Program Evaluation

Final Contract Report

Evaluation of a Learning Collaborative's Process and Effectiveness To Reduce Health Care Disparities Among Minority Populations

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Final Report

December 20, 2006

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EXECUTIVE SUMMARY

A. FOCUS OF THE REPORT

This report summarizes the results from the Mathematica Policy Research, Inc. (MPR) evaluation of the National Health Plan Collaborative (NHPC) to reduce racial and ethnic disparities, which is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation (RWJF). The Collaborative began in July 2004 and ended in September 2006; the evaluation began in June 2005. A second phase is planned, but this evaluation focuses on the initial Collaborative.

The Collaborative involved nine firms working to address racial and ethnic disparities in health care that may exist within health plans. The participating firms were large national and regional organizations that covered millions of lives; over half of them sponsored health plans in more than one location. The Collaborative's work focused primarily on disparities that may exist among firms' commercially enrolled members. Participants in the Collaborative agreed to focus on diabetes and to measure disparities using common HEDIS measures. Several organizations supported the work of the Collaborative—the two dominant support organizations are RAND and the Center for Health Care Strategies (CHCS).

The evaluation sought answers to several questions:[1]

1. How was the Collaborative structured, and what did it do?

2. What did the Collaborative accomplish and how sustainable will these efforts be?

[1] To assist in clear presentation of findings, we have taken the liberty of condensing the five evaluation questions into four, and rearranging components of the original questions into groupings that lend themselves better to summarizing the findings for purposes of this Executive Summary.

3. Did the support provided by the Collaborative process contribute to firms' ability to make progress in addressing issues related to disparities, and how valuable did firms view their participation to have been?

4. What can AHRQ learn about whether or how to engage in similar collaboratives in the future?

Drawing on a conceptual framework, we sought to understand what the Collaborative did to help firms (1) support firm leadership in building support for work on disparities; (2) collect or estimate the race and ethnicity of their membership to better identify potential disparities; (3) develop and test pilot interventions to reduce disparities; and (4) communicate the outcomes of the work to others outside the Collaborative. This summary focuses on what we learned; readers will find additional detail on all of these activities within the text of the report.

B. Data Sources

This was a qualitative evaluation that involved little primary data collection. We received Collaborative documents and sat in on the Collaborative's telephone calls and meetings as a silent observer. We also conducted three rounds of interviews with the lead staff of participating organizations and a broader set of staff from among the nine firms. In round two, we asked all participants to complete a "network feedback form" to support a formal network analysis of the Collaborative. All 15 participants responded to this request, although responses for some items were incomplete.

C. Findings and Conclusions

1. How Was the Collaborative Structured and What Did it Do?

From the start, the NHPC was structured as a learning collaboration that convened participating firms through meetings and calls to discuss activities in the area of disparities. Firms also received technical assistance from support organizations.

The Collaborative involved several diverse organizations whose interests and internal styles of operation differ. A key point of contention for the Collaborative was how much to emphasize broad-based efforts to build national and firm infrastructure for addressing disparities versus small-scale, specific pilot interventions designed to reduce such disparities. The focus of the Collaborative's work evolved over time, a factor important to understanding its accomplishments.

A key focus of work was on developing insights into existing disparities; RAND provided support to firms seeking assistance with geocoding and surname analysis so that they could better learn about disparities in care among racial and ethnic minority members with diabetes (and other conditions, should firms elect to include them). The Collaborative also provided an opportunity for firms to learn more about the activities of other

participating firms that are considered leaders in primary data collection efforts on race and ethnicity.

The Collaborative also encouraged firms to develop pilot interventions to reduce disparities and to focus on them during the Collaborative's second year. At firms' request, such interventions were defined broadly at the organizational, member, provider, or community level. However, sponsor and support organizations appear to have encouraged relatively small-scale interventions that could be assessed with HEDIS measures before and after implementation. This model was more relevant to some participants—for example, regional firms with relatively small total membership—than others. Collaborative sponsors have engaged a communications contractor, GMMB, to work with firms' communications staff on dissemination plans as the Collaborative progresses.

The success of the Collaborative needs to be assessed in context. For both sponsors and support organizations, work with large commercial health plans around disparities was a new and risky endeavor, as these organizations are complex and often difficult to understand. Participants had varying views of the Collaborative's goal and therefore what constituted success. Moreover, the scale of participating firms influenced what they could accomplish. Firms' scale has proved both a major strength (they touch millions of lives) and weakness (more barriers to change) for the Collaborative.

In the first round of interviews, sponsors reported seeing value in small steps that made disparities a more legitimate focus of quality improvement work among firms. They also saw the value of small-scale efforts that help firms understand information needed to measure disparities, and of using the Collaborative to improve communication within firms to increase support for addressing disparities.

2. What Did The Collaborative Accomplish, And How Valuable Do Firms Perceive Their Participation In It?

Despite adjustments to their efforts over time, the Collaborative maintained the participation of all firms that were involved at the start. Sponsors and support organizations can take pride in that outcome, since many events could have shattered the Collaborative. To a certain extent, it is not surprising that firms remained in the Collaborative—whatever its demands, firms probably perceived the costs of participation as relatively low in relation to the risks associated with dropping out. As one firm participant remarked, "No one wants to be left behind. That's a strategic disadvantage." Hence, although firms' continued interest is a positive sign, it is important to look more substantively at the accomplishments of the Collaborative. The main ones include:

- Increased organizational attention and commitment to disparities as part of the quality agenda for health plans

- Firms' growing recognition that their ability to generate primary data on race/ethnicity is critical to making progress

- Increased awareness among sponsor and support organization staff about how firms work, in ways that are relevant to understanding firms' contribution to disparities

The Collaborative had less success in sharing lessons about caring for patients in ways that reduce disparities and applying that knowledge to alter care delivery. We summarize below the findings on the Collaborative's progress in each area.

Organizational Commitment. All of the firms participated with the support of their senior leadership, designated well-placed senior staff to serve as liaisons, and involved their traditional reporting structures to keep executives aware of their efforts. Thus, participants in the Collaborative did so as official representatives of large organizations, a factor that contributed to their ability to influence organizational commitments to disparities. Most firms used their existing organizational channels to address concerns related to disparities, but the Collaborative also encouraged some firms to enhance their organizational structures to more effectively deal with this issue, including creating disparities task forces and the like. These structures—together with increased recognition of the issue, generated partly by firms' participation in the Collaborative—should sustain interest. While the Collaborative focused only on diabetes, firm responses suggest that any insights firms gain about disparities are influencing their thinking about care delivery in general.

However, there are challenges to sustainability, particularly stemming from the environment and the instability within the industry. All firms viewed the tight fiscal constraints imposed by the health care market as influencing their decision-making, although some are better positioned fiscally than others. Leadership turnover and change is also common in the industry. Among national firms, for example, one had limited participation in Phase I because of a merger and staff turnover, two others are now dealing with turnover of the chief executive for their corporation. To the extent that firm commitments have translated into permanent change—for example procedures for data collection, or the inclusion of interventions in standard operating systems—firms are likely to be better positioned to maintain the progress they have made already.

Primary Data to Better Identify Disparities. As a result of the Collaborative, firms are much more aware of the value of race/ethnicity data in supporting quality improvement efforts targeting racial and ethnic disparities. All but one of the firms now say the goal is to capture race/ethnicity for all their members; the exception is capturing it for selected patients in disease management programs. The geocoding/surname analysis experience in Phase I was important in helping firms develop a broader-based acceptance of the existence of disparities. It also highlighted to firms what geocoding/surname analysis could do (general patterns) and what it could not (member-specific identification to support interventions, or identify patterns when residential patterns are not highly concentrated by subgroups).

Despite the accomplishments, there remains a gap between what firms have done and what they ultimately seek to do. For example, one leading firm has primary data for only a small proportion of members, despite trying for several years to collect them. Two of the

firms committed to collecting race and ethnicity data have not yet determined how they will do so, and a third will not start until at least 2008, when its new IT system is in place. Firms also face additional barriers. Because participating organizations are large, even those that have data may not store it in a way that is accessible for various uses across the firm.

Because of the time it takes to generate useable primary data on race/ethnicity, some firms are planning to use geocoding/surname analysis into the future to benchmark change by geographic area or further identify locations for disparity-oriented interventions. While some tools will continue to be made available to firms by RAND in Phase II, firms seeking individual assistance from RAND will have to enter into individual contracts, as AHRQ will not fund it. The transition poses a structural barrier to sustainability. In retrospect, it could have been valuable to consider earlier how to institutionalize firm capacity to deal with these issues, although firms seem to be making their own arrangements.

Identification and Implementation of Interventions. Firms' efforts to pilot interventions to reduce disparities generally took a backseat to data collection. As firms gained insight on disparities, they began to think more concretely about what they, as firms sponsoring diverse health plans, could do to reduce disparities. By the end of the Collaborative, seven of the nine firms had either completed or were in the process of completing pilot interventions, and two were developing them. During this evaluation, it was too early for most to know the outcomes of their interventions; however, most thought their efforts created a framework and base for future expansion and learning, and planned to continue related interventions after Phase I ended.

Firm progress in pursuing interventions was challenging. These challenges included: 1) uncertainty about how to begin, and how best to intervene; 2) lack of data on race/ethnicity of particular members; 3) implementing effective interventions that could leverage the diverse functional systems in the firm and the split between corporate and regional responsibilities; and 4) logistical issues, such as recruiting physicians to participate in provider-based interventions.

The Collaborative led firms to view their work on disparities as a part of their quality improvement effort, rather than an additional or separate activity. This linkage allowed firms to create leverage to address disparities. Still, firms were constrained by the tight fiscal environment in which they operated and the competition for resources. The ability to build a business case for working on disparities was viewed as important to getting resources to address this and the quality improvement agenda in firms.

Enhanced Industry Knowledge in Staff from Sponsor/Support Organizations. While not a stated objective, participation in the Collaborative helped sponsors and support organizations learn more about large commercial health plans. Although some key staff in sponsor and support organizations were experienced in this area, others openly said they learned a great deal about the industry through their participation in the Collaborative.

3. Did the Support Provided By the Collaborative Process Contribute to Firms' Progress in Addressing Issues Related to Disparities and How Valuable Did Firms View Their Participation As?

Overall Value. Firm responses to the network analysis clearly paint a positive picture of the Collaborative overall, as an effort that contributed to their goals. In the round three interviews, all of the firms responded positively to a question about whether they viewed their participation as worthwhile relative to its costs. Consistent with their hopes at the start of the Collaborative, firms articulated this value as allowing them to leverage firm resources, enhance firm awareness of disparities, fuel internal efforts, and ensure momentum. Firms appreciated the sponsors' willingness to provide resources to support their needs. The fact that the Collaborative was sponsored by an important federal agency and a major health foundation enhanced its credibility and provided added value in the eyes of participating firms. Moreover, sponsors' decision to continue with a second phase of the Collaborative (as discussed more below) takes advantage of existing momentum, and the creation and institutionalization of disparities task forces (or similar) by several participating firms improves chances for longer-term sustainability.

Contribution of Collaboration. On a more concrete level, however, firms did not appear to necessarily benefit as much from collaboration as they might have, had they been willing to more openly share information or had the Collaborative been better structured to facilitate substantive learning, particularly with respect to evidence on reducing disparities. The network analysis indicated that sponsor and support organizations were seen as the "glue" that held the Collaborative together. Although termed a Collaborative, there was much more communication between firms and support organizations than from firm to firm. This finding was included in the interim report (which was shared with all participants), giving them an opportunity to consider it. From firms' discussion at the final Phase I meeting, it appears that they agreed with this conclusion. To some extent, limited sharing is a function of the culture of the firms and the markets in which they operate. As one firm noted in our interviews, "It [communication] is a double-edged sword. To learn, you have to tell." When AHRQ requested more information on this to aid in planning Phase II, firms thought the more specific focus of their work in the next phase (discussed below) would facilitate better communication, as would the experience they had working with one another and the trust developed during Phase I.

Also relevant to shared learning were the firm responses about their biggest disappointment: the Collaborative did not address their interest in knowing about "what works," especially in terms of interventions that might reduce disparities. While some of this could be a reaction to the lack of a solid evidence-based knowledge in this area, it appears that more could have been done to connect firms with sources and people who could provide insight on this issue and also to structure agendas so that they could learn more from one another. The effort required of CHCS to coordinate the complex structure of the Collaborative probably came at a cost in resources that could be devoted to more substantive support in this area. The fact that many firms did not want to focus on implementing pilot interventions may have further discouraged attention to this content, which it appeared firms wanted even if they did not want to use the Collaborative to talk about what they might do with the information.

Contribution of Communications. The communications and dissemination infrastructure was an important component of Phase I. While many participating organizations agreed that there was relatively little to communicate in the first phase, the communications work undertaken by GMMB was important in presenting a standardized and consistent message externally about the Collaborative. Moreover, much of the communications activity in Phase I—such as the development of a logo and other NHPC materials and the establishment of a core message—provides a foundation for Phase II, when the Collaborative may have substantively more to report on its activities in the area of reducing disparities.

Firm Requirements for Participating in the Collaborative. The most contentious issues for firms were the structure and requirements the Collaborative sought to impose. Reporting requirements were a particular concern, and at least some firms viewed the cumulative number of requests from sponsor-affiliated groups to be burdensome. At the final meeting of Phase I, firms' rejection of externally imposed reporting requirements was explicit—they said they wanted to be responsible for defining any measures of progress that would be used in Phase II and were uneasy about ways in which efforts could be monitored. While firms acknowledged that Phase I deadlines were valuable in pushing their efforts forward, they felt that responding to standardized reporting requirements provided more value to sponsors and support organizations with contractual requirements than to firms themselves which were not funded to participate in the Collaborative. This is consistent with the fact that for firms, a major cost of collaboration was the demands made on the busy senior staff whose involvement was essential in generating the stature and commitment from firms that the Collaborative sought.

4. What can AHRQ learn about whether or how to engage in similar collaboratives in the future?

The evaluation findings provide insight both on issues relevant to future efforts with large firms sponsoring health plans and, specifically, for Phase II of the Collaborative.

General Lessons. In designing an initiative similar to this, with large firms sponsoring health plans, sponsors would do well to be clearer from the start about the goals of collaboration. They should also be sure that the goals are shared by all participants, and adapt participation and structure accordingly.

Assuming a given set of goals, there are at least three generic questions that warrant consideration:

- ***Who Participates?*** There are not many firms that play a major role sponsoring health plans nationally or regionally. Those that do meet this criterion are diverse in structure (ranging from quite centralized to very decentralized), investment in quality improvement, linkages with provider systems based on ownership or history, geographic coverage, and other dimensions.

- ***What Model for Collaboration?*** There are a variety of ways to structure a collaboration. Ultimately, the form chosen should support the overall goals (neither these goals nor the structure seemed to have been given appropriate consideration at the outset of the Collaborative). The decision to have RWJF sponsor a support organization (CHCS) to complement RAND's work for AHRQ was a significant one that probably had more influence over the Collaborative than has been recognized. The Collaborative was structured on a model of traditional quality improvement work with smaller, less complex organizations—typically providers or small health plans with strong links to provider groups. Other structures may be more appropriate, depending on the goals. For example, if the goal is to inspire firms to prioritize work on disparities and to leverage firm scale to remove environmental barriers to doing so, it might be appropriate to use a workgroup model that includes politically savvy expert facilitators with deep knowledge of firms' workings—a former chief executive officer (CEO) who is well respected by firms and has a good grasp of public policy concerns, for example—and the support of consulting content experts. The Learning Network or Laboratory that some participants suggested could be another model.

- ***How to Leverage the Private Sector Effectively?*** Working with large private sector organizations that function in highly competitive markets is different from working with grantees beholden to the sponsor and financially motivated to cooperate. Sponsors seeking to engage large private sector organizations in group efforts should understand the reasons (business, political, personal) that drive a firm to participate, the constraints that are likely to limit their response, and the processes required to link the external work within the Collaborative to the firm's infrastructure and decision-making processes.

- ***How to Encourage Sustainability?*** Because Turnover in staff can be anticipated, sponsors need to think about how change can be institutionalized and instability within participating firms. The other side of sustainability involves doing as much advance thinking as possible about how to sustain work in firms after external support is over. AHRQ may want to consider building more formal requirements for technology transfer into RFPs to help leverage the work funded through AHRQ's support contracts.

5. Insights on the Next Phase of the Collaborative

To sustain attention on reducing disparities, sponsors have decided to proceed to a Phase II for two more years. While many details remain to be determined, the intent is to increase the specificity and clarity of objectives in Phase II, with a focus on particular activities that firms agree are important. While not all of the firms participating in the Collaborative will necessarily be involved in each of the activities, the foci for attention in Phase II are (1) developing approaches to primary data collection on race/ethnicity; (2) collective work on ways to enhance language access at the national and local market level; (3) developing the business case for work on disparities, both nationally and within firms; and

(4) continuing information exchange both among participating firms and with other stakeholders (which includes a communications component that builds on Phase I accomplishments).

While some might view the specific activities of Phase II as a more narrow scope of work—and perhaps more constraining—than Phase I, the fact that these activities were defined by participating firms, rather than sponsors or support organizations, should improve buy-in in Phase II. Some firms expressed discontent with being told what to do in Phase I. From our perspective the more collaborative approach in Phase II—at least in determining what activities to pursue—holds promise and allows firms more flexibility to focus on those activities of greatest interest to them. Further, it is beneficial to narrow the scope of work potentially of interest to firms when resources and time are limited. Focusing attention on a limited number of priority areas—while giving firms flexibility to participate in them or not—is an efficient approach to generate substantive change.

Our evaluation suggests that extending the Collaborative will be valuable to firms in sustaining and expanding the accomplishments to date. As one participating firm observed, the Collaborative serves as "the external cattle prod that keeps us moving." Moreover, by the end of Phase I, the Collaborative appeared to be gaining momentum. Given the external pressures on firms and the competition for resources, the Collaborative will encourage firms to continue to focus on the area of disparities and provide a platform from which they can share their experiences, successes, and, if they choose to, failures. This alone will be valuable to firms seeking insight and support.

However, the challenges should not be underestimated, particularly if Phase II success is to be measured in terms of concrete accomplishments. While the plan for this phase may appear more concrete and defined than that of Phase I, there are in fact many remaining ambiguities. From our observations of the process through which the Collaborative chose specific foci for Phase II works—primary data collection, language access, and the business case—we believe it will take strong leadership to move participating firms in a direction that is both useful to them and substantively clear and feasible. After tasks are better defined, support organizations may also find that they need to draw on additional expertise and organizations to achieve specific goals, such as the use of expert facilitators (such as former CEOs) or consulting content experts to lead collaborative sessions on particular topics as necessary.

Sponsors and support organizations may need to be more realistic about what they can accomplish with their own resources and the internal energy firms can devote to specific issues. On the one hand, keeping all stakeholders engaged requires a broad focus because each firm has its own priorities. On the other, to the extent that the focus is on collective accomplishments rather than communications support to firms, only so much can be done. Although there was a conscious effort to limit the number of activities in Phase II, we are concerned that the successful completion of each task may be complicated by defining these activities to include many interrelated tasks. For example, some at this stage appear to have national and market components (data or language access) and others national and firm-specific estimates (in terms of the business case for work on reducing disparities). The

Collaborative will also have to invest in enhanced information sharing and, potentially, strengthening the substantive content of support. If many of the same staff (within firms and within the Collaborative) are expected to support each of these things, there is a risk that none will be done well.

We are also concerned that too high a share of the resources available to the Collaborative have, in the past, been devoted to coordination rather than substantive analysis linked to other external efforts and scientific knowledge of the available evidence/state of the work in each target area. For example, for the primary data collection activities of Phase II, the Collaborative will need to identify how its efforts interface (if at all) with providers and/or purchasers and how they relate to existing governmental efforts at standardization. The Phase I experience reinforces the value of setting clear and realistic goals for Phase II so that the Collaborative's attention is not spread too thin or in too many directions.

6. Conclusion

In conclusion, the Collaborative has enhanced firms' interest in effective interventions to measure and address disparities. However, there remain many substantive issues about how to design and support such measures and interventions, and many political, organizational, and market factors that must be considered. We encourage participants in the Collaborative to carefully assess priorities and lessons from Phase I as they continue to work on the important issue of racial and ethnic disparities in health care.

CHAPTER I

INTRODUCTION AND PURPOSES

A. OVERVIEW OF THE EVALUATION

The Agency for Healthcare Research and Quality (AHRQ) contracted with Mathematica Policy Research, Inc. (MPR) to evaluate the National Health Plan Collaborative on Racial and Ethnic Disparities (NHPC), which was cosponsored by AHRQ and the Robert Wood Johnson Foundation (RWJF). The evaluation covers what participants view as "phase one" of the NHPC, as the Collaborative now has been funded for an additional two years of work following its original end in September 2006. In this first phase, the Collaborative involved nine firms working with associated support organizations to address racial and ethnic disparities in care that may exist within health plans. The firms are national and regional organizations; over half sponsor health plans in more than one location. The work of the Collaborative was focused primarily on disparities that may exist among commercially enrolled members because that is the dominant membership in health plans and there has been less work on disparities in this area than in Medicare and Medicaid.

Several organizations supported the work of the Collaborative in phase one; the two dominant organizations were RAND and the Center for Health Care Strategies (CHCS). Other involved support organizations included the Institute for Healthcare Improvement (IHI), subcontracting with CHCS, and GMMB, a communications firm hired by RWJF). Overall, sponsors view the Collaborative as important to their priorities, but also challenging because it requires that they develop relationships in new ways with large national firms sponsoring health plans. Not surprisingly, Collaborative goals have evolved over time and may not be consistently viewed by all participants, a theme we discuss later in the report.

After reviewing the background and status of the Collaborative (Gold et al. October 26, 2005), AHRQ agreed that the MPR evaluation would address five questions:

1. How was the Collaborative structured, and what did it do?

2. What did the Collaborative accomplish, and how valuable do firms perceive their participation in it to have been?

3. To what extent did the support provided by the Collaborative process contribute to firms' ability to make progress in addressing issues related to disparities?

4. Will the work on disparities be sustainable after the Collaborative concludes its assignment, and what tools may help measure such sustainability at that time?

5. What can AHRQ learn about whether or how to engage in similar collaboratives in the future?

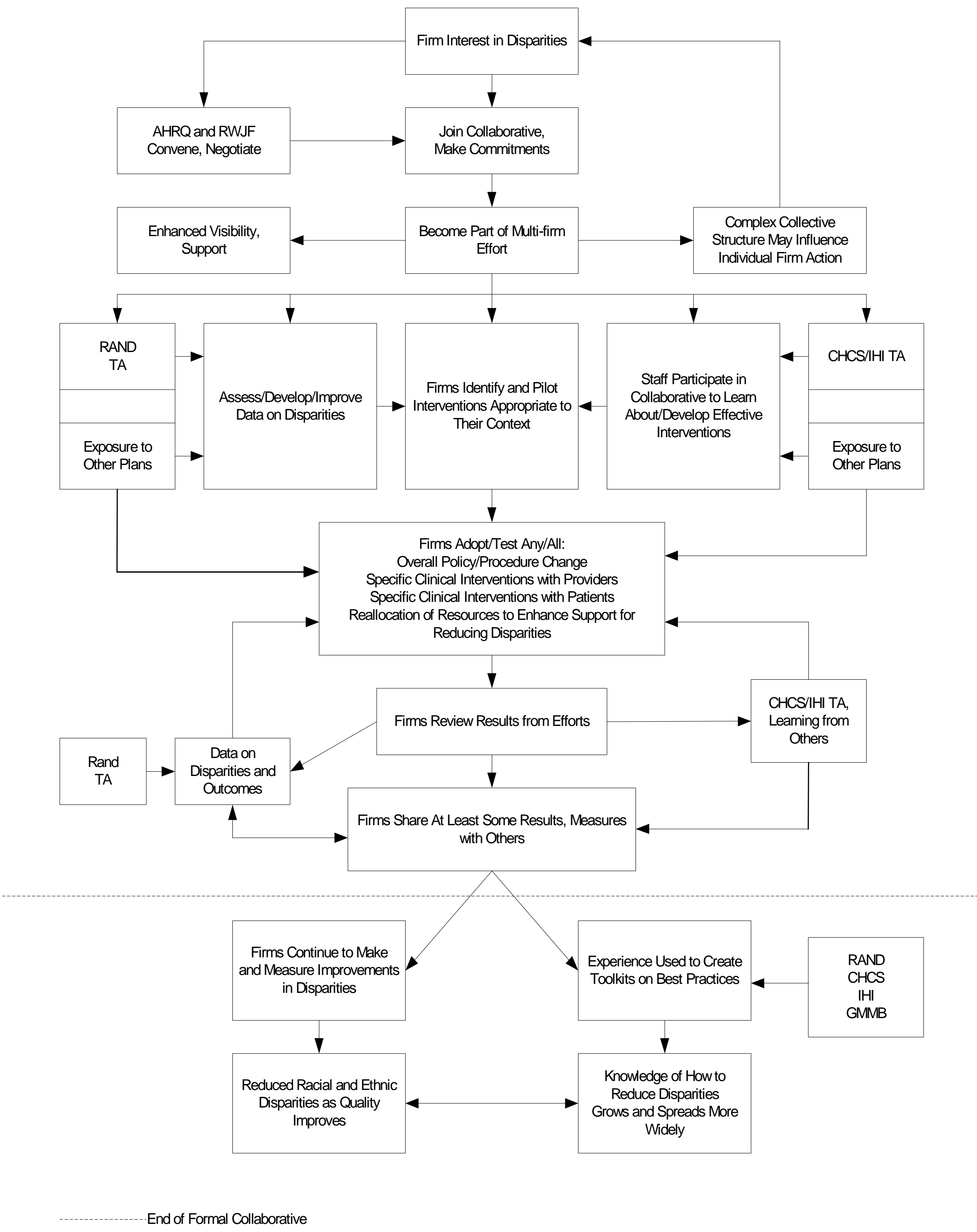
The evaluation builds on a framework that highlights the various ways in which the Collaborative could contribute to significant progress in addressing racial and ethnic disparities (Figure I.1). The framework highlights steps that health plans can take to reduce racial and ethnic disparities, and ways in which the Collaborative may contribute to plans' success.

The evaluation framework helps conceptualize the Collaborative and identify short-term indicators of progress that can help all stakeholders to assess the potential merits of the Collaborative and its contributions. Such short-term indicators of progress include, for example, participating firms' continued commitment of resources to reducing disparities, progress in developing improved data on disparities, the ability to identify and take action on evidence-based interventions, and what firms report (and we observe) as the added contribution of the Collaborative to their efforts to address disparities. Additional spillover effects could include stronger organizational support for the Collaborative by work that shares each others' knowledge across organizations, generic lessons for capturing data by race or ethnicity, stronger networks across organizations involving individuals who share similar functional responsibilities, and expanded knowledge of AHRQ's research by those in the field who can translate it into practice.

The evaluation was originally tasked with measuring, among other things, the Collaborative's ability to reduce racial and ethnic disparities.[2] As noted previously however, our initial review of the Collaborative at the start of the evaluation indicated that this was not a realistic goal, and AHRQ concurred with this assessment. Addressing racial and ethnic disparities is a major undertaking whose success depends on much more than just the actions of participating firms and whose execution, even among Collaborative participants, will require considerable time beyond the life of the Collaborative. The evaluation therefore focused on operationally feasible, mid-term outcomes that firms can reasonably control. In

[2] Specifically, the third of six areas of interest AHRQ defined for the evaluation asked the evaluator to "measure and assess whether the Collaborative has reduced or eliminated targeted health care disparities experienced by minorities in health plans participating in the Collaborative." We concluded, and AHRQ (and other sponsors and support organizations) agreed that this was unrealistic within the time frame of the Collaborative. The reframed evaluation questions eliminated this area of interest, and took into account AHRQ's desire to avoid burdening participating firms with additional requests for data (Gold et al. 2005).

Figure I.1. Simplified Logic Model for Learning Collaborative to Reduce Disparities



particular, we sought to understand what the Collaborative did to help firms (1) enhance efforts by firm leadership or others to pursue work in the area of disparities; (2) collect data or use geocoding/surname analysis to improve their ability to measure disparities or monitor the effects of pilot interventions to reduce disparities; (3) develop and test pilot interventions dealing with patients, providers, or the community to reduce disparities; and (4) communicate the outcomes to others outside the Collaborative.

The evaluation began in June 2005 and covered the period though the end of the original Collaborative (September 30, 2006). Both budgetary constraints and agency preferences resulted in an evaluation with little primary data collection. Instead, we acquired Collaborative documents and sat as a silent observer of the Collaborative's telephone calls and meetings. We also conducted three rounds of interviews with the lead staff of participating sponsor and support organizations and a broader set of staff from among the nine firms. At the start of the evaluation in summer 2005, we interviewed the lead staff from each participating organization (round one interviews) and reviewed documents in order to prepare a summary of the Collaborative's history and plan for the evaluation (Gold et al. 2005). Rounds two and three of the interviews were more extensive and focused on diverse staff from participating firms.[3] The second round, the most extensive of the three, was completed between December 2005 and February 2006. We also asked all participants to complete a formatted "network feedback solicitation" to support AHRQ's interest in a formal network analysis of the Collaborative (described further in Appendix C). The third round took place from August to September 2006.

Table I.1 summarizes the data collection plan and topics we sought to address in each round of the interviews. (Readers seeking more detail on the full evaluation design should see Gold et al. October 26, 2006.)

B. PURPOSES OF THIS REPORT AND DATA SOURCES USED

This report provides AHRQ and other Collaborative participants with feedback on the Collaborative including what it was, what participants did, and what was accomplished. Building on the framework described above, we consider the Collaborative's work in four areas:

- Contributions to the firms' efforts to address disparities,
- How it helped firms collect and analyze disparities (especially the value of geocoding and surname analysis),
- What pilot and other interventions were tested during the Collaborative, and

[3] Firms generally found our multiple requests for interviews burdensome (especially in round 2, when we requested substantially more interviews). Firms often did not distinguish between requests from the evaluation team and those of the support organizations. They cooperated but asked for fewer demands in the final round of interviews. Their concerns ultimately also will influence the shape of the Phase II evaluations.

Table I.1. Data Collection Plan

Type of Data	Persons to be Interviewed	Time Frame
Firm Interviews		
Initial Firm Contact and Background	Lead firm contact	August 2005
Organizational Structure vis-à-vis Collaborative	Lead firm contact	December 2005-February 2006
Collaborative Goals	CEO and other key executives	December 2005-February 2006
Views on Disparities Across Units of the Firm	Key department heads	December 2005-February 2006
Experience with Geocoding	Lead firm contact, quality improvement head, geocoding data contact	December 2005-February 2006
Localized Pilot Intervention (Including Module on Data for this Intervention)	Lead firm contact, local point persons (local plans)	August – October 2006
Collaborative's Contribution to Quality Improvement	Pilot staff, lead contact	August – October 2006
Collaborative's Influence on Corporate Commitment to Disparities	Lead firm contact, executive most closely associated with Collaborative	August – October 2006
Communications Objectives	Communications staff from each firm	August – October 2006
Overall Assessment of the Collaborative	Lead firm contact, executive most closely associated with Collaborative	August – October 2006
Interview Modules for Other Organizations (non-Firms) in Collaborative		
Support Organization Feedback	Support organizations (RAND, CHCS, and IHI)	July 2005, April 2006, fall 2006
Sponsor Organization Feedback	Sponsor organizations (AHRQ and RWJF)	July 2005, Fall 2006
Communications Objectives	GMMB, sponsor organizations, and support organizations	August – October 2006
Other Tools*		
Network Analysis Feedback Form	Firms, sponsor organizations, and support organizations	December 2005-February 2006
Disparities Data Worksheet	Firms (appropriate person to be determined by lead firm contact)	Planned for December 2005 but later dropped

*We originally planned to field a second round of the network analysis feedback form in summer 2006. This was dropped after firms expressed concern about the burden of time required to respond to requests from the organizations supporting the Collaborative. The evaluation also originally included a request to develop a survey form AHRQ could use a year after the Collaborative ended to assess the sustainability of the Collaborative, which was dropped because the Collaborative continued and because of the difficulty in capturing progress through a closed-ended instrument.

- How communications were used to support the Collaborative's goals.

This final report builds on the interim report, which covered initial findings in the first two areas listed. This final report updates, where relevant, the interim report and includes more detail on the pilot interventions and communication goals (as these activities were just starting at the time of our round two interviews). The report also provides a comprehensive analysis of the overall contribution of the Collaborative and the lessons for AHRQ.

The data sources used for the evaluation were developed by balancing evaluation needs with Collaborative firms' willingness to respond to questions or requests. Firms participating in the Collaborative did so voluntarily and their efforts were self-supported; they did not receive grants or other funding for participating. From their perspective, the Collaborative's demands needed to be consistent with each organization's own goals and particularly the competitive marketplace in which they operated. They saw benefits to collaboration, as discussed later, but were less convinced there were benefits to be gained from a substantial investment by their firms' staff in responding to data collection requests. However, with one possible exception, all of the firms participating in the Collaborative gave generously of their time and staff resources to support this evaluation. Additional detail on interviews is included in Appendix A.

C. Content of the Final Report

This final report of the evaluation covers the following areas of interest:

- A summary description of the Collaborative that builds on and updates the descriptions in the Interim and October 2005 reports (Chapter II).

- An analysis of firms' rationales for participating, including how they view disparities and whether the staff assigned to work with the Collaborative and other related structures appear to occupy an appropriate organizational locus from which to influence the organization's work on disparities (Chapter III).

- An analysis of and update on the status of disparities data collection, particularly for the commercial population within the nine participating firms, the potential contributions of the geocoding and surname work involving RAND and many of the participating firms, and the experience with common measures (Chapter IV).

- An analysis of the status of activities/interventions carried out by the firms to address racial and ethnic disparities among their members, as well as an examination of results available and any known implications for the firms' future work (Chapter V).

- An analysis of how communications were used to support Collaborative goals, including the experiences and perspectives of firm staff working with GMMB to address these issues (Chapter VI).

- The final report concludes (Chapters VII and VIII) with an examination of participants' perspectives on the Collaborative as a whole, as well as our analysis of the overall contribution of the Collaborative and lessons for AHRQ.

- The Appendix C documents what we found in our network analysis about how the Collaborative works and is viewed by participants (as reported in the interim report).

We mask the identity of firms in the report, as it bears on what firms told us in interviews or reported on the network feedback form. However, we identify firms by name in a few cases where the information is generally known to Collaborative participants or more broadly.

CHAPTER II

DESCRIPTION OF THE COLLABORATIVE

This chapter describes the organizations sponsoring, supporting, or participating in the Collaborative, what they said (in round one) about their initial motivation to participate, the structure and content of the Collaborative's work and future plans, and issues that bear on judging the Collaborative's success. Readers seeking more insight into the origins of the Collaborative will find a review of its historical development in Appendix B.

