

Health Disparities and Culturally & Linguistically Appropriate Services in Managed Care – a Feasibility Study

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Goals of Feasibility Study

- Explore feasible methods for monitoring and measuring health disparities and delivery of culturally and linguistically appropriate services (CLAS) by managed care organizations (MCOs) to diverse populations.
- Understand current state of evidence supporting common quality expectations.
- Identify potential methods for standardized measurement and assessment.

Importance

- National interest in health care disparities:
- IOM reports – Unequal Treatment, Crossing the Quality Chasm and AHRQ - National Health Care Disparities document health care disparities
- AHIP-RWJ survey: suggest more plans have access to race/ethnicity data
- Medical societies address physician's cultural competence; raise awareness on disparities
- National CLAS standards – federal mandates

Priority CLAS Topics

- Developing an Infrastructure for Data Collection
- Tracking Disparities/Reporting HEDIS by Race and Language
- Implementing Quality Improvement Activities/Developing Strategic Plans
- Ensuring Qualified Interpretation
- Providing Effective Language Access at the Point of Care
- Providing Culturally Competent Care at the Point of Care
- Engaging Communities/Developing Partnerships

Methods

Expert Panel – recommended and prioritized topic areas in CLAS

Key Informants - Interviewed with stakeholders on current activities and feasibility to address topics

HEDIS Analysis by Race - CMS race/ethnicity data on Medicare beneficiaries matched with patient-level HEDIS data; calculated disparities score and determined feasibility for reporting HEDIS by subgroups (min. 30 enrollees).

- Medicaid CAHPS items on interpreter needs and services analyzed by race/ethnicity.

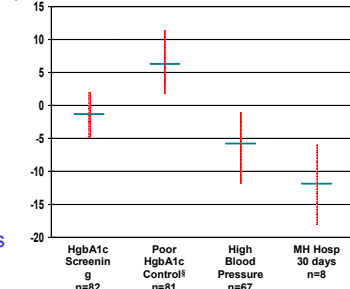
Literature Review – Reviewed evidence supporting effectiveness of interventions to improve quality of care, patient satisfaction and health outcomes; interventions included linguistic services, cultural competence and clinical care.

Figure 1. Percentage of Medicaid Enrollees who Got Needed Interpreter Services
Consumer Assessment of Health Plans Survey

Medicaid MCOs by region	% of Enrollees needing interpreter	Usually/Always got interpreter (Medicaid CAHPS)
Overall	6.3%	35.4%
Boston	8.8%	54.2%
New York	6.6%	37.8%
Philadelphia	5.2%	24.4%
Atlanta	7.5%	36.2%
Chicago	4.4%	28.1%
Dallas	6.3%	47.8%
Kansas City	0.0%	--
Denver	5.7%	46.2%
San Francisco	13.0%	55.0%
Seattle	4.8%	--

Findings

Figure 2. Plan-Level Disparity Scores
(Black HEDIS Rate Minus White HEDIS Rate)



Negative disparity score indicates where Blacks received worse quality of care than Whites on several HEDIS quality of care measures.

§ lower rate is better quality of care on this HEDIS measure. A positive rate indicates worse quality.

Figure 3. Feasibility of Plan-level Reporting of HEDIS measures by Race/Ethnicity

Measure	Number of Plans with At Least 30 Eligible Members in 2003				
	Total	White	Black	Asian	Hisp
Antidepressant Med Mgmt	122	82	7	4	7
Comp Diabetes Care	148	147	82	16	7
Breast Cancer Scr	146	142	72	10	8
Beta Blocker After Heart Attack	141	101	14	5	1
Controlling High Blood Pressure	141	140	67	11	4
Chol. Mgmt After Acute Event	145	125	20	4	1
Follow Up after Mental Health Hosp.	139	72	8	0	0

Language needs and Disparities in Medicare HEDIS

• **Language Needs (Fig. 1)** - Many Medicaid enrollees not getting needed interpreter services to speak to a doctor/provider. Unmet language needs is a problem for linguistically diverse enrollees.

• **Health Care Disparities in Medicare (Fig. 2)**

–Overall, blacks receive worse quality of care on most quality of care HEDIS measures

–Wide variation in disparities scores between health plans, from no disparities to disparities

• **HEDIS reporting feasibility (Fig. 3)**

–Only half of all Medicare plans can separately report on blacks on at least one quality of care measure

–Reporting plan-level HEDIS or CAHPS by subgroup for benchmarking is challenging

Assessing CLAS in Managed Care

–**Literature:** Limited evidence on cultural competence interventions, more evidence on linguistic services. Evidence that different types of interventions can reduce clinical disparities.

–**Expert Panel:** Plans need to adopt a QI model to address CLAS and Disparities:

- 1) Collect race/ethnicity data on diverse populations
- 2) Identify opportunities for QI/track disparities
- 3) Implement QI interventions
- 4) Report results

–Health plans, providers and communities need to work in partnership to address CLAS and Disparities

–**Stakeholder Input:** Policy changes are needed to address concerns about collection of race/ethnicity data from members; plans also need more guidance on effective ways to address CLAS and Disparities

Conclusions

- Plans are in the stage of “initiation and innovation” around CLAS/Disparities
- Plans need more guidance and evidence on effective interventions to reduce disparities
- Public policies needed to facilitate race/ethnicity data collection by health plans
- Large unmet language needs in linguistically diverse enrollees require attention
- Metrics to assess quality of care for diverse members needed (i.e. interpreter services)
- Disparities scores and HEDIS reporting by subgroup of potential interest for QI