provider satisfaction, while increasing costs of care and legal liability. Providing language services promotes high quality of care and service and makes good business sense, given the changing demographics of the communities we serve. There also are legal and regulatory requirements and guidance supporting these practices.

Health Care Disparities

Language assistance services are a key strategy to address health care disparities. Reducing health care disparities is a top national and Minnesota public health priority.

The Institute of Medicine released a report in 2002 entitled, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." It states that we need to: *Increase awareness of racial and ethnic disparities in health care among the general public and key stakeholders and to increase health care providers' awareness of disparities*. The Chair of the IOM Committee, Alan Nelson, MD, stated: *"The real challenge lies not in debating whether disparities exist, the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them."* One of the IOM recommendations is to: *Promote the use of interpretation services where community need exists.*

5-6-06

It has been documented that even though most health care providers want to offer them the same attention and concern as to any other patient, limited English proficient (LEP) and deaf and hard-of-hearing patients often encounter obstacles.

- They may delay making an appointment because of the difficulty communicating over the telephone. Meanwhile, the health problem may become more severe or advanced requiring more expensive or invasive treatment.
- Misunderstandings about the time, date, and location of appointments are more likely to occur if the patient does not understand English.
- Even when patients arrive at the facility on time, they may be late for appointments because of difficulty communicating with registration staff.
- There may be confusion and misunderstanding about the medical interview and examination affecting the documentation of a complete and accurate medical history and possibly the accuracy of the diagnosis.
- In addition, miscommunication can result in unnecessary or inaccurate tests. Even when tests are necessary, if patients are not given instructions in a language they can understand, they may not be adequately prepared physically or psychologically to undergo the procedures.
- Likewise, if patients are to comply with a treatment plan, they must have a clear understanding of what is required of them.

The provision of language assistance services increases the efficiency and effectiveness of the delivery of health care to persons who need these services. The cost of an interpreter is less than the cost of a blood test. There is a return on investment in interpreter services seen through the decreased number of unnecessary tests, procedures, and repeat visits, and increased medical and prescription drug compliance.

Who is Accountable?

The entire HealthPartners enterprise is accountable for the provision of language assistance services. All segments— medical, dental, and health plan — have responsibility to implement the Language Assistance Plan.

In addition, interpreter services are a covered benefit under the HealthPartners contract with the Minnesota Department of Human Services for state public programs products. Most health plan coverage, for example commercial plans, does not include interpreter services. In these situations the federal Health and Human Services (HHS) agency requires physicians or other providers or health care entities who receive federal financial assistance from HHS where the patient receives care to provide interpreter services at no charge to the patient.

The HHS Office for Civil Rights states that any recipient of HHS federal financial assistance must provide meaningful access to persons with limited English proficiency. This extends to the entity's **entire operation**, not just the part receiving federal financial assistance. Recipients of HHS federal financial assistance include:

- Hospitals, nursing homes, home health agencies, and managed care organizations.
- Universities and other entities with health or social service research programs.
- State, county, and local health agencies.

- State Medicaid agencies.
- State, county and local welfare agencies.
- Programs for families, youth, and children.
- Head Start programs.
- Public and private contractors, subcontractors and vendors.
- Physicians and other providers who receive Federal financial assistance from HHS.

How Success Will be Measured

Satisfaction data are a key indicator of our success. Various measurement tools will be used; for example, patient, member and provider satisfaction surveys.

Definitions

See Attachment A for a definition of terms used in this plan.

Demographics of our Population

HealthPartners is accountable for monitoring our community demographics and ensuring that our language assistance services match the community need. Our data collection efforts enable our ability to monitor and match the need.

See Attachment B for information on the demographics of our area and organization.

Best Practice for Providing Spoken and Sign Language Assistance

Our plan to achieve best practice includes the following:

- Establish a Language Assistance Plan for the enterprise
- Create tools to make it easy for staff to implement the plan
- Develop clinic models of effective and efficient delivery of interpreter services
- Establish service and quality expectations for interpreter vendors
- Establish oversight of interpreter services
- Monitor and evaluate how well we are doing
- Establish procedures for appropriate, third-party payor reimbursement of state public program interpreter services
- Pilot train-the-trainer model under the Regions Hospital Fellows in Cross Cultural Care program

Best Practice Services

HealthPartners works to ensure access to care and high quality services. HealthPartners shall assess the need and communicate options for spoken and sign language assistance services using professional, trained interpreters whenever possible. HealthPartners shall take reasonable steps to provide these services.

The following options represent best practice for language assistance services:

- Communication services for deaf and hard-of-hearing persons include but are not limited to: sign language and spoken interpreters; written communication; adaptive equipment such as, TDDs (Telecommunication Devices for the Deaf); closed caption television; and visual aids.

- Bilingual providers and staff who can communicate directly with patients and members in their preferred language. Bilingual providers and staff must stay within the scope of their job description when providing bilingual care and services. (See the Quality section regarding criteria for bilingual providers and staff.)

- Face-to-face spoken language interpretation provided by trained interpreters (employees or contracted vendors).

- Telephonic spoken language interpreter services, especially when an interpreter is needed instantly or when services are needed for an unusual or infrequently encountered language.

Use of any kind of interpreter should be documented in the record at each encounter.

Use of Nonprofessional Interpreters

Some individuals with limited English proficiency may request that a family member or friend act as an interpreter. Use of family members or friends raises quality concerns such as:

- the possibility of medical errors
- mistaken naming of body parts
- mental health diagnoses being missed due to family shame
- inadequate testing due to inadequate histories, etc.

The use of family members or friends as interpreters could result in a breach of confidentiality or reluctance on the part of our patients and members to disclose information critical to their situation.

In particular, the use of minors to interpret does not represent best practice.

When receiving a request for family members and friends as interpreters, it is appropriate to suggest that the family consider a professional interpreter. We must make the individual aware that he or she has the option of having the provider or physician provide an interpreter without charge. We cannot require an person with limited English proficiency to use a family member or friend as an interpreter. If the patient or member declines the use of professional interpreters, that is their right.

See *Your Guide to Interpreter Services* on ERIC for suggestions about how to discuss this with patients and members.

Documentation

Use of any kind of interpreter, including a family member or friend, should be documented in the record at each encounter.

If the patient or member declines the use of professional interpreters, this should be documented in the record.

When Do We Provide Language Assistance Services?

We provide these services when a patient, member, family member, guardian, assigned caseworker, provider or staff person identifies a barrier to communication.

At a minimum, an interpreter should be present for:

- Encounters with the doctor or provider
- Teaching
- Scheduled tests or procedures
- Ancillary services
- Patient discharges
- When the patient or family requests it

Methods of Providing Interpreter Services

- Face-to face trained interpreters — employees or vendors — trained in third party (triadic) interpretation

- Bilingual providers/employees
    - May be used for direct communication with a patient or member.
    - Should not routinely act as third-party interpreters since they have not been trained in third-party interpretation.
    - May interpret if they are competent in the skills of interpreting. However, they must be aware of potential conflicts of interest.

- The Language Line telephone spoken interpretation service

How to Arrange These Services

See *Your Guide to Interpreter Services* on ERIC to learn how to schedule interpreters and use the Language Line.

How to Respond to Telephone Callers with Limited English Proficiency

- Use the Language Line (See *Your Guide to Interpreter Services* on ERIC to learn how to use the Language Line)
- Use a bilingual employee working in the scope of their job description

Quality of Language Assistance Services

Interpreters must have training, meet requirements for providing high quality interpreter services, and demonstrate their competency.