A. ORGANIZATIONS PARTICIPATING IN THE COLLABORATIVE

AHRQ and RWJF cosponsored the Collaborative. AHRQ was the overall convener and contracted with RAND to conduct an initial needs assessment and to work with the participating firms to obtain and analyze racial and ethnic data. RWJF contracted with and paid the supporting organizations that provided guidance to the participating firms. CHCS was the central support organization responsible for organizing the Collaborative process and meetings, and for collecting firms' quarterly update reports (although firms' response to this reporting requirement remains incomplete). CHCS was also the main repository of the documentation on the work undertaken by the Collaborative. Under subcontract to CHCS, IHI provided a limited amount of support to the leadership team (i.e., the sponsors and organizations providing support to the Collaborative) of the Collaborative as well as advice based on its extensive work in provider-based quality improvement. In July 2005, RWJF entered into a contract with GMMB to support the Collaborative's communications objectives. Although RAND's work was initially viewed as distinct from that of the support organizations, CHCS, RAND, and IHI staff worked together to support the participating firms.

The Collaborative originally comprised 10 firms, but two—Anthem and WellPoint—merged during the first year of the Collaborative, leaving nine firms. Five of these nine are large national firms that operate health plans in many regions: Aetna, Cigna, Kaiser Permanente, United Healthcare, and WellPoint; Kaiser Permanente is unique because it is built on integrated delivery systems. Four are regional firms: Harvard Pilgrim Healthcare of Massachusetts, HealthPartners of Minnesota, Highmark Blue Cross-Blue Shield

Table II.1. Overview of Firms Involved in the Collaborative

Participating Firms	Scale and Location	Primary Products
	National Firms	
Aetna	Over 13 million covered lives that are served by 6 regions.	Primarily commercial; mix of HMOs and PPOs; serves large national accounts, among others, and has some Medicare business.
Cigna	Approximately 13 million covered lives in at least 42 states and DC.	Primarily commercial; mix of HMO and PPO products; serves large national accounts, among others.
Kaiser Permanente	Approximately 8.5 million covered lives, served mainly through integrated care system in 8 regions.	Primarily commercial with HMO products; Medicare products, particularly for those "aging in."
United Healthcare	Over 18 million covered lives; operates through related businesses for the commercial market (United Healthcare), Seniors (Ovations), Medicaid (Americhoice), and others.	Primarily commercial, although the firm offers a mix of products that address Medicare, Medicaid, and other market sectors. Recent merger with PacifiCare has enlarged its role in Medicare.
WellPoint	Approximately 28 million covered lives after the recent merger with Anthem. Affiliated with Blue Cross-Blue Shield (BC-BS) and offers products in 13 states.	Primarily commercial through a range of HMO, PPO, and other products. Also serves Medicare and Medicaid.
	Regional Firms	
Harvard Pilgrim Healthcare	About 900,000 covered lives in nonprofit health plan based in Massachusetts, Maine, and New Hampshire.	Primarily commercial with range of HMO, PPO, and other products, and some Medicare business.
HealthPartners	Over 630,000 covered lives in nonprofit health plan serving Minnesota and western Wisconsin. Has a staff model HMO affiliate (Group Health).	Primarily commercial in a variety of HMO, PPO products, and some Medicare business.
Highmark Inc.	Over 4.1 million covered lives in an independent, nonprofit BC-BS licensed plan serving western and central Pennsylvania.	Primarily commercial with some Medicare supplemental products (is affiliated with a Medicaid plan).
Molina Healthcare	Over 500,000 covered lives in 6 states in the west and north central United States. Headquartered in California. Includes a staff model unit.	Medicaid, SCHIP, and related programs.

Source: MPR summary based on publicly available information, 2005.

HMO = Health Maintenance Organization

PPO = Preferred Provider Organization

SCHIP = State Children's Health Insurance Program

Organization in Pennsylvania, and Molina Healthcare, Inc., headquartered in California. With the exception of Molina, whose business is largely in Medicaid, these commercial firms offer a variety of products geared to groups and individuals. Many also participate in Medicare. Table II.1 summarizes the key characteristics of each firm.

B. Collaborative Structure

The Collaborative was structured in ways consistent with many such collaboratives. Over the period of a year, the Collaborative was to meet in person three times in a general meeting. These collaborative meetings occurred over a 21-month period: on September 10, 2004; March 17 and 18, 2005; and June 20 to 21, 2006. In addition, the Collaborative held a final in-person meeting on NHPC key principals in Chicago on September 15, 2006, to determine the focus of Phase II. Table II.2 shows the activities and timeline for the Collaborative.

Two main support organizations received contracts to support the Collaborative's activities (RAND and CHCS). We summarize the way the main support organization contracts were structured, the commitments sponsors perceived the firms to have made to the Collaborative, the support provided by the Collaborative for collecting racial and ethnic data and developing pilot interventions, and the structure of support and plans for disseminating and communicating results.

1. Support Organization Contracts

RAND received two rounds of funding from AHRQ to support the Collaborative. The first contract was awarded on November 30, 2003, for assistance to begin in 2004. A second contract was awarded in spring 2005. Each contract totaled $200,000 to $225,000 and, although each was intended for a one-year period, they appear to have been extended to match the Collaborative's flow of work.

The scope of work for the first year's contract called for RAND to (1) recruit participants and convene the first meeting of the Collaborative; (2) interview participants to assess their capacity, readiness, and interest in working on disparities data (building on earlier interviews for the California Endowment); and (3) adapt the tool developed by RAND with United Healthcare as part of AHRQ's Integrated Delivery System Research Network (IDSRN) to help firms start measuring disparities. The document RAND prepared to support the award envisioned that baseline measures of disparities for at least some of the plans would be available during the first year and that AHRQ would fund additional tool development and pilot projects. To facilitate progress, RAND's work was to be complemented by a separately contracted "learning organization" expert. Interventions would not be tested until after the first year.

RWJF's contract with CHCS involved two years of funding (from September 1, 2004, through August 31, 2006), for a total of about $500,000, a portion of which was allocated to support from IHI. CHCS's project proposal envisioned a mix of participants, including

Table II.2. Timeline for Major Activities of Phase I of the Collaborative

Collaborative Activities July 2003 – December 2006	
Meeting at AHRQ (with the California Endowment) to discuss moving forward with a collaborative to address disparities. AHRQ and RWJF decide to cosponsor the Collaborative.	July 2003
AHRQ contracts with RAND for plans needs assessment and technical assistance.	November 2003 - January 2004
AHRQ and RWJF develop Memorandum of Understanding on Participation.	Summer 2003 - Spring 2004
RWJF contracts with CHCS (and through them, with IHI) to form the Learning Collaborative.	Spring 2004 (officially executed 8/2004)
Principals meet to review plans for first meeting of the Collaborative.	July 8, 2004
CHCS/IHI and RAND call firms to discuss Collaborative and provide initial technical assistance.	August 2004
First meeting of the Collaborative (at AHRQ in Rockville, MD).	September 10, 2004
Second meeting of the Collaborative in Santa Monica, CA.	March 17 - 18, 2005
Senior leadership of Collaborative meets in Chicago, IL (O'Hare airport).	June 20, 2005
Full Collaborative conference call.	July 27, 2005
GMMB contracted to design communication plan for the Collaborative to learn about communication priorities of the initiative and coordinate messages so that they are consistent across the Collaborative.	August 2005
GMMB releases National Health Plan Collaborative communications toolkit.	December 2005
Full Collaborative conference call.	April 26, 2006
Third meeting of the Collaborative in Washington, DC.	June 20 - 21, 2006
Stakeholder roundtable briefing in Washington, DC.	June 22, 2006
Full Collaborative conference call.	August 2006
Final Meeting of the Collaborative in Chicago, IL.	September 15, 2006
Formal end of Phase I of the Collaborative.	September 2006
GMMB summary report of the Collaborative.	October 2006
Quality Summit on Reducing Disparities and Improving Quality (conducted as part of CHCS's ongoing work for RWJF).	December 2006

Note: Additional activities of the Collaborative include technical assistance calls between the learning organizations and firms, as well as periodic conference calls of the Operational Committee.

those serving Medicaid and commercial markets, and work that would build on CHCS's Best Clinical and Administrative Practices (BCAP) typology.[4] CHCS expected challenges in applying the models they had historically used for quality improvement in Medicaid plans to collaboratives involving firms based in the commercial market because (1) the fragmentation among purchasers in the marketplace made it challenging to harness their power in ways that allowed health plans to send a consistent and effective message to providers about the importance of quality improvement and disparities reduction; and (2) their multi-location and product organization made focusing the intervention more difficult. As CHCS expected, its approach to the Collaborative departed substantially from the BCAP-like models originally proposed because firms had different views of the Collaborative's mission and their own needs; some perceived a need for less focus on small-scale improvement than is traditionally the case in learning collaboratives.

2. Participant Commitments and Motivation

Each participating firm in the Collaborative had its own goals derived from its organizational context and priorities. In addition, many of the key actors had been involved in nationally focused work to address disparities (see Appendix B). Based on the round one interviews, we summarize their goals as follows.

Sponsors. For AHRQ, supporting the Collaborative was consistent with the agency's emerging emphasis on the use of research to drive quality improvements and the active involvement of users. AHRQ's history of work on disparities and its new responsibilities for the National Healthcare Disparities Report (NHDR) made the agency particularly interested in working with health plans in a visible way to address perceived needs. Although RWJF staff say that they view AHRQ as the dominant and driving partner in the Collaborative, they also note that co-sponsorship of the Collaborative served important internal needs. In particular, RWJF's new leaders had significant interest in disparities, and involvement in the Collaborative allowed them to move while internal plans for funding were still under development. In addition, staff perceived that the foundation could work more actively with health plans given their leverage over large populations.

National Firms. In our round one interviews in summer 2005, the national firms—Aetna, Cigna, Kaiser Permanente, United Healthcare, and WellPoint—were not explicit about their objectives for participating in the Collaborative. It appears that they were motivated by perceived needs, both internal and external. They indicated they were using the Collaborative for a mixture of purposes, including making changes in delivery and dealing with political concerns. By allowing firms to work together, the Collaborative could reduce the risks perceived in addressing issues related to disparities. Some firms also felt that if they did not participate, they risked falling further behind the rest of the industry.

[4] The BCAP initiative encourages plans to organize rapid-cycle quality improvement work around efforts to identify a target population, stratify by risk, reach out to members, and intervene, measuring results to provide formative feedback that can guide future interventions or refinements.

Negative perceptions resulting from failure to participate were a concern for some of the organizations that were industry leaders.

Our round one interviews with national firms suggested that their interests focused mostly on developing organizational commitments to improve data infrastructure for addressing concerns over disparities. Although they might ultimately improve the quality of local care, organizations seemed more interested in learning how to employ knowledge internally than sharing what they were doing with other organizations. Nor were they interested in taking small local steps to improve quality (by relying on the rapid-cycle techniques that are a traditional part of learning collaboratives).

Regional Firms. While regional firms' objectives did not necessarily differ from those of the national firms, the impetus for participation was more distinct. Participating regional firms were typically large, well-established organizations that wanted to use the Collaborative to expand in areas they were already pursuing. Two of the four regional firms were recruited through their ties to RAND staff. Compared with national firms, regional firms found pilot interventions more relevant, although they were constrained by limited resources and competing priorities. At least one looked to the Collaborative primarily for insight on how to capture disparities data for its members.

Support Organizations. The support organizations are contractors that receive payments for carrying out a specified scope of work. However, given that the organizations have earned high regard and face many competing demands, their involvement also reflects particular organizational and staff interests. RAND's interest in the Collaborative was a natural outgrowth of its staff's earlier work on racial and ethnic disparities; Dr. Nicole Lurie, who served in the Clinton Administration as a federal government appointee in the area of racial/ethnic disparities, used her contacts and experience to move the Collaborative forward. RAND staff were also experienced in using geocoding and surname analysis to examine racial and ethnic disparities through AHRQ's Integrated Delivery Systems Research Network (IDSRN), in which it participated as a subcontractor on the Center for Health Care Policy and Evaluation's team based at United Healthcare.

AHRQ and RWJF divided responsibilities, with RWJF responsible for arranging for a support contractor to coordinate and guide the Collaborative's efforts. Few organizations that are involved in guiding quality improvement collaboratives are experienced with health plan (versus provider) collaboratives. After considering a range of firms, RWJF selected CHCS because although it works primarily in the Medicaid area, it is perhaps the only learning organization with a history of work on health plan collaboratives. RWJF and CHCS also have a history of successfully working together. RWJF asked CHCS to involve IHI because the latter brought knowledge and recognized leadership in provider-based initiatives. A key staff member at AHRQ familiar with IHI's work with community health center-based collaboratives encouraged the organization's involvement. The lead staff from CHCS and IHI had worked together as senior staff at RWJF, which gave them a good basis for establishing a partnership. Under the contract, CHCS is responsible for most activity; IHI staff provide targeted, substantive support in selected areas. Firms participating in the

Collaborative may not necessarily distinguish between the support IHI and CHCS provide, because of the way the two work together.

3. Firms' Initial Commitments

From the Collaborative's inception, participating firms struggled to varying degrees with how open to be about their internal processes and concerns, whether to share data, and whether to commit to shared activities. In an effort to secure clear commitments, AHRQ discussed an agreement with firms in 2003 and again on July 8, 2004, when the major organizational stakeholders—the sponsors, support organizations, participating firms, and their affiliated trade associations—held a two-and-a-half hour conference call to agree on how to proceed. An important area of discussion involved the commitments firms were making to the Collaborative. The Memorandum of Participation Principles stated that:

- ***Improving overall quality and reducing disparities are important national and plan objectives.*** Participating plans will commit senior leadership to attend three Collaborative meetings and intervening calls to report on progress.

- ***Data are needed to assess performance and assess quality.*** Participating plans agree to obtain the necessary data to move forward, with technical support from RAND as required.

- ***Workgroup measurement will focus on one or more accepted evidence-based measure.*** Participating plans agree to the common measurement expectations they define for the Collaborative.

- ***The workgroup will balance efforts to achieve consistency of measurement with flexibility reflecting varied plan market conditions.***

- ***The workgroup will balance its efforts to share data, pilot designs, and results with requirements for maintaining privacy, confidentiality, and proprietary interest.***

Participants also agreed that disparities in diabetes can provide a starting place for mutual work and that they would build on existing measurement efforts and thus involve HEDIS measures. Firms were not asked to formally approve or sign the memorandum. The way the final two principles dealt with consistency versus flexibility and sharing versus proprietary interest suggest that some lack of consensus about what firms would do existed from the start.

4. Support Activities During Phase I of the Collaborative

In addition to structuring and leading formal meetings, learning organizations supported the Collaborative in Phase I by providing assistance to firms by telephone. Several rounds of such calls were completed. While CHCS originally hoped to group firms for joint assistance calls, it found that firms preferred communicating separately. The calls were

important for documenting activity, as firms provided only limited detail in their progress reports, which were often missing information or submitted late. To coordinate their support to the Collaborative, key staff from each support and sponsoring organization participated in periodic conference calls—termed operational workgroup meetings—convened by CHCS. Firms were supposed to submit quarterly progress reports to CHCS. Compliance was spotty and CHCS ultimately put less emphasis on this activity, asking firms instead to prepare slides and other tools for briefing others in the Collaborative about their progress. As highlighted in the framework, the Collaborative structure could help firms advance their ability to deal with issues of racial and ethnic disparities, support overall firm and leadership commitment to addressing racial/ethnic disparities, and help firms better measure and assess disparities and take action to address them. Ultimately, the Collaborative can generate learning about disparities that can be shared with those in the Collaborative and others.

Measuring Disparities. In the Collaborative's initial year, most firms' focused on developing insights into disparities within the firm. RAND provided support for geocoding and surname analysis of firm data on members with diabetes, thereby helping firms to generate estimates of racial and ethnic disparities.[5] RAND recognized that firms had limited internal data on the racial and ethnic composition of their membership and that data improvements would take time (see Chapter IV). To that end, RAND formed a workgroup that appears to include all firms except the two that were already getting needed data. The hope was that developing such data would reinforce firms' sense that disparities were a problem warranting attention. While there was less active support to firms in collecting their own racial and ethnic data, geocoding/surname analysis helped firms appreciate the value of such collection and spurred them to consider how primary data could be collected. The Collaborative set up sessions for firms to learn about member organizations' work—particularly, that of Aetna, whose decision to capture member data was an important impetus for the Collaborative, and HealthPartners, whose affiliated clinics actively collect racial and ethnic data from patients who seek care. Support organizations also requested firms to submit common measures based on HEDIS diabetes indicators; however, firms did not prioritize this effort and response was varied (see Chapter IV).

Intervening to Reduce Disparities. From the inception of the Collaborative, firms disagreed about how much effort should be spent in developing and testing specific pilot interventions to reduce disparities. The organizations brought in to support the Collaborative were experienced in this area—one of the two AHRQ senior staff guiding the Collaborative's development had experience working with community health centers, and was very interested in pilot interventions. Round one interviews revealed an uneven interest among firms in testing pilot interventions. Support organizations reported a "push back" from firms to following a traditional learning collaborative model, especially with respect to using tools developed by CHCS and IHI for Medicaid plans or provider groups. Firms wanted to pursue strategies that made the most sense to them. Some perceived small scale

[5] RAND uses the term "surname" to refer to their use of enrollees' last names to identify those of Hispanic or Asian ethnicity.

pilots too narrow an approach, unnecessary given their existing investments in quality improvement, or inappropriate to the extent they had a provider emphasis if they perceived their health plan's strength favored member-based interventions. CHCS responded by clarifying that pilot interventions included a variety of activities: data collection/refinement, provider- and member-directed strategies, community-based strategies, and work on organizational assessment and capacity building. At the first group meeting, plans presented details of their existing initiatives. Many indicated that future intervention would follow the results from geocoding and other data analysis, an approach consistent with RAND's original concept that interventions would begin in Year 2.

In the second year of the Collaborative, firms further developed their interventions, some of which were new, while others built on existing activity (see Chapter V). As complex organizations with several ongoing activities, firms did not distinguish Collaborative-specific activity from other firm work.[6] Because many of the activities and interventions were not initiated until late in the Collaborative, most are ongoing, and there is limited information thus far on their impact. Firms said that these activities would, for the most part, continue after the formal end of Phase I of the Collaborative.

Building Communication and Dissemination Infrastructure. Although communications was not a part of the initial Collaborative infrastructure, the need to disseminate information about the Collaborative and what it was learning was always an important goal. To support that goal, RWJF entered into an 18-month, $160,000 contract with GMMB in summer 2005. The contract called for GMMB to coordinate all public communications related to the Collaborative. Since then, GMMB developed relationships with the communications staff at each firm, developed a logo and other material to create an identity for the Collaborative, and hosted the National Health Plan Collaborative Roundtable Briefing to publicize the work of the Collaborative (see Chapter VI). Currently, GMMB is drafting a Phase I report on NHPC activities, which will include a "call to action." While it is likely that communications will have a more substantial role in Phase II of the Collaborative, to date, RWJF has not yet decided exactly how that function will be handled and where the focus will lie.

C. CONTEXT FOR JUDGING THE SUCCESS OF THE COLLABORATIVE

The Collaborative involved nine diverse firms whose interests and operational styles needed to be coordinated. Because the Collaborative's model of engagement was new to many participants, the tools for structuring the Collaborative had to be developed. In view of participants' varied interests, support organizations found that they had to modify their proposed strategies substantially. A key point of contention involved whether to emphasize broad-based efforts to build national and firm infrastructure for improved measurement of disparities or specific interventions designed to reduce such disparities and, if so, on what

[6] For example, firms that have addressed quality assurance may have many ongoing initiatives. Their approach to disparities could involve building on these efforts to enhance their effectiveness in dealing with disparities.

scale. Because of participants' varying views on this subject, the goals of the Collaborative were not necessarily well defined or interpreted the same way by all participants.

In today's environment, firms face a wide range of competing demands—for example, two firms in this study were involved in a merger, and another two were dealing with recent and severe financial stress. Leadership changes are common, and the market continues to pose challenges for all firms. In our interviews, we typically heard that work on disparities was a high priority for quality improvement, but that each firm's ability to proceed depended on a range of considerations and market demands.

Initial interviews with senior leaders at AHRQ and RWJF revealed that both organizations were aware that participating firms cannot always influence care delivery directly, although they are responsible for millions of covered lives. Sponsor interviewees saw value in the Collaborative's ability to influence such organizations to make disparities a more legitimate focus of quality improvement work, to understand the value of relying on information to measure disparities, and to motivate "silo" components of firms to talk with one another. That is, the Collaborative's scale means that even small effects may be influential in enhancing work to address disparities in ways that will potentially affect many people.

CHAPTER III

FIRM PERSPECTIVES ON DISPARITIES AND COMMITMENT TO THE COLLABORATIVE

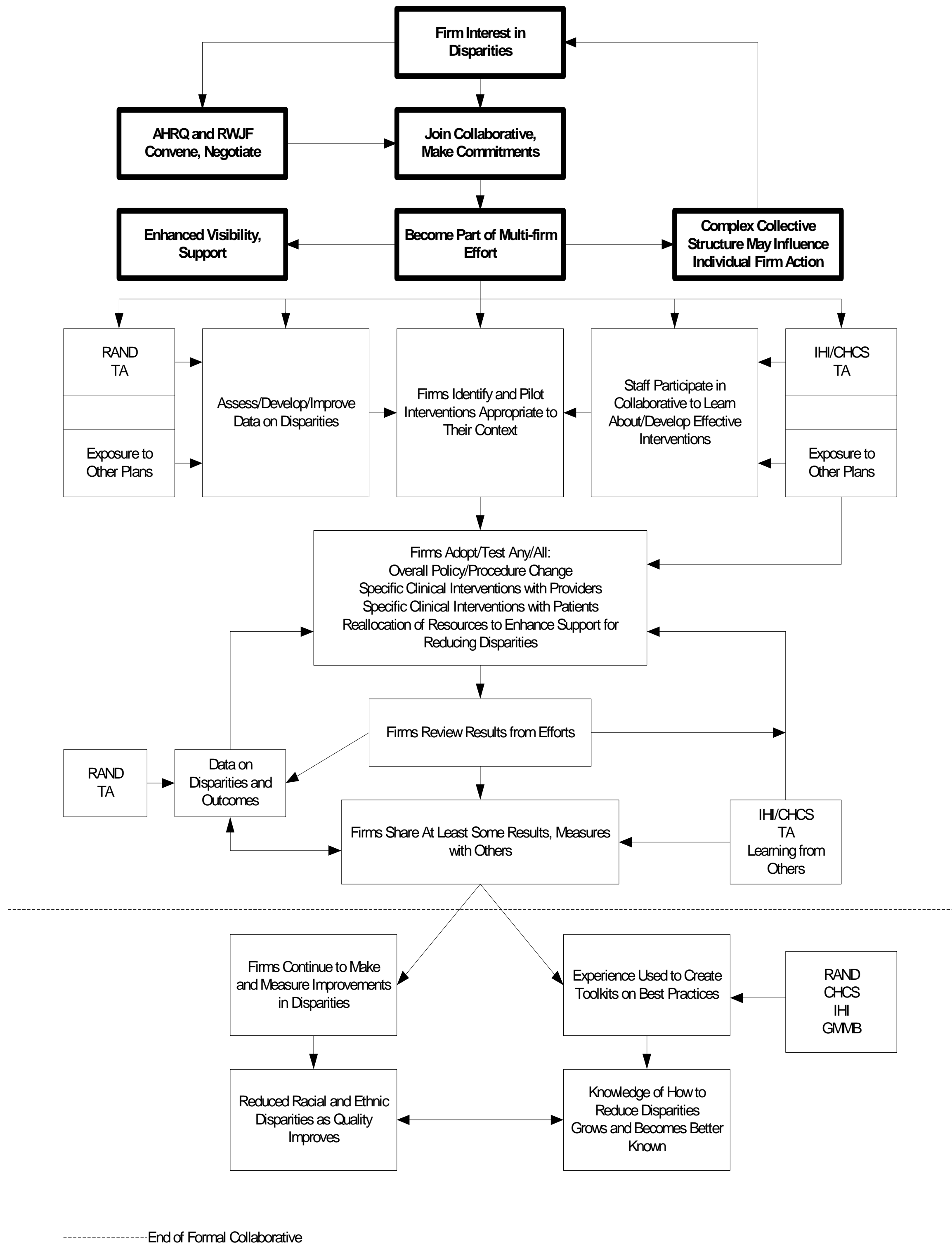
This chapter describes the relationship between the Collaborative and participating firms' commitment to the issue of racial and ethnic disparities—one of the four main outcomes of interest to this evaluation. The conceptual framework views gaining and enhancing such commitments as a critical first step in collaboration. (See top boxes in Figure III.1.) For the most part, the findings in this chapter are based on what firm staff reported in the second round of interviews. However, at the end of the chapter, we discuss how participating in the Collaborative influenced the firms' overall perspectives and focus on disparities.

A. OVERVIEW OF KEY FINDINGS

Firms said that they decided to participate in the Collaborative for a variety of reasons, including the national importance of racial/ethnic disparities, their interest in learning about the issue, their perception that collective action might be more efficient than individual action, and their ability to use participation to gain internal leverage or address more "mundane" organizational goals. The firms that participated in the Collaborative did so with the support of senior leadership. In fact, the senior leaders of each organization monitored the Collaborative's progress, which reflects the importance of the issue to the firm. In most firms, buy-in to the Collaborative or work on disparities appeared relatively concentrated among senior leaders. Because such leaders set the tone and agenda for an organization, this was by no means a trivial achievement. However, support from leaders did not necessarily mean that the buy-in carried over (at least during the study) to the many operational or geographical units within these complex organizations.

The Collaborative is not the only way in which the nine firms address disparities. Some had work that preceded the Collaborative; others said their participation put the issue more firmly on their radar screens. Firms with ongoing initiatives on disparities viewed the Collaborative through the lens of those pre-existing activities within the firm that defined the short-term organizational priority. Some firms said that the Collaborative was only one of many external efforts involving disparities.

Figure III.1. Simplified Logic Model for Learning Collaborative to Reduce Disparities: Commitment



Firms cautioned that their ability to invest in the Collaborative's activities was constrained by a variety of organizational considerations. The effort firms were willing to invest in part reflected the degree to which they viewed the Collaborative's focus as aligned with their own agenda and needs, and the degree to which they could balance work across competing objectives. For this reason, they urged that their organizational commitment should not be judged solely by the resources invested in the Collaborative.

The overall effect of the Collaborative on commitments to reducing disparities appears positive across all firms, although it is hard to quantify. Firms reported that rather than changing their perspectives on disparities, the Collaborative increased the visibility of the issue within the firm. However, in the case of a few firms with major organizational changes or strong competing commitments, it seems unlikely that these firms would have continued their work to reduce disparities had they not participated in the Collaborative. The fact that the firm would be judged externally (by the Collaborative) based on what they did enhanced the priority of action within each firm. The Collaborative was also viewed by many firms—especially those with the least prior focus on disparities—as enhancing the breadth of knowledge, interest, and commitment to work in this area across the firm. For the most part, such work was regarded as an integral part of quality improvement.

B. Why were Firms Participating?

The firms in the Collaborative became involved through a variety of routes (see Appendix B). Many of the national firms had been involved in earlier collective activities around disparities, thus making their participation in the Collaborative a natural next step. A few firms had established leadership positions in the field such that their involvement was inevitable and expected. Some became involved by circumstance—for example, a connection with one of the sponsors or support organizations.

While participants' histories and particular interests varied, our interviews point to five major reasons behind firm interest in the Collaborative (Table III.1). Typically, more than one reason drove firms' interest.

First, disparities are an important national issue. Hence, firms saw work in this area not only as "the right thing to do" but also an important business consideration to ensure that the products they offered addressed the increasingly diverse needs of the populations they sought to serve. Many firm leaders had been heavily involved in other national efforts to address disparities.

Second, working collaboratively rather than individually was viewed by firms as efficient both in communicating information and in gaining political support for shared objectives that require broad-based consensus—such as standardized methods of capturing race and ethnicity. Collective work also provided a certain amount of "cover," protecting firms concerned with adverse legal or other consequences associated with collecting data on the racial and ethnic characteristics of their members.

Table III.1. Five Most Important Reasons Cited by Firms for Participating in the Collaborative

1. Disparities are an Important National Issue and Business Need

   - With the country growing more diverse, disparities cannot be ignored, and firms need to be seen as addressing the needs of diverse populations
   - Working on disparities is the “right thing to do” and addresses community commitments

2. Enhanced Effectiveness by Collaboration

   - Efficient way to share expertise with others
   - Gain multi-stakeholder support for standardized national data reporting requirements related to race/ethnicity
   - Working together provides “cover” for firms from perceived risks in collecting racial/ethnic data

3. Knowledge Development to Support Action

   - Opportunity to learn from one another
   - Opportunity to assess firm’s efforts against others and align to emerging national practice
   - Want to understand size and drivers of disparities
   - Want to learn what works to reduce disparities
   - Want to understand how to collect data on racial/ethnic disparities

4. Participation Used to Gain Leverage for Making Disparities Important Internally

   - Hope to use the Collaborative to enhance high-level firm commitment to action and to prioritize reducing disparities within the firm
   - Internal staff champion was interested and pushed participation

5. More “Mundane” Considerations

   - AHRQ’s request would be hard to decline
   - Participation could enhance commitment to obligations associated with nonprofit status
   - Enhance reputation and further national aspirations through being part of a collaborative with national firms

Third, firms believed a Collaborative was a good way to find out more about disparities and how to measure and to reduce them. They also wanted to understand what others were doing and benchmark their own activities against emerging national practice.

Fourth, some firms or staff had internal goals that could be advanced by participating in the Collaborative. All of the firms in the Collaborative are complex organizations with competing interests. Senior executives with an interest in reducing disparities participated in the Collaborative in order to enhance firm commitment to and support for the issue. Sometimes, especially in smaller organizations, mid-level staff with a strong interest in the issue championed firm participation.

Fifth, more "mundane" considerations made participation attractive. Some firms perceived that they got involved because their participation was solicited by AHRQ, a request that was hard to decline. Participation could advance firm objectives—for example, create an image of the firm as a national player—or have the additional value of documenting work consistent with the firm's nonprofit status.

C. WHAT DID FIRMS HOPE TO ACHIEVE?

Interviewees from firms said that it is inappropriate to look at a firm's involvement in the Collaborative in isolation from its other ongoing work in disparities and elsewhere. While our analysis suggests that participation may have enhanced firms' commitment to addressing disparity issues, firms noted that the Collaborative's leaders should not assume that the Collaborative generated initial concern for the issue or was the only source of motivation. The participating firms were large companies that were involved in many collective activities, including work on disparities through their trade associations, quality alliances, and other coalitions.

Organizational context influenced firms' perceptions of what they hoped to gain from participation in the Collaborative. For example, firms that perceived themselves as already heavily invested in quality improvement might see fewer gains through learning from others or undertaking pilot interventions; for them, the Collaborative often made it easier to capture racial and ethnic data on members. A firm whose business was heavily based around racial/ethnic minorities perceived that it had more to share than learn, and was comfortable with that. There were several firms with existing internal initiatives to address disparities, and they perceived that following up on these priorities took precedence over new projects that might be spurred by the Collaborative.

The context of the Collaborative also influenced the resources firms could or wanted to make available to Collaborative activities. All of the firms involved in the Collaborative invested heavily in quality improvement and disease management, though their strategies varied, and some placed more emphasis on these areas of concern than others. In addressing disparities, they sought to build on these ongoing structures and strategies (as reflected in their approach to data collection and pilot interventions) rather than initiate new activities. In many instances, firms faced major organizational constraints on the resources available for participation in the Collaborative, particularly when dealing with challenges

such as mergers, emerging from bankruptcy, or multiyear efforts to reconfigure their entire information systems platform.

In sum, our interviews suggest that each firm participating in the Collaborative wanted to be involved in the meetings and communications with one another and perceived that doing so would have important benefits for it and its work on disparities. Beyond that, firms had their own agendas and priorities, all of which influenced their capacity to support the Collaborative's work and their interest in doing so with specific projects. These differences were apparent from the start of the Collaborative and were important in understanding firms' evolving responses to the requests of the Collaborative. The core principles stated by AHRQ in its Memorandum of Participation appeared more central to AHRQ staff than to the firms participating in the Collaborative. (None of the firms interviewed mentioned the principles explicitly when discussing their involvement in the Collaborative.) By agreeing to participate in the Collaborative, firms may have agreed to a limited statement of goals, but were more likely to feel that they were agreeing to work together to share information on disparities and use it in ways that would be valuable within their organizations.

D. How Was Firm Leadership in the Collaborative Positioned Within Each Organization?

Senior staff members led each firm's work within the Collaborative, reporting to senior managers in different locations at the top of each organization. Below, we review how firms positioned their linkages to the Collaborative and the implications for communications and reporting. We then discuss the implications of the leadership and communication structure for work on disparities throughout the firm. Some firms were more forthcoming about their internal operations than others. We avoid presenting details that would reveal aspects of internal operations that firms likely regard as sensitive and not publicly shared.

1. Organizational Location and Communication

In all cases, a firm's lead contact for the Collaborative was a high-level senior executive with direct access to senior firm leaders. Leaders varied across organizations; linkages to clinical leaders were more common than linkages to other leaders or the CEO. In addition, some lead contacts delegated day-to-day responsibility for work with the Collaborative to other staff in the organization. Such delegation appeared to increase in the second year of the Collaborative as firms took on more activity under pilot interventions.

Table III.2 describes some of the ways each firm structured its participation in the Collaborative. In four organizations, lead contacts reported to the medical leadership; in two other firms, lead contacts had dual reporting lines, involving both clinical leadership and health plan administration. In organizations where the lead reported to the CEO, the lead or CEO was a physician. In the one instance where the lead reported to an administrative executive in charge of marketing, the lead contact was selected because of extensive work with vulnerable populations; the lead receives support from a clinical staff member from

Table III.2. Selected Characteristics of How Firms Structured Staffing and Communication about the Collaborative

Firm[a]	Lead Contact and Organizational Role and Responsibilities	Delegation of Responsibilities	Reporting on Collaborative Progress	Organizational Mechanisms to Support Work on Disparities
Firm 1	Vice President who reported to Chief Medical Officer (CMO).	Lead was responsible for strategic guidance on policy and had a high-profile position that often involved public speaking.	Collaborative activity was reported to a leadership workgroup involving medical, data, and disease management leadership.	None, but recent reorganization brought disparities more clearly within the medical leadership of the organization.
Firm 2	Senior staffer who reported to Chief Executive Officer (CEO).	Supported by staff with firm-wide responsibilities for work related to Collaborative interests such as data collection, medical management, and communications.	As part of routine daily communication to CEO. Broader communications on the Collaborative appeared to occur as needed through firm-wide structures established to support the overall "enterprise initiative" in this area.	Firm Task Force on Racial and Ethnic Disparities was co-chaired by the CEO and Collaborative lead. External Advisory Board (preceded Collaborative's formation).
Firm 3	Vice President who reported to Executive Vice President and Chief Marketing Officer.	Lead coordinated closely with staff across firm.	Reported to the Taskforce monthly.	Cross-Cultural Care and Services Taskforce co-chaired by Collaborative lead and a physician, and charged with examining what is needed across the organization to reduce disparities.
Firm 4	Lead reported to the CMO and headed the clinical quality management area.	Lead worked with staff on geocoding analyses and developing interventions.	Lead reported to a person who was on the executive team for the organization that included key leaders and was the focus for day-to-day management.	None known.

