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**The National Health
Plan Collaborative:
Overview of Its Origins,
Accomplishments, and
Lessons Learned**

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OVERVIEW OF KEY POINTS

The National Health Plan Collaborative (NHPC) was formed in 2004 to bring large national and regional health plans together to reduce racial and ethnic disparities. Co-sponsored by the Agency for Healthcare Research (AHRQ) and the Robert Wood Johnson Foundation (RWJF), the NHPC was intended to provide a forum for health plans to better understand disparities and share strategies and best practices for measuring disparities and developing interventions to reduce them.

Beginning at the NHPC's inception, collaboration was a primary objective of participants. Sponsors supported this goal based on the perception that such collective action and engagement on the issue of health care disparities would heighten its prominence and encourage participating health plans (and indirectly the insurance industry overall) to appreciate why disparities are an issue. This could in turn lead them to think creatively on approaches to measure and reduce such disparities. Outside sponsorship from leading independent public and private sector sponsors also was considered essential by many participants, particularly in the NHPC's first few years, when the importance of and approaches to examining disparities among plan memberships were less clear.

In the five years after the NHPC's inception, most participating firms evolved from having little experience in collecting their members' race and ethnicity and measuring quality of care by race/ethnicity, to embracing and institutionalizing disparities measurement and reduction activities. While AHRQ's sponsorship of the NHPC ended in fall 2008, NHPC plans still are participating in disparities reduction activities under the direction of America's Health Insurance Plans (AHIP) and are using this new forum to share their expertise with other AHIP member plans.

The organizational context of participating firms in the NHPC was important to how the collaborative developed and progressed. The firms that participated in the NHPC are large, complex organizations. Change in these organizations typically occurs slowly, and competing demands and pressures within each firm often slowed progress—an important lesson for NHPC sponsors. That said, the NHPC did become more effective in setting and meeting its goals over time through the decision to focus on a few priority areas on which NHPC participants agreed.

Through their work on the NHPC, firms have become more committed to work on disparities and have modified their organizational structures to institutionalize such concerns. The NHPC enhanced communication and information sharing across firms in the industry, and generated an increased appreciation among public and private partners about their concerns and the factors driving their organizations. AHRQ's sponsorship of the NHPC thus can be viewed as a timely investment that has generated knowledge, commitments, and channels of communications that provide a valuable basis for future work on disparities.

This brief summarizes our findings from the evaluation of the NHPC.¹ We first provide background on the NHPC, including its beginnings, the way its work was divided across two phases (2004-2006 and 2006-2008), and where the NHPC stands currently. We then discuss what MPR's evaluation sought to achieve, along with its main findings, focusing first on overarching accomplishments related to disparities and then on accomplishments on specific activities. Next, we describe the NHPC Toolkit—the main vehicle through which the group disseminated its Phase II work. We conclude with a discussion of the broader lessons learned from the NHPC and how these are relevant both to disparities in general and to other policy issues in which public/private collaboration may be relevant.

I. DESCRIPTION OF THE NATIONAL HEALTH PLAN COLLABORATIVE

When the nation's policy and clinical leadership set its sights on overcoming the *Quality Chasm* (IOM 2001), it was perhaps inevitable that concern soon would grow over disparities in access to and quality of health care in the nation (IOM 2002). The formation of the National Health Plan Collaborative (NHPC) in mid-2004 was one response to this concern.²

Beginning at NHPC's inception, the NHPC sought to provide an opportunity for firms actively engaged in sponsoring health plans to collaborate in reducing racial and ethnic disparities in health care. Co-sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation (RWJF), the Collaborative was launched in July 2004. The first phase of work ended in September 2006. AHRQ then sponsored a second phase, which ended in September 2008. Although AHRQ's sponsorship of the NHPC has ended, NHPC firms still are sharing their experience in disparities reduction under the auspices of America's Health Insurance Plan (AHIP) and are using this forum to share their expertise with other AHIP members.

Nine firms participated in the NHPC during its first phase. Five of the nine were large national firms operating health plans in many regions: Aetna, CIGNA, Kaiser Permanente, UnitedHealth Group, and WellPoint. Four of the nine were regional firms: Harvard Pilgrim Healthcare of Massachusetts, HealthPartners of Minnesota, Highmark Blue Cross Blue Shield in Pennsylvania, and Molina Healthcare, Inc., headquartered in California. All but Molina (in which Medicaid is dominant) serve a diversified market and have substantial commercial business. In Phase II, the NHPC was expanded by the addition of a sixth national firm—Humana—and a fifth regional organization—BMC HealthNet, located in Massachusetts.³ By the

¹ The evaluation was funded by AHRQ. Our findings are based on observations of all of the meetings and calls of the Collaborative, a review of the documents generated for the meetings and calls, and periodic telephone discussions that evaluation staff conducted in confidence with each firm, support organization, and sponsor involved in the NHPC.

² For more information on the growing interest in disparities in the early 2000s, see Higgins and Taylor (2009).

³ Humana and BMC HealthNet joined the NHPC in June 2007 and October 2007, respectively.

end of Phase II, the NHPC included 11 national and regional managed care firms encompassing approximately 87 million covered lives.⁴

The plans became involved in this initiative in a variety of ways.⁵ Some had attended meetings on racial/ethnic disparities sponsored by the AHRQ or other organizations; others were known to be forward-thinking, with a strong interest in disparities, and were invited to participate by NHPC sponsors or support organizations. (For more information, see Gold et al. 2006 and Lurie 2005.)

The NHPC received support from several organizations throughout its history, as arranged through various contracts with support organizations and AHRQ/RWJF. The Center for Health Care Strategies (CHCS) was responsible for organizing the NHPC process, working closely with health plans to do so. RAND provided critical substantive support to the NHPC's efforts to understand, measure, and monitor disparities.⁶ In practice, both organizations worked closely with each other, and with the sponsors, to support the NHPC. Additional support was provided during Phase I by the Institute for Healthcare Improvement (IHI), a leader in clinical quality improvement with experience mainly on the provider side. GMMB, a communications firm, became involved in July 2005 and helped the NHPC to disseminate its work through the end of Phase II.⁷

Phase I of NHPC ran from July 2004 through September 2006. During this time, the Collaborative focused primarily on health care disparities among plans' commercially enrolled members (rather than those members with various forms of public coverage, such as Medicare and Medicaid). NHPC targeted disparities in diabetes care, given that diabetes is a condition known to affect a relatively large proportion of the population and a disproportionate number of racial and ethnic minorities. Diabetes is also a condition for which quality measures (specifically HEDIS measures) are readily available. In Phase I, NHPC sponsors and support organizations encouraged firms to develop and test small-scale pilot interventions for members with diabetes—a step for which many were not yet prepared. While the development of interventions occurred slowly and collaboration between participating firms was less than expected during the first phase (see Gold et al. 2008), by the end of Phase I, disparities measurement and reduction activities seemed to be gaining traction within participating plans; the Collaborative as a whole also appeared to be gathering momentum. As a result, AHRQ agreed to fund the NHPC for two more years.

⁴ For more information, see www.nationalhealthplancollaborative.org and Lurie et al. (2008b).

⁵ For more information on the origins of the NHPC, see Appendix B of Gold et al. (2006).