Professional Interpreters

- Demonstrated competency via certification, e.g., Registry of Interpreters for the Deaf (RID) professional interpretation; spoken language certification
- Trained in medical terminology
- Trained in HealthPartners-specific expectations
- Otherwise qualified if certification not available
    - Understanding of and sensitivity to cultural issues
    - Demonstrated proficiency in both English and the other language, including demonstrated ability to convey accurate information in both languages
    - Orientation and training that includes the skills and ethics of interpreting and the standards of practice (e.g., confidentiality)
    - Fundamental knowledge in both languages of medical terminology and our programs
- Upholds professional code of conduct

Bilingual Providers and Staff

- Competency requires more than just self-identification as bilingual. It is highly recommended that competency is demonstrated in some manner.
- Bilingual providers and staff may be able to provide **direct** communication services within the scope of their job description, but should not perform as third-party interpreters unless they have been trained to do so. Training for performing triadic interpretation represents best practice. For example, a bilingual medical office assistant should not be used to interpret for a medical encounter. A bilingual physician or nurse, however, could directly communicate with their patient during a patient encounter.

Education and Communication

Employees are informed of our language assistance services and policies in several ways.

- New employee orientation
- Internal communications
- Website
- Staff, management and committee meetings
- Clinic-specific training via the care delivery supervisor, business systems supervisor or equivalent
- Staff training within departments

Patient and Member Communication

Patients and members are informed about language assistance services by:

- Member materials
- Posted materials in care delivery settings
- Appointment scheduling process
- Providers and employees
- Member Services staff

Patients and members learn about our language assistance services at various points of contact:

- Patients entering the health care delivery system
- Members contacting health plan
- Sales communicating with potential members
- Brokers and employer groups communicating with potential members
- Appointment Center/medical office assistant staff

Oversight and Monitoring

The Cross-Cultural Care and Services Committee, leads the strategic development and review of initiatives related to language assistance across the enterprise. The Committee reviews implementation of the Language Assistance Plan semi-annually.

The Interpreter Services Workgroup provides enterprise-wide leadership regarding the provision of spoken and American Sign language services for limited English proficient, deaf and hard-of-hearing patients and members. The Workgroup promotes required and best practices in interpretive services system-wide, based on the principles of providing care and service to limited English proficient, deaf and hard-of-hearing patients and members which is safe, timely, efficient, equitable, and patient- and member-centered. (See Attachment C for membership of these committees)

Monitoring may be accomplished through data collection, surveys, complaint investigations, regular review, including annual executive updates, and community feedback.

We identify the languages needed by our populations throughout our enterprise in several ways.

Data Collection

- Health care delivery system data collection includes data on race, language and country of origin.
- Health plan member website data collection
- Disease- and case management data collection
- Member Services data collection
- CareLine data collection

Patient/Member Satisfaction Measures

- Patient and member satisfaction surveys

Complaints and Appeals Data and Monitoring

- Health plan data and monitoring system
- Delivery system data and monitoring system

Physician/Provider Satisfaction Measures

- Provider satisfaction surveys about interpreter services provided by vendors and employees

Community Feedback

- Annual meetings with key community organizations

Effectiveness Evaluation

- Organizational assessment indicate decline in use of family members
- Patient satisfaction increases
- Health care disparities monitoring

Senior Management Review

- Annual presentation to Strategy and Planning Committee

Regular Update Process

- Semi-annual review by the Cross Cultural Care and Services Task Force and the Interpreter Services Work Group

Attachment A: Definitions

Bilingual: a term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter, but by itself, does not ensure the ability to interpret.[1]

Bilingualism: ability to use two languages. Fluency in a second language requires skills in listening comprehension, speaking, reading, and writing, although in practice some of those skills are often considerably less developed than others. Few bilinguals are equally proficient in both languages. However, even when one language is dominant, performance in the other language may be superior in certain situations; e.g., someone generally stronger in Russian than in English may find it easier to talk about baseball in English.[2]

Interpreting: The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.[1]

Interpretation: The act of receiving a message in one language and sending exactly the same message in another language through a verbal or signed exchange. Interpretation also includes body language messages.[3]

Encounter: (for purposes of this document) A communication event in which the services of an interpreter are required.

Limited English Proficiency (LEP) or Persons with LEP: Individuals who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. (Note: This may not be easy to identify. Some people may know enough English to manage basic life skills, but may not speak, read or comprehend English well enough to understand in a meaningful way some of the more complicated concepts they may encounter in the health and human services systems.)[4]

Sign(ed) language: Language of hand gestures and symbols used for communication with deaf and hearing-impaired people.[1]

Translation: The conversion of written text into a corresponding written text in a different language.[1]

---

[1]The *Terminology of Health Care Interpreting: A Glossary of Terms,* published by The National Council on Interpreting in Health Care, 2001.

[2] *The Columbia Electronic Encyclopedia, Sixth Edition*, 2003, Columbia University Press.

[3]Durham et al, *Interpreting Services Manual*, Worchester: University of Massachusetts Medical Center, 1997.

[4]Minnesota Department of Health Glossary on www.dhs.state.mn.us

Attachment B: Demographic Description

We continually track the number and proportion of individuals with limited English proficiency in our area and organization.

Minnesota Demographics

- Minnesota's immigrant population continues to increase, according to the Minnesota Demographic Center. Here are the estimated numbers of immigrants in the state in 2004:
    - Hispanic   175,000
    - Hmong   60,000
    - Somali   25,000
    - Vietnamese   25,000
    - Russian   12,500
    - Laotian   13,000
    - Cambodian   7,500
    - Ethiopian   7,500

- In 2004, more than 9,800 immigrants came to the Minneapolis-St. Paul area, with the majority coming from Africa (3,693) and Asia (3,175).

- Minnesota's Hispanic population grew 166% during the 1990s, from 53,884 to 143,382. The number of Latinos in Minnesota is projected to grow 98 percent between 2000 and 2015. By 2030 this population will grow by 143,000 over 2000.

- Since the 2000 census, the percentage increase for Asians in Minnesota has been 18%.

- Minnesota has the largest Hmong and Somali populations in the U.S.

- Minnesota has the highest percentage of refugees of any state (30% of Minnesota immigrants are refugees vs. 10% nationally).

- In 2000, 8.5 percent of the Minnesota population spoke a language other than English at home.

- Language spoken at home for the population 5 years and over in the metro counties: Spanish or Spanish Creole 140,565; Hmong 41,878; German 37,298; African Languages 25,799; Vietnamese 18,249. (Census 2002)

HealthPartners Demographics and Data

The HealthPartners Organizational Assessment survey (2003-4) found that our top three languages are:
- Health plan - Spanish, Hmong, Somali/Russian
- Hospital - Spanish, Hmong, Russian/Vietnamese
- Clinic/providers - Spanish, Hmong, Somali

The top three languages after English in the HealthPartners Medical Group clinics are: Somali (2%), Spanish (2%) and Hmong (1%) (*November 2005*).

The hospital and clinics are collecting language, race, and country of origin data. In future, this will provide additional language information about the patients we serve.

Attachment C: Program Development & Oversight Structure

Cross Cultural Care and Service Task Force Members

Scott Aebischer, SVP, Customer Service, Product Innovation
Calvin Allen, SVP, HR & Corporate Strategic Planning
Steve Bunde, Senior Director, Corporate Integrity & Internal Audit
Jennifer Clelland, Director, Government Programs
Joe Dangor, Manager, Corporate Communications
Karen Dobbins, Senior Director, Diversity and Inclusion
Joe Hessburg, IS&T Consulting Analyst (First Trust)
Judy Jerde, Senior Nursing Project Coordinator
Pat Lund, Senior Specialist, Corporate Communications
Nancy McClure, SVP, HPMG & Clinics
Judy Moseley, VP, Patient Care Services (Regions)
Sandra Rainey, Executive Assistant, Executive Offices
Katie Sayre, SVP, Health Plan Operations & Government Programs
Jeanette TaylorJones, Manager Site Specialty Care (Riverside)
Krista Van Vorst, Strategic Health Informatics, Consultant
Deanna Varner, Community Relations Program Manager
Pat Walker, MD, Medical Director, Center for International Health, **Co-Chair**
Donna Zimmerman, VP, Government & Community Relations, **Co-Chair**