Table III.2 *(continued)*

Firm[a]	Lead Contact and Organizational Role and Responsibilities	Delegation of Responsibilities	Reporting on Collaborative Progress	Organizational Mechanisms to Support Work on Disparities
Firm 5	Medical Director who reported to the CMO; served as interface between clinical and administrative side.	Lead coordinated closely with staff across firm.	CMO approved decisions relating to the Collaborative; selected other executives involved as appropriate. Senior executive leadership was briefed in hour-long time slots periodically as is the Quality Management Council and Clinical Quality Committee.	Disparities/class committee created under Quality Management Council. CEO charged senior managers to come up with a comprehensive plan on disparities reduction that could be presented to the Board of Directors by the end of 2006. (A report to be Board was approved in September 2006.)
Firm 6	Internal staff consultant responsible for external and internal work on quality improvement, reported to the VP for clinical quality programs and informally to medical and network leadership.	Task-specific teams met to work on specific areas (e.g., geocoding and HEDIS) and reported to the executive lead team.	Reported to the Medical Director team charged with overseeing the Collaborative. Information also shared with the executive lead team that meets 2-4 times per year and includes five key executives involved in medical affairs, quality, customer service, human resources, and information services.	One focus of firm's nonprofit foundation was reducing disparities.
Firm 7	Clinical Director reported to the firm's lead for care management and for community efforts.	Lead's position provided linkages to quality leadership and the focus for the broader social commitment of the organization.	Lead reported to two senior executives who report directly to the CEO.	Disparities workgroup of senior leaders from throughout the organization meets regularly. (Preceded the Collaborative.)
Firm 8	Senior Vice President who reported to the CEO.	Day-to-day responsibility delegated to the medical director of a large affiliated plan.	Lead was briefed periodically about the Collaborative. Lead, in turn, reported to the CEO and other executives. Lead also reported to the Board on cultural competency, which they viewed as part of the Collaborative.	Firm had several support mechanisms in place, including a cultural competency institute.

Table III.2 *(continued)*

Firm[a]	Lead Contact and Organizational Role and Responsibilities	Delegation of Responsibilities	Reporting on Collaborative Progress	Organizational Mechanisms to Support Work on Disparities
Firm 9	Field Medical Director who reported to the top two medical leaders in the company.	Lead's position was responsible for coordinating care management across the organization.	Routine reporting to both medical directors and said to be shared among top leadership.	None, but strong research arm (now disbanded) has historically created capacity for analyzing geocoded data and disparities.

[a]Firms are presented in a random order in the table.

within the organization. The differences in placement of liaisons to the Collaborative reflected internal characteristics of how different firms worked and did not appear to have hindered external efforts at collaboration, especially when all firms' liaisons had stature, seniority, and access to top leadership.

The work of the Collaborative appears to have been well communicated within the top leadership circle. All firms in the Collaborative kept at least some of this circle informed about the Collaborative, and some did so for a wider group. Leads regularly briefed the person(s) they report to about the Collaborative, and the latter seemed to sign off on key decisions. The leads reported to staff who often reported directly to the CEO and sat on major executive committees of the organization. In some firms, the Collaborative lead periodically briefed the executive leadership on the initiative, sometimes at length. Three firms had established ongoing organization-wide taskforces or groups to support their disparities work, at least two of which formed before the Collaborative; lead staff from the Collaborative were actively involved in such taskforces. In each of the other firms (and perhaps these three as well), the degree of reporting on the Collaborative varied with the relevance of the Collaborative to other activities underway in the organization. Communication was broader in firms where the Collaborative was directly helping to drive the agenda than in firms where it was not being used that way (perhaps because the organization was already moving in a given direction to address disparities at the time the Collaborative was formed). A few firms seemed to have more limited communication on the Collaborative with senior leadership because the work of the Collaborative did not closely match perceived leadership needs. In these cases, disparities might still be important, but not in a way that the Collaborative could or would address.

2. Organizational Complexity and the Implications for Communication

It appears that a relatively small circle of individuals from all or at least most firms knew about the Collaborative, although a broader set of people may be included in a firm's disparities work. Those involved in the Collaborative are high-level managers who helped drive organizational priorities. Thus, their participation in and support of the Collaborative were likely to influence firm behavior. However, broader communication and support for

strategies that addressed disparities were necessary if firms were to eliminate racial/ethnic disparities. Several reasons probably explained why knowledge of the Collaborative might not be more diffused throughout the firms.

First, the firms are large, and it takes time to share information and develop buy-in across the organization. It was notable that the Collaborative—or at least the issue of disparities—was on the radar screen of at least some of the top leaders of participating firms.

Second (and as discussed later in this chapter), clinical interests defined the focus of early work of the Collaborative and thus these leaders were more aware of the Collaborative. The business sides of the organization—finance, marketing—have interests in the issue of disparities but frame the issue differently or do not place the same priority on this work without a push from senior leaders. Firms that had been involved most extensively in addressing disparities created cross-organizational structures to engage diverse components of the organization in supporting work to resolve disparities.

Third, the least centralized firms had a harder time implementing change. At least two of the national firms, for example, were heavily decentralized in assigning responsibility for care delivery and decision-making. Despite national firm leadership's encouragement of consistent national strategies, tensions between national and regional interests and priorities remained. Thus, even if both central and regional leaders agreed that disparities were an issue, each level may have had its own perspective on the primary actions to take; moreover, communications between central and regional efforts (or across regions) may have been incomplete. Thus, one firm moved much more slowly and cautiously in developing interventions than its national leadership might have wished, while another concentrated most of its early work in a state within one of its three core regions where support for such intervention was strongest.

The challenge of broad-based communication and buy-in was an issue for most firms, not just the largest or the least centralized. Most firms reported many steps between policy and execution. When firms took concrete steps toward implementation as part of the Collaborative—whether data collection, geocoding/surname analysis, or piloting interventions—additional staff were likely to become aware of the Collaborative. Nonetheless, given the scale of the firms in the Collaborative, such diffusion takes substantial time, and small-scale pilots were likely to touch only a small number of staff in the organization. The challenge, therefore, was to maintain the interest of senior leaders who set the tone and focus for an organization and to support a broader agenda that aimed not just to test change but also to introduce it across the organization.

E. What Were Firms' Perspectives on Disparities?

A focus on disparities took many forms within the participating firms. Indeed, the challenge for top leaders was to harness for mutual benefit the interest in disparities as conceived across the operational units of each firm. This section examines three ways in which disparities were relevant to firms; these emerged in our round two interviews.

1. Firms as Employers and Large Organizations

The nine firms participating in the Collaborative were large organizations employing many people. Both legal requirements and internal interests meant that the firms were becoming increasingly attuned to the diversity of their workforce. Each firm wanted to understand its workforce and make certain that firm policies were culturally appropriate. Several of the organizations employed diversity officers whose main interest was in workforce diversity. We interviewed some of these officers and found that they think about disparities largely from the perspective of human resources, with little or no involvement in the organization's care delivery or quality improvement functions.

A few firms built on their role as an employer to support their interests in disparities and work with the Collaborative. Given that firms purchased health care for their employees, they were positioned (albeit not without challenges) to capture self-reported employee race and ethnicity data. As employers, the firms also stood to benefit from improved health outcomes resulting from interventions intended to reduce disparities. Firms also stood to generate good will by providing culturally appropriate care. Thus, the firms' role as purchaser with a large workforce provided an opportunity for some to target initial work on disparities within a subset of the commercial population—firm workers and dependents covered by the health plan.

Firms also viewed reducing disparities as an important part of their role in working within the community or broader environment. For example, one large firm was proud of its work in supporting nursing scholarships and a leadership academy to further diversity in the workforce. A regional firm emphasized its CEO's involvement with other influential business and political leaders in a coalition pushing for coordinated regional economic development that could reduce the area's socioeconomic disparities. Another proudly cited its effort with community colleges in 17 states to raise certification rates for bilingual students seeking medical careers. Several participants in the Collaborative noted that their internally funded foundations—while typically not involved in the Collaborative—supported broad-based community-focused efforts relevant to the issue of disparities. In at least one case, the firm aimed to link its member-focused strategy for diabetes to community-based interventions targeting these broader goals through work in local pharmacies.

2. Disparities and Firms' Quality Improvement Agendas

The round two interviews showed that interest in disparities was linked more closely to quality improvement than to any other firm function and disparity initiatives tended to fall under the purview of the organization's clinical leadership.

Each of the firms in the Collaborative saw quality improvement and reducing disparities as related, but differed in how they conceptualized the relationship. In their comments on this issue, some firms seemed to describe tension between the two concepts, noting that disparities, especially in health care outcomes (but also in health care processes), were influenced by a far broader variety of factors than firms could influence—for example, socioeconomic status and environmental health behaviors. In fact, some firms were

Table III.3. Selected Firm Perspectives on the Relationship between Quality Improvement and Disparities

Disparities as Culturally Appropriate Care

- Quality and reducing disparities go hand in hand. For example, there is no way to do disease management without addressing culture and language.

- As one firm noted, disparities reduction and quality work are integrally intertwined. The better one knows one's members, the better one can serve them. Hence, while in the past a firm may have assumed "a rising tide raises all boats," there is growing recognition that providers need to be more sensitive to racial and ethnic issues if they are to address the needs of their members.

- Quality can be measured in many ways. Disparities are just another way of looking at quality. There is no single lens that is best. Another firm expressed what seems to be the same view by noting that any market has many segments that must be understood—programs must be tailored to minorities, occupational groups, military members, and others with specific needs.

A Focus on the Distribution (Versus the Mean) in Quality Improvement

- Working on disparities is an important way to improve overall HEDIS performance, complementing overall improvements with targeted improvements on subgroups of the enrollment where the system currently performed less well; this has the potential to raise the overall scores of the organization and its position as a quality leader.

- Disparities are part of overall quality improvement. The issue is not so much reducing disparities as raising overall quality, which in turn means improving care where it is worst.

concerned that efforts to address disparities would leave them overly accountable for outcomes beyond their control. When we asked senior leaders to comment on the relationship between reducing disparities and improving quality, their responses suggested that there were at least two views of how disparities relate to the quality agenda (see Table III.3).

One view held that reducing disparities translated into high-quality care through concern with providing culturally appropriate care. Such a definition led to an interest in training providers, making interpreters available, and implementing other initiatives that enhance care systems' ability to meet user needs. A related view was that disparities are an example of a more general need for market segmentation to identify variables that differentiate people so that each group's needs can be met.

These views can be distinguished from another view that focused less on variables that differentiate people's characteristics and more on means to address the distribution of outcomes in improving quality. From this perspective, raising average quality was critical; the disparities in outcomes were less relevant than the fact that some outcomes are

unacceptably low, regardless of the amount of disparity. Those with this view were probably more comfortable with quality improvement initiatives targeting areas of low performance than with race- or ethnicity-focused initiatives. Firms that appear to put more emphasis on quality improvement in positioning their products and plans were more likely than their counterparts to hold such a view.

We think that there is a link between a firm's view of disparities and the strategies they pursued to address them—including, for example, a focus on clinical versus social factors, the importance firms attached to capturing race/ethnicity data on all their members, and how they allocated their investments in quality improvement.

3. Disparities as an Opportunity or Threat to Marketing

Most firms explicitly stated that they wanted their membership to grow over time. Stagnant membership is almost always a problem because those who are continuously enrolled inevitably age and use more care. Unless a firm is able to attract new members, it may experience adverse selection and/or find its products priced out of the market. In addition, many firms viewed growth as an important business goal that could satisfy investors or reinforce other organizational goals.

Firms were particularly sensitive about reporting racial and ethnic information, particularly for African Americans, among whom a history of discrimination has led to high levels of distrust. Health plans often perceive that collecting racial or ethnic data before enrollment is illegal or will be viewed negatively by policymakers concerned that such data would lead to discrimination; our interviews uncovered evidence of this perception. In almost all cases, firms that did collect racial/ethnic information emphasized that it was voluntary. In approaching members for information, the firms sought to use sources that enrollees would regard as trustworthy and likely to use the information for the member's benefit. For example, firms tended to regard provider requests more favorably than plan administrative requests because patients might regard the former as more in their self-interest.

Yet, despite barriers to collecting racial and ethnic information, we found that marketing departments were very interested in using such data to enhance their success. Marketing staff used a different language from that of staff involved in quality improvement. Our interviews indicated that marketing staff saw their mission as member service. They viewed racial and ethnic subgroups as market segments to contact. They also indicated that membership was more likely to grow if they could show that interested members would know or be shown how to use health plans' systems. In the words of one marketing director, "'Ethnic marketing' is to marketing what disparities is to quality improvement." Firms that invested in addressing disparities said they did not do so for marketing purposes, but recognize that their investments allowed them to convey to purchasers their interest in

serving all the diverse members of their workforce.[7] They said employers were more interested in a firm's capacity to respond to employees in different languages, for example, than in the finer nuances of quality improvement. They felt these interests would grow in importance as the United States population became more diverse. At the same time, they also said that "rates, product, and network" were dominant in driving the employer market and that only the most progressive employers were directly concerned with the issue of disparities.

F. WHAT EFFECT DID THE COLLABORATIVE HAVE ON FIRM COMMITMENTS TO ADDRESSING DISPARITIES?

Because our evaluation began midway into the Collaborative, it is not possible to judge in full how firm perceptions changed over the course of the entire Collaborative. However, in our round three interviews, we asked firms' lead contacts and senior executives for their thoughts on this issue, and whether the Collaborative had any particular adverse effects on the commitment to reducing disparities. Eight of the nine firms participating in the Collaborative were part of this final round of interviews.

As lead contacts and other senior executives noted, their firms were aware before the Collaborative of disparities and the importance of addressing them. Yet the issue was more important to firms at the end of the Collaborative.

The shift was particularly striking in firms with the least emphasis on disparities before the Collaborative. One large national firm said that while its perspectives on disparities did not change, such perspectives were "more diffusely known throughout the organization," with staff aware that further quality improvement meant addressing disparities. Another firm, which integrated disparities into their disease management program after the start of the Collaborative, noted, "This is not 'side of the desk' stuff anymore. … It's incorporated into the way we do business and not a project or a pilot anymore." One firm that was already working on disparities said that its work would have gone a bit slower without the Collaborative. As another regional firm put it, "No one wants to be left behind." Even those that did not acknowledge any direct influence of the Collaborative described changes that seemed to derive from the work of the Collaborative—for example, starting to look within their minority populations at subgroups, taking steps to begin collecting primary data on members' race/ethnicity.)

As discussed further in Chapter VIII, firms typically expressed a desire for the Collaborative to continue beyond Phase I. Even though most felt that they would progress on their own, external collaboration reinforced these efforts and helped firms' efforts continue, despite the many competing priorities.

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[7] One firm used its work with minorities to build grassroots support among community and church leaders. Another firm told us that an RFP issued by the National Business Group on Health in early 2005 had a section asking it to address racial and ethnic disparities as part of the firm's bid. Another firm said that it had a purchaser with a diverse workforce and therefore viewed disparities as a high-priority issue.

CHAPTER IV

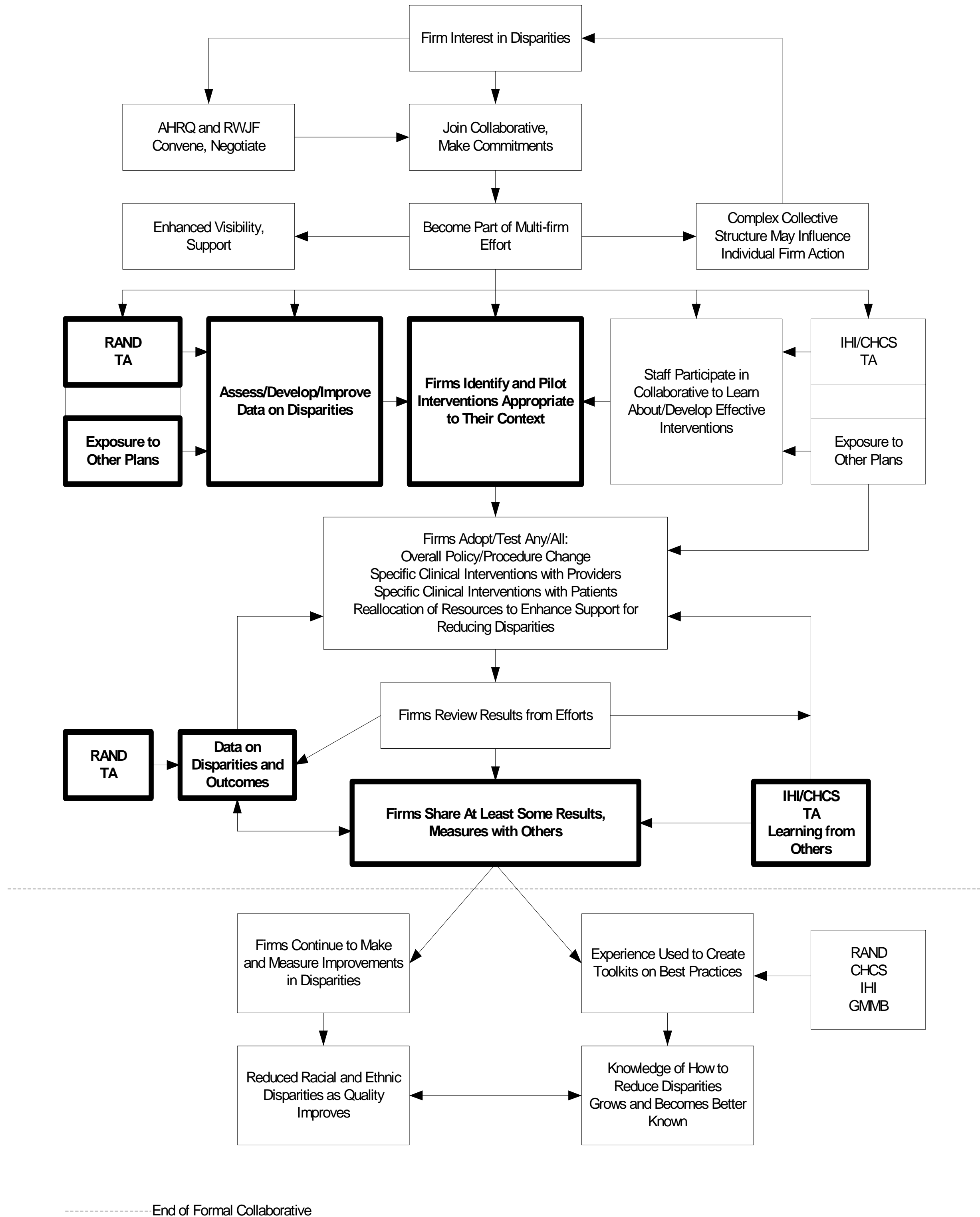
DATA TO SUPPORT WORK ON DISPARITIES

To reduce disparities, firms need to know what disparities exist and make changes in response. Of course, concepts become more complex in execution. Available firm data on the race and ethnicity of members are limited, making it difficult to measure member disparities in care processes and outcomes by race or ethnicity. In addition, several firms reported that important gaps exist in understanding disparities. For example, there is a limited evidence base to determine how best to improve care to reduce disparities in outcomes associated with members' racial or ethnic characteristics. There is little agreement on how best to measure effective reductions in disparities because absolute change in outcomes, and relative change in outcomes for one group versus another, may yield different conclusions. Faced with these constraints, there is a tension between taking the time to develop better measures and understanding of disparities and moving more immediately to implement interventions believed to have some promise in reducing disparities even if the evidence or ability to measure their effects is limited.

Measuring disparities was one of the four main areas the Collaborative sought to address (see Figure IV.1). A major focus of Phase I involved RAND working with firms to better estimate race and ethnicity for their members in order to assess disparities in diabetes care (using HEDIS indicators) and potentially other care. The results of this analysis helped inform firm leadership and in some cases formed the basis for intervention. Several firms saw weaknesses in what geocoding and surname analysis provided them; such limitations actually encouraged them to begin collecting their own data on the race and ethnic composition of their members. Few firms shared their HEDIS data on diabetes by race and ethnic subgroup with others.

This chapter provides an overview of findings. We review why capturing racial and ethnic data to measure disparities poses a challenge for firms. We discuss why geocoding and surname analysis were an initial focus of the Collaborative, and what these approaches did and did not accomplish. We then summarize, using the available information, firms' current status in collecting patient-level racial and ethnic data. We conclude with a discussion of the Collaborative's generally unsuccessful effort to motivate firms to report HEDIS measures on diabetic members to each other.

Figure IV.1. Simplified Logic Model for Learning Collaborative to Reduce Disparities: Measuring Disparities



Readers should note that Chapter IV focuses primarily on measuring disparities among firms' *commercial members,* the focus of the Collaborative.

A. SUMMARY OF FINDINGS

Gathering the necessary data to analyze disparities consumed much of Phase I of the Collaborative. Geocoding and surname analysis took much longer than anticipated and were controversial with sponsors for at least that reason, yet many firms found the results beneficial. Few firms had good data on the racial and ethnic characteristics of their members, but most assumed, because of national research, that disparities existed. The majority of firms involved in the effort at geocoding and surname analysis shared their results with firm leadership and said that the findings elevated the disparities issue within the firm. A few firms were disappointed in the results of geocoding and surname analysis because the technique was not sufficiently robust to provide insight relevant to patterns in their market. (A few also expressed disappointment that the geocoding/surname analysis yielded only proxy data that could not be used to target specific members for specific interventions.) Often, however, firms were able to use the results to some end. Although they were disappointed that the work took as long as it did, firms blamed themselves as much as RAND for delays, and perceived that on balance the process had a favorable benefit/cost ratio.

The Collaborative supported presentations of what leading firms were doing to collect race and ethnicity data directly from their members, but did not do more to directly support some firms' desire for assistance in modifying national policy to make it easier for them to obtain data on the race and ethnicity of their members. This omission was a point of contention among some participants in the Collaborative. Phase II will place more emphasis on primary data collection related to disparities, including efforts to define aspects of the way firms approach this to promote consistency.

The Collaborative did not succeed in getting all or most firms to share their data for common HEDIS measures. Such sharing was very important to sponsors and some support organizations, but firm buy-in appears to have been lacking from the beginning. The experience in the area of common measures highlights the challenges of communication and conflicting goals among participants in the Collaborative.

B. THE CHALLENGES IN CAPTURING RACIAL AND ETHNIC DATA

National policy on whether, how, and what to collect about the racial and ethnic characteristics of the population served by the health care system was still evolving over the period in which the Collaborative proceeded, a fact that shaped the opportunities and challenges faced by firms seeking such data (see Appendix B). Firms found it easier to capture racial and ethnic data for the Medicare and Medicaid populations than for their commercial members, because the Centers for Medicare and Medicaid Services (CMS) collected some of these data for Medicare beneficiaries and required states to provide them for Medicaid beneficiaries (Bierman, Lurie, Collins, and Eisenberg 2002; AHIP 2004). Firms sometimes maintained race and ethnicity data for particular subgroups of their commercial

members. For example, many firms in the Collaborative structured protocols for disease management programs so that such data were collected as part of a health risk appraisal. However, these data were not necessarily stored in ways that made them accessible across the firm.

Despite isolated efforts to secure direct data on the racial and ethnic composition of their membership, few, if any, national health plans had (or currently have) complete data on the racial and ethnic composition of all or even most of their members. Collecting racial and ethnic data requires both a process for obtaining information and a mechanism for maintaining and sharing the information across the organization.

Most commercial members enroll through employer groups. Some employer groups have racial and ethnic data on their employees and may be willing and legally able to share the information. The data tend to be specific to subscribers, not to others covered by the policy, such as a spouse or children. Further, unless employers require subscribers to re-enroll affirmatively each year, new requests for information will generate data only for those filing that year—those new to coverage, those changing family status, or those switching plans. Given the difficulties in reaching agreements with a broad range of purchasers, some participating firms with an interest in disparities have started by obtaining data on their own employees.

Firms can obtain racial and ethnic data by asking members directly, although they must comply with state-level legal restrictions or approval requirements. After member enrollment, the collection of racial/ethnic data is subject to fewer legal constraints, especially if the response is voluntary. Another alternative, especially for firms with strong linkages with providers, is to collect such data at points of service and possibly incorporate it as part of an electronic medical record. Most firms sponsoring health plans however do not have such strong linkages to providers. Regardless of their strategy for obtaining data, all firms must meet federal and other requirements that provide appropriate safeguards related to privacy and other concerns. Collaborative firms have found that even when they decide to collect data, there are no perfect strategies for doing so; despite the best intentions, progress is slow.

Firms also face challenges in maintaining and manipulating racial and ethnic data, especially if their systems were not initially designed to support such work. Unless the firm's IT platform has one or more fields for entering data on race and ethnicity, appropriate fields must be added, a process that is typically costly and time-consuming; in fact, such an addition may not be possible if the vendor of an old system no longer maintains it, as one firm found. In addition, there may be more than one IT platform in place across a firm and its affiliates, thereby limiting the pooling of data and access to it. Provider networks are complex; consequently, only a small share of affiliated providers may have racial/ethnic data or be willing to share the information. Willing providers may have IT platforms that are incompatible with those of the firm. Such inconsistencies occur even if the firm has providers integrated with the health plan. Many firms sponsoring health plans were themselves formed from mergers spanning several companies over several years. Each

legacy firm may bring its own IT platform. In many cases where integration is a goal, the process is ongoing.

At the Collaborative's inception, only a few participating firms had begun to collect data on the race and ethnicity of all of their members, with a few others planning to do so. Aetna had already started to collect members' race and ethnicity, which helped motivate other firms' interest in the Collaborative. Another regional plan was beginning to collect data, and two firms had policies in place that supported such data collection but found implementation challenging, in part because of competing demands. Of participating firms, only the sole Medicaid dominant plan in the Collaborative had such data for its entire membership—and that was because it could obtain this information from state agencies.

Recognizing that capturing racial/ethnic data would take time, RAND offered to work with interested firms in the early days of the Collaborative to apply geocoding and surname analysis to give participants a preliminary understanding of any disparities in their firm. RAND staff hoped that doing so would reinforce firms' perception that disparities were a problem warranting their attention, and motivate efforts to reduce disparities. Geocoding/surname analysis was also a technique in which RAND's staff were personally interested and experienced (Fremont and Lurie 2004).

C. Experience with Geocoding and Surname Analysis

1. Geocoding and Surname Analysis, and RAND's Approach

The goal of geocoding and surname analysis is to allow firms to generate estimates specific to the race and ethnicity of their members. The estimation technique assumes that firms already have the outcome data of interest for the population—such as membership-based HEDIS measures for diabetes—and lack mainly descriptor information on the racial and ethnic characteristics of members for whom outcomes are reported. In short, geocoding and surname analysis use proxy information that *is* known for members to estimate racial and ethnic characteristics. These data are then linked to outcome measures, such as HEDIS. HEDIS measures are more likely to be captured for HMOs than for other products because quality improvement goals, measures, and requirements are more developed there than elsewhere. Disparities are thus easier to measure in HMOs and other products that employ such measures.

RAND staff explained that most of the agreements with firms were structured such that firms provided individual surnames and physical addresses for relevant members—specifically, those with diabetes (the Collaborative's target population) and others of interest to the firm. Firms, rather than RAND, defined whom to include in the population of interest. RAND staff then analyzed surnames to identify Latinos and Asians, and converted member addresses to census block groups (of around 1,000 people). RAND next examined data on the census block of residence for members not classified as Latinos or Asians through surname analysis. While geocoding lends itself to several approaches, RAND's technique for the Collaborative coded as African American individuals who reside in census block groups with a population that is more than two-thirds African American and others as

white or other.[8] Based on its geocoding and surname analyses, RAND classified members into one of four mutually exclusive categories: African American, Asian, Hispanic, or white/other.

RAND returned the identifying information to the firm with its racial/ethnic code. In most cases, RAND did not have access to firm HEDIS data, as firms were sensitive about releasing such information. With the information from RAND, firms were to construct HEDIS diabetes indicators for the relevant population. HEDIS includes four process measures for diabetes (HbA1C monitoring, lipid profile, diabetic eye examination, and urine protein) and two outcome measures (HbA1c level controlled and lipid level controlled). Some firms calculated the subset of HEDIS measures that could be computed with administrative data without chart audits, since measures requiring chart audit can be expensive. Some firms provided information on a broader set of members that went beyond just those in the commercial market with diabetes and used the information to develop a broader set of measures about disparities.

For firms that were willing to share HEDIS data, RAND could do more to help them with analysis. For a few firms that expressed interest, RAND incorporated the data into a mapping tool to help firms visually analyze variations in HEDIS outcomes across geographic areas with diverse racial and ethnic characteristics. Based on firm experience in the first round of estimation, some firms contracted with RAND to provide specialized support whereas others either had or built such capacity internally or rejected the geocoding/surname analysis approach entirely. To the best of our knowledge, RAND has not developed a report documenting the work of the Collaborative on geocoding and surname analysis—perhaps because of firm agreements and sensitivities about public reports on their internal processes and data, or other reasons. As a result, information about this process comes from firm presentations to the Collaborative or interviews conducted for the evaluation.

RAND staff members indicated that geocoding works best in highly homogeneous areas—with high concentrations of members in particular racial and ethnic groups—although they believe that it also can be used effectively elsewhere, particularly with recent refinements. Given that geocoding is based on geography rather than on the individual, the technique is best suited for comparing HEDIS or other outcome measures across geographic areas that are known to vary in racial/ethnic composition. Firms can map areas to visually display the diversity therein and identify priorities for interventions. Mapping by geographic coordinates also allows firms to merge many other kinds of data available geographically. The geocoded/surname analyzed data are typically less useful as longitudinal measures of outcomes for person-specific interventions because of the assumptions used in constructing racial and ethnic identifiers using geocoding and surname techniques.

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[8] RAND has subsequently refined the method to allow the estimates to reflect uncertainty about the race/ethnicity of members residing in mixed racial/ethnic areas. RAND staff believe this change will lead to better estimates of racial/ethnic composition in heterogenous areas.

2. Firm Experience with Geocoding and Surname Analysis

At the July 8, 2004 meeting, RAND proposed to work with firms to support the analysis of racial and ethnic disparities by using geocoded and surname analyzed data; RAND then formed a workgroup of interested firms. All firms in the Collaborative participated in the geocoding and surname analysis process except one that already had race/ethnic data for all its members and a second that was actively engaged in capturing such data nationwide.[9] Originally intended to provide analysis that could be used in the first Collaborative meeting in September 2004, the work took much longer to complete (as discussed later). The delay reflects an often considerable underestimate of the time required to establish the necessary legal agreements with firms to share data and to have the firms' information systems generate the member data upon which racial/ethnic proxies are based.

All seven of the firms originally participating in geocoding/surname analysis ultimately received data with geocodes and surname identifiers for at least one time period and had an opportunity to use the data to develop measures of disparities. (An eighth firm recently began talking with RAND about developing such analysis.) In our round two interviews, we discussed the experience with geocoding and surname analysis with staff from each firm involved in the effort. The interviews varied in specificity and did not allow us to describe firms' geocoding experiences in detail with any rigor or consistency.[10] They do, however, provide a good indication of the range of firm experiences with the process (see Table IV.1). Since that time, some of the firms have continued their geocoding and surname analysis work and several have become more involved in the use of mapping techniques for visual display and analysis of data by neighborhoods and other areas.

Focus of Work. Firms varied markedly in the content and scope of the data they provided to RAND for geocoding and surname analysis. While some firms restricted their scope to diabetes, others went beyond this and included events such as Acute Myocardial Infarction (AMI). One regional firm included all of its adult commercial members in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) sample frame for its dominant state, along with a subgroup of Medicare enrollees and a targeted group of

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[9] This firm later decided to make use of geocoding and surname analysis to supplement its own data. While these analyses are not specific enough to support member interventions, they provide a vehicle for comparing areas consistently to identify those that might need to be targeted for geographically based interventions. The firm saw this as valuable because reporting was voluntary and could vary by area, and members providing their race/ethnicity were not necessarily representative of all enrollees in an area.

[10] Several reasons limited our ability to do so. First, AHRQ asked us not to request data from plans, a request most plans would not care to honor in any case because of its burden. Second, the firms are complex organizations whose initiatives do not lend themselves to easy characterization in a telephone interview without supporting documentation. Third, we went into the interviews with limited knowledge of each firm's efforts. While most firms were cooperative—and the technical staff involved in geocoding particularly so—we were covering a broad scope of inquiry and found it challenging to formulate a set of appropriate questions. Fourth, we interviewed staff who often were uncomfortable providing us much detail.

Table IV.1. Selected Firm Experience with Geocoding and Surname Analysis During Part of the Collaborative

Firm[a]	Target Population	Use of Data	Value of Exercise
Firm A	Members served by providers in their system that do not report race and ethnic data.	The geocoded data rate of African Americans was far below that in reported data. The results were therefore disappointing and not used.	The limited usefulness of geocoding reinforced the firm's previous commitment to begin collecting primary race/ethnic data for all members.
Firm B	Managed care members with diabetes and later other conditions (about 25 percent of membership).	Developed HEDIS indicators for 2003 and 2004. Efforts will be continued using 2005 HEDIS data with firm's purchased software.	Confirmed that existing approaches were similar to those of other firms. Results helped to identify and target specific areas of disparities.
Firm C	Diabetes and AMI members for a subset of health plans.	Results were analyzed and presented to firm leadership.	Staff say findings reinforced the value of work in this area among some key staff.
Firm D	Adult commercial members in the CAHPS sample frame for their largest state (n=450,000). Selected Medicare and Medicaid members.	Data used for analysis of a diverse range of HEDIS indicators over time. Firm has 2004 and 2005 data and plans to analyze 2006 HEDIS indicators.	Results led to an intervention aimed at improving eye exams for Hispanic diabetic members, focusing on practices identified in geocoding and surname analysis.
Firm E	Sample of members with chronic disease across regions (n=335,000).	Examined HEDIS indicators on diabetes management for four racial/ethnic groups. Focused especially on differences in outcomes in the region where firm is developing an intervention. Firm is continuing to pursue geocoding and may, in one region, expand it to other providers.	Results were to be used in identifying disparities until more self-identified race/ethnic data are captured via the electronic health record. Results also were to provide a baseline for pilot interventions.
Firm F	16,000 diabetic members of disease management programs.	Analyzed results to distinguish socioeconomic from racial influences on process and outcome measures related to diabetes and presented these to management.	Results focused the firm and put disparities on its radar screen. Led to a number of interventions, as well as collection of member reported data on race and ethnicity.
Firm G	All members known to be eligible for disease management programs (2 million); more intensive analysis in a single geographical area.	Results were not sufficiently targeted to support the intended member-specific outreach. Data are being reanalyzed to identify "hot spots" for geographically based pilots.	Staff formed an ad hoc working group to coordinate analyses and use them in structuring interventions.

[a]Firms are presented in random order.

Medicaid patients. This firm and a few others solicited support for several years of measures; others appear to have limited their focus to a single year. Firms structured their requests to match their needs. For example, one firm excluded members for whom it already had racial/ethnic data, and another used the rules it applies in defining all those categorically eligible for disease management. Many firms included in their request only a subset of their plans or geographic regions so that they could limit burden, address divergent interests among their affiliates, or handle any inconsistencies in IT platforms. Regardless of the variation, the total number of lives that appear to have been included in the exercise is impressive for the potential—provided the technique works—to understand the disparities by race and ethnicity in firms.