⁶ In Phase I, CHCS and RAND had separate support contracts, the former from RWJF and the latter from AHRQ. IHI was a subcontractor to CHCS in Phase I. AHRQ provided the main support in Phase II, with a contract to CHCS, which then subcontracted with RAND.

⁷ RWJF provided communications support throughout the NHPC via a contract with GMMB.

The NHPC's second phase ran from September 2006 through September 2008. Its intent was to increase the specificity and clarity of objectives, with a focus on particular activities that firms agreed were important. Plans collectively agreed to focus on three areas: (1) collecting primary data on race/ethnicity; (2) providing language services; and (3) developing the business case for work on disparities, both nationally and within firms. While work on the business case never materialized (primarily because of a lack of clarity about this work and the fact that it did not necessarily lend itself to group work), the Collaborative maintained its focus on the other two areas throughout Phase II. (For more information on the business case, see Lurie et al. 2008a.) A little more than halfway through Phase II, the NHPC participants organized themselves around three task forces—sustainability of the NHPC beyond Phase II, standardized data collection, and regional collaboration—to focus the group's efforts for the remainder of Phase II. Ultimately, the NHPC realized the need for setting priorities for its remaining time and focused primarily on the first two task forces (given that ideas for regional collaboration were the least developed of the three task forces and the most tangential to other Phase II work).

Collaborative activities in Phase II took the form of three in-person meetings, as well as conference calls (generally held on a monthly basis) on specific Phase II activities or special topics. In the final months of Phase II, the NHPC devoted substantial resources and energy to the discussion of its post-Phase II transition.

While the transition is not part of MPR's evaluation, we understand from NHPC participants that, since fall 2008, AHIP has convened conference calls of NHPC firms regularly to provide policy updates relevant to disparities activities. AHIP also has hosted a webinar on race/ethnicity/language data collection, in which several NHPC firms presented their data collection work to other AHIP member plans. Firms report that AHIP has focused on educating its membership on the collection of data, and AHIP is effectively tapping NHPC firms as a resource. Momentum for targeted work in this area has been affected by the demands of changes in national political leadership, the consideration of possible national health reform, and the recent serious economic downturn. Despite these events, firm representatives continue to see a strong potential for the Collaborative under AHIP's guidance.

Appendix A provides a timeline for the NHPC, including the activities leading up to its formation and those that occurred during both phases of work.

II. PURPOSES OF THE MPR EVALUATION

AHRQ contracted with Mathematica Policy Research, Inc. (MPR) to evaluate the NHPC, starting in June 2005 and followed that with another contract that extended the evaluation to cover the Collaborative's second phase. The purpose of the evaluations in both phases was to answer several questions:

- How was the Collaborative structured, and what did it do?
- What did the Collaborative accomplish, and how sustainable will these efforts be?

- Did the support provided by the Collaborative’s process contribute to the firms’ ability to make progress in addressing issues related to disparities, and how valuable did the firms consider their participation to be?
- What can AHRQ learn about whether or how to engage in similar collaboratives in the future?

To guide the evaluation, MPR developed a logic model that highlighted the various ways in which the NHPC could contribute to significant progress in addressing racial and ethnic disparities (Figure 1). The framework highlights steps that health plans can take to reduce racial and ethnic disparities, and how the Collaborative might contribute to plans’ success. We assessed the NHPC in terms of its ability to help firms (1) encourage and support firm’s leadership in championing work on disparities, (2) collect data on or estimate the race and ethnicity of their members to better identify potential disparities, (3) develop and pilot interventions to reduce disparities, and (4) communicate the outcomes of their work beyond the NHPC. (See boxes in logic model with asterisks.)

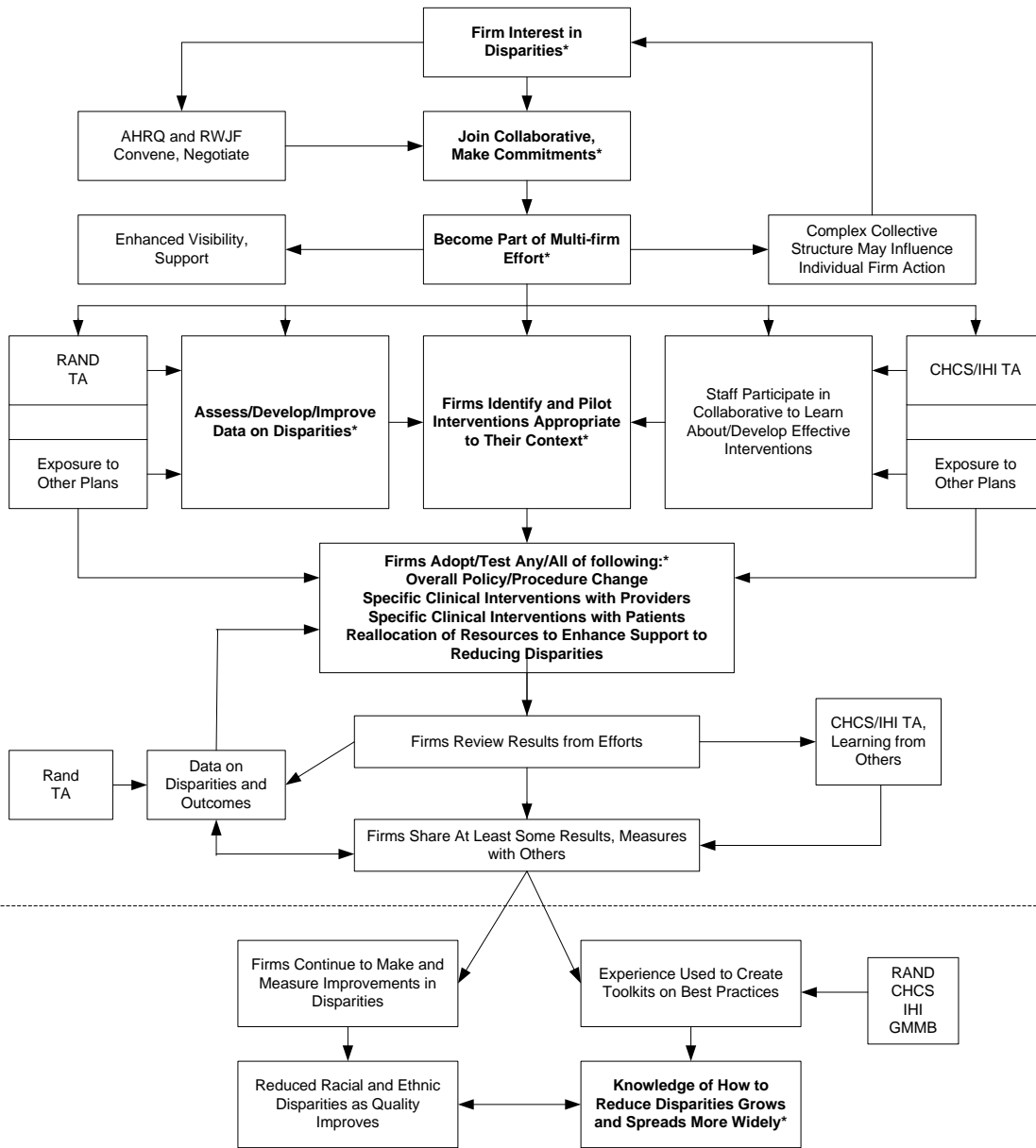
In both phases, the evaluation was largely qualitative, with little primary data collection. For instance, MPR obtained and reviewed all NHPC documents and sat in on the NHPC’s meetings and conference calls as a “silent observer.” In Phase I, we also conducted three rounds of discussions with the lead staff of all participating organizations as well as a larger group of staff from participating firms. We also asked all participants to complete a “network feedback form” to support a formal analysis of the NHPC as a communications network. In Phase II, we again conducted several rounds of discussions with NHPC participants, but targeted only the lead staff in each organization. Moreover, to minimize burden on the part of NHPC participants, these discussions were substantially shorter and more focused.

