

Cultural Competence California Style
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ABSTRACT

California health plans have led the country in implementing innovative practices to improve health care for diverse populations. This article reports on eight leading California plans' cultural competence activities, and how they were influenced by California's promulgation of cultural and linguistic competence standards for public insurance programs. While plans engaged in a variety of cultural competence activities before the standards were issued, some activities were clearly initiated or enhanced in response to the state standards. California's experience provides guidance to states considering following its lead, as well as to health plans and the federal government.

Keywords: California, cultural competence, disparities, ethnicity, health plans, managed care, minority health, policy, race

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INTRODUCTION

California frequently serves as the bellwether of health care trends that will later affect the rest of the country.¹ Such is the case with cultural competence in health care. California health plans have led the country in implementing innovative practices to improve service delivery to diverse populations. Demographics help explain the early adoption of cultural competence in California. “Minority” Californians constitute a majority of the population: 32 percent are Hispanic, 12 percent Asian/Pacific Islander, 7 percent African American and 1 percent Native American.² Twenty-six percent of California’s population is foreign born. One-fifth of Californians (6-7 million) have limited English proficiency and almost half of Medi-Cal (Medicaid) and Healthy Families (State Children’s Health Insurance Program) members primarily speak a language other than English.³

This article describes eight California health plans’ efforts to serve racially and ethnically diverse populations by increasing their cultural competence. While variants abound, most definitions of cultural competence stem from one developed more than a dozen years ago: “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professions and enables that system, agency or those professions to work effectively in cross-cultural situations.”⁴ The fact that the definition of cultural competence does not hint at what organizations must do to be culturally competent speaks volumes of the challenges faced by health plans. The California Department of Health Services (CDHS) took steps to operationalize the definition of cultural competence by spelling out its expectations for health plans serving publicly insured adults and children. It is in the context of the State’s active role in promoting

culturally competent health care that we examine health plan cultural competence activities in California.

CDHS REQUIREMENTS

In 1999 CDHS issued cultural competence requirements in the form of five policy letters that clarified nonspecific language contained in its Medi-Cal managed care contracts. (See Table 1.) The policy letters were crafted by the CDHS Cultural and Linguistics Task Force, consisting of the CDHS Office of Multicultural Health, the CDHS Division of Medi-Cal Managed Care, community advocacy groups, traditional Medi-Cal providers, and health plans. The endeavor proved arduous, taking over 3 years to forge documents acceptable to task force members. In developing the policy letters, the task force was guided by a set of basic principles including:

- Compliance with state and federal laws.
- Recognition that one approach to fulfilling the contract requirements may not fit all health plans.
- The need to be sensitive to the political environment in which the policy letters were being developed.
- The limitations of what the State could require within the established capitation rates given the lack of dedicated funding to implement the requirements.
- The need to develop policies to enforce the requirements.
- The need to recognize competing health plan priorities.⁵

These requirements were later incorporated into Healthy Families (State Children's Health Insurance Program), and in 2003 amendments to Medi-Cal contracts moved specific cultural competence requirements from the policy letters into the actual contracts.

METHODS

This study of California health plan activities to promote cultural competence is part of a larger national research project.⁶ To identify cutting edge approaches taken, trailblazers in the area of cultural competence, including 8 California health plans, were identified and interviewed. The sample was stratified on several characteristics, including tax status and size. (See Table 2.) The 8 California health plans came to cultural competence via different routes. Four were formed explicitly to serve minority populations, and 3 of these focused on Medi-Cal populations. Pursuing cultural competence was part of their core business. A fifth health plan embraced cultural competence as a business imperative, actively pursuing the minority population in both commercial and government markets, and 3 health plans pursued cultural competence in response to demands from private and public purchasers.

The first wave of data collection (semi-structured telephone interviews and collection of supporting materials) took place in 2000 and 2001, followed by a second wave in 2002. Case studies of the cultural competence activities of the plans were drafted. Researchers identified themes, and developed matrices that arrayed data by

theme and by plan for use in cross-plan analyses. A draft manuscript was shared with informants, and corrections were made based on responses.