Analytic Sophistication. The geocoding and surname analysis process was structured in such a way that its value depended at least partly on what firms did with the data they received. Firms varied in the analytic skills and resources available to support the analysis and in their preferences for support. At least half the firms had some experience with geocoding, typically for African Americans. A few of these firms preferred their own geocoding techniques for designating race to those used by RAND. Analysts in one firm, for example, relied on RAND only for surname analysis and used the firm's own probabilistic techniques to assign racial codes.[11] Another firm favored the same approach. Some firms did extensive analysis with the data. At least two firms examined the relative role of race and socioeconomic status in contributing to disparities and their differential effects on diabetes process measures versus outcomes measures. The firms used the results to develop a better understanding of disparities and the approaches most likely to be effective in designing interventions. Firms that could not access sufficient analytic support did far less analysis. For example, one large firm was limited in the programming resources available for geocoding-related analysis and found its progress substantially delayed. It had to purchase additional help from outside vendors for tasks other firms could easily handle in-house.

Perceptions of RAND Support. Those involved with the geocoding and surname analysis project generally expressed satisfaction with RAND's support. They felt that RAND staff met their expectations and that the help was valuable. They also reported that the exercise was not very burdensome. The main substantive disappointment we heard from a few particularly sophisticated firms focused on the fact that RAND staff did not provide more specific technical guidance, such as how to judge the substantive rather than statistical significance of a disparity. One firm perceived the support to focus more on the rigor required for research than the firm's needs. Otherwise, the main limitation, as noted, related to the delays associated with establishing the necessary administrative agreements with RAND to support the geocoding and surname analysis work. Firms typically attributed

[11] RAND used what is termed a "deterministic" method of assignment. Members are assigned either as African American or white/other according to whether the proportion of such residents in their census block is above or below 60 percent. "Probabilistic" assignment takes into account uncertainty about what the "true" identifier should be, given the heterogeneity of the population in the census block. RAND says they have now modified its techniques to include probabilistic assignment.

delays equally to RAND and their own administration. Delays were likely inevitable as firms sought to satisfy the Health Insurance Portability and Accountability Act's (HIPAA) privacy and other concerns. However, some reports suggest to us that management and administrative staff at the participating firms and at RAND could have been more nimble in moving the process forward.

3. Ultimate Value and Use of Geocoding and Surname Analysis

While firms varied in how valid they considered the results of geocoding and surname analysis for their markets, they generally said that they benefited from their involvement in the process. They perceived a positive benefit/cost ratio or provided examples suggesting as much.

Perceived Value. Most firms involved in geocoding and surname analysis stated that, despite the limitations of the resulting data, the technique was sufficiently robust to support the intended uses of the data. The firms shared their results with firm leaders. In some cases, the results provided new and valuable insights that helped firms better conceptualize the issues behind disparities. In others, the findings confirmed what firms already knew, reinforcing the importance of work in the disparities area, particularly among non-clinical staff who might need more convincing. Most firms reported that the analyses revealed some disparities. A few were pleased that disparities were less extensive than they thought or than in the general population. Firms also found value in analyses showing specific geographic areas that were more or less problematic on different measures. Firms using mapping found it valuable in graphically illustrating disparities for internal discussion.

Two firms and some staff in a third firm found the geocoding results disappointing. In one firm, the estimated proportion of African Americans based on geocoding was substantially below what the firm derived from patients with self-reported data; as a result, firm staff did not use the geocoded data. Another firm, perhaps unrealistically, had not realized that the analysis would be less useful in supporting member-specific rather than geographically targeted interventions. In this firm and another with a geographically diverse service area, staff in certain regions felt that the geocoding technique was not well suited to their market. They explained that the disappointing analyses stemmed from markets with very heterogeneous residence patterns by race/ethnicity. Most commonly, geocoded results were at issue. Some had only limited diversity in their membership; therefore, if the strategy for a particular subgroup did not work, the exercise had no other value. Firms with particularly diverse enrollments were also disappointed if the technique did not yield the sensitivity to isolate desired subgroups. (As mentioned before, RAND perceives that recent refinements to the methods address some of these concerns.)

Applications of the Analysis. For most firms—whether or not they found the results compelling—involvement in geocoding and surname analysis proved valuable. By our round two interviews, two firms had already used the data to formulate pilot projects, and several more were in the process of doing so. Others said that they planned to use the information to help them further identify needs and areas to target. One of the firms that found the results invalid used its failure as a vehicle for reinforcing its decision to capture

primary data on member race and ethnicity; respondents from two other firms similarly commented that limitations in geocoding and surname analysis solidified firm commitment to primary race and ethnicity data collection. Another firm had not yet found the data useful, but it reported that the process enhanced communication among midlevel staff responsible for such analyses, leading to an ad hoc group that is encouraging further firm investment in analyzing disparities and designing pilot interventions. This firm said that improved communication and the willingness to consider allocating more resources to disparities work were a direct result of participation in the Collaborative.

Future Plans for Geocoding/Surname Analysis. The Collaborative will not support firms in their individual efforts at geocoding and surname analysis during Phase II. However, of the firms that used these techniques in Phase I, over half have plans to continue the analysis, in some form. RAND staff indicated that at least half of the firms decided to use the mapping tool that RAND developed, one firm based on its own earlier experience and the others after another firm that used the tool during Phase I gave a presentation of their results at the June 2006 meeting. The lead contact from another firm indicated that they already had a similar mapping tool, but would be interested in continuing to do geocoding/surname analysis if the financial burden of doing so were minimal. One other firm generally lagged behind the others in this work during Phase I, due to internal reorganization, but has plans to continue geocoding and surname analysis with RAND under a separate contract, unassociated with their commitment to the Collaborative. This firm has hired an analyst to help it gain internal capacity to study disparities and hopes to use the RAND contract for training and other help getting started. Although, as discussed later, all but one of the firms have begun or have plans to begin primary race and ethnicity data collection, putting such systems in place takes time; current and continued work around geocoding and surname analysis holds appeal in that it allows firms to begin to address disparities in their minority populations, while developing longer-term systems to collect and maintain race and ethnicity directly from members. However, one of the firms that used geocoding and surname analysis extensively in the past has not expressed interest in continuing it in the future.

A potential issue for firms involves how to transition from building their geocoding and surname analysis using the support provided through the Collaborative to using their own resources. RAND's tools are not publicly available though we understand RAND has agreed to make its algorithms for assigning surnames available to firms in the Collaborative and is providing advice on vendors and low cost ways to purchase geocoding software.[12] Because of the way our firm interviews were timed, we did not learn about firm reactions to these options. At least two firms have contracted with RAND independently to support the geocoding/surname analysis efforts. While internalizing the function can help firms institutionalize the process, some do not have the expertise or staff to do so. In addition,

[12] Though some firms desire RAND to place the tools on the Collaborative web site for their use, we understand that RAND's ability to do so is limited because the tools currently are not set up for easy user interface so doing the conversion would have costs.

converting to other software may result in inconsistencies with prior analysis, thus detracting from firms' ability to leverage past work and trend experience.

D. Firm Efforts to Collect Race and Ethnicity Data

1. Direct Support from the Collaborative

With a few exceptions, the Collaborative did not directly support firms' interest in developing their own racial/ethnic data. The exceptions involved the Collaborative's support to help firms learn more about Aetna's Web Portal Approach and HealthPartners' activities in collecting information in their clinics. Almost universally, firms expressed respect for Aetna's initiative and its important influence on the industry. (HealthPartners' reliance on the affiliated medical staff meant fewer firms appear to have viewed it as applicable in their setting.) The Collaborative's response to firm requests to learn about the Web Portal took time, but at the June 30, 2005 meeting of firms' senior leaders, Aetna agreed to provide Collaborative participants with a demonstration of the portal; the Aetna demonstration (as well as the HealthPartners demonstration) took place via a Web call on October 20, 2005.

It is unclear why the Collaborative support organizations did not do more to address the interest among some firms in primary data collection on race and ethnicity. The support organizations' relative lack of emphasis on data collection stands in strong contrast to RAND's active interest in geocoding and surname analysis and CHCS/IHI's focus on pilot interventions. Of course, participating firms have their own IT platforms and unique concerns and may not have needed or wanted the support organizations to advise them on internal systems. However, the support organizations could have helped the Collaborative respond to some firms' expressed interest in help that might enhance support for external policy change (perhaps in the form of uniform standards and procedures) to face the internal challenges inherent in race/ethnicity data collection. For example, several firms mentioned that establishing a "safe harbor" could enable them to overcome any perceived legal barriers to collecting race or ethnic data. Another firm voiced strong interest in having the Collaborative build a broader coalition to promote standardized national approaches for such data collection that would help firms get this information via existing administrative systems. While support organizations did not directly work with firms to address these issues, at least one sponsor independently supported work directly relevant to firm concerns.[13]

As we discuss further in Chapter VIII, the second phase of the Collaborative will focus more heavily on supporting firms in their efforts to collect primary data on race/ethnicity. Firms have decided not to attempt to directly influence federal policy but instead, using their collective power via the Collaborative, to help shape the form in which race/ethnicity data

[13] RWJF has done work in this area independent of the Collaborative. For example, RWJF funded a policy brief on the legality of collecting and disclosing patient race and ethnicity data, which was released in June 2006 (www.rwjf.org/files/publications/other/RaceEthnicDisparitiesData06222006.pdf).

are collected and to better support firms that seek to collect such data so that their efforts are synergistic.

2. Indirect Influence of the Collaborative

While the Collaborative may not have directly pushed firms to improve their ability to collect primary race/ethnicity data, many participating firms expanded their data collection and plan to continue to do so. Firm involvement in the Collaborative appears to be at least one of many factors supporting such expansion decisions. At the Collaborative's outset, only a few firms had a policy of collecting data from all members; all but one now have such policies (Table IV.2). The exception is a firm that collects data selectively on race/ethnicity and is not yet convinced that its needs are sufficient to justify more universal collection, considering the challenges inherent in introducing such a change across the organization and its diverse IT platforms.

Given the scale and complexity of firms participating in the Collaborative, firms' success in fulfilling their goals for data collection remains to be seen. None expects to succeed in the near term, as racial/ethnicity data collection is a multiyear effort that requires decisions involving trade-offs and calculated risks. Firms such as Aetna that instituted member Web portals found that although the majority of portal users reported information, building up data on a large share of the membership posed a challenge. Further, firms face trade-offs in determining which racial/ethnic codes and categories to use. More extensive codes may be more accurate, but can also prove burdensome to both staff and members.

Provider-based firms appear to have an advantage in collecting racial/ethnic data because they are more closely linked with providers and thus have enhanced ability to capture race/ethnicity at the point of service. For example, the medical group affiliated with one firm collects information on language preference at point of scheduling so that it can arrange for an interpreter if needed; race/ethnicity, which is perceived as more sensitive, is collected during the visit. Staff are trained in and provided with scripts for use in eliciting racial/ethnic information as well as with materials for distribution to patients who want to know more about why the information is requested. Most health plans, however, are not provider-based systems. The other strategy that at least one firm has pursued involves capturing data on its own employees because this is something they can control and implement.

One encouraging note is that firms starting to collect data have reported less member opposition than they feared—perhaps in part because all reporting is voluntary. It may also be that efforts are "under the radar screen." More broad based efforts might generate more concerns by advocates. On the other hand, some firms noted that high levels of distrust exist in some communities and for some subgroups. One said that, in their view, provider support may be essential to capturing such data because enrollees would ask their providers about responding to any firm request. At least one other firm also noted the importance of having engaged minority community leaders in discussions about primary race and ethnicity data collection at the outset of its efforts. These comments raise the possibility that some firm strategies may be more effective if they can engage other stakeholders in their pursuit.

Table IV.2. Participating Firms with Policies Supporting Universal Collection of Primary Race/Ethnicity Data on Members

Firms with Complete Data for All or Virtually All Members

- ***Firm 1.*** This firm serves predominantly Medicaid members and receives such data from the state.

Firms with Data for a Meaningful Share of their Members

- ***Firm 4.*** The firm announced in 2001 that it would begin to collect such data. From 2002 to 2004, it worked to get approval from states and some major employers to include a field for such data on the enrollment form. In 2004, it initiated a member Web Portal that encourages voluntary reporting.

- ***Firm 6.*** About 30 percent of members are served by the medical group, which has collected such data since 2004 (with estimated 95 percent completion rate). Data are available for about 50 to 60 percent of members using system hospitals. After the experience with geocoding, firm decided to introduce a Web Portal with the goal of capturing primary data for members seen by other providers; this portal was introduced in January 2006.

Firms with Systems in Place to Collect Such Data

- ***Firm 2.*** An electronic medical record that was adopted a year or two ago includes a field for race/ethnicity that is supposed to be completed during on-site medical visits. However, the field uses a "soft" rather than a "hard" stop and compliance is low so far. One state in which the plan operates requires hospitals to collect such data; this yields information for a sizeable proportion of the membership in that region. Consideration is being given to making senior executives responsible for targeted completion, a step viewed as likely to be very effective in encouraging compliance.

Firms with Adopted Policies that are Designing Systems

- ***Firm 3.*** In late 2005, the firm made a commitment to collect race/ethnicity and preferred language data. The effort will begin with members in disease management programs and those completing health risk appraisal forms.

- ***Firm 5.*** The firm has committed to collecting race/ethnicity data but will not be able to implement the policy until at least 2008 because it must finish converting to a new IT system that has a field for such information. The firm has decided to use the same IT system as another Collaborative participant with whom they have business relations and believe that the system will support race/ethnicity coding.

- ***Firm 7.*** The CEO has decided to collect such data and formed a taskforce charged with deciding in 2006 how to do so. In the interim, the firm is selectively capturing such data on a voluntary basis as part of its customer relations management effort.

- ***Firm 8.*** The firm has decided to collect race/ethnicity data and will do so via its commercial enrollment form and a Web portal where members can volunteer this information. It is in the process of getting states' approval of the modified enrollment form and developing the new Web interface.

Note: Firms were randomly assigned to the codes Firm 1, Firm 2, and so forth.

E. HEDIS Data Submission on Common Measures

Sponsors originally designed the Collaborative with the expectation that firms would submit and share with other participants the HEDIS indicators for their diabetic population at a minimum of two time points (with an intervention occurring between the two). However, from the start, firms expressed reservations about this. When the Collaborative did make a formal but limited request, only a few firms responded

The record is somewhat ambiguous regarding how firms viewed the agreements about sharing common measures at the beginning of the Collaborative. From the start, AHRQ pushed for a consensus document outlining expectations. An initial draft proposed at the July 2003 meeting ushered in the formation of the Collaborative (see Chapter II). The draft was revised with feedback from the participating firms and reissued at the July 2004 meeting as a Memorandum of Participation. In it, firms agreed to commit to three meetings, to work with RAND to improve the race/ethnicity data available to them, and to use accepted measures (starting with HEDIS indicators for diabetes) to support their work. However, the agreement also stated that firms would have substantial flexibility in responding to market conditions and noted that shared data, pilot designs, and results would be balanced against requirements for maintaining privacy, confidentiality, and proprietary interests.

The issue of common reporting of HEDIS data did not arise again until mid 2005 at a leadership meeting of the Collaborative. While we did not attend the meeting, we understand that it was convened in response to some participants' concerns that the emphasis on geocoding and surname analysis was detracting from efforts that might lead to tangible and "scalable" pilot interventions to member plans. AHRQ staff told us, for example, that the support organizations felt that as long as the Collaborative kept analyzing data rather than intervening on disparities known to exist, there would be no actual impact on disparities. According to the minutes, participants agreed:

> The Collaborative needs to produce tangible and "scalable" benefits to its member plans for it to warrant their continued participation. In order to achieve such benefits however, the members concurred that they each had to make meaningful progress, contribute findings/models to the common good, and report to the Learning Organization fully and on a timely basis.

The meeting reportedly led to a re-energized Collaborative with more complete reporting and sharing among member firms and an agenda that shifted (at the sponsors' request) from geocoding and surname analysis to more active efforts at intervention.

We are not aware of the reasons for the delay, but CHCS/IHI did not formally request participating firms to submit HEDIS measures until November 3, 2005. The request was for firms to submit three or four specific HEDIS measures on diabetes for their full plan membership stratified by commercial, Medicare, and Medicaid lines of business. The request proposed four racial/ethnic categories consistent with those used in the geocoding and surname exercise. It also proposed submitting HEDIS 2005 (CY2004) data on December 15, 2005, followed by HEDIS 2006 (CY 2005) data on October 15, 2006, and potentially

HEDIS 2007 (CY 2006) data a year later. The memorandum proposed a new Disparity Index and a Quality Index to track performance over time.

As observers on the call when the request was under discussion, we heard firms ask about the scope of the request; staff could not provide answers immediately. Recognizing staff difficulties in responding to questions about scope, CHCS surveyed firms in the Collaborative to learn more about their concerns. In an April 2006 document, CHCS stated that all but two firms responded, and only one declined to provide the suggested measures (a decision that was modified after further discussion). However, by April 2006, only one firm had responded with data, with another said to have committed to provide data by the June 2006 meeting.

In round three, we had the opportunity to ask firms about the reasons for their (lack of) response to the request for HEDIS indicators. Most responses to this question were relatively brief. In many cases, it appeared that firms did not spend considerable time debating whether to respond to the request. The decision not to provide data did not appear to be central to the firms. Often they did not give it much attention, either because they felt they had already expressed their lack of interest in providing these data or because they examined the request and felt it would be too time- and resource-intensive. Firm feedback indicates that our earlier interpretations regarding firms' lack of support for collecting common measures may be on target.

First, firms are not necessarily able to report firm-wide HEDIS data by (proxy) race and ethnicity, at least universally. If firms capture such data, they typically do so for a subset of their population, such as those in particular disease management programs. To generate the measures requested by CHCS, many firms need IT support while all face competing obligations not under the control of firm staff involved in the Collaborative. The demands on resources associated with collecting common measures were cited as a large reason for the lack of support of these measures by at least four firms. We believe that the request for HEDIS data submission was later modified to give firms flexibility in defining their population of interest. Nonetheless, many firms were legitimately concerned about the potential utility of the indicators and remained sensitive about use of the indicators to compare firms or judge performance trends in the absence of their direct intervention. Our interviews clearly show that at least some firms remain relatively sensitive about the release of information on any aspect of their performance, particularly as related to measures distinguishing racial and ethnic subgroups. A couple of respondents also commented that too great a focus on comparative measures would have limited the opportunity for firms to be truly collaborative and to focus on understanding why disparities exist (rather than how much and at which firm they exist the most). However one participant from a support organization told us that, from personal experience, sharing data is the first step to true collaboration because it peaks the curiosity of participants in understanding what the data mean.

Second, the support that sponsors perceived from firms for publicly reporting HEDIS measures was based on tacit commitments made in Collaborative meetings, which, in hindsight, proved to be overstated. Many lead contacts viewed the request for HEDIS data

as another of the many requests they got from sponsor and support organizations. Interviewees told us that they reside in complex organizations and should not be expected to make binding commitments for their firms in such meetings. One interviewee observed, for example, that even a CEO's commitment could be difficult to obtain on the spot since other staff in the organization will be operationalizing the policy response and need to be consulted. IT constraints, in particular, can be problematic, a fact that firms confirmed on the April 2005 call of the full Collaborative.

Third, the sponsors' original goal to generate HEDIS data over time for use in assessing improvements gained through interventions was unrealistic given the Collaborative's two-year time frame, the complexity of the participating firms, and their diverse interests. One firm had significant experience in public reporting on common measures with other firms in their own market, and noted that even that effort—which involved like firms in a common environment—was very difficult and took a long time to develop. A respondent from this firm said collecting common measures was a laudable goal but not a practical one for a group as diverse as the Collaborative, and within such a limited time frame. Furthermore, regardless of whether firms could submit HEDIS indicators for 2005 and 2006, they clearly did not conduct the types of interventions that would likely drive noticeable change in national indicators over only two years.

Fourth, despite the efforts CHCS indicated it made to involve some firm experts in formulating the solicitation on common measures, the solicitation could have more fully addressed the firms' likely questions and taken into account the diversity across firms and the particular challenges of firms without single integrated systems across locales and product lines. The memorandum requesting common measures did not indicate which product lines should be considered—HEDIS data are more available for managed care, especially HMOs, than for other products—and did not appear to anticipate the operational issues firms might face, especially if a company divided authority by payer (the Collaborative focused mostly on the commercial sector), used several IT platforms, or did not focus its geocoding work on its entire population as opposed to those in a particular state or region. CHCS's inability to address these concerns in advance or respond in the meeting may have inadvertently reinforced firms' existing reluctance to share data.

As researchers, we understand firms' concerns about interpreting the data they provide, although the sharing of data among participating firms might have helped strengthen the group process and reinforce the importance of addressing disparities. Firm data would likely have covered diverse populations—for example, those in disease management programs or all members—and time frames. While two years of data might have allowed firms to serve as their own control and show trends, the interpretation of such trends could be problematic in the absence of an intervention or in the case of one whose focus did not match the data. Hence, shared data seem useful in pointing out the existence (or lack) of disparities but not in comparing disparities across firms or identifying how effectively firms have addressed them.

The lesson we draw from the Collaborative's experience is that if a sponsor wants to convince firms reluctant to share data to do so, it must make a more compelling case for the

value of shared data. It must also be certain that the request will be supported with assistance and is as operationally feasible as possible. Finally, the sponsor needs to be prepared to respond to the types of concerns firms may raise and make sure that firms express them openly in meetings and calls rather than ignoring the request.

CHAPTER V

INTERVENING TO REDUCE DISPARITIES

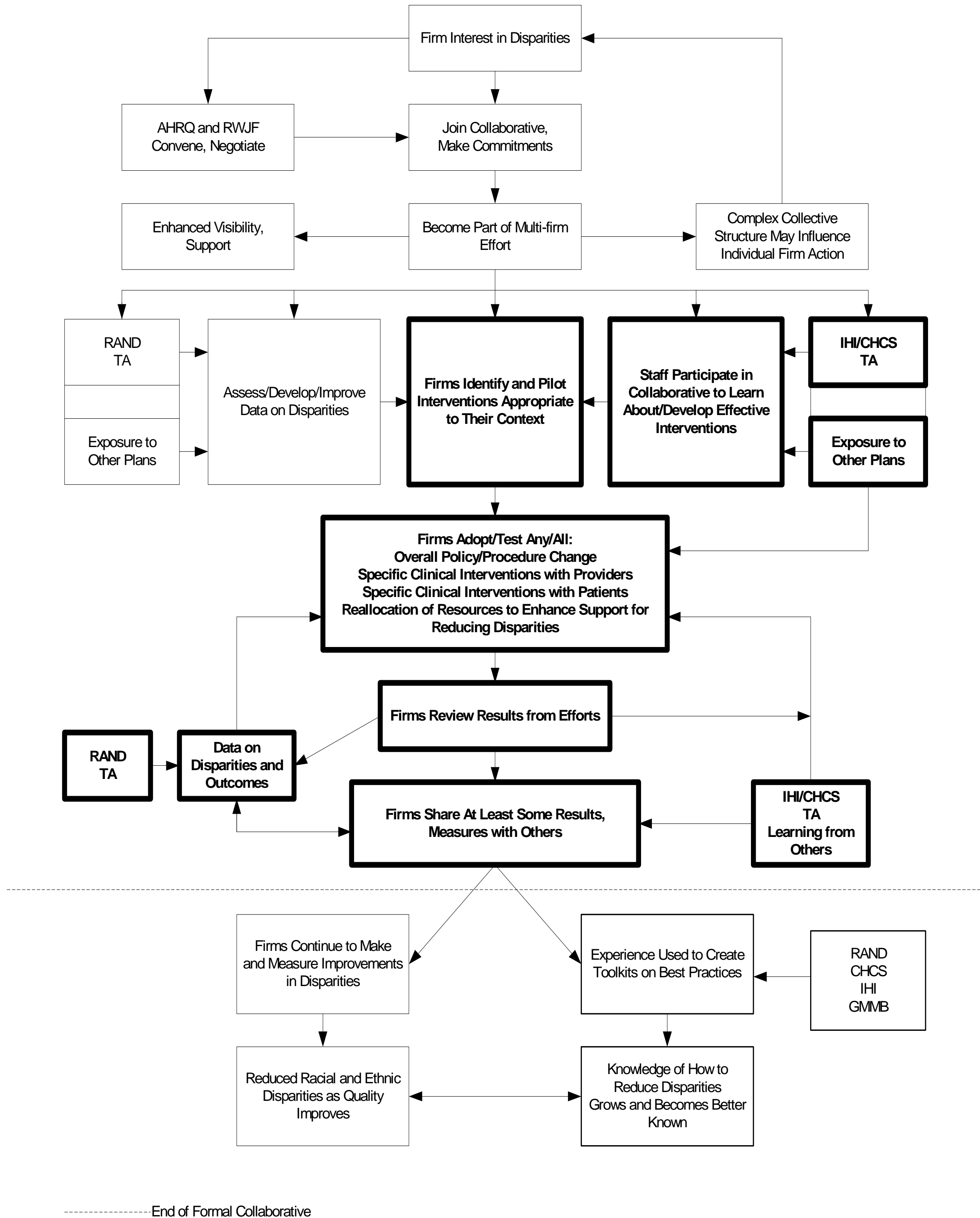
Launching pilot interventions intended to reduce racial and ethnic disparities was one of the four main areas of Collaborative focused on (see bold type in Figure V.1). Because most of Phase I was devoted to geocoding and data collection, most firms began to develop pilot interventions only during the last six months of the Collaborative. This chapter discusses the role of the pilot interventions in the Collaborative and how expectations for interventions changed over time; the interventions themselves; challenges facing the firms as they implemented the interventions, and the role and significance of the pilot interventions to the firms.

A. SUMMARY OF FINDINGS

During most of the Collaborative, the firms' efforts to implement interventions to reduce disparities took a back seat to data collection. As firms gained insight into disparities, they began to think more concretely about what they, as entities sponsoring health plans with different business practices, could do to reduce disparities. By the end of the Collaborative, seven of the nine firms had either completed or were in the process of completing pilot interventions, and two were in the process of developing them. Consistent with the agreed-upon Collaborative focus, diabetes in racial/ethnic minorities was the primary target of all pilot interventions, and four of the firms geared their interventions toward Hispanics and the others focused on other subgroups. Most pilots were small, though size varied by firm, and the interventions themselves varied markedly from one firm to the next. While it was too early at the time of this writing for most firms to know the outcomes of their interventions, most perceived them as creating a framework for future expansion and learning and planned to pursue related interventions even though Phase I was ending.

The firm's progress in developing interventions was challenging for a variety of reasons. First, firms were not sure where to begin, citing uncertainty about how to best intervene. Second, lack of data was a constraint for many firms because the ability to develop an appropriate intervention means having an understanding of the race/ethnicity of particular

Figure V.1. Simplified Logic Model for Learning Collaborative to Reduce Disparities: Pilot Interventions



members and an ability to geographically target those members. Third, the scale and complexity of the firms themselves made it difficult to implement effective interventions because of the need to coordinate activities in the face of the split between corporate and regional responsibilities and between the various departments and other functional areas in the firm. Fourth, logistical issues, such as recruiting physicians to participate in provider-based interventions, were a challenge.

The Collaborative led firms to view their work on disparities as a part of their quality improvement effort rather than as an add-on or separate activity. This link created leverage to address disparities within firms. Still, firms were constrained by the tight fiscal environment in which they operated and by competition for resources. The ability to build a business case for addressing disparities was viewed by firms as important to obtaining the resources needed to address the quality improvement agenda and disparities in health care.

B. Expectations for Interventions Changed Over Time

From the start, expectations for the Collaborative were high. With technical assistance from CHCS and IHI, sponsors planned that firms would design, implement, and complete targeted interventions for their minority populations by the end of the Collaborative's two-year operational period. Sponsors hoped to be able to point to improvement in health outcomes, such as better diabetes indicators, to demonstrate the Collaborative's success.

As the Collaborative got off the ground, however, it became clear that the original expectations were not realistic. One sponsor noted, "I think we were just incredibly ambitious and off target for a lot of it." The majority of firms did not have critical information on their members—such as race, ethnicity, and language preference—and without it, firms would find it difficult to develop targeted interventions. Not surprisingly, the firms spent most of the first part of the Collaborative working with RAND on data collection activities, including geocoding and surname analysis (see discussion in Chapter III).

Although the Collaborative discussed interventions earlier in Phase I, it wasn't until the last six months that most firms shifted their focus to developing interventions specifically related to their Collaborative efforts. According to an individual from one support organization, "I thought they would be further along on the interventions than they were. A lot of this is because of turnover or because of the time needed for data collection." Another support organization echoed the frustration, "It's disappointing to me that we couldn't get more folks to the intervention stage, but that was just unrealistic given time and measurement issues." In addition, by the time firms were ready to develop their pilot interventions, they had not yet built strong relationships with staff from CHCS and IHI. Probably for these and such other reasons as the firms' interest in keeping their internal processes confidential, they developed interventions with staff from their own organizations, often leveraging their own programs and/or activities rather than looking to support organizations for assistance.

Over the course of the Collaborative, the definition of an acceptable "intervention" broadened from a narrow pilot program to a wide range of firm activities, including cultural competency training, data collection, and long-term goals. The sponsors' definitions of "success" expanded as well. Over a year into the Collaborative, one sponsor noted, "Whether or not they moved the needle is less important than did they do something, did it work, and why or why not."

The analysis focuses on the primary intervention self-identified by the firms during our round three interviews. Seven of the nine firms had either completed or were in the process of completing their primary pilot interventions at that time; two firms were still in the development stage. We exclude from this analysis initiatives related to gaining broad support for firms pursuing disparities work or data collection activities related to the Collaborative, as these activities are the focus of other sections of this report. At this point, however, in some firms, these activities were at least as important as the interventions they piloted through the Collaborative.

C. Implementation Experience

1. Target Population

Consistent with the agreed-upon focus of the Collaborative, all firms targeted their primary pilot intervention to members of racial/ethnic minorities with diabetes (Table V.1). The majority of the firms focused on subsets of their Hispanic membership; fewer targeted African Americans or other minority populations. Most firms started small before scaling up to the region or firm level.

The exact size of the populations targeted, however, varied significantly from firm to firm and over time. One firm, for example, targeted diabetic Hispanic members in one of their care centers; while it originally expected to reach out to 200+ patients who would be encouraged to pursue a three-drug lipid-lowering regimen, the firm discussed the fact that physicians had contacted many of these patients, some of whom already were following the regimen. As a result, the firm reached out only to the 52 patients who were not known to be on the regimen or to have been contacted. Another firm targeted 150 to 200 Spanish-speaking members in their diabetes disease management program. A third firm, lacking information on patients' race, reached out via a call campaign to all their known diabetic patients (around 25,000), letting them know that certain ethnic/minority groups in particular might be at risk for diabetes and asking them to respond if they wanted more information. About 5,000 members responded, giving the firm the opportunity to follow up.

Some firms used the results of their geocoding/surname analyses to identify their target population. One firm, for example, whose intervention had not yet become operational, planned to use geocoding results to identify "clusters" of Hispanic members with diabetics not receiving HbA1c testing and/or lipid testing. Other firms focused their interventions in sections of their service areas generally known to have a diverse racial/ethnic composition (e.g., Miami, Florida, which is known to have large Hispanic and African American

Table V.1. Pilot Interventions Pursued by Firms in the Collaborative

Firm[a]	Target Population	Intervention Strategy
Firm I	Hispanic patients with diabetes and cardiovascular disease in 250 practices in six states.	Practices are encouraged to agree to participate at no cost in a Web-based patient registry that will provide the practices with a planner with real-time disease-specific patient information. Practices can use it for all their patients; the firm will get information on those patients who are in firm products, which will be compiled into a database,
Firm II	Target population not yet identified.	The firm is designing an intervention that will focus on the medical group and will involve changes to the care model process, targeting reduction of disparities in diabetes and preventive care. Will convene an equitable care expert panel in January 2007 to both examine the process of care and determine how to close the gap in care for groups whose care processes are below those of other groups.
Firm III	Hispanic and African American patients with diabetes (initial target population of 3,285 members).	Through its disease management vendor, the firm is providing reminders to providers whose patients missed appointments or were overdue for preventive services. Includes cultural competency training for disease management staff and targeted member mailings.
Firm IV	Members served through its disease management vendor's 10-state call center with a high proportion of African American and Hispanic members.	The firm is training center nurses and nurse coaches in its Health Advisor program in culturally appropriate ways to encourage appropriate medication use and compliance.
Firm V	Hispanic diabetic members in southern California.	The firm plans to use GIS to identify "clusters" with relatively large numbers of Hispanic diabetic members not receiving either HbA1c testing, lipid testing, or both. Will explore characteristics to help clarify contributing factors and potential impact of different interventions on narrowing the gap between Hispanic and other members as well as improving HEDIS scores for entire membership in the area.
Firm VI	Spanish-speaking members participating in a disease management program (n = 150-200).	The firm provided Spanish-speaking case managers to diabetic members upon request.
Firm VII	Hispanic members with diabetes in one of the firm's regions (n=52).	In collaboration with the region's Center for Excellence, the firm used a personalized letter from patients' providers to encourage patients to use a three-drug lipid-lowering regimen.
Firm VIII	Racial/ethnic minority diabetic members (n=4,693).	The firm implemented an interactive voice recognition call campaign to 24,667 diabetic members in which a culturally sensitive message explained that their race/ethnicity could affect their risk for diabetes and urged them to respond if interested in additional information. The firm sent diabetes-related educational materials and information on contacting health coaches to the 4,693 members who requested additional information.
Firm IX	An estimated 2,500 to 4,000 minority high-risk diabetic members in Massachusetts.	The firm partnered with Stop and Shop grocery stores to offer Community Care Days, on which the firm offered free interpreter services, eye exams, glucose meters and training, nutrition counseling and discount coupons for healthy foods, medication counseling by bilingual pharmacists, and educational materials in English, Spanish, and Portuguese.

Source: This table is a compilation of information confirmed through our round three interviews with firm staff.

[a]Firms are presented in random order.

populations). At least one firm combined these strategies. First, it implemented its pilot at a center composed of 90 percent Latino patients. After expanding the pilot to the region, however, the firm planned to use both surname analysis and GIS programs to identify the Latino population.

2. Intervention Strategies

Most large, national firms used a provider-based strategy as their primary intervention/activity for the Collaborative. In some cases, the intervention targeted providers employed by the firm. For example, one large national firm implemented a cultural competency program through which it aimed to train all nurse clinicians and physicians who interface with members as part of its diabetes disease management program. Another large national firm worked with a vendor to encourage its affiliated physicians to implement a Web-based patient registry that helped physicians to track patients with chronic diseases by showing past and needed future steps at upcoming appointments. A third national firm provided reminders to providers whose patients missed appointments or were overdue for preventive services.

Regional firms were more likely to use a variety of strategies and more often combined multiple interventions/activities "to try to move the needle" on diabetes interventions. For instance, once regional firm combined a provider- and a member-based intervention. First, it consulted with minority physicians about strategies for improving diabetes outcomes, thus identifying a lack of knowledge about diabetes among their patients as a barrier to controlling the disease (the provider-based intervention). Based on this information, the firm used an interactive voice recognition call campaign to reach its diabetic members and convey a culturally sensitive message explaining that their race/ethnicity could affect their risk for diabetes and urging members to respond if they were interested in additional information. The firm then sent information to members who requested it (the member-based intervention). Another regional firm partnered with Stop and Shop grocery stores to offer free interpreter services, eye exams, and other services to diabetic members (a community-based intervention) in combination with a dropped referral requirement (system redesign) and waived co-payments for diabetic retinal exams (member-based intervention,).