The NHPC’s work evolved over time; sponsors, support organizations, and participating firms learned more about each other and how they could work together. As the NHPC evolved, so too did the evaluation. In particular, while the Phase II evaluation continued to provide formative feedback on the overall evolution of the NHPC and the way it was working, it also examined existing work in NHPC’s priority areas (through literature reviews and discussions with national experts and relevant program staff). Evaluation goals in Phase II focused on generating two types of information: formative feedback on overall progress (as in Phase I) and case studies of outcomes of work in priority areas.⁸

⁸ While the case studies originally were intended to provide information on the external use of NHPC’s work in data collection, language services, and the business case for reducing disparities, there was not sufficient external dissemination to make this worthwhile. For this reason, the case studies briefly discuss the NHPC’s work, but focus more broadly on national and state-level activities in data collection, language services, and employer perspectives on reducing disparities.

FIGURE 1

SIMPLIFIED LOGIC MODEL OF THE NHPC TO REDUCE DISPARITIES



-----End of Formal Collaborative

III. ACCOMPLISHMENTS: INCREASED ATTENTION AND COMMITMENT, INSTITUTIONALIZATION, AND SHARING

During Phase I of the NHPC, participants increased their understanding of racial/ethnic disparities and came to know one another better, appreciate others' perspectives, and develop the trust that sponsors and support organizations have learned is critical to the NHPC's goals of collaboration and sharing. In Phase II, participants drew on that base of trust to pursue important shared priorities. While the NHPC fell short of the ambitious goals originally set by sponsors—particularly in Phase I—it was successful in supporting what appear to be critical changes in structures and processes within NHPC firms.

A. ACCOMPLISHMENTS IN PHASE I

Findings from the evaluation of the NHPC Phase I show that the Collaborative made progress toward some, though not all, of its objectives (Gold et al. 2006). The main accomplishments of Phase I included the following:

- ***Increased Organizational Attention and Commitment to Disparities as Part of the Quality Agenda for Health Plans.*** Participating firms had the support of their leaders and typically used or developed internal structures to enhance their ability to address disparities. Such infrastructure is critical because, to sustain their efforts, participating firms must confront both a constrained fiscal environment and, in many cases, an unavoidable instability in leadership.
- ***Firms' Growing Recognition That Their Ability to Generate Primary Data on Race/Ethnicity is Critical to Progress.*** In Phase I, the NHPC focused on helping firms to use geocoding and surname analysis as a proxy for primary data on race/ethnicity that could be used to assess disparities. The proxy information brought to light the disparities within the firms' plans and made them more certain that such primary data are critical in supporting quality improvement efforts targeted to members of racial and ethnic minorities. By the end of Phase I, all but one of the firms said that their goal was to collect such data for all of their members; the remaining firm was collecting the information for the subset of its enrollees who participated in disease management. However, the NHPC also revealed a substantial gap between what the firms had done and what they ultimately hoped to do.
- ***Increased Awareness Among Sponsor and Support Organization Staff About How Firms Work in Ways Relevant to Understanding the Firms' Ability to Contribute to Reducing Disparities.*** This was not a stated objective of the NHPC, but through their participation, sponsors and support organizations gained important insights into working with large commercial health plans. Although some key staff in these organizations already had industry experience, others said that they had learned a great deal about the industry through their participation in the NHPC.

Room for Improvement. The NHPC's first phase had less success in sharing lessons about caring for and interacting with members in ways that reduced disparities and in applying that knowledge to change care delivery. The time required to generate data on disparities delayed the firms in focusing on quality improvement. Only in the last year of Phase I did firms start to concentrate on this area. By the end of Phase I, however, seven of the nine firms either had completed, or were in the process of completing, pilot interventions, while two were developing them.

By the end of Phase I, it was too soon to judge the effects of the NHPC's efforts, although most firms said they thought such work created a framework and basis for future expansion, and they planned to continue their efforts. Aside from data, barriers to progress included (1) uncertainty over how to begin and how best to intervene, (2) challenges associated with gaining support for and implementing changes that involved a variety of organizational functions and responsibilities, and (3) difficulties facing firms in gaining the support of their associated physicians for interventions that included a provider-based component.

The NHPC's Contribution. Firms saw the first phase of the NHPC in a positive light. Consistent with its initial hopes, the NHPC allowed firms to leverage their resources, enhance their awareness of disparities, fuel internal efforts to address disparities, and ensure momentum for these changes. The fact that the NHPC was sponsored by an important federal agency and a major health foundation enhanced its credibility and added value from the firms' standpoint. Participants also acknowledged, however, that they did not necessarily benefit as much as they might have from Phase I of the NHPC, had they been willing to share information more openly, or had the NHPC been better structured to facilitate substantive learning, particularly with respect to evidence on ways to reduce disparities.

Given the experience obtained from Phase I, we encouraged NHPC sponsors and support organizations to develop a realistic set of priorities for the second phase, heavily focused on supporting substantive change in a few areas of high priority to participating firms. Firms also asked (through their feedback in our evaluation) for some organizational changes in Phase II to make the NHPC a more streamlined structure with fewer and more predictable demands on their time. This would allow them to fit the NHPC more easily into their ongoing work within their organizations. Based on our final evaluation report for Phase I, as well as other factors, AHRQ decided to sponsor a second phase of the NHPC. (RWJF also remained involved, although its Phase II sponsorship was limited to supporting communications through its contract with GMMB.) Phase II sought to continue to reinforce the participants' focus on measuring and reducing disparities while supporting firms in making concrete progress in targeted high-priority areas.

B. ACCOMPLISHMENTS IN PHASE II

In Phase II, the evaluation continued to focus on the organizational response to the NHPC. For example, there was interest in answering such questions as:

- Will firms continue to participate in the NHPC, and with what level of commitment? If there is leadership or staffing turnover, can firms manage to retain their interest in both the NHPC and addressing disparities overall?
- How will the inclusion of Humana and other potential new firm(s) in Phase II affect the NHPC's ability to work together on its goals and outcomes?
- Has the focus on particular activities strengthened or weakened the firms' commitment to reducing disparities?
- Will firms continue to view the NHPC as valuable, and if so, why? Are firms collaborating with one another? How much sharing of information and ideas actually occurs?