Interpreter Services Work Group

Chris Boyer, Senior Interpreter, Hearing Impaired
Steve Bunde, Senior Director, Corporate Integrity Internal Audit
Jennifer Clelland, Director, Government Programs, **Co-Chair**
Denise Edgett, Manager, Clinical Services, Integrated Homecare
Richard Flatz, Manager, Urgent Care Services
Sarah Horst, Appointment Center Trainer, Call Center
Kathy Jenkins, Spanish Interpreter, Regions Hospital
Jane Johnson, Outpatient Case Manager, Riverside Internal Medicine
Diane McGuire, Manager, Patient & Health Education
Carrie McWell, Senior Manager, Member Services, Riverview Service Center
Nancy Niggley, Sign Language Interpreter Lead
Tracy Pederson, Senior Coordinator Public Programs, Government Programs
Pat Showers, Senior Director, Dental Clinic Operations
LouAnn Thornberg, Business Systems Administrator, HealthPartners Eye Care
Michaela Timmers, Senior Manager, Member Services
Sidney Van Dyke, Manager, Interpreter Services, Regions Hospital, **Co-Chair**
Lori Wenborg, Business Systems Administrator, Surgical Specialties
Jennifer Wiltse, Manager, Provider Relations and Contracting
Donna Zimmerman, Vice President, Community & Government Relations

Attachment D: Resources

- HealthPartners Cross Cultural Care and Services Website (http://eric)
- www.lep.gov: Pathway to the federal government's activities on language access and includes a link to Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance
- National Standards for Culturally and Linguistically Appropriate Services in Health Care, US Department of Health and Human Services (www.omhrc.gov/CLAS)
- The National Council on Interpreting in Health Care (www.ncihc.org)
- Bridging the Language Gap: How to Meet the Need for Interpreters in Minnesota, Report from the Working Group of the Minnesota Interpreter Standards Advisory Committee
- Health and Human Services Office for Civil Rights (OCR) Limited English Proficiency (LEP) guidance (www.hhs.gov/ocr/lep)
- Diversity Rx website sponsored by the National Conference of State Legislatures, Resources for Cross Cultural Health Care, and Henry J. Kaiser Family Foundation (www.diversityrx.org)
- National Association of the Deaf (www.nad.org)
- Registry of Interpreters for the Deaf (www.rid.org)
- Midwest Center on the Law and the Deaf (www.mcld.org)

HealthPartners ®

Your Guide to Interpreter Services

Our Language Assistance Plan was created to help us provide high quality interpreter services to patients and members who have limited English proficiency (LEP) or who are deaf or hard-of-hearing. We want to reduce health care disparities among the people we serve and provide care that is safe, timely, efficient, effective, equitable and patient & member centered. *Your Guide to Interpreter Services* is designed to make it easy for you to serve patients and members who need language assistance.

Our interpreter services will be based on best practices to improve quality and reduce disparities. These practices include:

- Use of professional interpreters whenever possible, rather than family members or friends.
- Documentation of interpreter services.

This guide is about spoken language and sign language assistance services. It is **not** about translation of written materials, which is another type of language assistance. That topic will be addressed later.

Contents of this guide:

- How we provide interpreter services
- How to arrange these services
- How to use the Language Line
- How to use bilingual staff
- How to respond if a patient or member wants to use family or friends to interpret
- How to respond to questions from or about interpreters
- Where to get more information

To review the complete Language Assistance Plan and related information, visit the Cross Cultural Care and Service site on ERIC (accessible through "Quick Links").

How we provide interpreter services

We provide high quality, professional language assistance to our patients and members in several ways.

❖ **Professional trained interpreters who do face-to-face interpretation.** We do this through our own staff and through contracted vendor agencies.

    Staff interpreters
- We have staff interpreters in some of our locations: Regions Hospital, HealthPartners Specialty Center, Midway Clinic, Center for International Health, and St. Paul Clinic. Over time we will add staff interpreters to other clinics as volume warrants.
- Staff interpreters are available in the following languages: American Sign Language, Amharic, Cambodian, Hmong, Lao, Russian, Somali, Spanish, Thai, Vietnamese.
- Patient satisfaction surveys tell us that satisfaction is highest when our staff interpreters are used. Our costs are lower when we use staff interpreters.
- In locations where we have staff interpreters, in most cases they are the interpreters who should be used.

    Contracted agency interpreters
- We contract with selected agencies to provide face-to-face interpreter services in locations where we don't have staff interpreters in the needed language and to serve patients when staff aren't available.
- Only contracted interpreter vendors should be used.

❖ **The Language Line**
- Provides interpreter services over the phone
- More than 150 languages are available round-the-clock
- Best for when patients or members are on the phone; when interpreter is needed instantly; when services are needed for an unusual or infrequently encountered language; or when the patient and provider have waited more than five minutes beyond the start time for an appointment for a professional interpreter to arrive.

❖ **Bilingual staff**
- Some staff are bilingual and may provide direct language assistance services within the scope of their job.

❖ **Communication services for deaf and hard-of-hearing people**
    These services are different than language assistance services for people with limited English proficiency. We serve our deaf and hard of hearing patients through:
- Sign language interpreters
- Written communication & visual aids
- Adaptive equipment such as TDDs (telecommunication devices for the deaf)
- Closed-caption television

```
┌─────────────────────────────────────────────────────────────┐
│                      IMPORTANT NOTE                          │
│                                                             │
│  Use of family members or friends is not considered best    │
│  practice for many quality and confidentiality reasons.     │
│  See page 15 for suggestions on how to encourage use of     │
│  professional interpreters.                                 │
│                                                             │
└─────────────────────────────────────────────────────────────┘
```

How to arrange an interpreter

When scheduling an appointment, verify that the language information we have is correct and complete. Patients should be asked what language they'd like to use with the provider. If they respond with anything other than English, an interpreter should be scheduled.

All patients requiring an interpreter should have an interpreter scheduled to accompany them to their appointments regardless of whether their provider is bilingual or the patient requests that a family member interpret. The interpreter is valuable for the check-in and other services the patient receives while at their visit (rooming nurse, lab, tests, etc.)

The specific guidelines and procedures for how to arrange an interpreter vary by location. Check with your supervisor on how your area scheduled interpreters. In general, interpreter services are scheduled on Epic using "advanced visit types" or standard interpreter scheduling protocol, or they are scheduled through the Appointment Center.

We contract with selected external agencies and generally only those agencies should be used. Clinics have designated their preferred agency among the contracted agencies and in most cases that's who should be scheduled when an agency is used.

Interpreters from contracted agencies for patients who are members of a health plan's public program (e.g. a member of the Medica Medicaid plan) must be part of that health plan's contracted network of interpreter vendors..

The following pages indicate how to arrange interpreter services by location.

```
┌─────────────────────────────────────────────────────────────┐
│                      Documentation                          │
│                                                             │
│   ❖  Use of any kind of interpreter, including a family     │
│      member or friend, should be documented in he record    │
│      at each encounter.                                     │
│   ❖  If the patient or member declines the use of a         │
│      professional interpreter, this should be documented    │
│      in the record.                                         │
│                                                             │
└─────────────────────────────────────────────────────────────┘
```

The Language Line

The Language Line is available round-the-clock and offers phone interpretation in more than 150 languages. The Language Line is used:

- If an interpreter isn't available for a clinic or hospital appointment
- If the patient or member is calling us on the phone
- If we need to contact the patient or member between visits
- If the patient and provider have waited more than five minutes from the appointment time for the professional interpreter to arrive

What equipment is needed?

The Language Line can be used in rooms with a phone jack. We most commonly use it with a speaker phone that has a "conference" function, although it can also be used with a phone with multiple handsets or by passing a standard phone back and forth between the patient and provider.

How to use the Language Line

It's easy to use the Language Line. Basically you just dial the toll-free number, provide account information and request the language needed. See page 11 for specific instructions.

Tips for Using Language Line

Working with an interpreter
Give the interpreter specific questions to relay to the patient or member. Group your thoughts or questions to help the conversation flow quickly.