HEALTH PLANS' CULTURAL COMPETENCE ACTIVITIES

While California health plans engaged in a variety of cultural competence activities before the issuance of the CDHS policy letters, some cultural competence activities were clearly initiated and others were enhanced in response to the policy letters. This section describes the activities of study plans.

Community Advisory Committee (CAC)

Many plans were prompted by the CDHS policy letter to develop a CAC, although their composition varied considerably. CACs composed solely of plan members tended to have a limited scope, focusing on concrete tasks such as reviewing health promotion materials and programs, while CACs composed of community representatives tended to provide recommendations on the future direction of the plan's cultural competence efforts.

Some plans viewed CACs as a helpful method for obtaining community input, while others did not find them valuable. Without the expectations set by the CAC Policy Letter, it is unlikely that all of the plans would have put forth the considerable effort required to develop and maintain their CACs.

Health Education and Cultural and Linguistic Group Needs Assessment (GNA)

None of the eight plans studied had undertaken a comprehensive, systematic assessment of the needs of minority members prior to the promulgation of the CDHS policy letters. To comply with GNA requirements, plans conducted telephone and in-person interviews of members from predominant ethnic groups; surveyed providers and community-based organizations; reviewed studies conducted by universities and community groups; and analyzed utilization, pharmacy, and HEDIS® data.⁷

Plans with fewer minority members probably conducted the extensive GNA only as a result of the policy letter. Plans where minority members predominate would likely have conducted some kind of assessment of their minority populations' needs, but not necessarily as comprehensive.

Linguistic Services⁸

The types of interpreter services varied among the plans and reflected the number of limited-English-proficient members and the level of organizational commitment to cultural competence. In the case of one plan, only telephone interpreter services were available, while another plan relied heavily on bilingual clinicians, using ad hoc (family, friends, or staff who are not employed as interpreters) interpreters when needed. Use of ad hoc staff interpreters was not uncommon, but the majority of plans in this study had a policy of paying for professional interpreters.

While most of the plans offered interpreter services prior to the distribution of the Linguistic Services Policy Letter, the letter stimulated plans to evaluate the extensiveness and quality of the language services that they provided to limited-English-proficient

members. Several plans developed surveys to assess the second language skills of providers and their support staff more accurately, and at least two plans implemented a testing requirement to assess the proficiency of multilingual member services staff. Formal criteria defining service and quality requirements were developed by one plan that served as a basis for selecting telephone interpreter services. Plans also turned their attention to the adequacy of language assistance for more rarely spoken languages that still met the threshold.

Cultural Competence in Health Care

In contrast to other policy letters, the Cultural Competency in Health Care Policy Letter provided guidance rather than set requirements. Our data cover five major components addressed in the policy letter – designated cultural competence staff, workforce diversity, health promotion, education and training, and data collection.

Designated Cultural Competence Staff

The policy letter called for designating staff to be responsible for cultural competence. All plans exceeded the guidance by creating new staff positions, and in some cases departments, devoted to integrating cultural competence within the plan and provider network. This reflects the additional workload associated with implementing the policy letters.

Generally, two to five staff members were devoted to cultural competence activities. Cultural competence staff incubated innovations and worked within existing structures to integrate cultural and linguistic competence into the organization. This included overseeing linguistic services including translation of key documents; providing

and/or coordinating cultural competence training; setting up a system for identifying, tracking, and addressing member complaints related to cultural competence issues; and coordinating organization-wide cultural competence initiatives.

Plans varied in their placement of cultural competence staff within the organizational structure and the level of organizational influence the staff had. Plans that integrated cultural competence into their quality improvement activities were more likely to place cultural competence staff under health plan operations, enabling the cultural competence staff to become intimately involved in and to influence the plan's day-to-day work. Plans that associated cultural competence with diversity issues were more likely to place cultural competence staff under the medical management division, which tended to limit the staff's scope of influence. Cultural competence staff members were most effective when top management had embraced cultural competence and communicated this support throughout the organization.