3. Planned Measures of Intervention Success.

To date, only one of the firms (a large, national firm) involved in the Collaborative explicitly planned to judge the success of its intervention on improved *outcomes* of its targeted population, such as improved HbA1c test results (see Table V.2). According to our round three interviews, the majority of the remaining firms, including all of the regional firms, defined (or planned to define) their success as improvements in *process* measures, such as HbA1c testing and LDL screening rates. One regional firm noted, "That [analyzing outcome data] would be so complicated it's not even on the radar screen right now."

While not explicitly assessing success in terms of outcome measures, one national firm reported that it modeled its pilot on studies that showed improved outcomes in their

Table V.2. Firm Reported Status and Results of their Interventions in the Collaborative[a]

Firm[b]	Planned Measures of Success	Intervention Status/Results
Firm I	Ability to sign physicians up for program. Claims-based measures.	In process. To date, six physicians have signed up for the program. Quarterly data collection began in October 2006.
Firm II	Not yet determined.	In process of developing intervention.
Firm III	Cholesterol screening, HbA1c testing, and flu shot rates. Outcome measures.	Pilot complete. Actively managing 1,737 members. Firm presented analysis they say did not find statistically significant difference in screening rates between treatment and comparison groups, but found outcomes of the treatment group to be slightly better than the comparison group.
Firm IV	Patient satisfaction and phone call assessments.	In process. 80-90% of nurse clinicians or physicians who interface with members have had cultural competency training. Plans to finish training nurses in disease management in fall 2006 and broaden to larger portion of clinical staff in 2007.
Firm V	HEDIS scores.	Under development. Plan will begin identifying “hot spots” from geocoding results in spring 2007.
Firm VI	Process measures (for example, HbA1c, LDL, and DLE testing/screening).	Program is expanding to all Spanish-speaking members. Preliminary data show that areas participating in the intervention improved over nonparticipating areas on measures of HbA1c testing and screening for LDL and DLE. Have begun to measure emergency room and inpatient care utilization.
Firm VII	The number of members who picked up the medications.	Pilot complete. Bi-lingual letters sent to 52 patients in region in April 2006. Of these patients, 33 picked up the medications (63.5% response rate). Pick-up rate was higher for women than men. Those who picked up medications were members who were more compliant/responsive in general. Researchers would like to conduct follow-up phone calls to find out why the members did/did not pick up medications, but calls are not likely to take place (because of resource/time constraints). Plans to expand to all Hispanic members in region (possibly as high as 50% of the region’s 475,000 members).
Firm VIII	Clinical performance measures (HbA1c testing, etc.). The number of members who contacted health coaches.	Analysis in process. Plans to follow up with another phone call in September/October 2006 to identify race/ethnicity of members who requested the additional information.
Firm IX	Rate of annual eye exams.	Pilot complete. 115 people participated in the fall 2005 Stop and Shop event (20% of whom were the firm’s members). 2.5% overall response rate among members. Now refining intervention to appeal to business managers and large group practice providers in underserved areas.

Source: Information in this table was confirmed through our round three interviews with firm staff. The information reflects what firms reported to MPR staff and is not based on any additional independent analyses by MPR staff.

[a]Interventions are described in Table V.1.

[b]Firms are presented in random order.

intervention populations. Thus, while not specifically examining outcome measures in its pilot program for the Collaborative, the firm assumed that improving the process measures would also improve outcomes.

Findings and Status. The majority of firms are in the process of measuring and/or analyzing their results. One large national firm, for example, did not find statistically significant differences in screening rates between intervention and comparison groups, but they did find outcomes of the treatment group to be slightly better than the comparison group. Preliminary data for one regional firm, on the other hand, show that areas participating in the intervention had improved screening/testing rates over those in the non-participating regions. Several firms recognized that while most may not actually reduce disparities under the short timeframe of the National Health Plan Collaborative, firms developed the capacity to reduce disparities. "We've built a framework that we can now expand upon to identify and address disparities. It's foundation work that wouldn't have happened without the Collaborative. We have a way of identifying people for interventions to reduce disparities."

Future Work. While it is too early for most firms to determine the success of their interventions, most firms made plans to continue and/or expand their pilot activities/interventions to additional members, regions, and/or disease conditions. One national firm, for example, planned to expand its pilot intervention from the initially targeted 52 members to an entire region of the firm with approximately 475,000 patients, half of which are Latino. Similarly, one regional firm expanded its pilot activities from Spanish-speaking members with diabetes in three counties to all Spanish-speaking members enrolled in the health plan. Pilot interventions will continue into Phase II of the Collaborative (see Chapter VIII).

D. Challenges Facing Firms

Firms faced a number of challenges in implementing pilot interventions to reduce disparities among their member populations. First, firms lacked an evidence-based on how to develop interventions. One firm noted, "Literature wasn't there on interventions." Another firm said that "where to begin, how to target disparities, and what interventions to implement" was a challenge. Also according to the firm's spokesperson, "I'm still wrestling with . . . what's the big lever to close the gap? This is not clear to me going forward. . . . Right now, I'm flying blind, and just selecting interventions and approaches on face validity."

Firms also cited a lack of data as an impediment to developing interventions. "Until we have concrete information on our members, it's awfully hard to create interventions that are directed in the right way." Similarly, obtaining resources to implement interventions proved challenging for many. One regional firm noted, "Getting resources for work we want to do is hard."

Firm structure was also cited as a challenge. Making any changes in large national firms is difficult. But the regional structure of national firms made it doubly difficult for them to focus on change at a macro-level because the regions have significant authority over care

delivery and decision-making. Even at small firms, it is difficult to make changes when they put corporate-level decisions into play. For instance, it took one regional firm almost one year to implement a "no referral necessary" policy change for diabetic retinal exams.

In addition, firms cited logistical issues as challenges to implementation. "Bringing all of those resources together—making sure everyone was trained and making sure everyone knew what to do—was a Herculean effort." One firm, for example, had trouble recruiting physicians to participate in their provider-based intervention. Even after recruiting them, the firm was faced with the issue of familiarizing and training the physicians on the Web-based system used for the intervention. "It takes a lot of education to get the doctors used to the system." Another firm could not integrate data from its pilot intervention into the rest of its quality improvement data system.

E. Intervention Role and Importance at Firms

Many firms view their activities/interventions to reduce disparities as part of their quality improvement efforts, rather than as a separate activity (see discussion in Chapter III). "Disparities are just another way to look at quality." This view is useful in terms of funding and otherwise sustaining disparities initiatives. One firm noted that the link between quality improvement and disparities work helped it in the way of funding because there was no budget specific to disparities projects. That is, "we definitely see disparities work as relating to quality improvement—it's the main argument we're using for resources." Also, another firm recognized this important link for the future sustainability of these activities. "Future sustainability means institutionalizing disparities work into quality improvement work, so it's just something that happens."

While most firms recognized the potential value of their activity/intervention if it was successful, the specific activity/interventions at this point are often one of many of the firms' quality improvement efforts and are not seen as a main priority. One firm noted, "Reducing disparities is ranked well below survival." It's possible that this viewpoint is the byproduct of competition from outside forces. For example, one firm is tied up with integrating its new IT platform, and another has been focused on a recent merger. Despite these "distractions," however, many firms claim that their pilots would persist even if the Collaborative ended. One large national firm noted, "In many cases, the pilots would continue." Regional firms agree, "The Collaborative started the original interest in these areas, but I think it would be self-sustaining at this point."

Many firms are trying to use the interventions to build a business case for disparities interventions. One large national firm claims that initiatives have already shown a return on investment, and several other firms are approaching their disparities work with this in mind. One firm is attempting to conduct an analysis to support a business case for disparities, "To the extent that we can say, because we now have more folks managing their diabetes, and we know what it costs to treat diabetes when it's not managed. . . . Purely from the financial standpoint, we can say that we can save money." Overall, firms said that developing the business case for disparities work is a priority as they move forward. This issue will be a major focus of Phase II activities (see Chapter VIII).

CHAPTER VI

BUILDING COMMUNICATION AND DISSEMINATION INFRASTRUCTURE

This chapter examines the communications and dissemination infrastructure of the Collaborative, based on information collected during round three of our interviews[14] (see the bottom of Figure VI.1). As in previous chapters, we first present a summary of our findings. We then describe the rationale and background of Collaborative communications, followed by a discussion the Collaborative's major communication and dissemination activities in Phase I. We end by discussing the perspectives of participating firms and other organizations on communications support, including the successes and challenges, and what the Phase I experience highlights as important issues to consider in Phase II.

A. OVERVIEW OF FINDINGS

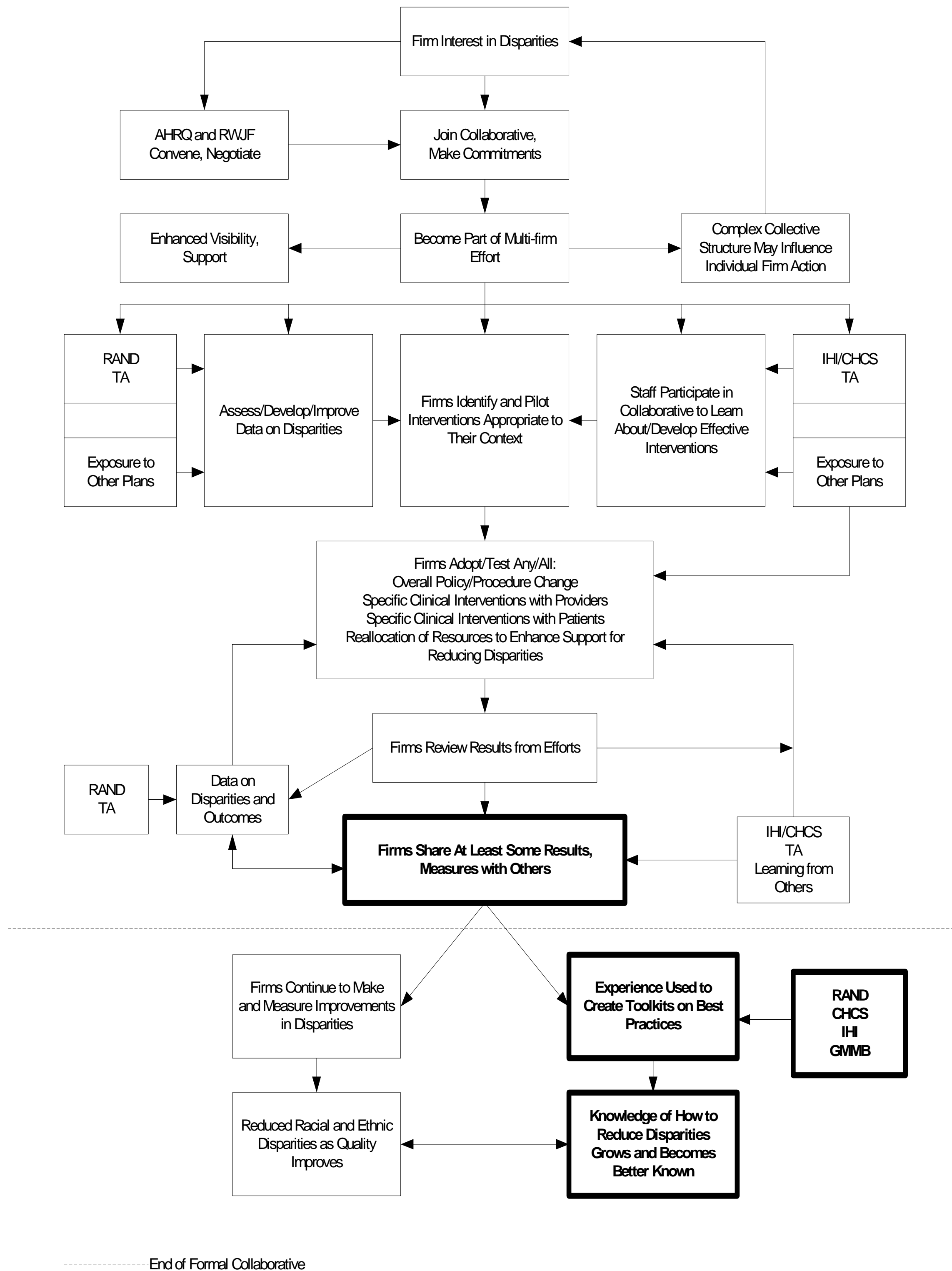
Firms, support organizations, and sponsors alike generally had a positive assessment of the communication and dissemination activities of Phase I of the Collaborative, although many recognized that there was little to communicate or disseminate yet and use of existing communications materials appeared limited. Nonetheless, the communication work done over the last year—which included the development of the NHPC logo, materials, and standardized messaging—was viewed as an important foundation for Phase II, when NHPC (and perhaps individual firms) will have more to report about their activities in the area of reducing disparities.

B. RATIONALE FOR COMMUNICATIONS AND DISSEMINATION

Reaching out beyond the Collaborative to other audiences is a core activity, one that will have an influence on the Collaborative's overall ability to expand health plans' awareness of

[14] Because communications activities were just beginning during round 2 of our interviews, we did not collect information on communications until round 3.

Figure VI.1. Simplified Logic Model for Learning Collaborative to Reduce Disparities: Communication and Dissemination



and attention to the issue of disparities. Key support organizations planned to support this focus in their own ways. For example, CHCS had plans to develop a toolkit and also to share lessons more broadly with plans as part of their upcoming Quality Summit on reducing racial/ethnic disparities. RAND hoped to work with Collaborative members to publish articles describing the Collaborative's experience and encouraging attention to these issues. Each participating organization (firms and nonfirms alike) also had its own interests in how communications about the Collaborative were to be handled.

In summer 2005, RWJF funded GMMB to provide communications support to the Collaborative. RWJF staff indicated that the primary goal of the communications contract was to help provide consistency and standardization in how the Collaborative was described externally to stakeholder organizations, policymakers, and others, and to establish a "brand identity" (including a logo). These goals were fairly simple and straightforward, and RWJF staff did not expect much media attention during this phase of the Collaborative.

The communications support and tools provided by GMMB were designed primarily for firm leadership participating in the Collaborative, although communications or public relations staff at most firms were also involved in the development of Collaborative materials—both so they could provide feedback and fully understand the purpose of the materials.

C. MAJOR COMMUNICATION AND DISSEMINATION ACTIVITIES

Shortly after the start of its contract, GMMB developed a communications plan that established a series of guidelines and goals for the Collaborative's communication activities. The communications plan also provided some boilerplate language describing the Collaborative. The core messages of the Collaborative were as follows:

1. In response to years of well-documented and persistent racial and ethnic disparities in our nation's health care system, nine leading health insurance companies have combined forces to form the National Health Plan Collaborative to seek out and test best practices to address the problem. While others in America's health care system—purchasers, patients and providers—also have critical roles to play, the Collaborative represents a collective effort by health insurance companies to do their part to solve this unacceptable problem.

2. The Collaborative is a groundbreaking project bringing together major health insurance companies with organizations from the public and private sector to identify ways in which the quality of health care can be improved for racially and ethnically diverse patient populations. Participating health insurance companies are exploring interventions aimed at communities, providers, and other stakeholders. The initial focus of the Collaborative is on improving the quality of care for patients with diabetes. Over the next year and a half, the National Health Plan Collaborative will work to engage other health care decision-makers—major health care insurance purchasers, health care providers and

policymakers—to join ongoing efforts to find solutions to racial and ethnic disparities in health care.

3. In January 2007, strategies and lessons learned from the Collaborative will be shared with other health care decision-makers and leaders.

The communications plan also made several recommendations about venues for disseminating the Collaborative's work (including the roundtable briefing and America's Health Insurance Plans' Building Bridges conference, described in more detail below). Finally, it also indicated that GMMB would provide members with information of interest to the Collaborative as a whole, thereby creating a vehicle for firms to discuss publications and other documents related to disparities—both those generated by Collaborative and those developed externally. One example was Nicole Lurie's editorial in the *New England Journal of Medicine,* which listed Collaborative members (Lurie 2005). Another example was a paper on by Asch et al. (2006) that was externally generated but of interest to many firms participating in the Collaborative because of its controversial finding that differences in health care quality by sociodemographic subgroups are small in comparison to the gap between observed and desirable levels of health care quality for each subgroup.

Per the communications plan, GMMB produced several tools in Phase I of the Collaborative. The first was the toolkit designed to establish standard messaging and branding of the National Health Plan Collaborative. Produced in December 2005, the toolkit included a brochure on NHPC, a list of frequently asked questions (the answers to which firms can use to address inquiries about the Collaborative), a racial disparities fact sheet, and information on usage of the Collaborative's logo.[15] The toolkit also provided talking points about the Collaborative for firm leadership to use in public forums, and included a Microsoft Powerpoint® presentation template with the Collaborative's logo and other basic information. A few members of the Collaborative used the materials in the toolkit—along with direct support from GMMB—to prepare for an Alliance for Health Reform briefing in Washington, DC, in late 2005.[16]

GMMB also created the Collaborative's Website, which was made public in February 2006 (see http://www.chcs.org/NationalHealthPlanCollaborative/index.html). Drawing on many of the materials included in the NHPC toolkit, this Website provides basic information on the Collaborative, including its mission, participants, activities, a fact sheet on disparities, and a list of frequently asked questions. No information is available about use of the site (such as the number of hits or user sessions), although support organizations suspect that Collaborative participants are probably the most frequent users of the site.

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[15] All toolkit materials were provided to participating firms in hard copy well as electronically.

[16] In addition to sharing several copies of the toolkit with each of the participating firms, GMMB has made available selected materials from the NHPC toolkit in a few other forums, such the Alliance for Health Reform briefing on racial/ethnic disparities in December 2005 and a Kaiser Family Foundation briefing on the National Healthcare Disparities Report in April 2006.

The most prominent communications activity during Phase I was the Collaborative's roundtable briefing in Washington, DC, in June 2006. (This briefing was held immediately before the start of RWJF's second annual conference on disparities and quality of care, in the same venue.) As part of this one-and-a-half hour briefing, senior leadership from AHRQ and RWJF introduced the session and lead contacts from each of the nine participating plans presented briefly on their firm's activities as part of the Collaborative. Over 50 people attended this briefing in person, and over 200 people registered to listen to the Webcast of the briefing via the NHPC Website.[17]

One of the final communications activities in Phase I of the Collaborative was a presentation at America's Health Insurance Plans' (AHIP) Building Bridges conference in early November 2006.[18] Specifically, GMMB worked with AHIP and Collaborative participants to organize a session in which lead contacts from three participating firms, along with Stephen Somers from CHCS, each presented on various aspects of the Collaborative. GMMB also recently produced a summary report on the Collaborative—which drew from MPR's interim report and other sources—for distribution at the conference.[19] The report includes information on who is participating in the Collaborative, what participants came together to accomplish, activities to date, and next steps. The summary report culminates with a "call to action," which makes several recommendations to the health care community, including (1) standardizing primary data collection criteria, (2) encouraging other health plans to participate in Collaborative initiatives, and (3) encouraging other health plans to address the problem of disparities.[20]

Each core support organization is also engaged in using its own strengths and resources to further disseminate the Collaborative's message and reach target audiences in a variety of ways. For example, RAND and CHCS staff recently drafted a manuscript describing the Collaborative and its work to date, which they will submit for publication to the American Journal of Managed Care. In addition, although it is not an official Collaborative activity, CHCS has included several Collaborative participants as presenters at its upcoming Quality Summit on Improving Health Care for Racially and Ethnically Diverse Populations in December 2006.

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[17] Information on the number of registrants who actually watched the Webcast online is not available

[18] In addition, representatives from three firms in the Collaborative are participating in the CHCS Quality Summit on Improving Health Care for Racially and Ethnically Diverse Populations in December 2006. This summit, however, is neither an official Collaborative activity nor sponsored by the Collaborative per se.

[19] The summary report will likely be disseminated elsewhere as well.

[20] In summer 2006, GMMB discussed with Collaborative members the possibility of developing several issue briefs on the Collaborative. Lacking much concrete detail to disseminate at this stage, GMMB opted to develop a summary report on the Collaborative instead.

D. PERSPECTIVES ON COMMUNICATIONS SUPPORT

Use of communications tools. Use of GMMB tools and support varied somewhat by firm, although no firm appeared to be a heavy user. While a few firms have contacted GMMB for additional copies of toolkit materials or other support, staff from several firms noted that they have not yet needed communications support because they have no concrete actions yet to report and have not received any inquiries about the work. Most firms did not use the Collaborative toolkit directly (although a few firms circulated toolkit materials to staff internally); nonetheless, many appreciated having the information available to them. A couple of firms suggested that the toolkit could have had more information, such as specific examples for communications staff of how the materials could be used. Use of the Collaborative Website also appears to have been rather limited to date.

It is important to note that during Phase I, the Collaborative's communication tools focused on policy issues rather than firms' operational uses. In this phase, firms were generally not at a stage where they could actively promote their interventions or other Collaborative activities to key customers—such as purchasers, consumers and providers—and the utility of these tools must be understood in that context.

Both firm and nonfirm perceptions on the roundtable briefing in June 2006 were uniformly positive. All thought the briefing was a good way to publicize the Collaborative's work and believed that GMMB played an important role in presenting a unified message from the Collaborative as a whole and standardizing the presentation format used by all firm representatives.

Successes. Staff from several firms and support organizations agreed that the communications work in Phase I was helpful in setting up a foundation and allowing the Collaborative to be ready for communications and dissemination in Phase II. Many saw establishing a Collaborative logo and standardizing the message as a very positive development. In the words of one lead contact, the Collaborative "got an identity" from the communications work. Moreover, the communications work to date—especially for the roundtable briefing in June 2006— helped firms to see that the Collaborative's "message would have more power if they were all saying the same thing consistently," according to one sponsor.

Almost all firms found GMMB to be professional, organized, and helpful. Firm staff believed the materials for the roundtable briefing were well done and commended GMMB for its help in preparing for the briefing and its persistence in getting firms to present a unified message.

Challenges. The primary challenge to date has been the relatively little activity about which to communicate at this early stage of the Collaborative. In the words of one support organization staff member, "the Collaborative has to have something to say before communications can help." Most firms agreed that the ability to communicate and disseminate was limited at this stage, and additional communication would have been premature. As one firm representative suggested, "our first priority is getting something

solid done and rolling it out." Only after this point will firms—and the Collaborative as a whole—have something significant to communicate.

While RWJF charged GMMB with communicating a consistent and unified message for the Collaborative as a whole, it is worth noting that firms may have other distinct communication needs. Although firms are clearly interested in promoting the work of the Collaborative externally, a couple of the participating firms—all of which are large, complex organizations—were also interested in communicating about the work within their own organizations. One firm, for example, believed GMMB was substantially less helpful to individual firms in communicating their own work on disparities—either internally or externally—than promoting the Collaborative as a whole (the latter of which was GMMB's charge).

Support and sponsor organizations noted that the competitive dynamics between plans affected the group's ability to communicate, at least in the earlier stages of Phase I. One support organization said it was initially "extremely difficult to get them to communicate as a group, just given the number of players involved"— and taking it one step further to communicate a single unified message externally was even more challenging.

Several characteristics of participating firms also influenced GMMB's ability to perform its communications function. For example, the size of firms participating in NHPC has sometimes made it difficult for GMMB to know if it reached the appropriate communications people. (Moreover, the chain of command in these large firms often slowed response time to signing off on Collaborative materials or other documents.) Another challenge involved turnover among communications staff at several of the firms, which made it difficult for GMMB to sustain relationships over time.

Perspectives Moving Forward. When asked about the possible role of communications in Phase II of the Collaborative, staff from many firms expressed an expectation for increased communications and dissemination, as there will be more concrete activities to cover. Moreover, consistent with findings elsewhere in this report, there is a strong perception (among firms and nonfirms alike) that firms are becoming more comfortable sharing with one another as a group, which is gradually improving communication within the Collaborative. According to one support organization, this may give the Collaborative more ability to speak collectively in Phase II. Finally, staff from several firms indicated that employers/customers are getting more interested in disparities and the actions health plans are taking to address those disparities. If this trend continues, actively promoting the work of the Collaborative may become more useful over time.

In terms of future communications activities, a few communications staff stated that helping promote success stories as they become available would be helpful in phase two. Other firm staff suggested that GMMB could help them promote Collaborative activities within their firms (Collaborative participants are large firms that typically need help communicating internally.)

Sponsor organizations indicated that future communications goals will become clearer as participating firms reach consensus on their overall goals for Phase II. GMMB is

currently preparing a proposal to RWJF for communications activities in the Collaborative's next phase.

As the Collaborative moves into its next phase, one possible tension in the communications realm involves organizations' desired focus versus that of the Collaborative as a whole. While sponsors want to ensure that the messages of the Collaborative are presented consistently to policymakers and stakeholders, at least some of the firms may be just as concerned with communicating firm-specific activities to other audiences—such as purchasers, providers, and possibly consumers—that are key to firm success. As the Collaborative moves into its next phase and reporting increases, it is important to consider how these preferences might be aligned.

CHAPTER VII

PERSPECTIVES ON THE COLLABORATIVE'S INFRASTRUCTURE AND PROCESS

This chapter examines the infrastructure and process of the Collaborative in terms of its ability to promote the goals of the Collaborative. The underlying premise is that collective action will be more successful than each firm acting on its own. This analysis draws from our interviews with firms and other organizations, our observations during a variety of Collaborative meetings and calls, and a network analysis of relations between Collaborative members. It examines the communication across participating firms, the tangible and intangible resources brought to or generated by the Collaborative, and the work required of participating firms. The chapter concludes with an assessment of how well the infrastructure and process of the Collaborative matched its goals, and a delineation of issues that warrant consideration in structuring future endeavors.

A. SUMMARY OF FINDINGS

Firm responses to the network analysis and interviews clearly paint a positive picture of the Collaborative overall; firms viewed the Collaborative as contributing to their organizations' goals. However, firms did not appear to benefit as much as they might have had they shared information more openly with each other, or had the Collaborative been better structured to facilitate substantive learning, particularly about evidence on how to reduce disparities. To some extent, limited sharing is a function of firms' culture and the markets in which they operate. However, firms anticipated that the more specific focus of work in Phase II would facilitate better communication, as would the experience they had working with one another.

Almost universally, firms said their biggest disappointment was the Collaborative's inability to address their interest in knowing about "what works"—particularly interventions that might reduce disparities. While some of this may be a reaction to the lack of a solid evidence-based knowledge in this area, it also appears that more could have been done to connect firms with sources and people who could provide insight on this issue and to structure agendas so that firms could learn more from one another. The learning sessions, for example, could have included faculty presentations on what is known. The effort

required of CHCS to coordinate the Collaborative and also the large number of support organizations probably came at a cost in resources that could be devoted to more substantive support in this area. In hindsight, it appeared that firms wanted information on what works, even if they did not want to use the Collaborative to talk about what they might do with the information. The most contentious issue for firms involved the structure the Collaborative sought to impose and the requirements it placed on firms. Reporting requirements were a particular concern, and some firms at least viewed the cumulative number of requests from sponsor-affiliated groups to be burdensome.

The experience of the Collaborative yielded a number of valuable lessons for organizations seeking to engage in future efforts with large firms that sponsor health plans, as discussed at the end of the chapter.

B. STRENGTH OF COLLABORATION: INSIGHTS FROM THE NETWORK ANALYSIS

We used network analysis to help us understand how the Collaborative functioned.[21] The network analysis involved asking each participant in the Collaborative—firms, sponsors, and support organizations—to complete a brief structured feedback form that included two primary sets of questions: one on the Collaborative overall and the other on the relationships among (and assessments of) other participants. The questions were asked in round two, or the end of 2005, about six to nine months before the end of the Collaborative. (Some perspectives may have changed by the end of Phase I.) The analysis was designed to provide tools to assess the way participants interacted with one another and the support provided by diverse organizations to the Collaborative's goals. We summarize here the main findings from this analysis whose methods, findings and conclusions are documented more completely in Appendix C.

1. Overall Perceptions of the Collaborative

Participants' responses clearly paint a positive picture of the Collaborative overall (Table VII.1). All but one participating organization felt that the Collaborative was at least somewhat important to attaining organizational goals (Question 1). In fact, 10 of the 15 organizations in the Collaborative (6 of the 9 firms and 4 of the 6 nonfirm organizations) reported that the Collaborative was very important or crucial for achieving organizational goals related to reducing health disparities. On average, organizations—at least as of January 2006—felt that the Collaborative had carried out its responsibilities and commitments "to a considerable extent," with firms slightly more positive than nonfirm organizations (Question 2).

[21] The analysis was part of the second round of data collection. We originally planned to field it again at the end of the Collaborative, but dropped this plan in response to firms' concern over the burden of participating in the evaluation.

Table VII.1. Perceptions of the National Health Plan Collaborative

	All Organizations (15 total)	Firms (9 total)	Key and Other Support Organizations, Sponsors (6 total)
1. Overall, how important was the Collaborative in attaining the goals of your organization?			
Not at all important	0	0	0
A little important	1	1	0
Somewhat important	4	2	2
Very important	7	3	4
Crucial	3	3	0
2. To what extent has the Collaborative carried out its responsibilities and commitments?			
No extent	0	0	0
A little extent	0	0	0
Some extent	3	2	1
Considerable extent	9	4	5
A great extent	3	3	0
3. To what extent has your organization carried out its responsibilities and commitments to the Collaborative?			
No extent	0	0	0
A little extent	1	1	0
Some extent	1	1	0
Considerable extent	9	5	4
A great extent	4	2	2
4. To what extent do you feel the relationship between your organization and the Collaborative is productive?			
No extent	0	0	0
A little extent	0	0	0
Some extent	2	2	0
Considerable extent	9	6	3
A great extent	4	1	3
5. To what extent is the time and effort spent in developing and maintaining the relationship with the Collaborative worthwhile?			
No extent	0	0	0
A little extent	0	0	0
Some extent	1	1	0
Considerable extent	7	6[a]	1
A great extent	7	2	5
6. Overall, to what extent are you satisfied with the relationship between your organization and the Collaborative?			
No extent	0	0	0
A little extent	0	0	0
Some extent	1	1	0
Considerable extent	12	7[a]	5
A great extent	2	1	1

Table VII.1 *(continued)*

7. To what extent has your organization changed or influenced the activities of the Collaborative?			
No extent	0	0	0
A little extent	2	2	0
Some extent	4	3	1
Considerable extent	6	3	3[a]
A great extent	3	1	2
8. To what extent has the Collaborative changed or influence the activities of your organization?			
No extent	0	0	0
A little extent	3	2	1
Some extent	5	1	4
Considerable extent	5	5	0
A great extent	2	1	1
9. Are the payoffs of the Collaborative for your organization reasonable relative to your contribution?			
No extent	0	0	0
A little extent	0	0	0
Some extent	1	0	1
Considerable extent	8	5[a]	3
A great extent	5	4	1[b]

Note: Data collected in December 2005-January 2006 and reflect perceptions of the Collaborative as of that time period.

[a]Includes one respondent whose answer fell between "some" and "considerable."

[b]One respondent did not answer this question.

Participants were positive about their own participation in the Collaborative, although some firms acknowledged that they themselves had done less than they might have been able to. When asked to rate their own organization on carrying out responsibilities and commitments to the Collaborative, almost all organizations were very positive (Question 3). Two firm representatives (both from national firms), however, indicated that their organizations carried out their responsibilities and commitments only to "a little extent" (one) or "some extent" (one). Almost all respondents reported that the relationship between their organization and the Collaborative was productive and worthwhile (Questions 4 and 5); support and sponsor organizations were somewhat more positive than firms on these dimensions. Likewise, all organizations reported that they were satisfied with the relationship between their organizations and the Collaborative to at least some extent (Question 6).

Support and sponsor organizations reported changing or influencing Collaborative activities more than firms did (Question 7), a response that is not surprising, given the role of these organizations in shaping the Collaborative and working one-on-one with firms. In comparison, firms were more likely than other organizations to say that the Collaborative

had changed or influenced their organization's activities, with six of the nine firms saying this was the case to a "considerable extent" or "great extent" (Question 8). All organizations said that the payoffs of the Collaborative were reasonable relative to contributions, with firms somewhat more positive on this dimension than sponsor and support organizations (Question 9).

2. Dynamics within the Collaborative

In addition to asking each participant about the Collaborative overall, we asked them to rate each of the other organizations in various ways, often involving the same questions as used for the overall Collaborative assessment as part of the structured feedback form. Our network analysis highlighted a number of key findings about how communications occurred in the Collaborative and the roles played by diverse participants (see Appendix C for more detail).

The analysis highlighted the central role that key support and sponsor organizations played in the Collaborative. Not only were they viewed as visible and active participants in the Collaborative process, but they also appeared to act as the "glue" that held the Collaborative together. They had the most contact with participating firms and formed the primary pathways linking participants. The support and sponsor organizations also engaged in a substantial amount of contact with one another. Key support and sponsor organizations also played an important role in contributing to action and change among other organizations.

Though named a "Collaborative" the network analysis revealed that there was much less communication between firms than between firms and the individual sponsors or the support organizations. On process measures such as communication, firms reported limited one-on-one interaction from firm to firm (although a few firms were seen as providing many good ideas to the Collaborative process). Only a few firms characterized other firms as having a "considerable" influence on them or their actions. However, firms still viewed each other as important, and most respondents reported that other organizations were carrying out their responsibilities and commitments to the Collaborative, at least to a small extent.

A few of the firms—namely, one national and one regional firm—stood out as more important and influential members of the Collaborative than others. Conversely, several firms consistently ranked toward the bottom on these measures. Organizations' ratings of whether the Collaborative was productive and worthwhile and whether it yielded a reasonable payoff compared with the level of organizations' contributions were all fairly favorable and did not appear to vary greatly with by organizational standing (though one national firm with low standing tended to rate the Collaborative lower than other firms).

C. Firm Perspectives On Communication Within The Collaborative

Consistency between Network Analysis and Round Two Interviews. The findings from the network analysis were consistent with the profile of the Collaborative we obtained concurrently in our second round of interviews. Given the competitive nature of the health

plan industry, it is not surprising that firms generally did not communicate with one another outside of formal Collaborative meetings. Unless firms operated in different markets (as is the case with regional firms) or had a business imperative for additional collaboration (as at least one regional organization had with a national firm), the firms were likely competitors. Firms also participated in the Collaborative for different reasons (see Chapter III). Although firms did not necessarily say that they were reluctant to share information, the way they described their internal clearance processes made it clear that release of firm-specific information was an important threshold decision that needed to be approved by top leadership.

Firm Reaction to Interim Report Findings. Because the interim evaluation report was shared with firms, they had the opportunity to see what the network analysis and other findings revealed about the way the Collaborative was functioning. We did not explicitly ask firms to react to the analysis, but we were able to gain insight into their perspectives on these issues both through discussions in subsequent meetings of the Collaborative and also through their responses to our questions on their overall views of the Collaborative in the final round of interviews.