NHPC Participation. At the end of Phase II, all firms were participating actively in the NHPC—although, as always, some were more active than others. Most notably, the majority of firms appeared to have made substantial progress in integrating and institutionalizing their disparities work into the mainstream of their organizations, as described in more detail below. Several firms' representatives characterized their Phase II disparities activities as having moved from the “corner of the desk” to a more central position, with others in their organizations—including senior management—paying more attention to this work. Moreover, months after the end of Phase II, members appeared to be either steady in their disparities work or on a path to expansion (based on our correspondence with firms in March 2009).

NHPC Reinforced Firms' Work on Disparities. The NHPC helped to motivate firms' work on disparities. Many NHPC participants noted that membership in the Collaborative provided the leverage needed to obtain senior management involvement and commitment to disparities work. One firm representative commented that “being a member on its own was valuable because it allowed more resources in [the health plan] to be directed to disparities work.” A number of NHPC participants noted that learning what their competitors were doing regarding disparities kept them focused on this work. In the words of one firm's representative, NHPC participation—and the accompanying knowledge of other firms' activities—provided “additional credibility and motivation to what was being done [internally], especially for the far reaches of the organization.” Staff from another firm described Phase II as “critical... in terms of raising this issue to a new level in our organization.” Another firm's representative noted that participating in the Collaborative “made us talk about our [disparities] activities and be a bit more transparent with other health plans regarding where we are.” One member mentioned, however, that the Collaborative may have benefited from tighter linkages with other groups doing notable disparities work, such as the Institute of Medicine's (IOM) Roundtable on Health Disparities.

The increased focus on disparities is impressive in light of competing pressures, such as business concerns and merger activity in several NHPC firms during Phase II. In the words of one nonfirm representative, “...despite major upheavals in the plans, things have remained standing” and, by some accounts, the disparities work of several firms has begun to flourish. Several potential challenges lie ahead, however, as discussed in this brief's conclusion.

Firms placing an increased priority on disparities also was reinforced by several changes in the external environment during Phase II. First, policy developments in California (in the form of Senate Bill (SB) 853, requiring access to language services for patients) and Massachusetts (in the form of state regulations requiring hospitals and health plans to collect data on patients' race/ethnicity) garnered the attention of health plans. California's SB 853 had a large impact on health plans operating in that state, with one large firm reporting that it spent \$1 million on translated documents for each translated language. Similarly, the Massachusetts policy has prompted increased activity in firms operating there. One firm's representative noted that its accelerated activity regarding race/ethnicity data collection would not have happened without the Massachusetts mandate. Not surprisingly, national plans are particularly concerned about states regulating myriad different approaches to data collection and language access. Second, NHPC firms reported increased interest in disparities among both public and private employers, as evidenced by requirements included in the RFPs eliciting bids for group coverage. Finally, several firms' representatives noted that the changing demographics in the United States (e.g., the growing proportion of Hispanic persons in the population) helped to make the business case for reducing disparities in a broad sense, since there is likely to be a change in the composition of their future customer base. (For more information, see Au et al. 2009.)

Institutionalization of Disparities Activities. Disparities work also became more clearly institutionalized in many NHPC participating firms during Phase II. As one NHPC organization stated, "The plans have established a real infrastructure [internally]... now it has roots." Moreover, this institutionalization of activities raised awareness within each firm and helped "connect the dots" between internal disparities activities.

While examples of institutionalization are available for most NHPC firms, a few notable developments include:

- CIGNA developed a cross-function group, the Disparities Council, which held its first official meeting in May 2008. Also, the firm announced the appointment of Dr. Collette Edwards to a new national medical director position with a focus on disparities.
- Highmark created a new health equity and quality area within its quality and medical performance management department; Dr. Rhonda Johnson heads this group.
- Kaiser Permanente (KP) added an equity metric to its "executive dashboard"; this is shared systematically with senior quality improvement leaders. KP's CEO sponsored the development of a disparities website under KP's umbrella of sites.
- Molina created a new Vice President position whose duties will include work to improve access to care, as well as creating and implementing programs to reduce identified health disparities.
- UnitedHealth Group developed an enterprise-wide committee, the Multicultural Clinical and Business Advancement Team, in fall 2007.

- Several firms noted that disparities work has been institutionalized within their organizations via regular or semiregular presentations to their Boards of Directors on disparities activities.
- Many firms have pursued cultural competency training activities, with several targeting both clinical and nonclinical staff and some conducting training enterprise-wide.
- Several firms began collecting patient self-reported data on race/ethnicity/language through online enrollment, creation of a data warehouse populated with information from hospitals and physician groups, interactive voice response systems,⁹ and electronic health record (EHR) systems.

Increased Sharing and Trust. NHPC participants uniformly suggested that sharing and trust between organizations increased substantially during Phase II, relative to Phase I—both for the group as a whole and one-on-one.¹⁰ Firms’ representatives indicated that sharing with and learning from others was not only a primary purpose but also a major accomplishment of Phase II. Furthermore, in contrast to the anticipated concern over the impact of expanding the NHPC to include new firms, the expansion appeared to have no effect on sharing and trust (perhaps in part because only two new firms were invited to join during this time). While several key firm representatives participated throughout the Phase I and II, there also was staff turnover for a number of firms; therefore, the trust that developed among NHPC participants seems largely at the organizational rather than individual level.

All participants seemed pleased with the group’s move over time toward a much more open atmosphere and found the in-person meetings—especially the last in Phase II, in July 2008—particularly open and informative. Many firms noted that learning from others about what activities were successful or not helped them to anticipate challenges and not repeat the same mistakes. One firm’s representative characterized Phase II as a “sounding board and repository for best practices.” Sponsors and support organizations were particularly pleased that firms were picking up and using others’ ideas—and that all participants appeared comfortable with that approach.

Firms’ representatives reported more active internal sharing of information regarding NHPC meetings and calls, in part because of the institutionalization discussed above. In the words of one national firm’s representative, who shares NHPC information directly with an internal committee focused on disparities, “I can’t say enough how helpful it is to bring back information on what other plans are doing.” Another representative, who also regularly updates internal staff

⁹ Some health plans use interactive voice response (IVR) technology to conduct educational outreach calls to members about preventive services and other member communications. For more information, see the NHPC toolkit’s case study of Harvard Pilgrim’s work in this area, available at the following link: <http://www.rwjf.org/qualityequality/product.jsp?id=34018>.

¹⁰ See Gold et al. (2008) for a discussion of communications and relations among NHPC organizations in Phase I.

on NHPC activities, suggested that staff in his organization always are very interested in what other firms are doing.

Informal communication between firms also grew substantially during Phase II, representing a marked change from Phase I. Several NHPC members noted that informal communication (such as telephone calls) now occurs between firms, particularly for the last six to eight months of Phase II. Moreover, whereas the support organizations had to facilitate these types of firm-to-firm interactions in Phase I, this usually was not necessary in Phase II.

NHPC as a Leadership Organization. The NHPC originally was conceived as a group of firms that were leaders in the area of disparities, or at least had a strong interest in reducing them. Since the NHPC's inception in mid-2004, many other efforts focused on disparities have emerged. Several NHPC participants also have participated in forums, collaboratives, and other groups. While the field has grown, NHPC organizations still identify the NHPC as a leader in the field. Specifically, several firms involved in disparities work outside of the NHPC say they now realize that the NHPC was in the forefront of disparities work. For example, several NHPC firms have worked with the Disparities Solution Center at Massachusetts General Hospital, and a few other representatives of firms served as faculty at a recent meeting of the group. According to a staff member of one firm, this work "has shown me how far ahead the NHPC is." Another firm's representative stated that the NHPC members "sometimes think that all health plans must be doing what the [plans in the] Collaborative are doing, but that's not the reality."