Workforce Diversity

Almost all the plans failed to establish corporate-level strategies or formal diversity programs aimed at recruiting, promoting and retaining multi-racial and multi-ethnic providers and health plan staff beyond standard equal opportunity policies. Of all the components of cultural competence, this is the area that the policy letters influenced the least. The main strategy to diversify provider networks was to contract with providers who traditionally served low-income populations, who are more likely to be members of minority groups themselves.⁹ For non-clinical health plan staff, diversity efforts tended to concentrate on hiring bilingual individuals for member services positions.

Despite the lack of formal policies, several plans had diverse non-clinical workforces. These tended to be minority-focused plans that hired employees from the heavily minority communities where plans and their members were located. Once diversity was achieved, it had a tendency to be self-maintaining. Diversity among front line staff was more common than diversity at the management, executive or board level, although minority-focused plans were more likely to have ethnic representation at high levels.

Health Promotion

Health plans, acknowledging that their health education and disease management materials had not initially been culturally appropriate for all ethnic groups within their membership, modified the materials to make them more culturally relevant and translated them. One health plan partnered with a disease management firm to develop culturally competent programs. Evaluation of such activities was largely absent.

Education and Training

All plans had some form of cultural competence training and education. Orientation for new staff and clinicians was the most common venue for cultural competence training, and frequently cultural competence materials were integrated into orientation programs rather than presented as a stand-alone module. The vast majority of cultural competence training outside of orientation was offered sporadically and on a voluntary basis, with only a small proportion of plan staff and clinicians being trained. Plans relied more heavily on manuals and other written materials than in-person training to educate staff and clinicians. Training topics ranged from cultural sensitivity to communication skills to culture-specific information, with no consensus emerging on

their relative importance. While many plans reported training both staff and clinicians, several plans reported being unsure what training non-clinical staff should receive. Little formal evaluation of training was conducted, with pre- and post-tests administered at a few plans.

Plans' lack of success in implementing ongoing education and training programs may have been due, at least in part, to the fact that Cultural Competence Specialists' expertise lay more in process improvement than workplace training. Cultural Competence Specialists were, however, aware of the training deficiencies and some had plans to raise the level of cultural competence education and training to meet the policy letter's guidelines.

Data Collection

Few plans directly collected race, ethnicity and language (r/e/l) data on all members. One plan systematically collected r/e/l data, but only for new members at the time of enrollment. Another plan collected language data, but not race or ethnicity data, from all members. For Medi-Cal members, plans generally relied on r/e/l data provided by CDHS that are collected by Medi-Cal employees at the time of enrollment. None of the plans had established information systems "capable of identifying and profiling culturally or ethnically specific patient data," as recommended in the policy letter.

Plans used language data for planning purposes, such as assessing the adequacy of interpreter services and bilingual clinicians in their provider networks, and to conduct plan business with limited-English-speaking members. Language data were not frequently shared with the provider network.

While no plan collected racial or ethnic information on providers, plans collected information on the languages that providers speak. Language capabilities data were often published in provider directories to allow members to select providers who spoke their preferred language.

All plans collected r/e/l data as part of a variety of member surveys, including those conducted for the Medi-Cal-required GNA and consumer satisfaction surveys. However, most plans acknowledged that in order to meet the guidelines for cultural competence, comprehensive member-specific r/e/l data were needed.

Translation of Written Information Materials

All health plans conducted at least some translation activities. Most plans used vendors to translate materials, and frequently used bilingual staff to review translated materials. Plans could not afford to translate all materials, and decision-making about which to translate tended to be ad hoc. One plan prioritized key clinical documents, while another plan's senior management team made translation decisions. In most plans, the health education, member services, and marketing departments initiated requests for translations.