At the final leadership meeting of the Collaborative in September 2006 (where the topic was gaining consensus on the content of Phase II), AHRQ staff raised the issue of openness of communication, noting that there wasn't as much sharing in Phase I as there could have been, both within and outside the Collaborative. This norm limited group learning and, AHRQ staffers noted, the ability to leverage firm's work in the Collaborative to generate more broad based knowledge and action on issues related to disparities. Firms seemed to accept the communication shortfalls noted in the interim evaluation report as valid. For example, one participant (from one of the firms that was more open in their communications) remarked that company executives reviewing the interim evaluation asked "how this was a Collaborative when there is very little collaboration." In the meeting or in our interviews, a few participants noted that on occasion they heard information about other projects being pursued by participating firms and wondered why these examples had not been brought to and shared with the Collaborative. In some cases, the communication failure could be attributed to the way agendas were set or the fact that the staff participating in the Collaborative may not have been the same as those involved in the activities of interest. But in other cases, participants were perplexed about why a firm would be more open in discussing relevant accomplishments in some venues than others, wondering if the interest was more in generating publicity than sharing and collaborating.

Firms acknowledged the downsides of less open communication, but were frank about the dynamics that might lead to this occur. As one large participating firm noted, "It [communication] is a double edged sword. To learn you have to tell." Firms observed that disparities had been a "hot" issue this year, attracting attention in a very brutal and competitive marketplace in which a net decline in the number of covered lives enhanced competition among firms and necessitated "casting a wide net" in attracting a wide spectrum of racial and ethnic groups. For competing national firms in particular, these dynamics and the involvement of marketing staff increased the reluctance to share information that might, in the firms' views, reduce their competitive edge. Some regional firms expressed

disappointment with these dynamics, which they viewed as slowing down progress of the group.

Attitudes toward this issue were not necessarily consistent across firms. For example, one regional firm thought there was more collaboration than it expected, even though it acknowledged that competition limited firms' willingness to share information. A participant with extensive experience in other kinds of collaboratives suggested that it was better to view the Collaborative as a "learning community" than a true collaboration, since the latter is by nature more focused on synergy and team building, elements that were not a big part of the Collaborative. Perhaps with a similar perspective, a participating support organization suggested the "Learning Laboratory" model; on the other hand, at least one firm expressed concern over a focus on learning or research per se, rather than work that was supportive of the firm's overall business objectives.

The Collaborative members were at different stages in their work on disparities, which many firms viewed as limiting progress. While firms agreed that the group was heterogeneous, firms' own perceptions of their status did not necessarily correspond to the views of others. That is, firms had a tendency to perceive their efforts to address disparities more positively than others saw it, despite consensus on a few industry leaders. In a few cases, the differences between how firms perceived themselves and how others perceived them was striking, as can be seen in the network analysis.

Looking Toward the Future. Despite the limited communication, a review of what firms did through their work with the Collaborative indicates that they were adapting what they learned about others' efforts to suit their own needs. Aetna's Web portal, for example, was a mechanism several firms adopted. Many firms also expressed a sense that communications were becoming a little more open towards the end of the Collaborative than they were initially (given the trust that had developed among organizations over time), and that the Collaborative had a stronger shared identity. Both firms and the sponsor/support organizations were optimistic, within bounds, that there would be more sharing across firms in the second phase of the Collaborative than in the first. Communication, they thought, would be enhanced by the focus on a specific set of activities.

At the same time, expecting extensive sharing may be unrealistic for this type of endeavor, which involves large businesses, the largest of whom are in direct competition with one another. While Collaborative participants may like each other as individuals, they represent organizations that at times bring a history of fierce rivalry, resulting in antagonism. If a major strength of the Collaborative is that the participants have strong links with top executives, participants probably exist in a culture in which "corporate sign off" is critical to any external communication. Researchers and "content experts" would likely feel more empowered to share because exhibiting their expertise either adds to their value within the firm or is a cost that firms are willing to pay to retain such experts. Senior managers, in contrast, are members of or are closely affiliated with line management, and may be expected to be more cautious in sharing information externally or making commitments that could be viewed as binding for the company. Although these are our speculations, they might explain

why there was so little sharing of what appears, at least to an external observer, to be fairly general content.

Another factor behind the limited sharing relates to the spillover effects of closed communication on curiosity. One of the support organizations told us that in their experience, sharing data is the first step to seriously interesting participants in sharing and understanding each firm's experience. With firms limiting how much was revealed, the "meat" that generated true collaboration may have been missing from the Collaborative. To the extent these dynamics apply, it will be valuable to recognize and deal with them in Phase II of the Collaborative.

D. The Contribution Of Sponsors/Support Organizations

1. Being Part of a Sponsored Collaborative

The fact that the Collaborative was sponsored by an important federal agency (the Agency for Healthcare Research and Quality) and a major health foundation (the Robert Wood Johnson Foundation) enhanced the credibility of the Collaborative in the eyes of participating firms. One senior executive said, for example:

> "Having the Collaborative out there and especially sponsored by the federal government sends a signal: we want you to measure and attempt to lower disparities. It is an important signal…without it, public perception will be that firms are doing it [collecting racial and ethnic data] for reasons of economic or racial profiling, not quality improvement."

Another observed:

> "A group like this is prestigious—it's got important players around the table and a national scope that has elevated, for anyone who may have doubted, the importance of the issue (of disparities) beyond the altruism that comes from the philosophy of a single organization."

As a third said, "The sponsors [AHRQ and RWJF] are certainly recognized by our board…the involvement of (such) substantive organizations gives [the Collaborative] 'cachet.'" While the existence of more than one sponsoring organization has the potential for conflict, most participants generally perceived that the two sponsoring organizations worked well together and with the support organizations. However, the visibility of the sponsors with participating firms varied across Collaborative participants. For all firms, sponsors were most appreciated for their support and the cachet they brought, as well as for their flexibility. Firms, realistically, viewed the support organizations as responsible for handling the day-to-day work of supporting the Collaborative. Several firms mentioned that the Collaborative involved well-respected support organizations (paid for by the sponsors) helped keep the effort focused.

2. Firm Perspectives on Support Organizations and Overall Support for the Collaborative

Although support organizations made great efforts to coordinate with one another, participants made distinctions among them. Consistent with the way the Collaborative was structured, firms viewed CHCS and RAND as the two main support organizations. They saw CHCS as the facilitator of the process and "glue" that held the Collaborative together. RAND, in contrast, was respected for the substantive knowledge it brought and particularly for the help in supporting the firm's work on geocoding/surname analysis. Both the network analysis and our interviews show strong support among firms for the contribution of each organization to the Collaborative. In contrast to the two main support organizations, IHI staff working with CHCS staff were less visible in the Collaborative, which is consistent with their more limited role. GMMB was well regarded for its support to communications goals, as discussed in the previous chapter.

Positive Overall Assessment. Firms were positive about the contribution the support organizations made to the success of the Collaborative. They were especially appreciative of sponsors' willingness to make resources available to support their needs. As mentioned in the interim report, some firms viewed the large number of organizations sponsoring and supporting the Collaborative—including MPR as the evaluator, a function they did not necessarily distinguish from the others—as imbalanced, since in some meetings it meant there felt there were "more of them than us." Yet, the firms were very positive on the contributions made by staff from support organizations during meetings. While we heard that there was a "complicated leadership structure with too many constituents that don't all seem to be aligned," firms provided little in the way of concrete examples of problems generated as a result. The main exception appears to be through effects on the diverse demands made of them by different organizations, each seeking information for their own purposes in ways that were not always coordinated. In addition, while less visible to firms, the leadership structure also meant that efforts at coordination consumed a significant share of the resources available to support the Collaborative, including regular calls of an "operational committee" including all partners and sponsors.

Strengthening the Evidence Focus. Firms were very positive about the contribution of the Collaborative and the support organizations. The most universally perceived gap in what firms received from the Collaborative was in the area of information addressing firms' interest in interventions that might reduce disparities. While they may not have been interested in pursuing particular interventions and may not always have felt this was what they sought from the Collaborative, they were hoping for evidence, insight, and support on reducing disparities. They expressed desire for more information on "evidence-based practice," "existing tools," "interventions that work" and "best practice sharing." Perhaps because firms received more substantive help with geocoding/surname analysis, they were more interested in understanding what the research showed about ways they could effectively intervene. However, learning more about how to directly collect race/ethnicity data was also noted as a desire.

One senior executive articulated the desire most broadly by saying, "What I'm wrestling with at the end of the day is, what's the big lever to close the gap? What will move the needle

[in terms of disparities]. Right now, I'm flying blind and just selecting interventions and approaches on face validity."

One national firm participant noted that implementing interventions based on face validity was appropriate, and cautioned that the search for evidence could lead to a "research bottleneck" delaying action. Yet, most sought more information about disparities, and were concerned that both too little was known about effective interventions and that the Collaborative did not focus enough on sharing what was known. As noted above, this was the main area of disappointment expressed by firms.

Reporting Requirements. The most contentious issue involved the structure the Collaborative sought to impose and the requirements it made of firms. As we discussed in the interim report after the second round of interviews, a number of firms objected to the demands they felt the Collaborative made on them to report progress or move in a specific direction. The core principles in the early Memorandum of Understanding—such as common measures and sharing—were more meaningful to AHRQ staff than to firms, none of which mentioned any such explicit overall agreement.

Reporting requirements and other demands for information were a particular concern among firms. Firms perceived the cumulative number of requests from sponsor-affiliated groups to be burdensome. They did not want to respond to periodic requests from the support organizations for formatted feedback on their work or to provide common measures. They were confused when a request to respond to a survey about common measures (from CHCS) was closely followed by a request from MPR for feedback on the relationships among participants and to set up interviews. Responding to requests was particularly challenging because it often required coordination across many staff and organizational entities within the firm. Generating a response not only required many people, but also the coordination time of the lead contact who had many other responsibilities.

At the final meeting in Chicago in September 2006, firms' rejection of externally imposed reporting requirements was explicit—they said they wanted to define any measures of progress that would be used in Phase II, rather than have sponsor or support organizations define measures for them. They also expressed considerable unease about ways in which efforts could be monitored. Although these views are clear, one firm that strongly opposed such requirements admitted in our final interviews that having timelines did push it to respond, and others noted that external demands helped to generate action both from participants ("Type A people who want to be Number One") and from organizations (since the external demands of the Collaborative helped them garner resources). However, these qualifications applied to concrete activities, not to specific reporting requirements or documentation that the Collaborative might require.

Model for Collaboration. As discussed previously, firms did not like the expectation that they would all pursue similar strategies. One interviewee observed that the Collaborative was "trying to fit everything into one shoebox and that's just not the way to proceed," as firms move at different paces and use different approaches to reducing disparities. Another suggested that AHRQ and other organizations perhaps had "become a little omnipotent in believing that without them the firms wouldn't be doing these things

[focusing on disparities]." In our final round of interviews, one participant suggested that perhaps the sponsors of the Collaborative had inadvertently established negative dynamics through their interest in using an IHI-like collaborative model developed around providers rather than plans. Another said that rather than meeting firms where they were, the model imposed its own structure and expectations. Commercial firms were also slightly distrustful of the Medicaid focus of CHCS's prior work. Even at the end of the Collaborative, a few still referred to the "Santa Monica meeting" (that is the second meeting of the Collaborative in March 2005) where such a structure was rejected, using that as one explanation for why the request for common measures got so little attention from many of them.

Logistics. Firms participating in the Collaborative were mostly positive about the value of meetings though they perceived some room for improvement in the agendas to help them be able to share and learn more, with more substantive focus on issues. Some expressed concern over scheduling, which they felt provided too little advance notice to allow them to lock in the dates and times and also were timed with too much emphasis on sponsor/support organization schedules than those of the firm participants. The lack of active use of the internal Web site was mentioned One participant suggested that using this site more actively between meetings to post substantive content could both help add to that dimension of the Collaborative and maintain momentum in between meetings.

E. FIRM PERCEPTIONS OF RESOURCES INVOLVED IN COLLABORATION

"**Worthiness" of Participation.** All eight of the firms we interviewed in the third round of the Collaborative responded positively to our query about whether their participation in the Collaborative had been worthwhile relative to the amount of time and resources it required. The value, as they elaborated, was viewed as:

- Being able to leverage the Collaborative to attract internal resources (in other words, moving disparities up on the priority list)
- Keeping momentum going and identifying pockets of opportunity
- Helping meet contacts from other plans and obtaining internal attention
- Identifying a direction and generating enthusiasm because others were also engaged making it a "movement"
- Using the Collaborative to highlight their ongoing work and help gain internal access to information
- Bringing plans together and contributing to a team effort
- Raising awareness of the issue, focusing on firm strategy, and fueling internal efforts
- Serving as the impetus to start programs within their firms

These perspectives paralleled in many ways the concerns firms cited as original reasons for participating in the Collaborative.

Firm Resources for Participation. As firms requested during the June 2006 meeting, we asked in the third round of interviews whether they had quantified the resources required for firm participation in the Collaborative. No one had done so comprehensively (and most not at all). One firm explained that it only looks at the issue of resource requirements when doing activities that take on a certain threshold of staff burden, but the Collaborative had so far been manageable, and requests had not yet reached that threshold. The firm explained that the real burden comes when it has to construct measures, hire staff, and so forth. The distinction between the costs of participation and of pursuing work related to addressing disparities appears critical for all firms.

Large-scale interventions and data system redesign are what appear to create large demands on resources for these firms. Firms pursuing these efforts typically reported that they were doing so as part of the costs of doing business, not because of the Collaborative. Put another way, firms would not make large investments solely because of their participation in the Collaborative—the investments had to make sense in terms of strategic and business objectives.

This is not to say that firms found it easy to secure the resources needed for the Collaborative. To undertake geocoding, firms needed resources to create records and—because most wanted to maintain control—skilled staff to analyze the resulting data. Although firms acknowledged that RAND support and economies of scale inherent in the Collaborative helped offset costs, generating sufficient financial and human resources was challenging for some firms and typically involved a significant commitment. One large firm said it had a consulting data analyst working 60 percent time over two years (at a cost of around $50,000) to support the geocoding work, in addition to the costs involved in developing the data and providing staff oversight. We were not clear whether these were resources were new or reallocated from related or different purposes. Another firm, smaller in scale and able to build on existing capacity, said that the geocoding/surname analysis work took about 20 to 40 hours annually (to prepare files for RAND and later analyze the geocoded and surname analyzed data). One firm supported geocoding by internally funding another part of their organization to do it. Another firm devoted a full-time staff member to this effort, although responsibilities also included other analytical support relevant to disparities. Because the firm's programming resources were limited, it had to purchase from a vendor some services that other firms could access internally.

Interventions undertaken specifically for the Collaborative also generated costs. Internal quality improvement initiatives, for example, required efforts to sample, prepare letters, construct measures, and so forth. Although the overall costs for such activities may be small in relation to the scale of these firms, accessing such resources often required negotiating for time and priority among scarce resources in a highly competitive environment. Garnering such resources without benefit of the Collaborative would probably have been more difficult.

The other main cost associated with the Collaborative involved the time of senior firm executives. One large national firm estimated that their lead contact, a senior executive, spent five percent of time on business related to the Collaborative. Another noted that it took time to brief staff and prepare for the weekly meetings. A third firm said that the Collaborative required the time of the executive lead contact plus the briefings of senior management. By and large, firms seemed to regard these as good expenditures, particularly when for meetings that might serve other purposes, such as professional staff development or learning. On the other hand, the fact that executives were "doing it off the sides of our desks," as one lead contact from a national firm observed, made staff particularly sensitive to spending any time that was regarded as "busywork" that might satisfy the requirements of support contractors but not contribute to efforts regarded as valuable to the firm.

F. Issues For Future Consideration

The experience of the Collaborative illuminates important issues to consider in designing future initiatives with large firms sponsoring health plans. (Lessons for Phase II of the Collaborative are discussed separately in the next chapter.)

1. Who Participates?

The health care industry is concentrated in a fairly small number of firms that play a major role sponsoring health plans nationally or regionally. These firms are diverse in structure (centralized versus decentralized), investment in quality improvement, linkages with provider systems based on ownership or history, geographic coverage, and other dimensions. Although the Collaborative sought to build on large national firms, the distinctions among these national firms did not appear well-recognized by the sponsors and support organizations at the beginning of the Collaborative, and it appears that decisions on who else would participate were strategic to individual support organizations that issued the invitations—particularly, RAND. As we noted in the interim report, sponsors said they were attracted to national plans because they touched many lives, but sponsors also appeared unprepared for the implications of such scale. Particularly absent in the considerations was a framework for the bridge between what large national firms provide (large-scale efforts and the potential to shift incentives across complex structures that ultimately link to providers) and what clinicians do (deliver care to individual patients in specific locations.)

Given the small number of major firms and their diversity, there is likely no optimum set of participants for any health plan collaborative. We cannot say that the firms in the Collaborative could have been better selected. However, it could be useful to make decisions on participation more strategically in light of the objectives of the Collaborative. For example, if the goal is to influence national policy or change policies across the industry, participants should include the largest and most influential firms. On the other hand, if the goal is to intervene in care delivery, one must recognize the way health plans relate to providers, the diversity in the industry, and the distinctions between centralized and decentralized firms so that the right firms and people therein are included. Established distinctions within the industry, particularly between commercial and Medicaid dominant firms, warrant consideration to encourage a mix of participants who can learn from one

another. It also would be valuable to consider whether to include firms that are heterogeneous or homogeneous with respect to their level of sophistication, work on disparities, and quality improvement.

2. What Model for Collaboration?

There are a variety of ways to structure a group collaboration. Ultimately, the form chosen should support the overall goals. In this case, neither the goals nor the structure seemed to have been given sufficient consideration at the outset. The decision to have RWJF sponsor CHCS to complement RAND's work for AHRQ with the Collaborative was a significant one that probably had more influence over the Collaborative than has been recognized. Specifically, through this decision, and the selection of support organizations (both CHCS and its subcontractor IHI), the Collaborative was structured according to a model of traditional quality improvement work with smaller, less complex organizations (typically providers or small health plans with strong links to provider groups). There were to be three meetings, with intervening work to measure, share data, intervene on a specific condition and measure success at the patient level. Firms would work internally and on the same things. When participating firms urged more flexibility of goals, this structure was modified but maintained.

Other structures may be more appropriate, depending on the goals. For example, if the goal is to inspire firms to make addressing disparities a greater priority and to leverage firm scale to remove environmental barriers to doing so, a workgroup model using politically savvy expert facilitators with deep knowledge of how firms work—for example, a former CEO who is respected by firms with a good grasp of public policy concerns—and support of consulting content experts might be appropriate. This certainly is a model used by many industry groups. Another option is the "Learning Community" or "Learning Laboratory" mentioned by some participants where the expectation probably is less achieving certain documented accomplishments but sharing and expanding knowledge generally on ways to address disparities.

3. How to Effectively Leverage the Private Sector?

Working with large private sector organizations that function in highly competitive markets is different from working with grantees beholden to the sponsor and financially motivated to cooperate. Sponsors seeking to engage large private sector organizations in group efforts should understand and respond to the reasons—business, political, personal, and other—that drive a firm to participate, the constraints that are likely to limit their response, and the processes required to link the external work within the Collaborative to the firm's infrastructure and decision-making process.

Goals and requirements need to account for each of these factors and also for the diversity in ways firms are likely to handle the same function. For example, the experience of the Collaborative reinforces the importance of appreciating bureaucratic processes that apply to making decisions for the firm or approving information for external communication, collecting information that may be the responsibility of more than one

division within the firm, and taking action that may require commitments of multiple firm units. Similarly, the Collaborative experience highlights the importance of anticipating firm concerns related to the market—for example, anti-trust issues or what firms view as their unique "edge"—and such political considerations as constraints imposed by the incentives of the reimbursement system, specific regulations that may limit firm options for collecting data on race/ethnicity, and others.

4. How to Encourage Sustainability?

In considering how best to encourage sustainability, an important issue to consider—which is not unique to the private sector—involves maintaining continuity of participation and memory on projects that span long periods of time. There are several aspects of this. First, because turnover in firm personnel can be anticipated, it may be valuable to consider ways in which short-term successes can be institutionalized in organizations and thus less vulnerable to change with personnel. Second, because firm participants are likely to have many demands on their time, effective techniques for maintaining their interest without imposing unnecessary distractions also could be valuable. The Web could be used to reinforce decisions and share content and progress between Collaborative meetings. And third, it probably is worth considering upfront to whether to select participating firms in ways that limit barriers from instability. In the health care industry, instability through mergers, acquisitions, and leadership turnovers is to be expected. However, at certain points an organization may be just too distracted to be able to effectively participate in a collaboration.

The other side of sustainability involves doing as much advance thinking as possible about how to sustain work that has been supported by external support organizations after those resources are no longer available to participating firms. In the future, AHRQ may want to consider building more formal requirements for technology transfer into its external support contracts so that public support for technology development can be leveraged to serve a broader audience.

CHAPTER VIII

ACCOMPLISHMENTS, SUSTAINABILITY AND INSIGHTS FOR PHASE II

A. MAIN ACCOMPLISHMENTS AND THEIR SUSTAINABILITY

At the start of our evaluation, a participant suggested that the Collaborative would be a success if the firms all were still participating at its conclusion "They all stayed," another participant observed at the end of the Collaborative. Sponsors and support organizations can take pride in the fact that the Collaborative remained intact despite several events that could have shattered it. Yet, to a certain extent, it is not surprising that firms remained in the Collaborative—firms tended to perceive the costs of participation as relatively low in relation to the risks associated with dropping out. As one firm participant remarked, "No one wants to be left behind. That's a strategic disadvantage." While firms' continued interest in the Collaborative is a positive sign, it is important to look more substantively at the effort, what it accomplished, and how sustainable these activities will be.

The previous chapters have provided considerable detail on what was and was not accomplished through the Collaborative. We have drawn four major conclusions about what the Collaborative has accomplished with respect to reducing racial and ethnic disparities. These are:

- Increased organizational attention and commitment to disparities as part of the quality agenda for health plans

- Growing recognition among firms that collecting primary data on member race/ethnicity is critical to making progress

- Limited progress in learning more about how to alter care for patients in ways that will reduce disparities and especially in applying knowledge to alter care delivery

- Increased awareness among diverse staff from sponsors and support organizations about how firms work in ways that are relevant to understanding their contribution to reducing disparities

We discuss each of these below.

1. Organizational Commitment to Addressing Disparities

Members of the Collaborative participated as official representatives of large organizations, which contributed to their ability to influence organizational commitments to disparities. All of the firms participated with the support of their senior leadership, designated well-placed senior staff to serve as liaisons, and involved their traditional reporting structures to keep executives aware of their efforts.

Most firms used their existing organizational channels to address concerns relating to disparities, but the Collaborative also encouraged some of them to enhance their organizational structures to more effectively deal with disparities. Before the start of the Collaborative, two of the five national firms had modified their structures to help foster attention to disparities—one had established a firm-wide disparities taskforce reporting to the CEO, the other a Cross-Cultural Care and Services taskforce under medical leadership. The Collaborative reinforced these structures. Using the Collaborative as an impetus, a third created an informal mid-level staff workgroup that sought to develop support for and initiatives addressing disparities. Of the four regional firms, two formed interdepartmental committees/taskforces to address disparities and culturally and linguistically appropriate care, and at least two had briefed or planned to brief their Board of Directors on progress in meeting disparities objectives. Another institutionalized its disparities work by moving it from its "incubator" research and development department to its Office of Medical Affairs.

These structures—together with firms' increased recognition of disparities issues, via their participation in the Collaborative and other factors—should sustain interest. While the Collaborative focused only on diabetes, firm responses suggest that insights about disparities in diabetes care are influencing their care delivery in general.

However, there are challenges to sustainability, particularly stemming from the environment and the instability within the industry. All firms viewed the tight fiscal constraints imposed by the health care market as influencing their decision-making, although some are better positioned fiscally than others. Leadership turnover and change is also common in the industry. For example, one national firm's participation in Phase I was limited because of a merger and staff turnover, two others are now dealing with CEO turnover. Such turnover has the potential to reduce organizational knowledge of the Collaborative's work, slow decision-making, and modify priorities. Firms whose commitments have been translated into permanent change—for example, in data collection procedures or standard programming—are likely to be better positioned to maintain their progress, although further progress may be more challenging. Because not much as been publicized about the Collaborative to date, the cost of slower progress may not be as high as

it would be if external expectations were higher. This could change as plans to increase awareness of the Collaborative become implemented.

2. Primary Data to Better Identify Disparities

As a result of the Collaborative, firms more strongly believe that primary race/ethnicity data are important in supporting quality improvement efforts that take into account the diversity in their enrollment. All but one of the firms now say their goal is to capture race/ethnicity for all members, and the latter firm is capturing it for selected patients in disease management programs. The geocoding/surname analysis experience in Phase I played an important role in helping firms develop a broader-based acceptance of the existence of disparities. It also highlighted to firms what geocoding could do (general patterns) and what it could not (member-specific identification to support interventions, or identify patterns of disparities when residential patterns are not highly concentrated by subgroups).

Despite what has been accomplished, there remains a large gap between what firms have done and what they ultimately seek to do. For example, one leading firm still has member race/ethnicity data for only a relatively small proportion of members, despite several years of concerted data collection. Two of the firms committed to collecting race and ethnicity data have not yet determined how to do so, and a third will not start until at least 2008, when its new IT system is in place. Firms seem to have an easier time collecting data on small subgroups of enrollees—those who visit portals or are in disease management—than obtaining more universal data for their entire enrollment, or sufficiently complete data in geographical areas to calculate rates and proportions (which is essential to geographic analysis). Most firms appear to feel it necessary to capture such data via their employer groups or from members, because working with providers will be difficult. Even those with affiliated providers face data collection challenges absent a strong push from management. Furthermore, because organizations are large, those that have data may not store it in such a way that it is accessible to other divisions and people within the firm. Phase II will prioritize supporting firms in primary data collection but the challenges—technical, organizational, and political—should not be underestimated.

Because of the time it takes to generate useable primary data on race/ethnicity, some firms plan to use geocoding/surname analysis to benchmark change by geographic area or further identify locations for disparity-oriented interventions. Firms used RAND support and methods in Phase I. While RAND will continue to make some tools available in Phase II, firms seeking individual assistance will have to enter into individual contracts with RAND, as external resources to support this are not available. The transition poses a structural barrier to sustainability. At least one firm has purchased its own software and plans to continue internal efforts, although it remains to be seen whether issues of consistency arise. Three others have or are considering contracting with RAND for some ongoing support or training to complement their internal efforts. In retrospect, it could have been valuable to consider earlier how to institutionalize firm capacity to address these issues, although firms seem to be making their own arrangements.

3. Limited Progress in Identifying and Implementing Interventions

During Phase I, firms made at best limited progress in modifying their care processes with the goal of reducing racial and ethnic disparities. Pursuit of interventions to reduce disparities took a back seat to data collection efforts for most of the Collaborative. As firms gained insight on disparities, they began to think more concretely about what they, as firms sponsoring health plans in diverse ways, could do to reduce disparities.

By the end of the Collaborative, seven of the nine firms had either completed or were in the process of completing pilot interventions, and two were in the process of developing them. Consistent with the Collaborative's focus, all of these interventions targeted primarily race/ethnic minority members with diabetes; four firms focused on Hispanic members and the others other subgroups. Most pilots were small, although size varied, and the approaches differed markedly across the firms, as described in the report. At the time of this evaluation, it was too early for most firms to assess the outcomes of their interventions. Still, most perceived that these pilot programs created a framework for future expansion and learning, and planned to pursue related interventions after the end of Phase I.

Firm progress in pursuing interventions was challenging for a variety of reasons. First, firms were uncertain where to begin, citing uncertainty about how they best could intervene to fill the gap. Second, firms were constrained by lack of data, as many interventions require knowing the race/ethnicity of particular members and most require at least an ability to geographically target. Third, the scale and complexity of firms created challenges to implementing effective interventions that could leverage the diverse functional systems in the firm and the split between corporate and regional responsibilities. Fourth, logistical issues, such as recruiting physicians to participate in provider-based interventions, were a challenge.

Perhaps the Collaborative's most significant contribution to care delivery was that it increased firms' awareness of the role disparities play in the quality improvement agenda. By the end of the Collaborative, firms typically saw this connection, rather than viewing addressing disparities as an additional or separate activity. Still, firms were constrained by the tight fiscal environment in which they operated and the competition for resources. Firms viewed building a business case for working on disparities as important to securing resources to address the issue, as well as for quality improvement.

4. Enhanced Industry Knowledge in Staff with Sponsor/Support Organizations

Although some key staff in sponsor and support organizations felt that their experiences in the Collaborative were consistent with their understanding of firm behavior, others openly acknowledged that they learned a great deal about the industry through the Collaborative. In most cases, the latter group of participants had more experience with provider-based organizations (or government research) than with complex health financing organizations like those in the Collaborative. These organizations were surprised by the severe limitations in available race/ethnicity data and the challenges in collecting it, as well as the organizational and other barriers within each firm and between it and the provider community. Conversely, participants were positively impressed with the interest and

commitment to quality improvement among firms participating in the Collaborative. They also came to understand why many firms preferred member interventions to those focused on providers, as well as the reasons that progress was slow and efforts typically long-term. (Although they were not necessarily convinced that the trade-offs between this kind of focus and others made sense.) As a result, sponsors and support organizations developed a greater understanding of why firm goals typically relate more to policy changes than to changes that actually benefit patients immediately and directly. However, many still viewed provider-based organizations as more immediately relevant to reducing disparities.

Contribution of Communications. The communications and dissemination infrastructure was an important development in Phase I of the Collaborative. While many participating organizations agreed that there was relatively little to communicate in the first phase, GMMB's communications work was important in presenting a standardized and consistent external message about the Collaborative. Moreover, much of the Phase I communications activity—the development of a logo and other NHPC materials and the establishment of a core message, for example—has provided a foundation for Phase II work, when the Collaborative may have substantively more activities and result to report.

B. PLANS FOR PHASE II

To encourage continued attention to concerns over disparities, sponsors have decided to proceed to a second phase for an additional two years. The support infrastructure will be streamlined with a single contract (from AHRQ) to CHCS, with RAND serving as subcontractor. (RWJF will continue to be a co-sponsor and responsible for communications.) While many details are yet to be determined, the intent is that the Phase II objectives will be clearer than those of Phase I, with a focus on particular activities that firms agree are important. Not all of the firms participating in the Collaborative will necessarily be involved in each Phase II activity, but the foci for attention in Phase II are to be:

- Development of approaches to primary data collection on race/ethnicity
- Collective work on ways to enhance language access in the national and local markets
- Creation of the business case for work in this area, both nationally and within firms
- Information exchange, both among participating firms and with other stakeholders
- Communications related to the accomplishments of Phase I

Details defining these objectives are still being developed, as are agreements with plans on how success will be measured.

C. INSIGHTS RELEVANT TO PHASE II

The Phase I experience suggests that continuing the Collaborative will be valuable to firms in sustaining and expanding the accomplishments to date. As one participating firm observed, the Collaborative serves as "the external cattle prod that keeps us moving." Given the external pressures on firms and the competition for resources, the Collaborative will encourage firms to continue to focus on disparities and provide a platform for sharing experiences, successes, and, if they choose, failures. This alone will be valuable to firms seeking insight and support.

However, there remain significant challenges to a successful Phase II, particularly if success is to be measured in terms of concrete accomplishments. While the activities firms have agreed to pursue in Phase II may appear more concrete and defined than those of Phase I, that clarity is to some extent misleading. While topic areas for Phase II have been defined, many details remain unclear and significant effort will still be required to drill down into the details of each topic. Moreover, from our observations of the process through which the specific areas of focus (primary data collection, language access, and the business case) were defined, we believe it will take strong leadership to move participating firms forward in a direction that they take ownership of and find useful, and that also makes progress on work that is both substantively and operationally clear and doable. The fact that firms themselves decided on Phase II activities—even though they require additional definition and specificity—likely increases the extent to which firms feel invested, at least at this stage. However, commitment will carry the work only so far, unless it can be leveraged to develop, implement, and succeed in specific substantive accomplishments.

In seeking clarity, sponsors and support organizations need to be realistic about what they can accomplish with the resources they have made available and those that firms can generate internally. On one hand, keeping all stakeholders engaged requires a broad focus, because each firm has its own priorities. On the other, to the extent that the focus is on broad, collective accomplishments rather than a process focused mainly on supporting communications among firms, only so much can be done. Although a conscious effort was made to limit the number of explicit activities in Phase II, there may be a natural tendency to handle differences of opinion among Collaborative members by expanding the scope of efforts to include all ideas instead of making strategic choices among competing priorities. As we read the scope for Phase II, such "scope creep" is reflected in defining goals to have national and market components (primary data, language access). Similarly the work to define business case for reducing disparities has been defined broadly at both the macro and firm business levels—referred to in Collaborative discussions as "Big B/little b" needs (each of which has its own set of complicated measurement and design issues). Beyond the specific objectives of concern to the task force, the Collaborative will have to invest in enhancing general information sharing and perhaps strengthening the substantive content of support in a number of areas. If these tasks all tap the same resources from firms and support organizations, there is a risk that none may be done well.

We also are concerned that too high a share of the resources available to the Collaborative have, in the past, been devoted to coordination rather than substantive analysis linked to other external efforts and scientific knowledge of the available evidence/state of

work in each area. For example, in focusing on primary data collection, the Collaborative will need to identify how its efforts interface (if at all) with providers and/or purchasers and how they relate to existing efforts at standardization, such as Office of Management and Budget (OMB) or state requirements regarding collection of racial/ethnic data.

In conclusion, the Collaborative has enhanced firm interest in effective interventions to measure and address disparities. However, there remain many challenges in designing and supporting such measures and interventions, and many political, organizational, and market factors to consider. We encourage participants in the Collaborative to assess their priorities and lessons learned from Phase I as they continue to work on this important issue.

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Appendix A

Additional Detail on Round 2 and 3 Interviews

Round Two. The second round of interviews sought a better understanding of (1) the location of the Collaborative lead and other participating staff within each organization; (2) how top leadership viewed the Collaborative in the context of broader organizational goals and any differences in views across units of the firm; (3) the firm context with respect to gathering self-reported data on race and ethnicity and using it to assess racial and ethnic disparities among members; (4) the experience of firms participating with RAND in geocoding and surname analysis; and (5) additional feedback on firms' experience with the Collaborative to date.

We conducted 54 round two interviews with 60 people—an average of about 6 interviews per firm and at least 5 interviews with each firm except one that limited its participation to a group interview with the three staff members most closely involved with the Collaborative.[1] Most firms were extremely helpful in supporting our interview requests. We were able to interview many of the staff specified in the protocol along with a few others (fewer than 5 of the 54) recommended by staff because of their perceived relevance.[2] While we succeeded in interviewing many of the staff types called for in the evaluation plan, we were more consistently able to interview those most closely involved in the Collaborative than others. In addition, the executives interviewed were more likely to represent the clinical side of the organization than health plan administration. This means that while we gained insight into marketing, legal, and information technology (IT) issues, we were often not able to interview staff specifically responsible for these functions.[3] In about half the firms, we succeeded in gaining access to the most senior executives, including the CEO of a national firm and several medical or operations directors. In the other half, we were told that executives viewed the staff we were interviewing (who were senior) as capable of adequately conveying their concerns. Though disappointing, the responses seem understandable given the demands on executives' time.

In addition to telephone interviews, we planned to collect two other types of data in round two. To provide feedback on communications within the network, we asked each of the nine participating firms and six support organizations/sponsors to complete a structured

[1] Of the other eight firms, we conducted five interviews with two firms, six interviews with one firm, seven interviews with three firms, and eight interviews with two firms. With one exception, we conducted fewer interviews with national firms than local/regional firms, although the overall level of cooperation among all of these firms was high.