IV. ACCOMPLISHMENTS ON TARGETED ACTIVITIES

Most NHPC members perceived Phase II as more successful than Phase I, not only in terms of firms' commitment to and institutionalization of disparities work, but also in concrete progress made on targeted disparities activities. Here we discuss initial expectations and ultimate outcomes in the two areas that consumed much of the attention during Phase II: (1) collection of race/ethnicity (and, to some extent, language) data and its standardization, and (2) improving access to and quality of language services.

A. RACE/ETHNICITY/LANGUAGE DATA COLLECTION AND STANDARDIZATION

As initially conceived, Phase II was designed to support firms' efforts to capture primary data on race/ethnicity (with a growing emphasis on language data during this phase), including developing guidance both consistent with best practices and responsive to what NHPC participants anticipate will be a desire among users for collecting these data with some uniformity across firms (so that they are reporting at least a minimum amount of consistent information). Early in the process however, firms were reluctant to endorse a uniform approach. Support organizations concluded that organizational structures were sufficiently different that it made more sense to focus less on promoting a specific standardized way of collecting race/ethnicity/language data than on encouraging firms to collect such data using whatever means and strategies were appropriate for their environment.

Phase II was marked by firms' increased commitment to data collection. By the end of this phase, all of them were collecting direct data in some form but still varied substantially in the extent to which they were doing so. One firm's representative characterized the evolution of the NHPC's thinking on primary data collection as moving from a "prove it to me" attitude a few years ago to a strong conviction at this point about its value. Moreover, firms uniformly view primary data collection as the gold standard towards which they need to work. At the same time, they recognize that secondary sources (such as purchaser data on employees and Medicaid data on beneficiaries) provide another useful avenue for race/ethnicity/language collection, and that indirect or proxy methods (such as geocoding and surname analysis) likely will remain important, as discussed in more detail below.

Activities surrounding direct data collection were important in Phase II. At its start, NHPC firms shared information as to how to collect primary data on race/ethnicity/language, including member surveys about race/ethnicity/language, questions asked during clinical encounters, and assurances given to members about how the data would be used. Firms also shared information on member responses and reactions to these inquiries. As one firm's representative stated, "We set the stage that health plans can ask for this information and not be totally lambasted in the marketplace."

Differences in firms' organizational structures and product mixes influenced the strategy to which they gravitated in addressing issues of race/ethnicity/language data. Firms like Molina, for example, serves a largely Medicaid population which provided them with a unique access to data from states (the purchaser)—something that the other predominantly commercial-based firms in the NHPC did not have.¹¹ The NHPC spent some time exploring the feasibility of obtaining similar data from employer accounts but found this avenue less fruitful; some firms had encountered employer resistance to sharing this information (because of legal concerns, administrative costs, and other issues), and only one firm successfully obtained data through this source during Phase II.¹² The other external source of race/ethnicity/language data is from providers (e.g., physician groups and hospitals) who collect these data during clinical encounters. Firms' use of this source is still relatively limited, as providers often are reluctant to share data with health plans for legal and other reasons. However, some firms with strong organizational ties to provider groups were able to capitalize on this capacity to obtain data for at least some of their patients.

Given most firms' limited ability to obtain member race/ethnicity/language data from employers and providers, most NHPC firms concluded that if they wanted such data, they would have to collect it themselves. Firms in the NHPC studied Aetna's experience with using member portals to collect these data, as well as the emerging experience of other NHPC participants with diverse strategies for data collection, including through member surveys and during member educational outreach calls.

¹¹ While health plans serving Medicare and Medicaid beneficiaries can obtain information on beneficiaries' race and ethnicity from federal and state governments, only limited race/ethnicity distinctions are possible in Medicare data, and Medicaid data varies substantially by state in its quality and completeness.

¹² For more information on the barriers to employers sharing these data, see Higgins et al. (2009).

As the NHPC firms became more sophisticated in collecting data, the importance of a mixed-methods approach to data collection emerged—that is, firms began using multiple sources of input data on race and ethnicity, with the goal of aggregating data from these sources across members (Table 1).¹³ Firms increased the number of sources from which they collected direct data, based both on growing awareness of alternative sources and the limitations of any single approach. NHPC firms now collect these data through various channels, including health risk assessments, web portals, member surveys, disease management programs, during clinical encounters, and during enrollment. Individual firm strategies vary to match both their operational configuration and views of what approaches will be acceptable in the marketplace; a key emphasis is voluntary reporting by the relevant subgroups.

TABLE 1

METHODS USED BY NHPC FIRMS FOR COLLECTING RACE/ETHNICITY/LANGUAGE DATA

Direct Methods
Primary Sources
Enrollment data
Disease management programs
Health risk assessments
Encounter data (e.g., physician office, hospital)
Health plan direct outreach
Member web portal
Member survey
Member-initiated contacts (e.g., customer billing inquiries)
Secondary Sources
Centers for Medicare & Medicaid Services (Medicare beneficiaries)
State Medicaid agencies (Medicaid beneficiaries)
Employer
Insurance broker
Indirect Methods
Geocoding and surname analysis
Third-generation methods (using Bayesian statistics)

Source: NHPC Toolkit, Chapter 4.

By the end of the formal NHPC, signs were emerging that firms' ability to make progress in race/ethnicity data collection on their own might have limits. Several NHPC firms that have been collecting direct race/ethnicity data for several years have reached a plateau of 25 to 35 percent of members for whom they can collect these data directly. For example, Aetna, which began collecting data in 2002, had direct race/ethnicity data for about 30 percent of its actively enrolled membership as of 2008. Similarly, HealthPartners has collected these data for about 32 percent

¹³ For detailed information on which sources and strategies each NHPC firm was using at the end of Phase II, see the National Health Plan Collaborative Toolkit, Chapter 4, available at the following link: <http://www.rwjf.org/qualityequality/product.jsp?id=33988>.

of its membership. While firms are considering ways to boost the numbers of members with direct data beyond the 30 to 35 percent threshold, this development suggests that, unless a fundamental change occurs in the environment, indirect methods of estimating race/ethnicity may continue to play an important role in firms' disparities work in the future.

Standardization of Race/Ethnicity/Language Data Collection. Later in Phase II, the NHPC expanded its focus on the potential for standardization of data collection.¹⁴ While such data collection was a priority from the beginning of Phase II, standardization per se was not. About midway through this phase, NHPC members began coalescing around the idea of promoting standardization at the national level. The impetus for movement in this area was state efforts (e.g., California and Massachusetts) to encourage and specify standards for primary data collection of race/ethnicity/language. These state efforts generated concern within the industry about lack of national uniformity, should each state pursue its own unique approach. In addition, UnitedHealth Group's leadership in this area and its push for health plans to be "out in front" on this issue industry-wide also helped to galvanize support for standardization within NHPC.