The Translation of Written Materials Policy Letter enhanced awareness among plans of the need to translate documents for limited-English-proficient members. Translating a wide range of materials into all threshold languages and using the rigorous translation process outlined in the policy letter, however, was clearly burdensome for the plans. The challenges of translation spawned collaboration among health plans. For example, a

group of health plans joined forces to revise the health education behavioral assessment that CDHS required for new Medi-Cal members to reflect language and culture.

FOLLOW THE LEADER

States that are considering following California's lead should be emboldened by this study's finding that a deliberate and concrete state policy on cultural competence can in fact influence health plan behavior. Many of the health plans sampled in this study were recognized leaders in cultural competence at the time CDHS developed its requirements. Even for these trailblazing plans, there are clear indications that the CDHS policies set a high bar to aspire to and accelerated their adoption of strategies to increase cultural competence. For plans that were less savvy or interested in cultural competence, CDHS requirements served as a catalyst, moving them to take some action, if only to meet the requirements of an annual state audit. California took this lesson to heart when legislation was signed into law in 2003 that imposes many of the same requirements on managed care organizations for commercial populations that CDHS had mandated for the publicly insured.¹⁰ States developing their own cultural competence requirements for health plans can benefit from California's experience.

- **Consult with health plans and advocacy organizations.** The involvement of plans – and in particular those with cultural competence expertise – lent credibility to the process and limited the likelihood of asking plans to do things that would be technically impossible. Advocates were instrumental in serving as a countervailing force against some health plans' efforts to limit cultural competence standards.

California's approach of engaging health plans and advocacy organizations at the beginning of the process may have played a role in the success achieved thus far in promoting cultural competence.

- **Make requirements explicit.** Public purchasers are often vague about what they expect from health plans in terms of cultural competence.¹¹ California issued policy letters to spell out expectations concerning how nonspecific contractual requirements were to be fulfilled, and later incorporated these details into the contracts themselves.
- **Build consensus on collection of racial, ethnic and language data.** Despite encouragement in the policy letters, collection of r/e/l data by health plans was rare. One reason may be the lack of a clear consensus about the appropriateness of collection of such data. California is one of four states that statutorily prohibit health insurers that are not managed care plans from requesting r/e data on insurance application forms.¹² California's Proposition 54, defeated in 2003, would have banned the collection of r/e data by public agencies and any group receiving state funding. Proposition 54 reflects an undercurrent of opposition to collection of r/e/l data that states have to address. State health officials will want to work closely with other state policy makers, such as legislators, attorney generals, and insurance commissioners, to build consensus around the issue of r/e/l data collection. Work within minority communities is also important to gain support for r/e/l data collection. While some minority groups, especially African Americans, may be initially distrustful of r/e/l data collection, involving these groups in data collection planning

can result in support for such data collection.¹³ To send clear messages to health plans, states may choose to *require* health plans to collect r/e/l data from members, as is done in South Carolina (racial data only) and Texas (language data only).¹⁴ Medicaid agencies may also want to improve the accuracy of the r/e/l data they collect, share r/e/l data with health plans, and assist plans in using the data to improve health care.

- **Provide implementation tools.** Providing culturally competent health care is a complex undertaking. Each plan had to figure out how to comply with contract specifications and policy letters. Implementation tools, particularly in the areas of workforce diversity and training and education, might have promoted greater compliance.
- **Monitor and enforce requirements.** Several informants reported that some plans responded minimally to the policy letters and that CDHS annual audits were key in securing even that level of compliance. Cultural competence requirements that are not enforced create inequities, whereby compliant plans bear the short-term cost of improving health care to minority Americans.

HEALTH PLAN TAKE-AWAYS

Health plans in California developed a wide variety of strategies for improving their cultural competence, and in particular, a range of responses to the CDHS policy letters. Without a formal evaluation, it is difficult to assess definitively the effectiveness of these

differing approaches. However, our interviews with plans on the “cutting edge” provide four suggestions for plans aspiring to cultural competence.

