

# Collection of Data on Race/Ethnicity and Language Proficiency of Providers

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**Objectives:** To determine the extent to which health plans were collecting and using data on the race, ethnicity, and language proficiency of network physicians and other network providers.

**Study Design:** Survey of health plans conducted in 2010, with results compared with data from similar surveys conducted in 2006 and 2008.

**Methods:** Surveys were sent by e-mail to representatives of 250 health plans identified through the Atlantic Information Service's *Directory of Health Plans: 2010*. Basic descriptive statistics were used to characterize response patterns to individual items in the 2010 survey and to compare responses to matching items in the 2006 and 2008 surveys.

**Results:** Approximately half of responding plans reported collecting data on race/ethnicity of providers. This proportion was not significantly different from that of previous years' surveys, and several plans that had been collecting data on providers' race/ethnicity in 2006 had discontinued the practice by 2010. Nearly all plans reported collecting data about languages spoken for 1 or more types of employees or providers. Plans were more likely in 2010 than in 2006 to verify language proficiency of staff and share this information with plan members.

**Conclusions:** Even though health plans and other healthcare organizations were more likely in 2010 than in the past to collect data on member/patient race, ethnicity, and language preferences, collection and use of data on providers' race/ethnicity have not expanded in scope since 2006. Collection and use of data on providers' proficiency in languages other than English were more common.

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For author information and disclosures, see end of text.

Since 1998, a variety of public and private policy initiatives have encouraged health insurance plans to collect data on the race and ethnicity of their members,<sup>1</sup> and health plans have also been either encouraged or required to collect data on language needs of members who are not proficient in English.<sup>2</sup> The data are used to identify disparities in care, identify targets for quality improvement initiatives, and set priorities for translation and interpretation services. The overall goal is to ensure that access to care and quality of care do not vary as a function of race, ethnicity, or primary language, and to improve healthcare quality for all plan members.

In a closely related set of policy and health plan initiatives, data on the race, ethnicity, and language proficiency of network physicians have also been collected.<sup>3</sup> It is presumed, with some empirical justification,<sup>4</sup> that physicians who share significant elements of background and culture with patients will find it easier to communicate essential healthcare messages, to better understand patients' feelings and experiences, and possibly to provide better quality care.<sup>5,6</sup>

Health plans that have information on the race, ethnicity, and language proficiency of providers can use this information to provide members with the opportunity to voluntarily select providers through a variety of specific mechanisms. Plans can use the information as a foundation for initiatives to increase the racial, ethnic, and linguistic diversity of physicians for inclusion in their provider networks so that there can be network physicians available for members who have linguistic needs or cultural preferences. More specifically, provider information available to members at the time of plan enrollment can include information on race, ethnicity, and language to enable members desiring a physician who can understand their cultural beliefs and language needs to make a selection using information provided by the plan.

Collection of data from physicians or other providers about race, ethnicity, and language poses some unique challenges to health plans. Some providers may be reluctant to provide such data out of concern that patients may actually select against, rather than for, a specific characteristic.<sup>7</sup> Providers may also fear that plans might use the information to exclude, rather than include, them in network contracts.<sup>8</sup> Providers with moderate fluency in a non-English language may indicate that they speak that language, but actually do not have sufficient proficiency to carry out complex medical discussions with patients.<sup>9</sup> Some providers, like some patients or plan

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members, may not accept or understand the specific race/ethnicity categories and may find it difficult to answer such questions, even if otherwise willing.<sup>10</sup> For all these reasons, health plans' collection of data on the race, ethnicity, and language fluency of providers has been more complex and more challenging than collection of data on the race, ethnicity, and language needs of members.<sup>11</sup>

The Patient Protection and Affordable Care Act (ACA) of 2010 created an additional element of context for the collection of race, ethnicity, and language data on providers, as it included a requirement that health plans certified for participation in federal and state insurance exchanges include "essential community providers" in order to serve low-income or medically underserved individuals (Section 1311). Although the legislation and associated regulations did not specify race, ethnicity, and language competence as defining characteristics of essential community providers, the law encourages health plans to improve healthcare access for a population of patients who generally access care in medically underserved areas.

Since 2003, America's Health Insurance Plans Foundation (AHIPF), with funding support from the Robert Wood Johnson Foundation (RWJF), has conducted periodic national surveys of health plans' collection and use of race, ethnicity, and language data.<sup>12</sup> The early surveys in the series focused on collection of data on race, ethnicity, and language preferences of members, but surveys since 2006 have included questions on collection of such data from network providers. In this article, we summarize findings from the 2010 AHIPF-RWJF survey on health plans' collection of race, ethnicity, and language data from providers and compare responses from 2010 with those of earlier surveys that also included questions designed to collect race, ethnicity, and language data from network providers and health plan staff.