Interpreter identification
Language Line interpreters identify themselves by first name and number only. For confidentiality reasons, they do not divulge either their full names or phone numbers.

Length of call
Expect interpreted comments to run a bit longer than English phrases. Interpreters convey meaning for meaning, not word for word. Concepts familiar to us often require explanation or elaboration in other languages or cultures.

Line quality problems
If you experience problems with the sound quality and the Language Line operator is still on the line, ask him or her to re-dial the interpreter. If the Language Line operator has left the line, call back, explain the problem and ask the operator to stay on the line for sound quality.

Give the Language Line a Try!
If you've never used the Language Line, it may seem intimidating. You can hear a recorded demonstration of over-the-phone interpretation by calling the Language Line demonstration line at 1-800-821-0301 or visit their website at www.LanguageLine.com.

Using the Language Line

At Regions the Language Line is accessed through the hospital operator. At the HealthPartners Specialty Center the Language Line should be accessed through the switchboard operator, but can be accessed directly if the operator is not available. In most our other locations and programs, the Language Line is accessed locally by the department or service.

1. **At all locations:** Try to determine the language needed and the patient's phone number. Ask the patient to hold for an interpreter. Non-English-speaking people often recognize "interpreter" and will hold while you get one.

2. Press the "conference" button to put the patient on hold. (If you know the language you need, you can call then Language Line first and then call the patient.)

3. **Regions** staff should dial "0" for the Regions operator to access the Language Line. **HealthPartners Specialty Center** staff should dial "0" for assistance from the switchboard operator, if available. Otherwise call directly. **Most other staff** should call the number assigned to their site to access the Language Line. *Check with your supervisor for your site's number.*

4. When you reach the Language Line, an operator will ask for the language you need, client ID, organization name and personal code. *Since each location and program has different accounts, get this information from your supervisor and fill it in here.*

   o   Client ID: _____
   o   Organization name: _____
   o   Personal code is the accounting unit code :_____

5. Brief the interpreter on the nature of the call and what you want to accomplish.

6. Press the "conference" button to connect you, the interpreter and the patient.

7. If the patient didn't stay on the line, put the interpreter on conference hold, dial 9 and the patient's phone number.

8. Say "end of call" to the interpreter when the call is finished.

Click here to check out commonly asked questions about Language Line:

http://www.languageline.com/pdf/QnA_Interpretation_062204.pdf

Use of bilingual staff

Bilingual providers and staff can communicate directly with patients and members in their preferred language. Bilingual providers and staff must stay within the scope of their job description when providing bilingual care and services.

- Bilingual staff should not routinely act as third-party interpreters since they have not been trained in third-party interpretation.
- They may interpret if they are competent in the skill of interpreting both in writing and orally.
- Bilingual staff must be aware of potential conflicts of interest.

Competency requires more than just self-identification as bilingual. It is highly recommended that competency be demonstrated in some manner.

What if the patient wants to use a family member or friend?

Use of nonprofessional interpreters, such as family members and friends, does not represent best practice. Use of family members raises quality and confidentiality concerns.

- Greater likelihood of medical errors
- Mistaken naming of body parts
- Mental health diagnoses being missed due to family shame
- Inadequate testing due to inadequate history, etc.
- Breach of confidentiality
- Reluctance of patients or members to disclose information critical to their situation.

We want to encourage use of professional interpreters whenever possible.

- It is appropriate to suggest that the patient consider a professional interpreter.
- We must make the patient aware that he or she has the option of having the provider arrange a professional interpreter without charge.
- We cannot require a person with limited English proficiency to use a family member or friend as an interpreter.
- We cannot prohibit use of family or friends if the patient or member insists on it, but we should try to encourage use of professional interpreters.

Documentation is important

- ❖ Use of any kind of interpreter, including a family member or friend, should be documented in the record at each encounter.

- ❖ If the patient or member declines the use of a professional interpreter, this should be documented in the record.

Here are some hints on how to encourage use of professional interpreters.

- **Thank the family member for their caring and concern and willingness to interpret:**
"Thank you very much for offering to interpret. However, we have a policy in our (clinic/hospital) to use our professional interpreters when they are available. I am sure your (parent/child/relative) appreciates your help, and today you can relax and be a (daughter/son/spouse) instead of being an interpreter!"

- **Explain that you as a doctor, nurse or other staff member prefer to work with professional interpreters: "**I prefer to work with professional interpreters because I'm used to working with them. They are trained to understand health care and medical terms that your (family member/friend) might not know. It also lets your (family member/friend) relax and just be supportive as a (family member/friend)."

- **If, when making the appointment, the patient says that he or she does not want to have an interpreter, you as a medical office assistant or scheduler should still order one and say:** "I have been instructed to have a medically trained interpreter at your appointment. The interpreter is for the provider and office staff. You and your provider can make a decision about how best to use the interpreter at the time of service."

- **If, when making the appointment, the patient says she doesn't want an interpreter at the appointment and will bring a family member, you as a medical office assistant or scheduler can say:** "If you'd like to bring your nephew with you, that would be fine, but I am going to order an interpreter for the provider's and staff's benefit. I have been instructed to have a medically trained interpreter at your appointment. You and your provider can make a decision about using the interpreter at your appointment."

Family members often don't want to be the interpreter. Explaining the reasons listed above gives them a reason not to do so.

Many younger people are obligated by social and cultural norms to care for their parents, including being an interpreter. If we put the onus on ourselves as care providers, then it eases the mind of the family member, because "the doctor asked for the professional interpreter," instead of "I don't want to interpret for you, Mom or Dad."

Document Use of Interpreter

Use of any kind of interpreter, including a family member or friend, should be documented in the record at each encounter.

If a patient or member declines the use of a professional interpreter, this should be documented in the record.

How to Handle Questions From or About Interpreters

Here are suggested responses to questions or situations that may arise with interpreters.

If a health care provider has concerns about the quality or service provided by the interpreter:
The provider can thank the interpreter and let them know their service is no longer needed in the visit. The Language Line would be an alternative way to meet the patient's needs. In addition to addressing the immediate need, it's also important to provide feedback to the supervisor of the interpreter. For staff interpreters, please talk to the interpreter's supervisor. For contracted interpreters, please contact interpreterservsctrl@healthpartners.com which will get your concern to the appropriate area.

When the interpreter on the phone wants to be the interpreter at the visit, but does not work for the preferred vendor designated by our clinic:
"The clinic prefers that I book their interpreters through (agency name), so I will be ordering an interpreter through that agency." (If the patient is insistent on using a nonpreferred interpreter, they may, but this should be documented in the appointment notes.)

When the interpreter calls to make an appointment for the patient and the patient is not on the phone with the interpreter:
"Is the patient on the line with you? If not, I can give the patient a call with the assistance of the Language Line."

When the scheduled interpreter says she wants to be arranged through another agency. (Sometimes interpreters tell us they can make more money if we change our order.):
"The clinic prefers me to book their interpreters through (agency name), so if you do not want to be ordered through (agency name), I will be happy to order another interpreter."

If a contracted interpreter says he will also provide a ride to the patient (and expects to be reimbursed): "We are committed to making sure our patients have transportation to their appointments. If (patient) is covered by HealthPartners Care, I will transfer you to Ride Care to make those arrangements." (Note: Except for HealthPartners Care, patients do not have coverage under a health plan for transportation.)

Got questions? Where to get more information

Here are some resources that can help answer your questions about language assistance services.

❖ Visit the "Cross Cultural Care & Service" site on ERIC.
  The information and resources in the "Interpreter Services" section of this site are frequently updated, so check it out when you want information.

❖ Email Interpreter Services Central: interpreterservsctrl@healthpartners.com

  This is your central resource for questions related to Interpreter Services.

  Simply email your question and it will be sent to the appropriate person who can answer it. This person is expected to respond to you within 24 hours.