- **Dedicate staff to cultural competence.** A consensus emerged from our interviews that if health plans are to make significant progress in cultural competence, staff dedicated to cultural competence activities are needed. Plans that initiated cultural competence activities by enlisting staff with other responsibilities to manage them eventually recognized the need for at least a full-time cultural competence coordinator.
- **Link cultural competence to quality improvement.** While no single organizational model emerged in the case studies, cultural competence activities pursued in connection with quality improvement efforts seemed more likely to be integrated into the plan’s operations.
- **Improve capacity to track racial, ethnic, and language data.** Plans with better data about the demographics of their membership used that information to design and implement services to meet the needs of their members. Plans were unable to achieve policy letter standards without collection of member-specific data.
- **Collaborate and get assistance where possible.** Cultural competence was discovered to be a very complex undertaking. Many tasks, such as translating documents, were complicated and resource-intensive. Cross-plan collaborations were

found to be extremely helpful. Since the data were collected for this study, the Industry Collaboration Effort (ICE) has established a national Cultural and Linguistics Services Team, with collaborative activities being undertaken by several Cultural and Linguistics Subgroups.¹⁵

THE FEDERAL ROLE

While this study has focused on state and health plan activities, it also has implications for federal policy. Cultural competence has been gaining prominence in the national arena, where it is pursued as a strategy for reducing racial and ethnic health disparities as well as a means of ensuring that patients' rights are preserved.¹⁶ Actions taken include the publication of national standards for culturally and linguistically appropriate services (CLAS), and the issuance of guidance on how to comply with Department of Justice regulations requiring organizations that receive federal funds to provide meaningful access to people with limited English proficiency.¹⁷ Our case studies suggest several ideas for future federal efforts.

- **Promote standardized collection of racial, ethnic, and language data.** In a recent study many health plans noted that standardization of r/e/l data collection, which would allow for greater comparison across plans and the entire health care industry, is critical to combat disparities in health care.¹⁸ Plans suggested that federal agencies could encourage a systematic approach to collection of these data, such as requiring use of racial and ethnic codes for transactions covered by the Health Insurance Portability and Accountability Act.

- **Identify and evaluate innovative efforts.** One of the areas in which few strides have been made is in the evaluation of cultural competence activities. While “best practices” have been publicized, few rigorous evaluations of interventions, other than language assistance, have been available to guide health plan decisions.¹⁹ Studies that address the return on investment for cultural competence interventions would also provide incentive for their adoption.²⁰

- **Provide resources for implementation of successful interventions.** Resources for implementation can take the form of financial assistance. For example, the Medicaid program provides federal matching funds for oral interpretation and written translation services.²¹ Resources can also include developing tools and assisting plans with implementation. Examples of such efforts funded by various parts of the U.S. Department of Health and Human Services include: the National Center for Cultural Competence that provides training and technical assistance as well as developing and disseminating products, *The Providers Guide on Quality and Cultural Diversity* web site that includes materials and tools for organizations seeking to become culturally competent, the on-line continuing medical education program *A Family Physician's Practical Guide to Culturally Competent Care*, and guides such as *Providing Oral Linguistic Services* and *Planning Culturally and Linguistically Appropriate Services*.²²

- **Increase supply of minority health professionals.** The failure of health plans to adopt recruitment and retention strategies aimed at minority health professionals

should not distract from an underlying problem -- the shortage of minority health professionals. Minorities are under-represented in medical schools and in the health professions, and recent policies regarding affirmative action and international medical graduates is expected to exacerbate this situation.²³ To monitor progress in diversifying the health care workforce, the Agency for Healthcare Research and Quality has incorporated new measures of workforce diversity into the 2006 National Healthcare Disparities Report.