## METHODS

### Sample

The sampling frame for the 2010 survey was developed using listings in the Atlantic Information Service's *Directory of Health Plans: 2010*.<sup>13</sup> Leased networks, plans that were no longer in business or had merged, plans with unknown enrollment, and very small plans (enrollment <6500 for commercial, <20,000 for Medicaid, and <5000 for Medicare plans) were excluded, and local/regional subsidiaries of large national companies were collapsed into their respective corporate entities. The final list consisted of 250 plans (both members and

### Take-Away Points

National surveys of health plans were conducted to determine the extent to which health plans were collecting and using data on the race, ethnicity, and language proficiency of network physicians and other network providers.

- Plans were more likely in 2010 than in 2006 to verify language proficiency of staff and share this information with plan members.
- Collection and use of data on providers' race/ethnicity have not expanded in scope since 2006.
- Collection and use of data on providers' proficiency in languages other than English were more common.

nonmembers of America's Health Insurance Plans [AHIP]), all of which were surveyed. Plans were asked to respond to the survey questions for the product (commercial, Medicare, Medicaid) with the largest enrollment. However, because most health plans had the largest enrollment in a commercial product, 11 multiproduct plans were also asked to respond for 1 additional product, Medicare or Medicaid, so that the distribution of product-specific enrollment in the sample reflected the composition of the industry. Data sampling for previous surveys was described in a previous publication.<sup>12</sup>

### Survey Methods

Prior to e-mailing the survey to plans, AHIP utilized multiple internal and external contact lists, information from previous survey responders, and company websites to identify the appropriate plan representative to complete the survey. The AHIP staff also sent invitations to companies in the sample to notify the potential respondents about the upcoming survey and ask to confirm their participation.

The surveys were fielded by e-mailing an Excel-based questionnaire, the same approach that had been used in the 2008 survey. (In 2006, the survey was fielded by e-mailing an invitation to a web-based survey.) The AHIP staff sent several reminders to nonresponding plans. All submissions were checked for accuracy and consistency, and several plans were contacted again and asked to clarify their submissions or provide supplementary information. Of 250 plans, 127 (51%) responded to the 2010 survey, including 59 commercial (48% of eligible plans), 51 Medicaid (59%), and 17 Medicare plans (43%). The responding plans represent a total enrollment of 170 million individuals.

### Analysis

We calculated the proportions of health plans with specific characteristics of interest. The statistical analysis was done by using SPSS 16.0 (SPSS Inc, Chicago, Illinois). We conducted the statistical testing for the difference between binomial proportions by calculating the  $z$  scores and the corresponding  $P$  values. Because our sample included the large share of

■ **Table 1.** Reasons Health Plans Collect Race and Ethnicity Data on Network Providers, 2010

Reasons	No. (%)			
	Commercial (n = 24)	Medicaid (n = 25)	Medicare (n = 8)	Total (n = 57)
To assess diversity within your provider network	21 (87.5)	22 (88.0)	8 (100.0)	51 (89.5)
To assess patients' access to minority physicians/clinicians within a geographic area	19 (79.2)	20 (80.0)	7 (87.5)	46 (80.7)
To communicate this information to your enrollees	21 (87.5)	15 (60.0)	4 (50.0)	40 (70.2)
To identify opportunities for involvement in health plan quality improvement initiatives, committees, and/or community coalitions	10 (41.7)	9 (36.0)	2 (25.0)	21 (36.8)
To identify opportunities for leadership training and mentorship	2 (8.3)	2 (8.0)	0	4 (7.0)
Other	1 (4.2)	1 (4.0)	0	2 (3.5)

the population, the finite population correction was included in the significance testing. Because our sample included a large share of the population (>5% of operating health plans in the United States), the finite population correction factor was included in the significance testing. This technique takes into account the actual size of the population from which the sample has drawn.

## RESULTS

### Race/Ethnicity Data of Providers and Staff

Slightly fewer than half of the survey respondents in 2010 reported collecting data on race or ethnicity on any or all of the physicians or other clinicians in the provider network. The proportion of plans collecting these data did not vary markedly by plan type: 41% of commercial plans, 47% of Medicare plans, and 49% of Medicaid plans (45% overall). When weighted by plan membership size, these proportions rose to 53% in Medicaid plans, 74% in Medicare plans, and 58% in commercial plans, or 58% overall. This increase due to weighting indicates that larger plans were more likely to report collecting these data than smaller plans.

Overall, health plans in 2010 reported having race and ethnicity data on 47.3% of their network providers (unweighted data), or 12.8% when weighted by enrollment. The distinct difference in proportions in the unweighted versus weighted analyses suggests that smaller plans were more successful in obtaining race/ethnicity information on providers than were larger plans. Medicaid health plans were more likely to successfully obtain these data from providers than commercial and Medicare plans (37.7% vs 11.7% and 4.2%, weighted data).

**Table 1** summarizes the reasons given by plans reporting the collection of race/ethnicity data on providers for doing

that data collection. Assessing diversity of provider network and ensuring member access to “minority physicians” were the 2 reasons most frequently cited. (Plans could indicate more than 1 reason for data collection.)

Approximately half of the plans that collected this information made it available to enrollees, and the proportion of plans making information available did not vary significantly by plan type—46% for commercial plans, 50% for Medicare plans, and 52% for Medicaid plans (49% overall). Those plans that did make information available to enrollees reported doing it through a health plan provider directory (89% of plans making information available to enrollees), through a health plan website (64%), or through interactions with customer service representatives (60%).