  Note: Interpreter Services Central is **not** designed for immediate, urgent questions. For those, consult with your supervisor.

HealthPartners/GHI

Subject: **Interpreter Services**	**Attachments** ☐ Yes ☒ No
Key words: Interpreter's, Interpreter conduct and expectations	**Number** AI001
Category: Business Practices (BP)	**Effective Date** 01/01/2007
Manual: HPI Administrative Program	**Last Review Date** 01/01/2007
Issued By: Hospital and Regional Network Management	**Next Review Date** 01/01/2008
Applicable To: • interpreters • interpreter services agencies • all primary care medical groups and providers • all specialty care medical groups and providers • all facilities and facility providers *Some exclusions may apply	**Origination Date** 01/01/2007
	Retired Date
Review Responsibility: Contracted Care Division	**Contact** Rhonda Klint

I. **PURPOSE:**
   The purpose of this policy is to set forth HealthPartners' customer service, quality and business expectations of interpreters.

II. **POLICY:** Interpreters, interpreter services agencies, primary care medical groups and providers, specialty care medical groups and providers, and facilities and facility providers will abide by any and all procedures listed below.

III. **PROCEDURE(S):**

Billing the Health Plan for State Public Programs Coverage
   • Interpreter services agencies should submit claims to HealthPartners for Covered Services only for HealthPartners members with certain state public programs coverage: Prepaid Medical Assistance Program; Prepaid General Assistance Medical Care; Prepaid MinnesotaCare; Minnesota Senior Health Options.

   • Covered Services include interpreter services for medical, dental, home care, skilled nursing facilities and Personal Care Attendant (PCA) services. Covered Services do not include interpreter services provided in connection with inpatient hospital services, which are the responsibility of the treating hospital

   • Ancillary expenses related to providing interpreter services (for example: interpreter's mileage, parking, or meals) are either not allowable or built into the reimbursement for the service and thus are not separately billable. The interpreter services agency should not submit claims to HealthPartners for these expenses.

   • HealthPartners contracts with a network of interpreter services agencies to provide interpreter services to HealthPartners members and patients. Spoken language interpreter services provided by a vendor that is not part of this defined network will require a referral by the primary care clinic and HealthPartners will not process a claim for payment without a referral from the primary care clinic.

- HealthPartners currently does not have contracts for sign language interpreter services.   Some of HealthPartners preferred vendors are listed below.
  - All Hands
  - C S D
  - ASL Interpreter Services

No Health Plan Coverage for Other HealthPartners Products or Fee-for-Service Medicaid Products:
- Sign and spoken interpreter services are not a covered benefit under any HealthPartners' products not listed in the first paragraph on the preceding page. Therefore, interpreter services agencies should not submit claims to HealthPartners and HealthPartners will not make payment for interpreter services rendered to a HealthPartners member covered under these other HealthPartners' products. The treating provider/clinic is responsible for providing and bearing the costs of interpreter services provided to patients under these other HealthPartners' products.

- Interpreter services are a covered benefit for patients with fee-for-service Medical Assistance, and fee-for-service MinnesotaCare coverage but the treating provider/clinic must seek and obtain payment from the Minnesota Department of Human Services for interpreter services provided to patients with these coverages. Thus, interpreter services agencies should not submit claims to HealthPartners and HealthPartners will not make payment for interpreter services rendered to patients in these fee-for-service products.

How to Provide Interpreter Services for HealthPartners
- Contracted medical groups, facilities and providers provide access to interpreter services (for patients for whom this is a HealthPartners covered service), in several ways:
  - Contracts with Interpreter Service Agencies;
  - Staff interpreters; and/or,
  - Telephonic interpreter access with Language Line.

- The interpreter's agency must have a contract with HealthPartners in order to provide interpreter services for HealthPartners members and patients.

- The clinic or health plan must request the interpreter through the interpreter services agency. Individual interpreters cannot book the interpreter appointment directly.

Customer Service Expectations
HealthPartners expects contracted interpreters and interpreter services agencies to follow these customer service requirements for interpreter service visits. These requirements are critical to the quality of the care and service provided.
- Members initiate scheduling, confirmation and cancellation of medical/dental appointment with assistance from the interpreter.

- Interpreter must check in and out at the front desk and fully complete all appropriate paperwork.

- The interpreter is expected to assist members with appointment check-in.

- The interpreter is expected to stay with the member for the duration of the appointment, including but not limited to, lab, radiology, and pharmacy.

- If the interpreter's agency is aware that the clinic or facility has an interpreter for the designated language on staff, the interpreter services agency should not supply an interpreter without the approval from the appropriate facility contact person.

- The interpreter shall not make or receive phone calls, (unrelated to the appointment) or conduct any other personal business during the appointment.

- Verification of member eligibility must be done by interpreter services agency representatives and not by individual interpreters.

- If requested by the member, the interpreter must assist the member with booking future clinic appointments. The member or their authorized representative must be present in person or via telephone when this appointment is set.

- The interpreter services agency must make best efforts to provide gender appropriate interpreters if requested by the member or clinic.

- The interpreter services agency must furnish and require the use of identification badges that include a picture, name of the agency and full name of the interpreter.

- If there are performance issues with specific interpreters, the interpreter services agency will implement a corrective action plan or disciplinary action. In addition, the interpreter services agency shall monitor the quality of interpreter performance. Examples of possible performance issues include, but are not limited to:

    - Late arrivals to appointments without a valid reason or notice
    - Missing appointments without a valid reason or notice
    - Lack of fluency in languages
    - Leaving an appointment prior to completion of assignment
    - Failure to wear ID badge or provide identification to staff when requested
    - Soliciting business from clinic patients or staff
    - Fraudulent documentation
    - Offering unsolicited advice on a member's insurance coverage

Spoken Language Interpreter Guidelines: HealthPartners expects all Spoken Language interpreters to follow these guidelines.

- The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing all legal requirements regarding disclosure.

- The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.

- The interpreter strives to maintain impartiality and refrains from counseling, advising or projecting personal biases or beliefs.

- The interpreter maintains the boundaries of the professional role, refraining from personal involvement.

- The interpreter continuously strives to develop awareness of his/her own and other cultures, including cultural attitudes regarding biomedical issues, encountered in the performance of their professional duties.

- The interpreter treats all parties with respect.

- The interpreter strives to continually further his/her knowledge and skills.

- The interpreter must at all times act in a professional and ethical manner.

Adapted from A National Code of Ethics for Interpreters in Health Care • July 2004
For more information please visit WWW. NCIHC.ORG

Sign Language Interpreter Guidelines: HealthPartners expects all Sign Language interpreters to follow these guidelines.

The Registry of Interpreters for the Deaf, Inc. has set forth the following principles of ethical behavior to protect and guide interpreters and transliterators for hard of hearing and deaf consumers. Underlying these principles is the desire to ensure for all the right to communicate.

- Interpreters/transliterators shall keep all assignment-related information strictly confidential.

- Interpreters/transliterators shall render the message faithfully, always conveying the content and spirit of the speaker using language most readily understood by the person(s) whom they serve.

- Interpreters/transliterators shall not counsel, advise or interject personal opinions.

- Interpreters/transliterators shall accept assignments using discretion with regard to skill, setting, and the consumers involved.

- Interpreters/transliterators shall request compensation for services in a professional and judicious manner.

- Interpreters/transliterators shall function in a manner appropriate to the situation.

- Interpreters/transliterators shall strive to further knowledge and skills through participation in work-shops, professional meetings, interaction with professional colleagues, and reading of current literature in the field.

- Interpreters/transliterators, shall strive to maintain high professional standards in compliance with the Code of Ethics.

Adapted from the Registry of Interpreters for the Deaf

Professional Training for Interpreters
Interpreter services agencies must have requirements for professional training of their interpreters. Professional training is critical to the quality of interpreter services provided.
- The interpreter service agency is expected to have professional requirements for its interpreters.

- The interpreter service agency is expected to provide ongoing professional training opportunities.