[2] Typically, staff had responsibility for diversity issues within the firm, often related to the firm's workforce objectives. As discussed in Chapter III, the interviews illustrated that, beyond their care delivery function, the firms involved in the Collaborative are major employers and, as such, have an interest in the diversity of their workforce and their ability to contribute towards broader community goals related to diversity.

[3] Among the nine firms, we were able to interview the marketing designee in three firms and the legal designee in three firms. IT interviews typically took place with staff involved in geocoding and surname analysis. We were less successful in talking to staff with overall responsibility for IT within the firm. Gaps in marketing and IT interviews appear to reflect competing demands on these staff. Gaps in legal interviews reflect the difficulty of persuading firms to identify staff appropriate to respond to the legal issues related to disparities.

worksheet that elicited feedback on both the Collaborative overall and the contribution of diverse organizations. We planned to complement this with a request that firms complete a data capabilities worksheet to provide better insight into baseline and current capabilities in collecting self-reported racial and ethnic data for members. However, we dropped this component because of the potential burden and conflict with competing pressures on firms in the Collaborative,[4] along with our growing recognition that most firms had only collected race and ethnicity for a very small proportion of their commercial members. (Firms can get limited racial and ethnic data for Medicare and Medicaid members directly from those purchasers.) Instead, we captured general insights into the topics covered by that worksheet as part of the interviews we conducted.

Round Three. The third round of interviews sought a better understanding of (1) how top leadership viewed the firm's commitment to disparities and their overall perspectives of the Collaborative; (2) the specific pilot initiatives carried out by the firms to address racial and ethnic disparities among their members; and (3) the experiences and perspectives of firm staff working with GMMB to address communications issues related to the work of the Collaborative. The more limited scope of inquiry in round 3—and the recognition that firms were hesitant to spend substantial time responding to questions—led to fewer interviews in round 3 than round 2.

In this round, we conducted 23 interviews with 26 people; one firm opted not to participate.[5] We conducted an average of approximately three interviews per participating firm.[6] We interviewed the lead contacts from all eight firms participating in the round 3 interviews. To learn about the pilot activities, we interviewed additional staff involved in the pilot initiatives from five of the firms; the other three firms either had no clear pilot activity or the lead contact said that they could provide the information we needed about it. In addition, we interviewed firm staff involved in the Collaborative's communications work at seven of the eight firms.[7] Although we wanted to re-interview the same senior executives we talked with in round two, we were able to do so in only about half the firms. The others

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[4] CHCS, for example, had just asked firms to respond to a survey on their capacity to provide common HEDIS measures.

[5] Firms felt it was burdensome to respond to multiple requests for interviews, particularly after round 2 when substantially more interviews were requested. Also contributing to this feeling, firms typically did not distinguish between requests from the evaluation team and those from support organizations.

[6] Of the other eight firms, we conducted one interview with one firm, two interviews with one firm, three interviews with four firms, and four interviews with two firms.

[7] Five of the firms utilized staff from their communications/public relations divisions as the primary communications contact for the Collaborative. For one firm, the communications contact was also the staff member managing the day-to-day work related to the firms' disparities initiatives. We also found that one firm was in the process of hiring a new communications staff member (the former communications contact for the Collaborative left the firm a few months prior to our round three interviews), but the lead contact for that firm was moderately involved in the communications work and was able to speak to the firm's communications activities and perspectives.

typically believed that their senior executives had provided their views earlier so talking to them again when they had many demands on their time was not a priority.

Appendix B

Background on the Collaborative and its Origins

GROWING PUBLIC POLICY INTERESTS IN HEALTH DISPARITIES

Interest in racial and ethnic disparities in health care grew substantially in the late 1990s; at the same time, interest in quality improvement was on the rise (Table A-1). In 1998, late into his administration, President Clinton appointed Dr. David Satcher to the posts of Surgeon General and Assistant Secretary for Health. Satcher brought with him an interest in the disparities issue that would ultimately result in disparities emerging as one of the two goals for Healthy People 2010. At about the same time, John Eisenberg, then head of AHRQ, was asked to head an HHS interagency work group on quality.

When AHRQ was reauthorized late in 1999, the legislation called for preparation of an annual National Healthcare Quality Report and an annual National Healthcare Disparities Report beginning in 2003. That same year, Congress also requested the Institute of Medicine to prepare a report on racial and ethnic disparities in health care. The Office of Management and Budget (OMB) had already issued revisions to its classification of racial and ethnic data that were slated to go into effect in 2003. The National Committee on Vital and Health Statistics and, specifically, its Population Subcommittee began to examine the implications for data collection and analysis, both within and outside the private sector.

Although the transition from the Clinton to the Bush Administration resulted in some shift of emphasis, the push for reporting on quality and disparities was already well established. Drs. Satcher and Eisenberg continued to serve early in the Bush Administration while Senator Frist's interest in the issues contributed to bipartisan appeal.

INDUSTRY INTEREST

While much of the discussion of disparities focused on federal data and initiatives, other public sector initiatives also examined the capacity of private sector providers and health plans to track disparities and participate in improvement efforts. For example, the National Committee on Vital and Health Statistics (NCVHS) examined issues associated with collecting disparities data in the private sector. In 2001, Jack Rowe, who had recently taken charge at Aetna Health Care, decided that it was in the firm's interest to collect racial and ethnic data so that Aetna could examine disparities; the firm began to do so in late 2002, announcing the initiative publicly in early 2003.

Industry interest in the Collaborative reflects a response to the release of national reports on disparities in 2002 (IOM) and 2003 (AHRQ) as well as an effort undertaken by other major national firms to position themselves to respond to Aetna's initiative. In their drive for collaboration, firms started to look for a vehicle to address issues of disparities—a potentially sensitive concern—both collectively and within an environment that favorably addressed their antitrust, legal, and other concerns.

Table B.1. Timeline of Increased Interest in Racial and Ethnic Disparities

Developing Policy Focus on Racial and Ethnic Disparities Late 1990s-early 2003	
Policy interest in quality improvement grows: Institute of Medicine (IOM) issues a report on measuring the quality of health care and starts work on what would become the "Quality Chasm" report; HHS establishes Quality Inter-agency Coordination Task Force under the leadership of John Eisenberg of AHRQ.	1998-1999
Healthcare Research and Quality Act of 1999 enacted reauthorizing AHRQ and mandating the annual publication of a National Healthcare Quality Report and a National Healthcare Disparities Report, starting in 2003.	1999
Congress requests IOM to assess disparities in the kinds and quality of healthcare received by U.S. racial and ethnic minorities and non-minorities.	1999
HHS Issues Healthy People 2010 with two explicit goals: increase the quality and years of healthy life, and eliminate health disparities.	2000
IOM releases pre-publication copy of *Unequal Treatment*, its report on disparities.	2002
Aetna makes a public announcement that it had authorized collection of racial and ethnic data in 2001 and began to collect such data as of October 2002.	Early 2003
GAO responds to a request by Senator Frist for a report on "Health Care: Approaches to Address Racial and Ethnic Disparities."	2003
The National Research Council of the National Academy of Sciences issues a report on "Eliminating Health Disparities: Measurement and Data Needs."	2004
National Committee on Vital and Health Statistics (NCVHS) conducts hearings and reviews other information to assess the current limitations of health data on racial and ethnic groups, writing to the HHS Secretary with their comments as a response to the IOM report on racial and ethnic disparities and the National Health Care Disparities Report.	2004
America's Health Insurance Plans (AHIP) submits findings to RWJF from its survey of health plans on the data they have availability on race and ethnicity of their members.	mid-2004

Networked Leaders. Many of those actively involved in the Collaborative today were engaged in both public and private efforts related to disparities and personally committed to the issue. Dr. Lurie, now at RAND, worked for David Satcher as a Deputy Assistant Secretary of Health and was the point-person on disparities for much of the work in that office. In this capacity, she also worked with AHRQ leaders, including then-director Dr. Eisenberg and Carolyn Clancy (then a center director and now head of the agency). RWJF's current president, Risa Lavizzo-Mourey, also had been in the senior AHRQ leadership during the Clinton Administration. She was Co-Vice Chair of the IOM committee on disparities and made disparities one of the new priorities at RWJF when she assumed leadership of the organization in the early 2000s. John Lumpkin, who was brought in by Dr. Lavizzo-Mourrey to head the health care work at RWJF (where disparities was located), previously served as chair of NCHVS when it was dealing with the issue of disparities data.

Well-positioned individuals in the industry also had a long history of engagement in public policy issues and brought an active interest in the disparities issue. The following are notable examples.

- Woody Myers, then executive vice president at WellPoint Health Networks, was a reviewer of the IOM report on disparities and came to his position at WellPoint after working on health benefits for General Motors and heading the New York City Health Department. (After the WellPoint-Anthem merger, Dr. Myers left the firm.)

- Ray Baxter, head of community benefits at Kaiser Permanente, made reduction of disparities a priority when he joined the firm. He was previously in a leadership position with Lewin Associates and had led the San Francisco Department of Public Health and the New York City Health and Hospitals Corporation.

- Jack Rowe, Aetna's president and CEO, started in 2000; he previously led the Mt. Sinai-NYU Health System in New York City, where he was active in public policy activities and served as a commissioner of the Medicare Payment Advisory Commission.

- Reed Tuckson, senior vice president of consumer health and medical care advantage for UnitedHealth Group (the parent company for affiliated health businesses), assumed his position in 2000 after working in senior positions at the American Medical Association and elsewhere. He chaired IOM's Quality Chasm Summit Subcommittee and served in the late 1980s as the District of Columbia's commissioner of health. (Dr. Lewis Sandy, currently executive vice president for clinical strategies at UnitedHealthcare, one of UnitedHealth Group's main business divisions, was previously executive vice president at RWJF.)

- Kathy Coltin, director of external quality and data initiatives at Harvard Pilgrim, served on the NCVHS Subcommittee on Populations and participated in its work to measure racial and ethnic disparities.

These historical connections pointed to the personal, as well as organizational interests and connections that helped shape the Collaborative.

BUILD UP TO COLLABORATIVE

Exactly when the seeds were sown for the Collaborative is a matter of debate. In any event, the process that ultimately led to formation of the Collaborative had its origins in the discussions that started in the late 1990s among overlapping sets of health plan representatives, government officials, and researchers. Clinton Administration official Dr. Lurie says that she, along with AHRQ leaders, grew concerned about the limited amount of data for documenting disparities within health plans. In response, they convened a meeting in mid-1999 (cosponsored by HHS and the Commonwealth Fund) with representatives of managed care plans, purchasers, and federal agencies. HHS also cosponsored a 50-state study of laws regulating data collection (also funded by the Commonwealth Fund). Ultimately, these activities and the underlying concern about disparities led firms sponsoring health plans—working with Dr. Lurie, who was by then at RAND—to request support from the California Endowment to help think through issues associated with addressing disparities (Bierman, Lurie, Collins, Eisenberg 2002; Lurie interview 2005). During this period, RWJF funded the American Health Insurance Plans (AHIP) to survey health plans about their data on disparities (AHIP 2004).

The decision to pursue a collaborative under AHRQ's sponsorship occurred in summer 2003. In July of that year, AHRQ convened a meeting facilitated by Larry Bartlett of Health Systems Research that brought together members of the California Endowment, RAND, and a number of national and other firms sponsoring health plans. AHRQ staff members say that the genesis of the meeting occurred when firms approached AHRQ for technical assistance in forming a collaborative and measuring disparities. For the industry, collecting data on race and ethnicity raised a host of organizational issues and concerns about legal liability, marketing risks, and so forth. Working collectively under the AHRQ umbrella was potentially attractive to firms seeking to minimize perceived individual risks. RWJF senior staff also attended the meeting at AHRQ's invitation. We have not interviewed staff from the California Endowment, but we gather that AHRQ's interest in the Collaborative allowed the California Endowment to reduce its involvement in the issue.

At the July meeting, attendees reached agreement on guiding principles for their work (Health Plan Learning Collaborative Agreement). These principles state that:

- Improving quality and reducing disparities are inextricably linked.

- Improving quality and reducing disparities are important health plan objectives.

- Quality measurement and performance assessment is the foundation on which quality improvement is based. Plans cannot improve what is not measured.

- Performance assessment will focus on selected domains of clinical care to be chosen on the basis of national priority (e.g., IOM's 20 priority areas, as well as NHQR and NHDR).

- The Collaborative will build on existing quality measurement and performance assessment efforts whenever possible.

- The Collaborative will support consistency in quality measurement and performance assessment.

- The Collaborative will support strategies that improve quality and reduce disparities.

- The Collaborative will support flexibility in quality improvement strategies so that plans may intervene at the consumer, physician, or organizational levels.

- The Collaborative will foster an environment in which it can share its experiences with the broader health community.

AHRQ's commitment to the Collaborative was to provide technical assistance, information on evidence-based approaches to quality improvement strategies, and opportunities for dialogue and learning.

After the July 2003 meeting, AHRQ began to put in place vehicles and agreements that would operationalize support for the Collaborative. In September 2003, AHRQ awarded RAND a sole-source contract to support the Collaborative in assessing needs and collecting and analyzing data; RAND's earlier involvement with plans on the disparities issue as well as Allen Fremont's work in measuring disparities involving UnitedHealthcare under AHRQ's Integrated Delivery System Systems Research Network (IDSRN) led to RAND's involvement. RWJF agreed to cosponsor the Collaborative. AHRQ and RWJF staff worked through spring 2004 to define their respective roles and responsibilities. Ultimately, they decided that RWJF would fund the learning organization, which comprised of CHCS and IHI, to help facilitate the process of collaboration; these arrangements were in place by spring 2004. (The official contract with CHCS is dated August 25, 2004.) The first official meeting of the Collaborative took place on September 10, 2004.

APPENDIX C

NETWORK ANALYSIS[1]

[1] While MPR staff drafted this chapter, Patrick Doreian, a consultant to the project based at the University of Pittsburgh, guided the overall analysis and design of the network component of the evaluation. Mr. Doreian helped identify relevant items and is responsible for most of the analysis that we considered in framing findings from the work.

A. Overview of Network Analysis

The Collaborative aims to help the nine participating firms work together to reduce racial and ethnic disparities among their members. To understand more fully the relationships between participants in the Collaborative and learn how the Collaborative functions, we conducted network analyses of the Collaborative. The analyses provide tools for assessing whether the support organizations are offering assistance (and through what channels) and whether participating firms are interacting with one another. The analyses also provide a means of examining whether the sponsor organizations are perceived as visible and active participants in the Collaborative. In addition, the analyses offer some indication as to whether certain organizations contribute more to the Collaborative than others and/or benefit more from their participation. Specifically, the network analyses allow us to capture organizations' perceptions of contributions and benefits, and whether these contributions and benefits are equal across participating organizations.

Brief Overview of Findings. The results of the network analysis indicate that the sponsor organizations and primary support organizations play a central role in the Collaborative. They have the most contact with participating firms and form the primary pathways that link participants (including both firms and nonfirm organizations). Firm-to-firm relations are much less prevalent than firm-to-nonfirm relations. In fact, interactions and influence between firms are generally quite limited outside the Collaborative, a result that may be expected and even appropriate given the competitive environment in which participating firms operate. Nonetheless, most organizations participating in the Collaborative find each other important, and most respondents report that other organizations are carrying out their responsibilities and commitments to the Collaborative, at least to a small extent. A few of the firms—namely, one national and one regional firm—stand out as more important and influential members of the Collaborative than other firms.

Background. Network theory focuses on the relationships and ties among actors or organizational entities (Wasserman and Faust 1994). Even though network analysis may capture individual actors' attributes, its focus is on relational patterns between actors. Such analysis can be used as a purely descriptive tool, but we relied on the analysis to develop an understanding of the relationships that promote or impede the Collaborative's ability to work effectively in addressing concerns related to disparities. We applied the tools of network analysis to describe the relationships among the organizations participating in the Collaborative and to identify relevant network properties that shed light on the Collaborative's outcomes.

The network analyses for the evaluation focus on relationships and perceptions *between* participating organizations in the Collaborative rather than *within* participating organizations. While the Collaborative hopes to affect the internal workings of participating organizations, our focus on relationships between participants is appropriate given that the Collaborative is most committed to developing inter-organizational ties. Moreover, an analysis of the network structure within each participating organization was not possible given the size and

complexity of participating firms (especially the national firms) and the scope of the evaluation.[2]

Methods. To collect information on the relationships between and perceptions of organizations participating in the Collaborative, we developed a network feedback form based roughly on an instrument developed by Van de Ven and Ferry (1980). We used questions from the instrument that were most relevant for assessing the Collaborative and modified question wording to make sense in the context of the Collaborative. The feedback form included two primary sets of questions:

- ***Nine questions about the Collaborative overall***, such as whether the Collaborative has been worthwhile and whether it has influenced the organization's activities

- ***Eight questions (including one two-part question) about relations between and assessments of other Collaborative participants***, such as the extent of communication between the respondent's organization and each of the other organizations outside of Collaborative meetings and the influence of other organizations on the respondent's organization with respect to disparities.

The feedback form is included in Appendix B.

We asked the lead contact at each firm, support organization, and sponsor organization to complete the feedback form in late 2005—approximately 15 months after the start of the Collaborative. Although we did not receive some forms until January 2006, we achieved a 100 percent response rate (15 organizations). Some respondents, however, did not complete certain portions of the feedback form—particularly questions that asked respondents to assess the contributions of other organizations participating in the Collaborative—leading to substantial item nonresponse on a few questions. In fact, we dropped Question 15 ("To what extent has your organization changed or influenced other organizations with respect to disparities?") from the analysis because half of the Collaborative's 15 organizations did not answer or answered "cannot assess." Question 13 ("To what extent has each organization carried out its responsibilities and commitments involving disparities in regard to the Collaborative during the past six months?") also resulted in relatively high non-response, with 6 organizations rating few or no other organizations. We still present the results of Question 13, however, noting the missing data. For other questions in which respondents were asked to rate other organizations, two organizations often did not provide ratings.

[2] To understand firms' internal relationships related to reducing disparities, we employed the less formal approach of structured interviews with firm participants. We had originally hoped to explore communications systematically among senior executives and various line managers in order to develop a sense of the existence and strength of relations but found that the organizational structures were so complex and our interviews too limited to fully support this. However, Chapter III provides an analysis of how the Collaborative is positioned within each firm and the degree to which the firm is known for its work related to the Collaborative or, more generally, for its work on disparities.

Even though we achieved full cooperation on the network feedback form among Collaborative participants, the number of respondents remains small (15). Therefore, while a systematic analysis of national versus regional firms (as well as other types of participating organizations) would be interesting, the sample size does not support it. However, we do observe some interesting differences in firms versus nonfirm organizations (i.e., sponsor and support organizations) and draw such distinctions in this chapter where appropriate. We also distinguish among key support organizations (CHCS and RAND), other support organizations (GMMB and IHI), and sponsors (AHRQ and RWJF) on certain dimensions of the analysis as appropriate as the three sets of organizations have distinct roles in the Collaborative.

Caveats. An important caveat in examining the network analyses relates to the reliance on self-reported data. While analyses of networks frequently rely on self-reports, any given organization's frame of reference varies from that of other organizations. Moreover, some organizations may be more forthcoming or unbiased in their ratings than others. In some ways, the fact that organizations are asked to rate one another for our network analyses provides a partial check on self-reports; for example, Organization A may report that it fulfilled its commitments to the Collaborative, but other organizations may report that Organization A did not fulfill its commitments. Such unreciprocated claims may provide clues about the appropriate operation (or not) of the Collaborative.

An additional caveat is that an effective collaboration can occur in many different ways. Not all participants need to be highly communicative or influential. An extremely "dense" network—in which all participants communicate with all others—is actually inefficient. Therefore, while we draw out certain findings in this chapter, our analysis is not necessarily meant to be normative but rather is descriptive of the Collaborative process and its early outcomes as far as resulting action and change.

The remainder of this chapter focuses on participating organizations' overall perceptions of the Collaborative, followed by various analyses of the Collaborative network. For more information on the methods underlying the network analyses, see Appendix C.

B. OVERALL PERCEPTIONS OF THE COLLABORATIVE

The network feedback form first asked the lead contact from each participating organization to provide feedback on the Collaborative as a whole by responding to a core set of nine questions as follows:

- Overall, how important was the Collaborative in attaining the goals of your organization?
- To what extent has the Collaborative carried out its responsibilities and commitments?
- To what extent has your organization carried out its responsibilities and commitments to the Collaborative?

- To what extent do you feel the relationship between your organization and the Collaborative is productive?

- To what extent is the time and effort spent in developing and maintaining the relationship with the Collaborative worthwhile?

- Overall, to what extent are you satisfied with the relationship between your organization and the Collaborative?

- To what extent has your organization changed or influenced the activities of the Collaborative?

- To what extent has the Collaborative changed or influenced the activities of your organization?

- Are the payoffs of the Collaborative for your organization reasonable relative to your contribution?

As presented in Table C.1, all but one participating organization felt that the Collaborative was at least somewhat important to attaining organizational goals (Question 1). In fact, 10 of the 15 organizations in the Collaborative (6 of the 9 firms and 4 of the 6 nonfirm organizations) reported that the Collaborative was very important or crucial for achieving organizational goals with regard to reducing health disparities. On average, organizations felt that the Collaborative has carried out its responsibilities and commitments "to a considerable extent," with firms slightly more positive than other (nonfirm) organizations (Question 2).

When asked to rate their own organization on carrying out responsibilities and commitments to the Collaborative, almost all organizations were very positive (Question 3). Two of the firm representatives (both from national firms), however, indicated that their organizations carried out their responsibilities and commitments only to "a little extent" (one) or "some extent" (one). Almost all respondents reported that the relationship between their organization and the Collaborative is productive and worthwhile (Questions 4 and 5); support and sponsor organizations were somewhat more positive than firms on these dimensions. Likewise, all organizations reported that they were satisfied with the relationship between their organizations and the Collaborative to at least some extent (Question 6).

Support and sponsor organizations reported changing or influencing Collaborative activities more than firms did (Question 7), a response that is probably not surprising given these organizations' roles in shaping the Collaborative and working with firms on a one-on-one basis. In comparison, firms were more likely than other organizations, however, to say that the Collaborative had changed or influenced their organization's activities, with 6 of the 9 firms saying to a "considerable extent" or "great extent" (Question 8). All organizations said that the payoffs of the Collaborative were reasonable relative to contribution, with firms

Table C.1. General Perceptions of the National Health Plan Collaborative

	All Organizations (15 total)	Firms (9 total)	Key and Other Support Organizations, Sponsors (6 total)
1. Overall, how important was the Collaborative in attaining the goals of your organization?			
Not at all important	0	0	0
A little important	1	1	0
Somewhat important	4	2	2
Very important	7	3	4
Crucial	3	3	0
2. To what extent has the Collaborative carried out its responsibilities and commitments?			
No extent	0	0	0
A little extent	0	0	0
Some extent	3	2	1
Considerable extent	9	4	5
A great extent	3	3	0
3. To what extent has your organization carried out its responsibilities and commitments to the Collaborative?			
No extent	0	0	0
A little extent	1	1	0
Some extent	1	1	0
Considerable extent	9	5	4
A great extent	4	2	2
4. To what extent do you feel the relationship between your organization and the Collaborative is productive?			
No extent	0	0	0
A little extent	0	0	0
Some extent	2	2	0
Considerable extent	9	6	3
A great extent	4	1	3
5. To what extent is the time and effort spent in developing and maintaining the relationship with the Collaborative worthwhile?			
No extent	0	0	0
A little extent	0	0	0
Some extent	1	1	0
Considerable extent	7	6[a]	1
A great extent	7	2	5
6. Overall, to what extent are you satisfied with the relationship between your organization and the Collaborative?			
No extent	0	0	0
A little extent	0	0	0
Some extent	1	1	0
Considerable extent	12	7[a]	5
A great extent	2	1	1

Table C.1 *(continued)*

7. To what extent has your organization changed or influenced the activities of the Collaborative?			
No extent	0	0	0
A little extent	2	2	0
Some extent	4	3	1
Considerable extent	6	3	3[a]
A great extent	3	1	2
8. To what extent has the Collaborative changed or influence the activities of your organization?			
No extent	0	0	0
A little extent	3	2	1
Some extent	5	1	4
Considerable extent	5	5	0
A great extent	2	1	1
9. Are the payoffs of the Collaborative for your organization reasonable relative to your contribution?			
No extent	0	0	0
A little extent	0	0	0
Some extent	1	0	1
Considerable extent	8	5[a]	3
A great extent	5	4	1[b]

[a]Includes one respondent whose answer fell between "some" and "considerable."

[b]One respondent did not answer this question.

somewhat more positive on this dimension than sponsor and support organizations (Question 9).

Clearly these responses paint a positive picture of the Collaborative overall. Although there was relatively little variation in the average response across questions, respondents across all organizations were most positive about the time and effort required by the Collaborative being worthwhile and least positive about the extent to which the Collaborative influenced the respondent's own organization (the latter of which was driven by the responses of sponsor and support organizations rather than by those of firms).

C. Relationships in the Context of Collaborative Goals

The network feedback form also included a series of eight questions to assess the presence and strength of relationships *between* Collaborative participants, and the corresponding answers provide the data for our network analyses. These questions asked respondents to rate all other participating organizations on various dimensions, such as their influence, the extent to which they carried out their responsibilities and commitments, and their contribution of good ideas to the Collaborative. For each question, respondents assessed each of the other 14 organizations using an ordered response scale (such as to no extent, to a little extent, to some extent, and to a considerable extent).

The following section describes four categories of findings from our network analyses: (1) the strength of pre-existing ties, (2) how the Collaborative works, (3) the perceived contributions to organizational action, change, and influence, and (4) the overall standing of participating organizations. We mapped Questions 10 through 17 from the feedback form into the first three categories above (based on the dimension reflected in each question). In addition, we use information from Questions 10 through 17 to create measures of overall standing. A large amount of missing data led to the exclusion of Question 15 ("To what extent has your organization changed or influenced other organizations?") from our analyses.

1. Strength of Pre-existing Ties

The feedback form queried respondents about relationships that existed prior to the start of the Collaborative between an organization's participants in the Collaborative and those of each of the other organizations. While prior relationships are not a prerequisite for a successful collaborative, they do reveal information about the extent of existing relationships and provide information about the relations formed during the Collaborative. They suggest relationships that were needed in order to undertake joint work for the Collaborative.

A two-part question (Question 10 of the network feedback form) captured: (1) any personal acquaintance with the key Collaborative staff from each organization before formation of the Collaborative and (2) if that acquaintance existed, the extent to which the respondent's organization had an effective working relationship with the other organizations. The main findings include the following:

1. The sponsor organizations reported a prior acquaintance with all or almost all other participants before the start of the Collaborative. The support organizations each had prior acquaintance with at least 8 of the other 14 organizations, though the key support organizations reported knowing fewer organizations than other support organizations prior to the start of the Collaborative.

2. Conversely, at least 10 organizations (and more than 10 for some organizations) reported a prior acquaintance with the sponsor organizations and key support organizations before the start of the Collaborative.

3. One national firm reported a prior acquaintance with all other members of the Collaborative. In general, however, firms varied substantially in the number of organizations with which they had a prior acquaintance, with the average firm acquainted with four other organizations before the Collaborative.

4. Eleven of the 14 other organizations in the Collaborative (including 6 of the 8 other firms) indicated a prior acquaintance with one particular national firm. (This was *not* the same firm that reported a prior acquaintance with all members of the Collaborative.)

5. In only a few instances did two firms both report mutual acquaintance with one another (firm-to-firm "reciprocated" ties), perhaps reflecting the competitive environment between firms or maybe a difference in perceptions across respondents about the definition of a prior acquaintance.

6. When asked whether their organization had an effective working relationship before the Collaborative with organizations for which respondents reported an existing acquaintance, participants most commonly reported effective working relationships with the sponsor organizations. Participants also reported effective working relations with the key support organizations on a relatively frequent basis. That is, before the Collaborative began, firms were more likely to have effective working relations with sponsors or support organizations than with one another.

2. The Collaborative Process

Understanding the Collaborative process—including if and how much participants communicate and share information with one another—is essential to uncovering the ways in which the Collaborative might effect change. Three questions included in the network feedback form provide information on the Collaborative process and the way the Collaborative functions (Questions 11, 13, and 17). The questions provide some sense of the success of the Collaborative process in terms of communicating, carrying out commitments, and providing ideas. These questions are:

1. During the past six months—outside of formal Collaborative meetings—how frequently have people from your organization who are involved in the Collaborative communicated or been in contact with people in the organizations listed below?

2. To what extent has each organization carried out its responsibilities and commitments involving disparities in regard to the Collaborative during the past six months?

3. Which organizations provide good ideas for dealing with disparities at meetings of the Collaborative?

Communication. Sponsor and support organizations reported a substantial amount of communication with each other outside of formal Collaborative meetings; in fact, communication between nonfirm entities represents the most "dense" part of the communication network. A fair amount of communication also occurs between the two key support organizations and firms. This result is not surprising and is consistent with what we understand to be the way the Collaborative works—an approach that lends itself to extensive consultation between individual support organizations and firms and then among

the support organizations in order to coordinate efforts.[3] A number of organizations also reported communication with GMMB, though substantially fewer than the number reporting communication with the two key support organizations. This finding is consistent with the fact that GMMB has communicated about media toolkits with firms' communications departments, particularly in late 2005 (when the feedback form was distributed).

Outside of formal Collaborative meetings, firm-to-firm communication was limited. Only a few firms reported communicating with other firms, with regional firms reporting the large share of such communications. Three firms (two national and one regional) reported no communication with any other firm outside of Collaborative meetings. It is possible that the lack of such communication explains why firms found it valuable to rely on sponsors to convene the Collaborative as a vehicle for addressing competitive or other barriers to communication.

Figure C.1 provides an illustration of communication between participants. The first six rows of the figure correspond to the 6 sponsor and support organizations (labeled s1 through s6 and listed in a random order), and the remaining nine rows correspond to the firms (labeled f1 through f9 and listed in a random order).[4] The rows represent how a given organization rates each of the organizations listed in the columns (which represent the 6 sponsor and support organizations, followed by the 9 firms, from left to right). For example, boxes 2 through 15 of the first row show how support organization 1 rated all other organizations (S2, S3, and so forth) in the Collaborative. The shaded blocks in the figure represent some level of communication, with darker shades indicating more frequent communication. The black squares represent the strongest ties between Collaborative organizations. White boxes indicate no communication between organizations, and red boxes indicate missing data. (Blocks on the figure's diagonal are in light red, given that organizations did not rate themselves.) Consistent with the discussion above, the figure shows that most communication occurs between nonfirm organizations and between firms and nonfirms rather than between firms.

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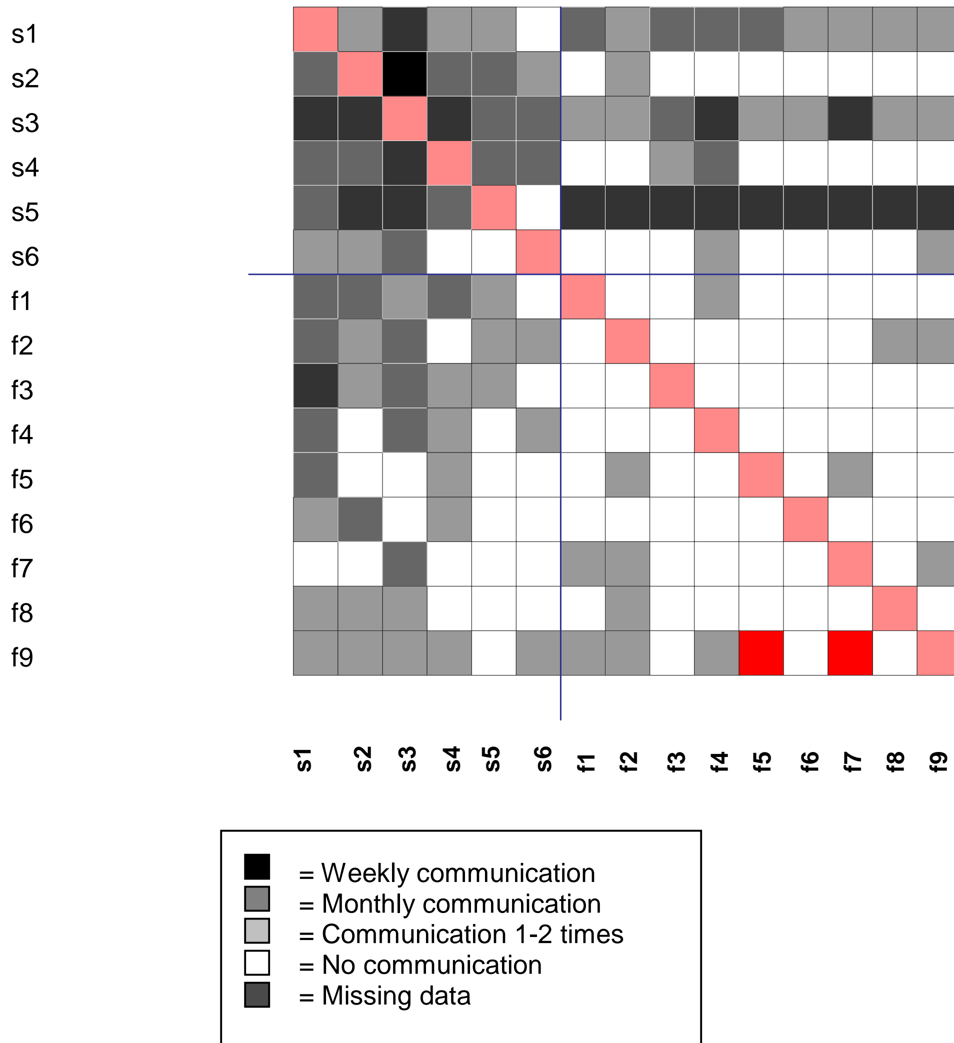
[3] The Collaborative was structured so that RAND provided technical assistance to firms—particularly on geocoding and surname analysis activities—and CHCS organized meetings of the Collaborative and collected periodic status reports from firms. Often, staff from several support organizations participated together as a team on individual calls with a firm, and frequent conference calls (known as "operational committee" calls) were conducted to help support and sponsor organizations prepare and coordinate their activities as part of the Collaborative.

[4] Although organizations are de-identified and listed in a random order in the figures presented in this chapter, we do use the same ordering of organizations in Figures C.1 through C.4.

Figure C.1. Frequency of Communication and Contact Between Collaborative Participants



Question: During the past six months—outside of formal Collaborative meetings—how frequently have people from your organization who are involved in the Collaborative communicated or been in contact with people in the organizations listed below?

Note: The first six rows of the figure correspond to the six sponsor and support organizations, and the remaining nine rows correspond to the firms. The rows represent how a given organization rates each of the organizations listed in the columns (which represent the six sponsor and support organizations, followed by the nine firms, from left to right). The diagonal of the figure is irrelevant since firms were not asked to rate themselves.

Carrying Out Responsibilities and Commitments. With the caveat that a substantial amount of data is missing for the question on responsibilities and commitments, most organizations that rated other organizations felt that others were carrying out their commitments and responsibilities to at least a little extent. (In terms of missing data, four of the nine firms rated few or no other organizations, and two of the support organizations did not rate other organizations.) Only one organization, a national firm, reported that four other (mostly national) firms were not carrying out their responsibilities and commitments. Generally, firms tended to rate other firms as carrying out their responsibilities "to a little extent" or "to some extent" and rated other (nonfirm) organizations more favorably. Support and sponsor organizations rated firms much more favorably on commitments and responsibilities than firms rated each other.