Several meetings of the standardization workgroup in winter and early spring 2008 resulted in the NHPC seeking external help on this issue. As one firm's representative said, "There was a clear declaration on the necessity of settling the definition of R/E/L once and for all... a clear sense that we need health plan leadership as well as policy leadership to drive the process." Another NHPC organization concurred, saying: "The standardization [workgroup] crystallized the issue. They realized the problem was beyond what they could solve."

Ultimately, NHPC firms met with Carolyn Clancy, the Director of AHRQ, and others to discuss the possibility of an IOM study on race/ethnicity/language standardization. Since that time, AHRQ has commissioned the IOM to develop a study that will recommend appropriate racial and ethnic categories, and perhaps promote standardization in data collection. The results of this study are expected in mid-2009.

Federal legislation also may have an impact on data collection and perhaps its standardization. The Medicare Improvements for Patients and Providers Act of 2008, which requires a report with recommendations for improving the identification of health disparities among Medicare beneficiaries based on beneficiary data on race, ethnicity, and gender within four years of enactment, is likely to have important implications for data collection by health plans.¹⁵

By the end of Phase II, NHPC firms—particularly national firms—continued to believe in the importance of standardization and remained concerned about the possible proliferation of varying state standards if national standards are not developed. While some firms characterized the NHPC's push for standardization in Phase II as a major accomplishment, others described progress on this front as slow and disappointing. Standardization could limit firms' flexibility in

¹⁴ For general information on recent federal and state activities surrounding race/ethnicity data collection, see Higgins and Taylor (2009).

¹⁵ See Sec. 185 of H.R. 6331.

data collection and increase their costs, but NHPC firms generally seemed to perceive the benefits of a uniform approach as outweighing the costs. Moreover, a few large firms appeared reluctant to embrace primary data collection fully until an approach was codified, so standardization may begin to push these firms forward.

B. ACCESS TO LANGUAGE SERVICES

The second area of emphasis in Phase II was on work to enhance firms' ability to provide high-quality care to patients with limited English proficiency by developing recommendations on how to select and evaluate vendors for language services, support provider adoption of such services, and encourage employers and members to use language services.

At the start of Phase II, the NHPC considered developing an operational pilot related to language services in one community (partially driven by Molina's suggestion for such joint work). However, several firms did not wish to commit to joint work—in large part because it might have required them to coordinate competing internal and external demands. Moreover, some NHPC participants may not have been well positioned organizationally to grasp everything their firm was doing in the area of language access. This was particularly true for firms that use a central contract to support a variety of administrative services or that purchase language services through one or more vendors. NHPC participants instead opted for collecting and developing broad-based tools, such as standards for interpretation services, which each could use in their own way.

Firms' awareness and knowledge of language services increased substantially as a result of this Phase II activity. One firm's representative described the major accomplishment surrounding this component of Phase II as "consciousness raising," noting that, in the past four to five years, the firms had been focused more on collection of race/ethnicity data, while language access "wasn't on our radar." NHPC members generally agreed that language access was a productive area, in which firms were "creative and willing to share" during Phase II.

California's SB 853 played a major role in catalyzing NHPC firms' interest in language services. Although the SB 853 was passed in 2003, it took some time for regulations to be developed. The regulations, developed by the Department of Managed Health Care (DMHC), mandated that health plans operating in California provide limited-English proficiency members with language assistance services at all points of care (translating vital documents in threshold languages and providing translation and interpreter services as needed), beginning in January 2009. National plans were particularly attuned to this policy development because California represents a large market and other states might follow suit. Indeed, several states likely will be looking to California's experience to understand what works prior to considering their own possible implementation (Au et al. 2009).

Language access materials shared between NHPC members in Phase II included vendor selection criteria for translators and interpreters, information on various approaches to interpretation and translation (including advantages and disadvantages), guidelines for in-house translation reviews, and various translation checklists and worksheets (some of which were compiled based on information from NHPC firms). UnitedHealth Group's webinar presentation

of its in-language provider directory for Asian Americans was considered by several firms as one of the more useful Phase II webinars.¹⁶ (Information on the in-language provider directory is included in the NHPC Toolkit, as is a discussion of promising practices in interpreter services based on Kaiser Permanente’s qualified bilingual staff model and health care interpreter certificate program. See <http://www.rwjf.org/qualityequality/product.jsp?id=34010>.)

V. DISSEMINATING PHASE II WORK THROUGH THE NHPC TOOLKIT

NHPC participants as well as AHRQ and RWJF staff, perceived the dissemination of the group’s Phase II work as an important goal. The primary dissemination vehicle was the NHPC Toolkit, a collection of resources to help health plans address racial and ethnic health disparities. The Toolkit was unveiled on September 8, 2008 at AHRQ’s annual conference. Developed by GMMB in collaboration with all NHPC participants, the Toolkit includes the following key elements:

- Background information on racial and ethnic disparities, the importance of racial and ethnic data collection and provision of language services, national and state policy endeavors in these areas, and the efforts of the NHPC
- Descriptions of racial and ethnic health data collection strategies adopted by NHPC firms
- Summaries of firms’ language access improvement activities
- Information on making the business case for quality improvement and disparities elimination
- Case studies of several NHPC firms’ efforts to address racial and ethnic disparities

Currently, the Toolkit is maintained on the RWJF website.¹⁷ Links to the Toolkit are available on the NHPC and AHIP websites.

Perspectives on the Toolkit. NHPC participants expressed predominantly positive reactions to the Toolkit. Several firms’ representatives felt that it was one of the most important accomplishments of Phase II. Multiple representatives noted that the Toolkit is not only a marker of NHPC’s success, but also a valuable source of practical information for non-NHPC health plans attempting to address racial and ethnic disparities. One firm’s representative suggested that “it is one of the best health care toolkits [I have] ever seen.” Another member commented that

¹⁶ UnitedHealthCare won a “Recognizing Innovation in Multicultural Health Care Award” from NCQA in 2007 for its work on the in-language provider directory for Asian Americans. Since the final NHPC meeting, NCQA has announced its 2008 awards recognizing innovation in multicultural health care. Five of the seven awardees were NHPC firms (Aetna, Highmark, Molina, UnitedHealth Group, and WellPoint). For more information, see <http://www.ncqa.org/tabid/826/Default.aspx>.

¹⁷ The Toolkit is available at the following link: <http://www.rwjf.org/qualityequality/product.jsp?id=33960>.

the Toolkit has been met with interest and enthusiasm when shared with health plans outside of the Collaborative.

Dissemination Activities. The NHPC has disseminated the Toolkit in a variety of ways. Links appear on the NHPC and AHIP websites. AHIP announced the Toolkit's launch in its *Hi-Wire* newsletter. In addition, both RWJF and CHCS introduced it to their constituencies via their listservs. Its launch at the AHRQ annual conference was accompanied by distribution of a one-page description of its contents, written by GMMB. In addition to these methods of dissemination, NHPC firms have found other ways to share the Toolkit with people outside of their own organizations. For example, one member presented it to a health plan association conference and another shared it with a non-NHPC health plan that eventually created a link to the Toolkit from its own website.