- The interpreter service agency is expected to have requirements, such as:

  o Demonstrated competency via certification, (e.g., Registry of Interpreters for the Deaf (RID) professional interpretation; spoken language certification)

  o Training on medical terminology

  o Training on expectations of contracted third party payers, including HealthPartners

  o Demonstration of qualifications if certification not available:

    ▪ Understanding of and sensitivity to cultural issues
    ▪ Demonstrated proficiency in both English and the other language, including demonstrated ability to convey information in both languages, accurately
    ▪ Orientation and training that includes the skills and ethics of interpreting and the standards of practice (e.g., confidentiality)
    ▪ Fundamental knowledge in both languages of medical terminology

- The interpreter service agency is expected to develop and maintain a Code of Conduct for its interpreters to maintain and uphold.

HealthPartners' Contract and Communication
- HealthPartners' contract with each interpreter service agency specifies the contractual obligations and specific payment rate amount.

- If you have questions about HealthPartners' contract, please contact your HealthPartners Contracting Representative.

- HealthPartners holds meetings with its interpreter service agencies as needed. These meetings are to review HealthPartners' expectations and to address any issues or questions.

Note: These systems and standards described above may be superseded or supplemented by specific terms set forth in written agreement between HealthPartners and a provider group or interpreter services agency.

IV.   **COMPLIANCE:**

V.   **ATTACHMENTS:**

VI.   **APPROVAL(S):**
Interpreter Services Business Operations Workgroup
NAME: Electronically approved by Babette Apland
TITLE: Senior Vice President Health Care Management

VII.   **ENDORSEMENT:**

Translation Checklist

Steps in the translation process:

- [ ] 1. Determine your target audience, language, ethnicity, reading level, and other factors.

- [ ] 2. Determine what materials need to be translated.

- [ ] 3. Develop a list of key health messages your document will convey.

- [ ] 4. Work with individuals from the identified language/ethnic group(s) to ensure materials are appropriate.

- [ ] 5. Choose potential translators from your vendor list.

- [ ] 6. Complete Translation Request Worksheet.

- [ ] 7. Obtain an itemized estimate in writing from the translator/agency to establish per word cost, turnaround time and project management fees, and to document any special instructions prior to assigning the project to the translator.

- [ ] 8. Develop a budget and time-line for translation completion.

- [ ] 9. Make arrangements to ensure your translation will be proofread/edited by a second translator, either by requesting this service from the translation agency when obtaining a cost estimate, or if working with an individual translator, by selecting a second translator to perform proofreading/editing services.

- [ ] 10. Review key messages and technical terms with the translator and go over translation process.

- [ ] 11. Obtain translation and field-test it with community providers, community residents, and/or staff. When performing peer reviews, forward the Guidelines for In-house Translation Reviews and the Translation Quality Assurance Form to the reviewer, along with the translation and the English originals.

- [ ] 12. Negotiate any changes or discrepancies, if needed, by utilizing [INSERT APPROPRIATE DEPARTMENT OR ORGANIZATION] glossaries.

- [ ] 13. Make sure your translation lists the language into which it is translated, thus allowing staff to identify the appropriate language for distribution.

- [ ] 14. Have typeset copy proofread by your translator before the document is printed.

- [ ] 15. Make a back-up copy on a CD with your final translation, any image files, and fonts used—especially non-roman fonts. Make sure you have alternative formats for all documents that will be posted on your website.

NATIONAL
HEALTH PLAN
COLLABORATIVE
Reducing Racial and Ethnic Disparities &
Improving Quality of Health Care

Guidelines for In-House Translation Reviews

Employees reviewing translations and those requesting internal reviews should follow these guidelines to ensure quality and to record translation vendor performance.

Please forward the translated documents to your internal reviewer, a copy of the English originals, these guidelines, and the Translation Quality Assurance Form.

- **Peer reviewers should focus on two areas: errors and context barriers.** The reviewer's task is to correct mistakes and to point out contextual barriers by offering constructive feedback and suggestions for improvement. Reviewers should not concentrate on style. Ask yourself: is this really an issue or is it a matter of taste?

- **Peer reviewers should be native speakers.** Please consider regional differences of the language. For example, Spanish varies greatly among countries and regions. Before deciding that a work or expression is incorrect, double check to make sure that the word is in fact incorrect and not a word that sounds foreign only because you are not accustomed to using it. Remember that our US audience comprises a variety of speakers from different countries and regions. Therefore, we must make a conscious effort at including those variations in our translations.

- **Use the following steps to guide the review process.** Following are standard procedures for reviewers to follow, consisting of seven steps.

  Step 1: Read the translation first. Set aside the original English document to read later. Read the translation right through to assess the quality and suitability of the language version. By reading only the language version at first, you should gain a general impression of the ideas expressed in the other language, without your judgment being affected by what the English version says.

  Step 2: Take mental notes. As you read, make a mental note of where you have to pause to "get the meaning", or if any part of the translation is not possible to comprehend.

  Step 3: Read the English version and compare the translated document with the English version. If you think the translation is not a high enough standard to be published as health information for members of the public, please inform the project coordinator immediately to discuss whether you should continue the checking process.

  Step 4: Review the translation for accuracy of context, meaning, message, grammar, and spelling. When reviewing the translated document, ask yourself the questions outlined below. Identify and mark any significant inaccuracies and write on your copy of the translation what you think it should say in the target language. Where appropriate, include brief explanatory comments.

  —Does the translated document convey the same meaning as the original English?

  —Does it contain all, and only, the essential messages that were in the English original, and is it easy to follow?

  —Are medical terms accurately translated into language that will be understood by the intended reader?

  —Would the readers of the translated version, who only speak the other language, understand everything and be comfortable with the way it is expressed? Is the translation inappropriate or offensive for your audience?

  —Are there any mistranslations, additions or omissions, or unclear messages?

NATIONAL HEALTH PLAN COLLABORATIVE

Reducing Racial and Ethnic Disparities & Improving Quality of Health Care

—Are there any serious mistakes which distort or cloud the meaning of any part of the text?

—Are there grammatical errors, such as incorrect gender usage, mistakes in spelling, punctuation, script, accents, incorrect or inconsistent capitalization, or hyphenation?

—Is the language level appropriate? Are there words and phrases that the target population may not understand because of literacy issues?

—Does the translation maintain the same tone and reading level as the original?

Step 5: Proofread and check the overall presentation and layout. Are there any problems with general presentation, format and layout, font size, spacing or alignment of text? Proofread carefully to make sure that all dates and times are correct, also the format of postal addresses, codes etc., that titles and headings (including any in English) are consistent and complete. It is important to check that any English words or information included in the translated text have been spelled and inserted correctly.

Step 6: Complete the Translation Quality Assurance Form. Using the attached form rate the translated document for loyalty, accuracy, register, false cognates, appropriateness for culture/ audience, and grammar and style. Provide an overall rating of the translation, and general comments in one or two paragraphs on the quality of the translation. Comment, for example, if it has been translated "word for word" in a way that makes the meaning unclear. If you feel that the way the English original was written has led to problems for the translator, please make this clear. Remember that the project coordinator may not speak the language concerned, and is relying on you to explain why you consider the translation unsatisfactory.

Step 7: Contact your translator. Review your concerns, corrections, and comments with translator/translation agency and discuss changes for developing another draft of the translation.

**For questions or technical assistance, contact
[INSERT APPROPRIATE DEPARTMENT] at [INSERT PHONE NUMBER].**

Adapted from The Commonwealth of Massachusetts *Translation Guidelines for Written Materials* and the NSW Multicultural Health Communications Service *Seven Steps* translation guidelines.

NATIONAL
HEALTH PLAN
COLLABORATIVE
*Reducing Racial and Ethnic Disparities &
Improving Quality of Health Care*

Translation Quality Assurance Form

Date:
Translation Title:
Language:
Document saved in:
Agency/translator's name:
Edited/proofread by:

Do you strongly agree, agree, are not sure, disagree or strongly disagree with the following statements. Please check off the appropriate box for each.