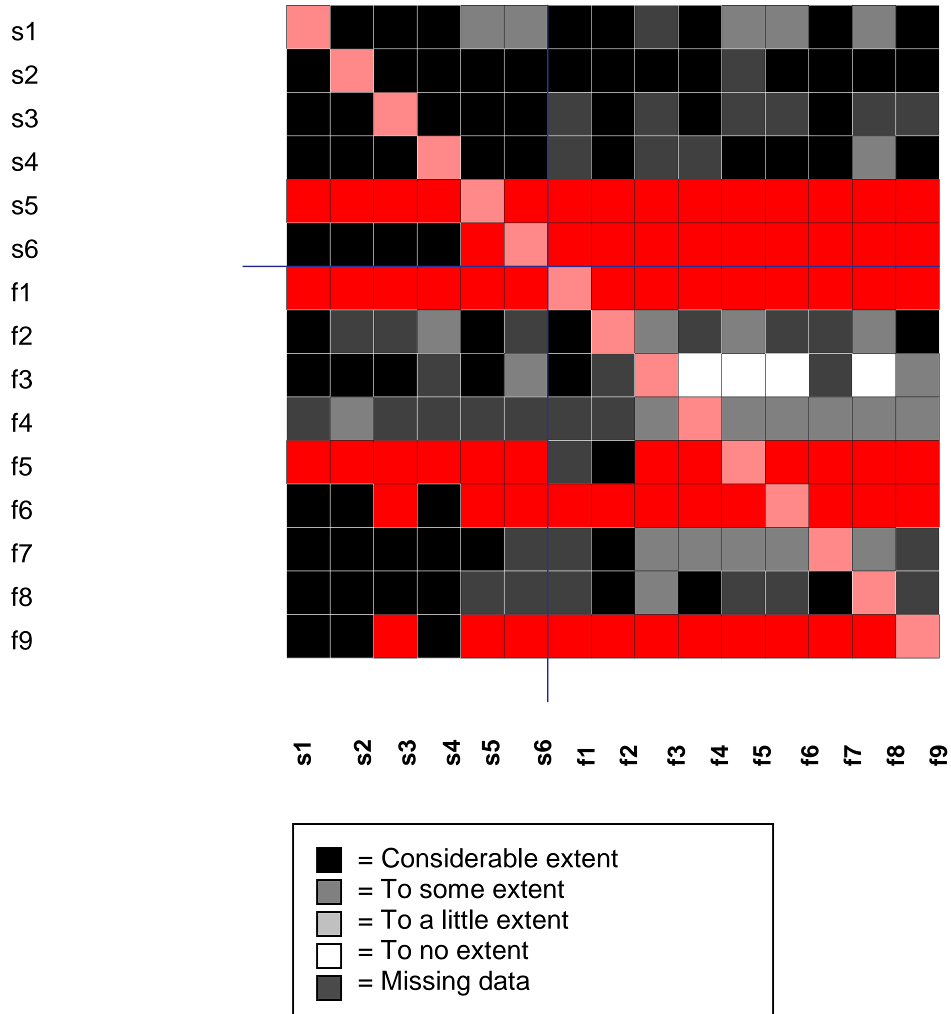
Figure C.2 provides an illustration of the network analysis of commitments and responsibilities. Again, darker shading indicates that the rated organization is seen as carrying out its responsibilities and commitments to a greater rather than lesser extent (with the darkest boxes indicating "to a considerable extent" and white boxes indicating "to no extent"). It is important to note the large amount of missing data, shown in red.

Providing Good Ideas. When asked to rate other organizations on whether they provided many, some, or no good ideas (Question 17), most organizations were rated by others as providing the Collaborative with at least "some good ideas" (Figure C.3). Firms and nonfirm organizations alike often rated the two key support organizations and the two sponsors as providing many good ideas. In addition, one national firm and one regional firm were identified by over half of the other organizations in the Collaborative as providing many good ideas. Conversely, two national firms were identified by nearly half of the other organizations as providing no good ideas. One firm saw only three other Collaborative organizations (all support organizations) as a source of good ideas. Six of the participating organizations saw all other organizations as sources of good ideas. The red diagonal squares reflect the undefined "self-ties" in the network.

3. Perceived Contributions of Collaborative Participants to Action and Change

While understanding the Collaborative process is important, the Collaborative's ultimate aim is to bring about outcomes, namely, organizational action and change in reducing racial and ethnic disparities among participating firms. We therefore wanted to assess whether any organizations were particularly important or influential (or not) with respect to the Collaborative, perhaps spurring others to action. Three questions in the network feedback form help provide information on the perceived contribution of other participating organizations to a given organization's actions and goals (Questions 12, 14, and 16) in terms of each organization's importance, productivity, and influence relative to the other organizations. These questions are:

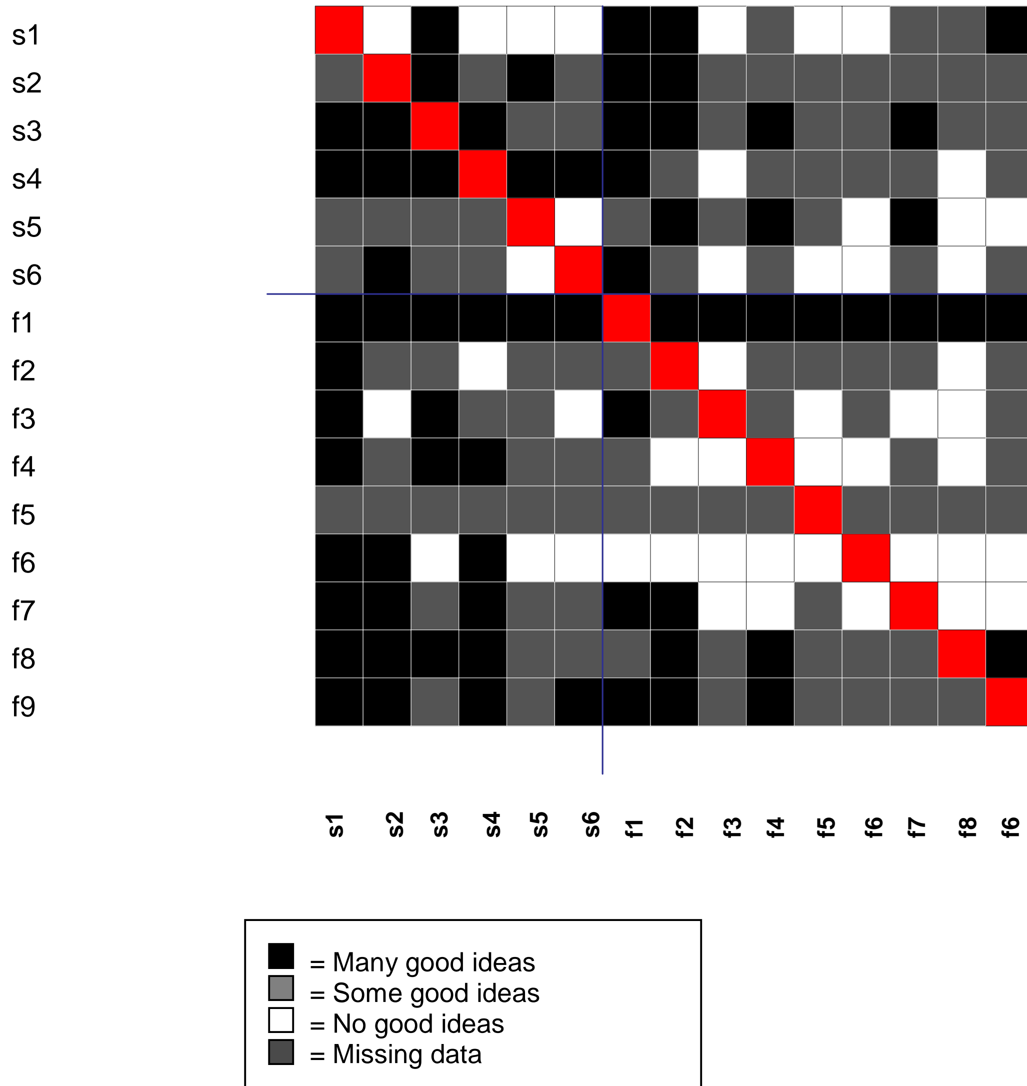
Figure C.2. Extent to Which Collaborative Participants Carry Out Responsibilities and Commitments to the Collaborative



Question: To what extent has each organization carried out its responsibilities and commitments involving disparities in regard to the Collaborative during the past six months?

Note: The first six rows of the figure correspond to the six sponsor and support organizations, and the remaining nine rows correspond to the firms. The rows represent how a given organization rates each of the organizations listed in the columns (which represent the six sponsor and support organizations, followed by the nine firms, from left to right). The diagonal of the figure is irrelevant since firms were not asked to rate themselves.

Figure C.3. Extent to Which Collaborative Participants Provide Many or Some Good Ideas



Question: Which organizations provide good ideas for dealing with disparities at meetings of the Collaborative?

Note: The first six rows of the figure correspond to the six sponsor and support organizations, and the remaining nine rows correspond to the firms. The rows represent how a given organization rates each of the organizations listed in the columns (which represent the six sponsor and support organizations, followed by the nine firms, from left to right). The diagonal of the figure is irrelevant since firms were not asked to rate themselves.

1. Overall, how important was each organization's work through the Collaborative in attaining the goals of your organization with respect to disparities?

2. To what extent do you feel the relationship between your organization and each of the other organizations with respect to disparities is productive?

3. During the past six months, to what extent has each of these other organizations changed or influenced the activities of your organization with respect to disparities?

While many other factors unrelated to the Collaborative's structure—including external and internal factors—could influence whether a given organization sees its relationships with other organizations as productive or influential, the three questions provide some information on the Collaborative's possible effects or outcomes.

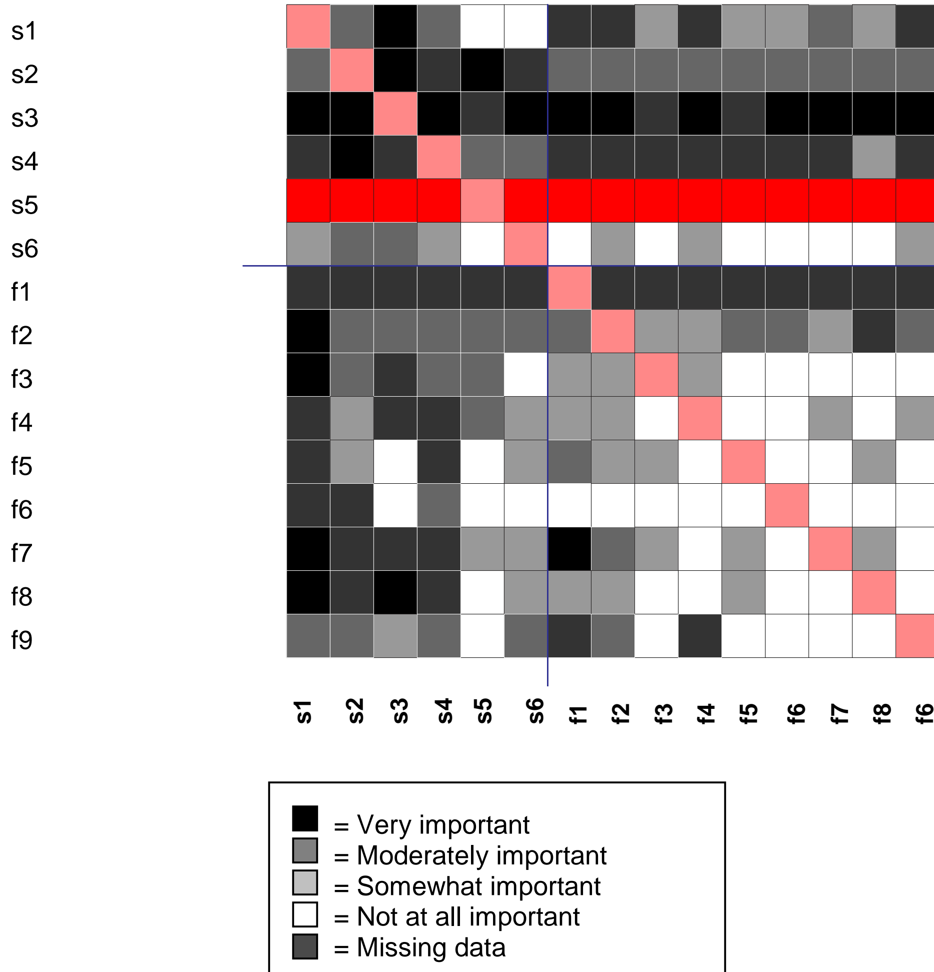
Importance of Others. Firms generally rated nonfirm organizations as at least moderately important in helping the firms attain their disparities-related goals (where the scale included not at all important, somewhat important, moderately important, very important, and crucial). However, few firms identified other firms as important to their organizational goals, with the most common ratings "not at all important" and "somewhat important." Firms' ratings of nonfirms make sense given that sponsor and support organizations were directly involved with helping firms with their work on disparities. It may be that most firms did not find other firms important in meeting their organizational goals, given that firms may have different goals and may be uncomfortable sharing their goals (given the competitive environment).

Sponsor and support organizations generally rated each other as at least moderately important to attaining organizational goals. Similarly, sponsor and support organizations tended to rate firms as at least moderately important to organizational goals. Thus, all three groups perceived that sponsors and support organizations were at least moderately important to the success of the Collaborative, but firms were less likely than the other groups to perceive other firms as important to them.

Figure C.4 provides an illustration of the importance of other organizations. (Note that one nonfirm organization did not rate other organizations.) Again, boxes with darker shading indicate stronger relationships, and white boxes show cases where an organization is "not at all important." Assessments of other organizations as not important are concentrated in the firm-to-firm ties. Again, it is important to stress that this result is not necessarily an adverse finding because participants bring different objectives to their participation in the Collaborative.

Productive Relationships with Others. When asked about the productivity of relationships with other Collaborative participants, most organizations saw their relationships with others as productive at some level (i.e., at least "to a little extent"). This finding suggests that participants see value in their participation. Collaborative participants most frequently reported considerably productive relationships with the key support

Figure C.4. Importance of Other Organizations to Collaborative Participants



Question: Overall, how important was each organization's work through the Collaborative in attaining the goals of your organization with respect to disparities?

Note: The first six rows of the figure correspond to the six sponsor and support organizations, and the remaining nine rows correspond to the firms. The rows represent how a given organization rates each of the organizations listed in the columns (which represent the six sponsor and support organizations, followed by the nine firms, from left to right). The diagonal of the figure is irrelevant since firms were not asked to rate themselves.

organizations and the sponsor organizations. All other organizations received only a few nominations (three or four at most) for providing a relationship that is productive to a considerable extent. Conversely, four organizations—three national firms and one regional firm—viewed relationships with a handful of other firms as not productive.

Figure C.5 provides a graphic representation of organizations reporting considerably productive relationships with other organizations participating in the Collaborative. Sponsor and support organizations are shown as rectangles and firms as ovals. The lines or "ties" between organizations with a single arrow reflect one of the two organizations in the pair reporting a productive relationship with the other organization (with the receiving organization being the one with which the relationship is considerably productive). Lines or ties with no arrows indicate that both organizations reported considerably productive relations with one another. The figure reflects the fact that, as described above, many organizations report considerably productive relationships with the sponsor and support organizations (shown as rectangles). Most firms are viewed as offering considerably productive relationships by only a few other organizations in the Collaborative.[5]

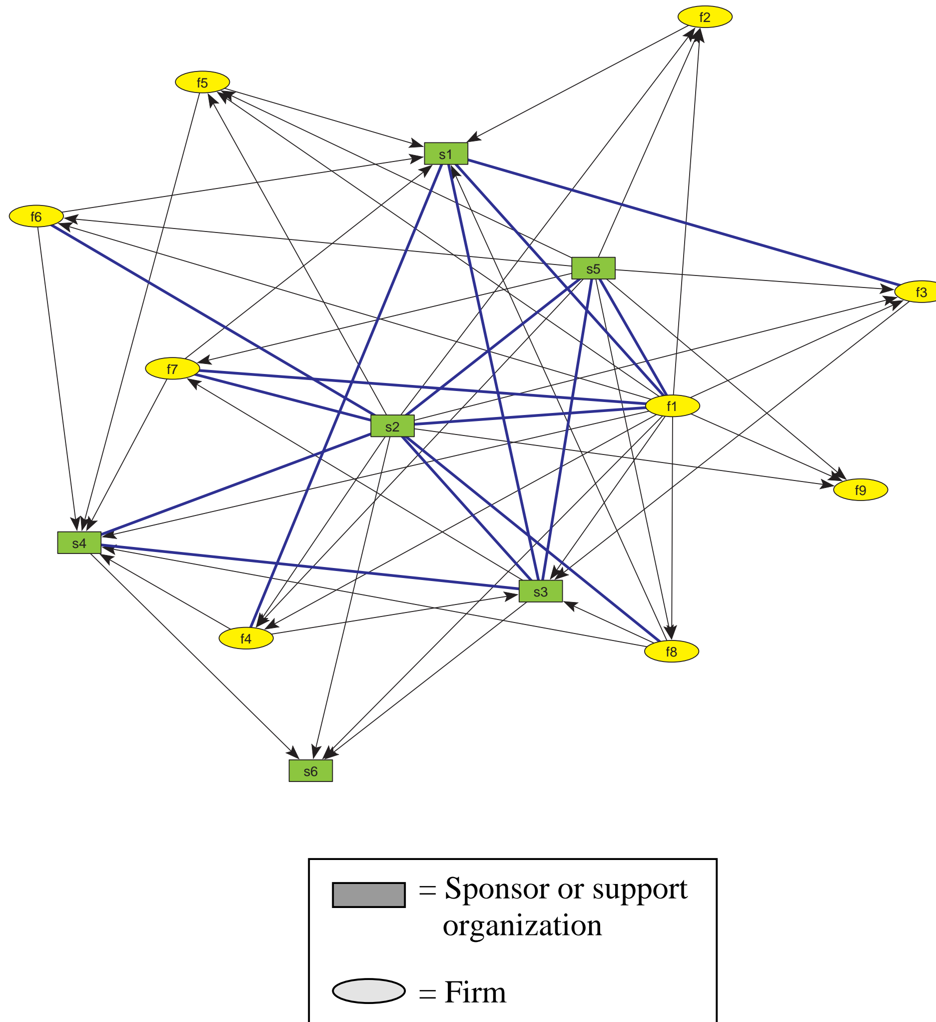
Influence of Others. Collaborative participants were asked to assess the extent to which other organizations in the Collaborative changed or influenced the activities of their own organizations relative to disparities. The sponsor and support organizations are reported to have the most influence on other Collaborative members (one of the key support organizations and one of the sponsors have the most influence). Only one organization (a regional firm) reported no external influence from any other Collaborative members. The results indicate that, with one possible exception, all of the organizations in the Collaborative have been influenced by other participants.

4. Overall Findings of Organizational Standing

To understand where participating organizations fit relative to one another, we also developed a general index of relative standing (Doreian 1986; Doreian 1987) of Collaborative members. Standing is determined by three factors. First, organizations have greater standing if they receive more "nominations," that is, many others identify them as influential or important. Second, greater standing is associated with nominations of greater strength (e.g., influence is "considerable" rather than "little"). Third, organizations have greater standing if their nominations come from other organizations with high standing. While we computed relative standing for several dimensions (importance, responsibilities and commitments, productive relationships, source of good ideas), we report only on overall findings in the interest of brevity.

[5] The absence of a line or tie between organizations indicates that a given organization either reported that its relationship with the other organization is not productive to a considerable extent or did not answer the question.

Figure C.5. Network Diagram Showing Reports of Considerably Productive Relationships Between Collaborative Participants



Question: To what extent do you feel the relationship between your organization and each of the other organizations with respect to disparities is productive?

Note: Responses to this question included to a considerable extent, to some extent, to a little extent, and to no extent. Ties shown in the figure reflect relationships that are productive to a considerable extent. Ties with a single arrow mean that one organization rated the other organization (receiving the arrow) as considerably productive. Ties with no arrows indicate that both organizations reported considerably productive relationships with one another.

Consistent with the findings above, the analysis of relative standing revealed that the two key support organizations and two sponsors generally have the highest standing in the Collaborative. (The same did not hold for the measure of standing related to source of good ideas; some firms rated higher than nonfirm organizations on this measure.) In addition, one of the national firms consistently had relatively high standing across several dimensions, as did one of the regional firms.

The analysis of relative standing also revealed some important information on the Collaborative as a whole. Most notably, there are no outliers in the distributions of relative standing.[6] In other words, even though participating organizations vary in their standing, no one organization stands out as extremely important or extremely unimportant to the Collaborative. For many social networks, where choices tend to concentrate on a small number of network actors, standing measures produce skewed distributions in which a few actors are viewed as extremely important or extremely unimportant.[7] The analysis of standing suggests that the National Health Plan Collaborative has good potential for collaborative learnings, given the relative equality in standing across organizations.

D. REVIEW OF KEY FINDINGS AND DISCUSSION

Several important findings emerged from our network analyses as follows:

1. First and foremost, the key support organizations and sponsor organizations play a central role in the Collaborative. Not only are they visible and active participants in the Collaborative process, but they also appear to act as the "glue" that holds the Collaborative together. They have the most contact with participating firms and form the primary pathways that link participants. The sponsor and support organizations also engage in a substantial amount of contact with one another. Key support and sponsor organizations also play an important role in contributing to action and change among other organizations.

2. Firm-to-firm relations are much less prevalent than firm-to-nonfirm relations. In terms of process measures such as communication, interactions between firms are limited (though a few firms are seen as providing many good ideas to the Collaborative process). Regarding firm-to-firm measures of action and influence, only a few firms reported considerably productive relationships with other firms, and influence between firms is limited.

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[6] For this analysis, we used box plots and interquartile ranges (see Koopmans 1987). The interquatile range is the difference between the first and third quartiles. Any data points more than 1.5 times the interquartile range above the third quartile (or the corresponding distance below the first quartile) are sufficiently extreme to be regarded as outliers.

[7] An example of organizations in a social service delivery network with such a distribution of a small number of high outliers is provided in Doreian (1999).

3. Still, most organizations participating in the Collaborative find each other important, and most respondents report that other organizations are carrying out their responsibilities and commitments to the Collaborative, at least to a small extent.

4. As suggested in the discussion of participants' overall standing, a few of the firms—namely, one national and one regional firm—stand out as more important and influential members of the Collaborative than other firms. Conversely, several firms consistently ranked toward the bottom of the measures of standing. These results likely suggest that some firms are contributing more than others. Organizations' ratings of whether the Collaborative is productive and worthwhile and whether it yields a reasonable payoff compared with the level of organizations' contributions are all fairly favorable and do not appear to vary greatly with by organizational standing (though one national firm with low standing tended to rate the Collaborative lower than other firms).

Given these findings, what are the implications for the Collaborative? And does the current structure represent a "healthy" network? While our network analyses reveal that firms rarely communicate with each other, such an approach may be completely appropriate. Contact and communication occur through other pathways, namely, the support and sponsor organizations. Interactions between organizations consume time, and it would be highly inefficient for all organizations in a network to communicate with each other. In fact, organizations interacting in a network face several strategic issues in securing resources or access to resources and obtaining favorable network locations (Burt 1990). In seeking favorable locations, no organization can afford to communicate with all other organizations unless required by its role. It follows, in general, that networks requiring substantial resources to form and maintain relationships should not be complete. In addition, given the competitive nature of the health plan industry, it is not surprising that firms generally do not communicate with one another outside of formal Collaborative meetings. Unless firms operate in different markets (as is the case with regional firms) or have some business imperative for additional collaboration, they may well limit their contact with one another. Moreover, it is probably unrealistic to expect higher levels of cross-firm contact in the future, particularly between national firms. Nonetheless, despite the possibility of logical reasons for limited firm-to-firm contact, some firms—namely, regional firms, which may be less concerned about competition—may be less satisfied than other organizations with the Collaborative's network structure.

Participating organizations came to the Collaborative with different motivations, as confirmed by the findings of the network analysis. Several firms reported in interviews that they wanted to learn what other firms were doing in the area of racial and ethnic disparities while fewer firms explicitly expressed an interest in making changes. Further, though firms did not necessarily say that they were reluctant to share information, the way they described their internal clearance processes made it clear that release of firm-specific information is an important threshold decision for a firm. These motivations and constraints therefore reveal some information as to why the Collaborative's network structure looks as it does.

Interim Feedback Form

Note: Feedback form draws heavily on Van de Ven and Ferry (1980), with permission from the authors.

INTERIM FEEDBACK ON THE COLLABORATIVE'S VALUE AND STRUCTURE FROM ORGANIZATIONS PARTICIPATING IN THE NATIONAL HEALTH PLAN COLLABORATIVE TO REDUCE DISPARITIES

Sponsored by: Agency for Health Care Research and Quality (AHRQ)

Conducted by: Mathematica Policy Research, Inc.

ORGANIZATION LABEL HERE

(Name, Address, Telephone)

ABOUT THIS REQUEST

The National Health Plan Collaborative involves many organizations working together to reduce disparities. To understand how the collaborative functions, we are requesting feedback on your organization's **general perceptions of the collaborative to date** and the **relationships between collaborative participants**. There are no right or wrong answers. **Individual responses to this request will be kept completely confidential** and will only be reviewed by researchers at Mathematica Policy Research, Inc. (MPR). **Findings will be reported in de-identified form.** If you have any questions about this request, please call Marsha Gold or Erin Taylor at 202-484-9220. Please be sure to answer every question and mark your answers clearly. **Please return** your completed questionnaire in the postage-paid envelope provided **by Friday, December 16, 2005**.

Completed by: ______________________________ Title: ________________________

Organization: ____

Address: ____

Telephone: (|___|___|___|)-|___|___|___|-|___|___|___|___|
Area Code Number

Date of Completion: |___|___| / |___|___| / |_2_|_0_|_0_|_5_|
Month Day Year

When answering questions 1 through 9, please think about the last 6 months of the collaborative with regard to disparities.

MARK (X) ONE BOX FOR EACH ROW

	Not at All Important	A Little Important	Somewhat Important	Very Important	Crucial
1. Overall, *how important* was the collaborative *in attaining* the *goals of your organization?*......................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

MARK (X) ONE BOX FOR EACH ROW

	No Extent	A Little Extent	Some Extent	Considerable Extent	A Great Extent
2. To what extent has *the collaborative* carried out its responsibilities and commitments?.................................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. To what extent has *your organization* carried out its responsibilities and commitments to the collaborative?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. To what extent do you feel the *relationship* between your organization and the collaborative is *productive*?..................................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. To what extent is the *time and effort* spent in developing and maintaining the relationship with the collaborative *worthwhile*?.........	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Overall, to what extent are you *satisfied with the relationship* between your organization and the collaborative?..................................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. To what extent has *your organization changed or influenced* the activities of *the collaborative*?..................................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. To what extent has *the collaborative changed or influenced* the activities of *your organization*?...................................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Are the *payoffs* of the collaborative for your organization *reasonable* relative to your contribution?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In questions 10 through 17, we are interested in your organization's experience with other organizations in the collaborative. ***FOR EACH QUESTION, PLEASE LEAVE BLANK THE RATING OF YOUR OWN ORGANIZATION.***

10. In general, *prior to* the start of your organization's participation in the collaborative . . .

	Were you and your team personally acquainted with the key people from the collaborative organizations listed below?		**IF YES: To what extent did your organization have an effective working relationship with each of these organizations prior to the start of the collaborative?**		
Organization	**Yes**	**No**	**To No or Little Extent**	**To Some Extent**	**Considerable Extent**
Aetna....................................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
CIGNA..................................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
Harvard Pilgrim	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
HealthPartners	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
Highmark..............................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
Kaiser Permanente	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
Molina	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
UnitedHealth Group	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
WellPoint..............................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
CHCS..................................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
GMMB..................................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
IHI...	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
RAND..................................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
AHRQ..................................	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3
RWJF	☐ 1	☐ 0	☐ 1	☐ 2	☐ 3

11. **During the past six months—OUTSIDE OF FORMAL COLLABORATIVE MEETINGS—how frequently have people from your organization who are involved in the collaborative *communicated or been in contact with* people in the organizations listed below?**

MARK (X) ONE BOX FOR EACH ROW

Organization	Not at All	1-2 Times	Monthly	Weekly	Daily
Aetna	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CIGNA	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Harvard Pilgrim	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
HealthPartners	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Highmark	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Kaiser Permanente	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Molina	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UnitedHealth Group	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
WellPoint	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CHCS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
GMMB	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
IHI	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
RAND	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AHRQ	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
RWJF	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

12. **Overall, *how important* was each organization's work through the collaborative in attaining the *goals of your organization* with respect to disparities?**

MARK (X) ONE BOX FOR EACH ROW

Organization	Not at All Important	Somewhat Important	Moderately Important	Very Important	Crucial
Aetna	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CIGNA	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Harvard Pilgrim	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
HealthPartners	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Highmark	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Kaiser Permanente	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Molina	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UnitedHealth Group	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
WellPoint	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CHCS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
GMMB	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
IHI	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
RAND	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AHRQ	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
RWJF	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

13. **To what extent has each *organization* carried out its responsibilities and commitments involving disparities in regard to the collaborative during the past six months?**

MARK (X) ONE BOX FOR EACH ROW

Organization	To No Extent	To a Little Extent	To Some Extent	Considerable Extent
Aetna	☐ 1	☐ 2	☐ 3	☐ 4
CIGNA	☐ 1	☐ 2	☐ 3	☐ 4
Harvard Pilgrim	☐ 1	☐ 2	☐ 3	☐ 4
HealthPartners	☐ 1	☐ 2	☐ 3	☐ 4
Highmark	☐ 1	☐ 2	☐ 3	☐ 4
Kaiser Permanente	☐ 1	☐ 2	☐ 3	☐ 4
Molina	☐ 1	☐ 2	☐ 3	☐ 4
UnitedHealth Group	☐ 1	☐ 2	☐ 3	☐ 4
WellPoint	☐ 1	☐ 2	☐ 3	☐ 4
CHCS	☐ 1	☐ 2	☐ 3	☐ 4
GMMB	☐ 1	☐ 2	☐ 3	☐ 4
IHI	☐ 1	☐ 2	☐ 3	☐ 4
RAND	☐ 1	☐ 2	☐ 3	☐ 4
AHRQ	☐ 1	☐ 2	☐ 3	☐ 4
RWJF	☐ 1	☐ 2	☐ 3	☐ 4

14. **To what extent do you feel the *relationship* between your organization and each of the other organizations with respect to disparities is *productive*?**

MARK (X) ONE BOX FOR EACH ROW

Organization	To No Extent	To a Little Extent	To Some Extent	Considerable Extent
Aetna	☐ 1	☐ 2	☐ 3	☐ 4
CIGNA	☐ 1	☐ 2	☐ 3	☐ 4
Harvard Pilgrim	☐ 1	☐ 2	☐ 3	☐ 4
HealthPartners	☐ 1	☐ 2	☐ 3	☐ 4
Highmark	☐ 1	☐ 2	☐ 3	☐ 4
Kaiser Permanente	☐ 1	☐ 2	☐ 3	☐ 4
Molina	☐ 1	☐ 2	☐ 3	☐ 4
UnitedHealth Group	☐ 1	☐ 2	☐ 3	☐ 4
WellPoint	☐ 1	☐ 2	☐ 3	☐ 4
CHCS	☐ 1	☐ 2	☐ 3	☐ 4
GMMB	☐ 1	☐ 2	☐ 3	☐ 4
IHI	☐ 1	☐ 2	☐ 3	☐ 4
RAND	☐ 1	☐ 2	☐ 3	☐ 4
AHRQ	☐ 1	☐ 2	☐ 3	☐ 4
RWJF	☐ 1	☐ 2	☐ 3	☐ 4

15. **During the past six months, to what extent has *your organization changed or influenced* the activities of each of these *other organizations* with respect to disparities?**

MARK (X) ONE BOX FOR EACH ROW

Organization	To No Extent	To a Little Extent	To Some Extent	Considerable Extent	Cannot Assess
Aetna	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CIGNA	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Harvard Pilgrim	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
HealthPartners	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Highmark	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Kaiser Permanente	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Molina	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UnitedHealth Group	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
WellPoint	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CHCS	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
GMMB	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
IHI	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
RAND	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AHRQ	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
RWJF	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

16. **During the past six months, to what extent has each of these *other organizations changed or influenced* the activities of *your organization* with respect to disparities?**

MARK (X) ONE BOX FOR EACH ROW

Organization	To No Extent	To a Little Extent	To Some Extent	Considerable Extent
Aetna	☐ 1	☐ 2	☐ 3	☐ 4
CIGNA	☐ 1	☐ 2	☐ 3	☐ 4
Harvard Pilgrim	☐ 1	☐ 2	☐ 3	☐ 4
HealthPartners	☐ 1	☐ 2	☐ 3	☐ 4
Highmark	☐ 1	☐ 2	☐ 3	☐ 4
Kaiser Permanente	☐ 1	☐ 2	☐ 3	☐ 4
Molina	☐ 1	☐ 2	☐ 3	☐ 4
UnitedHealth Group	☐ 1	☐ 2	☐ 3	☐ 4
WellPoint	☐ 1	☐ 2	☐ 3	☐ 4
CHCS	☐ 1	☐ 2	☐ 3	☐ 4
GMMB	☐ 1	☐ 2	☐ 3	☐ 4
IHI	☐ 1	☐ 2	☐ 3	☐ 4
RAND	☐ 1	☐ 2	☐ 3	☐ 4
AHRQ	☐ 1	☐ 2	☐ 3	☐ 4
RWJF	☐ 1	☐ 2	☐ 3	☐ 4

17. **Which organizations provide good ideas for dealing with disparities at meetings of the collaborative?**

MARK (X) ONE BOX FOR EACH ROW

Organization	No Good Ideas	Some Good Ideas	Many Good Ideas
Aetna	☐ 1	☐ 2	☐ 3
CIGNA	☐ 1	☐ 2	☐ 3
Harvard Pilgrim	☐ 1	☐ 2	☐ 3
HealthPartners	☐ 1	☐ 2	☐ 3
Highmark	☐ 1	☐ 2	☐ 3
Kaiser Permanente	☐ 1	☐ 2	☐ 3
Molina	☐ 1	☐ 2	☐ 3
UnitedHealth Group	☐ 1	☐ 2	☐ 3
WellPoint	☐ 1	☐ 2	☐ 3
CHCS	☐ 1	☐ 2	☐ 3
GMMB	☐ 1	☐ 2	☐ 3
IHI	☐ 1	☐ 2	☐ 3
RAND	☐ 1	☐ 2	☐ 3
AHRQ	☐ 1	☐ 2	☐ 3
RWJF	☐ 1	☐ 2	☐ 3

18. **Please use the space below to indicate anything else you want to add relative to the questions above.**

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Thank you for completing this request for feedback. Please return your completed questionnaire in the self-addressed, stamped envelope by **Friday, December 16, 2005**. If you do not have the return envelope, please mail to:

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600 Maryland Avenue, S.W., Suite 550
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Attn: Erin Taylor