Dissemination activities have resulted in people accessing the online Toolkit. According to recent RWJF web statistics, 689 people were referred to the Toolkit from other websites since its release.¹⁸ The majority of referrals have originated from the CHCS website (27 percent), followed by a weekly e-newsletter called *Case In Point Weekly* (5 percent), and the Families USA website (3 percent). About 3.4 percent of referrals came from Google searches, suggesting that people have heard of the Toolkit and have searched for it specifically. Another 1.6 percent of referrals came from the AHIP website.¹⁹

Use of the Toolkit. Recent observations from NHPC members and RWJF web analytics suggest that the Toolkit is being used and has been well-received internally by NHPC firms as well as by non-NHPC health plans. Since its September 2008 release, the Toolkit has remained a popular product on the RWJF site, logging about 4,500 unique views in the first four months after its unveiling. Web analytics of the RWJF site also show that it has been a popular product to print and e-mail. In addition, users spend more time on average (2.4 minutes) on the Toolkit pages relative to other RWJF products that fall under its Quality/Equality program area.

Several NHPC members reported having used the Toolkit. One firm's representative remarked that they have been "pulling examples from the Toolkit" to guide and develop internal data collection mechanisms and that the detail provided in it often has been sufficient to direct progress. In this case, at least two data collection activities the firm is pursuing are modeled on Toolkit examples. Other NHPC participants noted that they have presented the Toolkit to senior management and leadership or have used it as a background resource when responding to employer RFPs. Organizations outside of the NHPC have used the Toolkit as well.²⁰ One firm whose work is featured in it has received multiple calls from non-NHPC health plans for technical assistance and additional information on data collection. Another firm indicated that

¹⁸ Personal communication with GMMB staff in March 2009.

¹⁹ The referring sites described here include those organization websites with the largest number of referrals to the Toolkit. The remaining two-thirds of referrals were from websites that each had a small number of referrals.

²⁰ While we were able to obtain a general sense of the Toolkit's use, gathering specific information on the number and type of external users was beyond the scope of this study.

the Toolkit had been examined by health plans in California as a comparison with their efforts on data collection, which has been mandated by SB 853.

VI. LESSONS LEARNED

Collaboration with Large Firms Requires Understanding Their Organizational Context. The firms that participated in the NHPC are large, complex organizations. Change in these organizations typically occurs slowly, unless there is a strong directive from an organization's top leadership. Moreover, competing demands and pressures within each firm—in the form of constraints on information technology resources and staff, budgetary pressures, staff turnover, and merger activity—often slow progress. In addition, as a group, participating firms vary substantially in their structure (centralized versus decentralized), culture, and geographic coverage. For these reasons, firms were not able to take a single approach or intervention—as is sometimes done in quality improvement collaboratives involving smaller, less complex organizations—or move forward at the same pace. Yet participants successfully used the collaborative as a venue for sharing best practices, avoiding each others' mistakes, and pushing each other to continue progress.

Given the often slow and deliberative nature of organizations of this size and complexity, AHRQ's funding of Phase II appeared to come at a critical juncture. The end of Phase I finally saw a building of momentum on disparities work. Phase II saw the continuation of this work, its extension (beyond disparities in diabetes care to care for other conditions and preventive care) and, for many firms, its institutionalization. Phase II also saw markedly different interactions between NHPC participants, with substantially greater trust and sharing of information. This development was particularly notable, given the competitive nature of the industry. Most firms perceived this sharing to be one of the most valuable aspects of the Collaborative. Finally, as in Phase I, firms perceived that AHRQ's sponsorship of the NHPC afforded them greater consideration internally, by signaling federal backing of an important issue.

Setting Specific Goals Can Help Collaborative Focus, Particularly After There Is Initial Buy-in, but Flexibility Also Is Valuable. Deciding on concrete goals and specific activities at the start of Phase II allowed participants to be on the "same page" from the start, and appeared to make a difference in its success (relative to Phase I, in which activities were substantially less defined). These activities and related goals provided the group with focus. Moreover, letting firms decide on the activities and goals of Phase II gave them more ownership, in that the activities were valued by them and therefore provided a vested interest in completing them. (This is in contrast to the more prescriptive approach in Phase I in which sponsors and support organizations encouraged plans to develop small-scale pilot interventions whose success could be assessed via before-after comparisons of HEDIS measures—a step for which many were not ready.)

The NHPC was also relatively facile in altering its activities and goals as needed in Phase II. By late 2007, the NHPC dropped the business case work when the group realized these efforts lacked clarity and were not going to be fruitful, given that development of the business case did not lend itself to a group setting of competitors. Similarly, in early 2008, the NHPC developed several new task forces and the group began to spread itself too thin across a range of activities.

Realizing this—in part based on this evaluation’s formative feedback—the NHPC then prioritized its efforts toward disseminating its Phase II work and planning for the group’s sustainability after Phase II. These midcourse corrections were important in keeping the Collaborative on track and focused on high-priority tasks that could be most productive by the end of Phase II.

Reaching Out to Other Stakeholders Might Have Brought Opportunities. While NHPC participants widely agreed that Phase II was successful in focusing, sustaining, and institutionalizing their work on disparities, one criticism we heard was that the Collaborative did not reach out to external audiences. For example, several firms felt that connecting with large employers and/or employer groups—such as the National Business Group on Health—would have been useful in Phase II, if only to get the perspectives of these audiences on disparities. Also along these lines, representatives from NHPC firms sometimes reported learning of other disparities groups or activities—such as the American Medical Association’s Commission to End Health Care Disparities—and were surprised that they had not heard about them from the NHPC. The transition of the group to AHIP may offer new opportunities to engage other audiences.

Collection of Race/Ethnicity Data Among NHPC Firms Increased Substantially. NHPC participants made substantial progress on data collection efforts during Phase II. One of the most notable developments in this area was the recognition of the need for multipronged data collection strategies, particularly in light of the limitations of primary data collection. At the last Phase II meeting, several NHPC firms that had been collecting direct race/ethnicity data for several years reported reaching a plateau of 25 to 35 percent of members for whom they have collected these data directly. This limitation highlights the need for creative strategies for data collection and the continued importance of proxy methods. Moreover, employers remain an untapped source of data and could become an increasingly important source if existing barriers were overcome, such as many employers’ misperceptions about the legality of sharing employee data with health plans. In addition, data from providers such as physician groups and hospitals remain another important and largely untapped source. The mandate to collect race/ethnicity data in Massachusetts, however, may begin to move this approach forward, as hospitals and other providers are beginning to make arrangements with health plans to share patient race/ethnicity data.

The Public/Private Partnership of the NHPC Differed from Others AHRQ Has Undertaken. In recent years, AHRQ has increasingly worked with private organizations through programs such as Accelerating Change and Transformation in Organizations and Networks (ACTION), the Primary Care Practice Based Research Network (PBRNs), and other collaborations that may be more time limited (e.g. Partnerships for Quality), as a means to conduct rapid-cycle applied research and better link research to the operational settings in which it may be used. In contrast to these programs, the NHPC represented a different type of public/private partnership for AHRQ.

First, the NHPC was convened primarily as a collaborative. The firms participating in the NHPC were not grantees and received no direct financial support, although they benefitted from in-kind support provided by the support organizations and the NHPC infrastructure. The

voluntary nature of this kind of participation is inherently more ambiguous and challenging than that between funder and grantee. Firm “buy in” to NHPC goals thus was more critical to progress, since shared goals had to evolve rather than be mandated.