Statements	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Loyalty: I read the translated text and the English text and I understand the same message from both documents.	☐	☐	☐	☐	☐
Accuracy: I read the translated text and I get more information or different information than reading the English document.	☐	☐	☐	☐	☐
Register: I find the language in the translated text more difficult to read/ understand than the English.	☐	☐	☐	☐	☐
False cognates: I read the translated text and think I would not understand it as well if I didn't know English.	☐	☐	☐	☐	☐
Appropriateness for culture/ audience: The translated message sounds offensive or inappropriate to me.	☐	☐	☐	☐	☐
Grammar and Style: The translated text has grammatical mistakes, punctuation errors and format problems.	☐	☐	☐	☐	☐

	Excellent	Good	Average	Below Average	Unacceptable
How would you rate this translation overall?	☐	☐	☐	☐	☐

Recommendations/Comments:

Adapted from The Commonwealth of Massachusetts
Translation Guidelines for Written Materials

National Health Plan Collaborative Health Plan Descriptions

Aetna
www.aetna.com

Aetna, based out of Hartford, Conn., is a health care, dental, pharmacy, group life, disability insurance and employee benefits company. Aetna provides health insurance to more than 17 million medical members; 14 million dental members; and 10 million pharmacy members in all 50 states. Aetna offers commercial insurance to national, mid-size, and small employers; associations; individuals; and Medicare and Medicaid health plans in certain markets.

Boston Medical Center HealthNet Plan
www.bmchp.org

The Boston Medical Center HealthNet Plan, based in Boston, provides coverage to more than 240,000 MassHealth (Medicaid) and Commonwealth Care members throughout Massachusetts.

CIGNA
www.cigna.com

CIGNA, based in Philadelphia, is a health services and benefits company that serves millions of people worldwide through its health, pharmacy, behavioral, dental, disability, life, accident and international products and services.

Harvard Pilgrim Health Care
www.harvardpilgrim.org

Harvard Pilgrim Health Care, based in Wellesley, Mass., is a commercial plan serving 970,000 members in New England.

HealthPartners
www.healthpartners.com

HealthPartners, based in Bloomington, Minn., serves more than 1 million medical and dental health plan members nationwide through individual, group and Medicare plans.

Highmark Inc.
www.highmark.com

Highmark Inc., headquartered in Pittsburgh, is an independent licensee of the BlueCross BlueShield Association. Highmark Inc. serves 4.6 million people through the company's health care benefits business. The company also operates one of the nation's largest dental insurers and integrated vision companies, as well as offers stop loss, limited medical plans, worksite insurance and Medicare supplemental products.

Humana
www.humana.com

Humana, based in Louisville, Ky., serves 11.3 million members, including enrollees in Medicare Advantage, Stand-alone PDP, Tricare and commercial plans. Humana's regional and national networks include providers in almost every state.

Kaiser Permanente
www.kaiserpermanente.org

Kaiser Permanente, based in Oakland, Calif., is a nonprofit, group-practice, commercial health plan serving 8.6 million members in nine states and Washington, D.C.

Molina Healthcare
www.molinahealthcare.com

Molina Healthcare, based in Long Beach, Calif., serves patients covered under Medicaid, the Healthy Families Program, the State Children's Health Insurance Program and other government-sponsored health insurance programs. Molina serves approximately 1.2 million members in California, Michigan, New Mexico, Ohio, Texas, Utah and Washington state as well as 19 primary care clinics located in Northern and Southern California.

UnitedHealth Group
www.unitedhealthgroup.com

UnitedHealth Group, based in Minneapolis, is a managed health care company serving approximately 70 million members in 47 states. UnitedHealth Group provides commercial, individual, Medicaid, Medicare and a variety of other health services through seven operating businesses: UnitedHealthcare, Ovations, AmeriChoice, Uniprise, OptumHealth, Ingenix and Prescription Solutions.

WellPoint, Inc.
www.wellpoint.com

WellPoint, Inc., based in Indianapolis, is a health benefits company that serves approximately 34 million members; one in nine Americans receives coverage for his or her medical care through WellPoint Inc.'s health plans. WellPoint, Inc. is an independent licensee of the BlueCross BlueShield Association and serves its members as the BlueCross licensee for California; the BlueCross BlueShield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the BlueCross BlueShield licensee in 10 New York City metropolitan and surrounding counties and as the BlueCross or BlueCross BlueShield licensee in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), Wisconsin; and through UniCare.

Resource List

This list of resources presents a number of studies, reports, articles and other tools that may be helpful when developing and implementing efforts to reduce racial and ethnic disparities in health care. Many of these resources are referenced throughout the National Health Plan Collaborative toolkit.

Lavizzo-Mourey R, Richardson W, Ross R, et al. "A Tale of Two Cities." *Health Affairs*, 24(2): 313-315, March/April 2005. (http://content.healthaffairs.org/cgi/reprint/24/2/313)

This issue of *Health Affairs* provides the ingredients necessary to launch a meaningful national dialogue on eliminating health and health care disparities. The authors of this foreword, and the organizations they represent, have collaborated to support this special issue of *Health Affairs.* The papers contained within, in the aggregate, represent essential elements of a national blueprint to reduce and eliminate health disparities in the United States: a better understanding of the roles that race, class, and inequity play in contributing to disparities; opportunities for policy intervention; and tools for closing the disparities gap.

Smedley BD, Stith AY and Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: The Institute of Medicine, 2003. (http://www.nap.edu/catalog.php?record_id=10260#orgs)

Unequal Treatment offers recommendations for improvements in medical care financing, allocation of care, availability of language translation, community-based care and other arenas. The book concludes with recommendations for data collection and research initiatives.

***2007 National Health Quality and National Healthcare Disparities Report*. Washington: The Agency for Healthcare Research and Quality, 2007. (http://www.ahrq.gov/qual/qrdr07.htm)**

The *National Healthcare Disparities Report* describes the quality of and access to care for multiple subgroups across the United States and represents a source of information for tracking the country's progress over time.

Fisher ES, Goodman DC, Chandra A, et al. *Disparities in Health and Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project.* Princeton: Robert Wood Johnson Foundation, 2008. (http://www.rwjf.org/pr/product.jsp?id=31251)

The findings in this report highlight the importance of understanding health and health care within a local context and efforts to explore and address the underlying causes of disparities within and across regions.

***2005 National Health Quality and National Healthcare Disparities Report*. Washington: The Agency for Healthcare Research and Quality, 2005. (http://www.ahrq.gov/qual/nhqr05/nhqr05.htm)**

The *2005 National Healthcare Quality Report* is a comprehensive national overview of quality of health care in the United States.

Lurie N, Jung M, Lavizzo-Mourey R. "[Disparities and Quality Improvement: Federal Policy Levers](#)." *Health Affairs.* **24(4): 354-364, March/April 2005.**

This article describes multiple opportunities for federal and state governments to exert policy leverage, particularly through their roles as purchasers and regulators, and to influence progress toward eliminating disparities and improving quality.

Perot RT and Youdelman M. *[Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices](#).* **New York: The Commonwealth Fund, 2001.**

Using interviews conducted with administrators at federal health agencies, this report finds wide gaps between the goals of federal initiatives to eliminate racial and ethnic disparities in health care, such as Healthy People 2010, and efforts of federal health agencies to collect and report data needed to help achieve these goals. The report provides the first comprehensive analysis of the policies and statutes governing the collection of health care data by race, ethnicity and primary language.

Federal Register. **62(210): 58782, October 30, 1997.**

This notice describes OMB's revision of Statistical Policy Directive No. 15, "Race and Ethnic Standards for Federal Statistics and Administrative Reporting." The revised standards have five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino".