CONCLUSION

A variety of factors motivated California health plans to pursue cultural competence. This study shows that there is still much room for progress within California. No exemplary practices regarding recruitment and retention of a workforce of diverse staff and clinicians were found. Similarly, health plans struggled with both the content and the form of education and training activities. Even in the most advanced area – linguistic competence – all plans were not following what are thought to be best practices. The California experience demonstrated, just as CDHS had thought it would when it issued its policy letters, that evolving into a culturally competent organization takes time. The CDHS policy letters covered a wide range of activities, and plans are moving faster on some fronts than on others. Although state mandates can serve as a catalyst to the development of culturally competent services, mandates alone cannot spur innovation among plans that do not embrace change.

Given continued demographic changes across the country and increased state and national attention to the issue of health care disparities, health plans, states, and federal

agencies will undoubtedly continue to pursue and promote cultural competence. While demographics, markets, and politics will differ, the California experience is nevertheless instructive to those making the journey toward cultural competence.

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Table 1: California Department of Human Services' Cultural Competence Policy Letters

Policy Letter	Health Plan Requirements
Policy Letter #1: Community Advisory Committee (CAC)	Implement and maintain a CAC - consisting of plan members, community advocates, and traditional and safety net providers - to advise on cultural competency issues, and on education and operational issues affecting groups who speak a primary language other than English.
Policy Letter #2: Health Education and Cultural and Linguistic Group Needs Assessment (GNA)	Conduct GNA every three years to identify members' health risks, health-related behaviors and practices, health care and health education needs, cultural beliefs and practices, perceived learning needs, preferred methods of learning, and literacy level.
Policy Letter #3: Linguistic Services	<p>Monitor the language capability of providers who are identified in the provider directory as speaking a specific language.</p> <p>Evaluate the effectiveness of the linguistic services program.</p> <p>Institute a system to inform members of the availability of linguistic services.</p> <p>Provide linguistic services to all members who speak "threshold" languages (defined as 3,000 eligible beneficiaries residing in a county or a concentration of 1,000 eligible beneficiaries in a single zip code or 1,500 in two contiguous zip codes).</p>
Policy Letter #4: Cultural Competency in Health Care - Meeting the Needs of a Culturally and Linguistically Diverse Population	<p>No requirements.</p> <p>Defines cultural competence.</p> <p>Sets forth guidelines on how to implement cultural competence (e.g., recruiting and retaining staff that reflect the community served, designating staff to be responsible for coordinating and integrating cultural competence into the plan's operations, developing information systems that are capable of capturing member-specific culture and language data, and evaluating the effectiveness of strategies).</p> <p>Set forth guidelines for training and education on cultural competence to staff and providers.</p> <p>Encourages development of cultural competence quality improvement projects.</p>
Policy Letter # 5: Translation of Written Information Materials	<p>Translate documents into threshold languages.</p> <p>Strongly encourages plans to follow the quality translation process described in the policy letter.</p>

Source: Medi-Cal Managed Care Division All Plan Letters 99-01, 99-02, 99-03, 99-04, and 99005.

Table 2: Characteristics of Sampled California Health Plans

Geographic Service Area	Tax Status	Model Type	Number of Members	Percent Ethnic members	Percent Medi-Cal/SCHIP Enrollment
Northern Urban County	Not-for-Profit	Network HMO	78,000	66%	100%
Northern City	Not-for-Profit	Group HMO	14,000	NA	8%
California	Profit	Network HMO	2,200,000	NA	20%
California	Not-for-Profit	Staff Model HMO	6,000,000	33%	2%
Southern California	Profit	Network	NA	NA	NA
Southern Suburban County	Not-for-Profit	Mixed Model (subcontract to staff model HMO)	250,000	61%	100%
Southern California	Profit	Mixed Model	337,000	50% of Medi-Cal members 30% of commercial members	50%
Southern Urban County	Not-for-Profit	Network	780,000	85%	100%

Source: Authors' tabulation of 2000-2002 data provided by study health plans.
 NA = Not Available

NOTES

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¹⁵ ICE is a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies. For more information on Industry Collaboration Effort's Cultural and Linguistics Services Team, see www.iceforhealth.org/teamactivities.asp.

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