Second, the firms’ lead participants were not themselves researchers and instead occupied operational positions within the firms. Their interest in pursuing disparities reductions was motivated less by a research interest than by how they saw the work benefitting their organization and its goals, and also because of the value they often personally ascribed to the work. In many cases, they were asked to participate in the NHPC by top firm leadership. As a result, firms’ representatives in the NHPC were much more integrated into the executive leadership and operations of their firms than if they had been based in a separate research entity. However, their location and background within the firm also meant that they had many competing demands on their time and did not necessarily bring strong analytical grounding on literature-based best practices for measuring disparities and testing interventions.

Third, the NHPC offered AHRQ an opportunity to potentially influence health care quality on a much larger scale than its other partnerships to date, given that the NHPC covered 87 million lives by the end of Phase II. Because efforts were linked to top leadership in major firms within the industry, the NHPC had the potential to generate momentum that ultimately could change how health plans perceive, measure, and act on disparities. Such scale also has its challenges, however. Firms that participated in the NHPC, particularly the large national organizations, move very slowly and must consider change primarily from the perspective of their business and organizational needs. This type of partnership is less likely to result in dramatic breakthroughs and innovation than in the gradual accumulation of knowledge and shifts in orientation.

Challenges and Opportunities Lie Ahead. While many NHPC plans made strides in their disparities measurement and reduction activities in Phase II, plans—including others outside of the NHPC—are likely to face some significant barriers in the future. The magnitude of the current economic recession may hamper work on disparities as other issues and concerns become higher priority. One firm’s representative remarked, “In a market where companies are laying off workers and cutting budgets, it is uncertain who will pay attention to the issues the NHPC has been focused on, such as data collection, if it involves investing in health IT systems.” In addition, most employers—the primary purchasers of commercial health coverage—are not particularly attuned to issues of health care disparities (Rosenthal et al. 2009), and employer attention may fade even more in light of current economic considerations. In the current economic climate, a key focus likely will be on the potential for disparities reduction activities to improve health care quality while reducing costs.

Perhaps a key lesson from the NHPC is that such voluntary efforts enhance receptivity and infrastructure in ways that are important if firms are to effectively engage in initiatives to address disparities. However, such shifts are more likely to occur when the external environment reinforces them. The fact that states like California and Massachusetts are now requiring firms to collect and report data (race/ethnicity in Massachusetts and preferred language in California) and enhance their language services (California) has moved such work much higher on the priority lists of firms subject to those requirements.

While the Obama Administration has not yet indicated how it will approach disparities, it clearly has endorsed substantial increases in funding for information technology that will be used to drive quality improvement. This provides a valuable opportunity to capture uniform data on race/ethnicity/language essential to many strategies for disparities reduction. For the most part, federal efforts are directed at providers, not health plans, and privacy concerns are likely to constrain the ease with which information can be shared. However, such enhanced capacity, combined with external incentives to use it to enhance quality and reduce disparities, are likely to be critical to continued progress by health plans working on these priorities.

AHRQ's Investment in NHPC Resulted in Important Organizational Changes Within Participating Firms. As a government agency, AHRQ took a risk in supporting the NHPC by entering into a partnership with organizations it could influence but not control on an important issue (disparities) at a time when the health plan role and perspective still was unformed. In hindsight, initial expectations, at least from the sponsors, probably were unrealistic. The NHPC's work resulted in organizational change, but the impact of such change on people served by health plans is still not felt fully, and future progress is likely to be driven by external requirements as much as voluntary efforts. Yet the NHPC arguably paved the way for future change and helped to create a base that will support those efforts well. Sponsors' limited support generated many times that investment among NHPC firms in staff and systems work on disparities. Through their work on the NHPC, firms also became more committed to reducing disparities and modified their organizational structures to institutionalize these concerns. The NHPC also enhanced communication and information sharing across firms in the industry and generated an increased appreciation across public and private partners about the complexity of participating firms and how they work. The partnership of the NHPC therefore can be viewed as a timely investment that generated knowledge, commitments, and channels of communication that will provide a valuable basis for building future work on disparities.

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APPENDIX A

TIMELINE OF NHPC ACTIVITIES

Date	Activity
July 2003	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.
November 2003 - January 2004	AHRQ contracts with RAND for plans' needs assessment and technical assistance.
Summer 2003 - Spring 2004	AHRQ and RWJF develop Memorandum of Understanding on Participation.
Spring 2004	RWJF contracts with CHCS (and through it, with IHI) to form a learning collaborative (later named the National Health Plan Collaborative) – executed August 2004.
PHASE I	
July 2004	Principals meet to review plans for first meeting of the Collaborative.
August 2004	CHCS/IHI and RAND call firms to discuss the Collaborative and provide initial technical assistance.
September 2004	First meeting of the Collaborative at AHRQ in Rockville, MD.
March 2005	Second meeting of the Collaborative in Santa Monica, CA.
June 2005	Senior leadership of Collaborative meets in Chicago, IL.
July 2005	Full Collaborative conference call.
August 2005	GMMB contracted to design communication plan for the Collaborative to learn about communication priorities of the initiative and coordinate messages for consistency across the Collaborative.
December 2005	GMMB releases National Health Plan Collaborative Communications Toolkit.
April 2006	Full Collaborative conference call.
June 2006	Third meeting of the Collaborative in Washington, DC. Stakeholder roundtable briefing in Washington, DC.
August 2006	Full Collaborative conference call.
September 2006	Final Meeting of the Phase I in Chicago, IL. Formal end of Phase I of the NHPC.
PHASE II	
September 2006	NHPC leadership meets in Chicago; sets priorities for Phase II and forms 3 task forces.
October 2006	GMMB summary report released on NHPC Phase I.

Date	Activity
December 2006	Task forces begin monthly calls. Quality Summit on Reducing Disparities and Improving Quality (conducted as part of CHCS's ongoing work with RWJF).
March 2007	In-person meeting in Indianapolis; task forces disbanded.
April 2007	Call to discuss consensus reached in Indianapolis and action steps grid developed.
June 2007	First conference call including Humana as an official member; discussion of primary data.
July 2007	Language access call.
August 2007	Business case call.
September 2007	Primary data call. Webinar on translation process (presented by Molina).
October 2007	Language access call.
December 2007	In-person meeting in Santa Monica, CA.
January 2008	Language access call (including presentation by UnitedHealth Group on its Asian In-Language Directory). Task Force #1 (Sustaining the NHPC) and Task Force #3 (Regional Collaboration) calls.
February 2008	Task Force #1 call. Workgroup call (update on new task forces and plans for Toolkit).
March 2008	Workgroup call (NHPC priorities moving forward, update on Toolkit, and remaining activities through end of Phase II). Task Force #2 call (national equity agenda/standardization).
April 2008	Workgroup call (special topics include obtaining race/ethnicity/language from non-network clinics and collaborating with employer groups on clinical activities).
May 2008	Workgroup call (health literacy webinar).
July 2008	Final in-person meeting at RAND in Arlington, VA.
September 2008	GMMB releases the NHPC Toolkit. Formal end of Phase II of the NHPC.

Note: Additional activities of the Collaborative included technical assistance calls between the support organizations and firms in Phase I, and periodic conference calls of the Operational Committee (comprising the sponsors and support organizations) throughout Phases I and II.