Rosenbaum S, Burke T, Nath SW, et al. *The Legality of Collecting and Disclosing Patient Race and Ethnicity Data.* **Washington: The George Washington University School of Public Health and Health Services Department of Health Policy, 2006.**

This policy brief discusses the legality of collecting patient data on race and ethnicity as part of a program for quality improvement.

[Collection and Use of Racial and Ethnic Data by Health Plans to Address Disparities: A Final Summary Report](#). **America's Health Insurance Plans and the Robert Wood Johnson Foundation, 2004.**

In 2003/04, AHIP collaborated with the Robert Wood Johnson Foundation to conduct a survey and follow-up qualitative research to assess whether health plans and insurers collect racial and ethnic data on their enrollees and how this data is used to improve patient care.

Baker DW, Kenzie A, Cameron, et al. "Members' Attitudes Toward Health Care Providers Collecting Information About Their Race and Ethnicity." *Journal of General Internal Medicine,* **20(10): 895–900, 2005.**

This paper summarizes findings of research on patients' attitudes toward Health Care Providers (HCPs) collecting race and ethnicity data. The result shows that most patients think HCPs should collect information about race and ethnicity, but many feel uncomfortable giving this information, especially among minorities. It concludes that health care providers can increase patients' comfort levels by telling them this will be used to monitor quality of care.

[Tools to Address Disparities in Health: Data as Building Blocks for Change](#). **Washington: America's Health Insurance Plans, 2005.**

This toolkit is designed to assist in broadening health insurance plans' and health care organizations' understanding of the issues surrounding the collection of data on race, ethnicity and primary language and the use of this data to to improve the quality care.

Burke T, Stewart A, Harty ME, et al. "[The Legal Context for Employer Health Care Quality Improvement Initiatives That Collect and Report Information by Member Race and Ethnicity](#)." *BNA's Health Care Policy Report,* **16(25), 2008.**

Title VII of the Civil Rights Act of 1964 prohibits employment discrimination on the basis of race, national origin and sex. The analysis of Title VII and employer initiatives to use race and ethnicity data to assess health care quality documents the central role of stratified data collection in achieving the goals of Title VII in the workplace. Authors conclude that employer participation in workplace or community quality improvement projects that use race and ethnicity data to examine health care quality and report results are not only consistent with federal civil rights law but actually advance the central goal of Title VII.

[HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients](#). **Chicago: The Health Research and Educational Trust Disparities Toolkit Team and Northwestern University, 2005.**

The toolkit is designed to help hospitals, health systems, community health centers, medical group practices, health plans and other users understand the importance of collecting accurate data on race, ethnicity and primary language of persons with limited English proficiency and/or who are deaf or hard-of-hearing. By using this toolkit, health care organizations can assess their organizational capacity to collect this information and implement a systematic framework designed specifically for obtaining race, ethnicity and primary language data directly from patients/enrollees or their caregivers in an efficient, effective and respectful manner.

Baker DW, Cameron KA, Feinglass J, et al. "A System for Rapidly and Accurately Collecting Patients' Race and Ethnicity." *American Journal of Public Health,* **96(3): 532-537, 2006.**

Authors assessed the feasibility of collecting race and ethnicity data from patients using their own preferred racial and ethnic terms.

Weinick, R, Flaherty K, Bristol SJ. *Creating Equity Reports: A Guide for Hospitals.* **Boston: The Disparities Solutions Center, Massachusetts General Hospital, 2008.**

This guide is designed to provide a framework for equity reporting and to share lessons learned from experiences to date with creating and using such reports.

Eliminating Health Disparities: Measurement and Data Needs. **Washington: National Research Council of the National Academies, 2004.**

Current data available on race, ethnicity, SEP and accumulation and language use are severely limited. The report examines data collection and reporting systems relating to the collection of data on race, ethnicity and socioeconomic position and offers recommendations.

Piette JD. "Interactive Voice Response Systems in the Diagnosis and Management of Chronic Disease." *The American Journal of Managed Care,* **6(7): 817-827, 2000.**

Through literature review, this paper analyzes the feasibility, reliability, validity and potential clinical impact of interactive voice response (IVR) systems in the diagnosis and management of chronic disease. The results show that the information patients report during IVR assessments is at least as reliable as information obtained via structured clinical interviews or medical record reviews. Patients often are more inclined to report health problems to an IVR system than directly to a clinician. The few outcome evaluations of IVR-supported chronic illness management services indicate that they can have moderate impacts on some health and health behavior outcomes.

Lurie N and Fremont AM. "Looking Forward: Crosscutting Issues in Race/ethnicity Data Collection." *Health Services Research***, 41(4 Pt 1):1519-33, 2006.**

This article discusses issues related to making race and ethnicity data collection reliable and valid for addressing minority health disparities and strategies for improving the provision of data.

Cancer Facts & Figures for Hispanics 2006-2008. **Atlanta: American Cancer Society, 2006.**

This report presents statistics of cancer incidence, mortality, survival and risk factors for Hispanics. It is intended to provide information to community leaders, public health and healthcare workers and other interested in cancer prevention, early detection and treatment for Hispanics in the United States.

Breast Cancer Facts & Figures 2007-2008. Atlanta: American Cancer Society, 2007.

This report presents both general information on breast cancer, risk factors, early detection, survival and current research as well as statistics on who has breast cancer, who is most likely to get breast cancer and how the treatment of breast cancer is changing over time.

Fiscella K and Fremont AM. "Use of Geocoding and Surname Analysis to Estimate Race and Ethnicity." *Health Services Research,* **41(4 Pt 1):1482-500, 2006.**

This paper discusses two indirect methods for estimating race and ethnicity—geocoding and surname analysis. It addresses the advantages, accuracy and limitations of these methods and offers practical suggestions for using them.

Elliott M, Fremont AM, Lurie N, et al "As New Method for Estimating Racial/Ethnic Disparities where Administrative Records Lack Self reported Race/Ethnicity." *Health Services Research,* **2008.**

This paper describes the use of Bayesian Surname and Geocoding (BSG) for estimating racial and ethnic disparities. It compares the accuracy of this method to two other indirect methods: a non-Bayesian method that combines surname and geocoded information and geocoded information alone. The results show that the BSG method efficiently integrates administrative data, substantially improving upon what is possible with a single source or from other hybrid methods.

Lurie N, Fremont AM, et al. "The National Health Plan Collaborative to Reduce Disparities and Improve Quality." *The Joint Commission Journal on Quality and Patient Safety*, **34 (5): 256-265, 2008.**

This paper summarizes the progress to date on the National Health Plan Collaborative.

Morgan RO, Wei II, Virnig BA. "Improving Identification of Hispanic Males in Medicare: Use of Surname Matching." Medical Care, 42(8):810-816, 2004.

This article reports on two studies assessing the effectiveness of a Hispanic surname match for improving the accuracy of race and ethnicity codes for elderly males in the Medicare data sets.

U.S. Census Bureau. Demographic Aspects of Surnames. Available at: http://www.census.gov/genealogy/www/surnames.pdf, 2008.

This report documents both the overall frequency of surnames, as well as some of the basic demographic characteristics that are associated with surnames.

Flores G, Abreu M, Olivar MA, et al. "[Access Barriers to Health Care for Latino Children]()," *Archives of Pediatrics and Adolescent Medicine* **152(11): 1119-1125, 1998.; Weinick R and Krauss N. "Racial/Ethnic Difference in Children's Access to Care."** *American Journal of Public Health,* **90(11), 2000.**

This study identifies important access barriers to health care for Latino children, as cited by parents through a cross-sectional survey of parents of all 203 children coming to a pediatric Latino clinic at an inner-city hospital.

U. S. Census Bureau. *American FactFinder.* **Retrieved June 2008, from http://www.factfinder.census.gov.**

The Census Bureau's Population Estimates Program produces and disseminates the official estimates of the population for the nation, states, counties, cities and towns and estimates of housing units for states and counties.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* **Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.**

This Surgeon General report specifically focuses on the importance of information, policies and actions that will reduce and eventually eliminate the stigma attached to mental illness.