### Languages Spoken by Providers/Staff

**Table 2** shows the extent to which plans reported collection of data on language spoken for various types of plan employees or network providers. Because responding plans had the option of reporting on collection of these data for “all health plan staff” and/or specific staff in the framing of the response options, it is difficult to know whether collecting data on some specific classes of staff is truly done less frequently. Some plans outsource some or all of their behavioral care and/or disease care management, but the survey did not include questions on the extent of outsourcing practices.

In **Table 3**, responses to a question about testing for language proficiency of various types of plan employees or network providers are presented. In general, plans did not report doing formal testing of language proficiency for network providers and most types of plan staff. Customer service staff was the group most likely to be formally tested for language proficiency.

## Data on Race/Ethnicity and Language Proficiency

■ **Table 2.** Health Plans' Collection of Data on Languages Spoken by Network Providers and by Health Plan Employees, 2010

Type of Provider or Staff	No. (%)			
	Commercial (n = 58)	Medicaid (n = 51)	Medicare (n = 17)	Total (n = 126)
Clinical providers in the network	40 (69.0)	42 (82.4)	12 (70.6)	94 (74.6)
Provider office staff	20 (34.5)	26 (51.0)	5 (29.4)	51 (40.5)
All health insurance plan staff	23 (39.7)	19 (37.3)	6 (35.3)	48 (38.1)
Customer service staff	43 (74.1)	46 (90.2)	13 (76.5)	102 (81.0) <sup>a</sup>
Disease management/care management staff	33 (56.9)	36 (70.6)	14 (82.4)	83 (65.9) <sup>a</sup>
Marketing/sales staff	31 (53.4)	30 (58.8)	12 (70.6)	73 (57.9) <sup>a</sup>
Health promotion/wellness staff	26 (44.8)	30 (58.8)	10 (58.8)	66 (52.4) <sup>a</sup>
Behavioral health staff	30 (51.7)	25 (49.0)	8 (47.1)	63 (50.0) <sup>a</sup>
Quality improvement staff	25 (43.1)	23 (45.1)	9 (52.9)	57 (45.2) <sup>a</sup>

<sup>a</sup>This rate includes responses of health plans that reported collecting information on languages spoken for all health plan staff. We added the "all health insurance plan staff" responses to the subset of health plan staff categories.

■ **Table 3.** Health Plans' Assessment of Staff or Provider Language Proficiency, 2010

Type of Provider or Staff	No. (%)			
	Commercial (n = 58)	Medicaid (n = 51)	Medicare (n = 17)	Total (n = 126)
Clinical providers in the network	0	4 (7.8)	0	4 (3.2)
Provider office staff	1 (1.7)	4 (7.8)	1 (5.9)	6 (4.8)
All health insurance plan staff	4 (6.9)	6 (11.8)	0	10 (7.9)
Customer service staff	18 (31.0)	25 (49.0)	8 (47.1)	51 (40.5) <sup>a</sup>
Disease management/care management staff	9 (15.5)	14 (27.5)	5 (29.4)	28 (22.2) <sup>a</sup>
Marketing/sales staff	7 (12.1)	13 (25.5)	6 (35.3)	26 (20.6) <sup>a</sup>
Health promotion/wellness staff	6 (10.3)	15 (29.4)	4 (23.5)	25 (19.8) <sup>a</sup>
The health insurance plans' quality improvement staff	5 (8.6)	10 (19.6)	1 (5.9)	16 (12.7) <sup>a</sup>
Behavioral health staff	7 (12.1)	7 (13.7)	2 (11.8)	16 (12.7) <sup>a</sup>

<sup>a</sup>This rate includes responses of health plans that reported assessing the language proficiency level for all health plan staff. We added the "all health insurance plan staff" responses to the specific health plan staff categories.

As was the case for information on race/ethnicity, information on languages spoken by plan staff and network providers was conveyed to members primarily through the plan website, the provider directory, other printed member materials, and interactions with customer service representatives.

### Changes From Earlier Surveys

The proportion of health plans collecting data on race/ethnicity of providers did not change significantly from 2006 to 2010 (45.4% in 2006, 39.3% in 2008, and 45.2% in 2010).

In spite of the fact that the proportion of plans reporting collection of provider race/ethnicity data was essentially the same in 2006 and 2010, closer examination of the survey

data suggested that some plans that had been collecting providers' race/ethnicity data in 2006 abandoned the practice in subsequent years. There was a statistically significant decline, for example, in the data collection of race/ethnicity of providers for Medicaid plans: 77% collected data in 2006 but only 46% collected data in 2008 ( $z$  score =  $-4.62$ ,  $P < .001$ ). **Table 4** shows the specific pattern of changes in plans' collection and sharing of race/ethnicity data on providers among a subset of plans that responded both to the 2006 and 2010 surveys ( $n = 67$ ). Among plans that had been collecting data in 2006, nearly as many stopped by 2010 ( $n = 15$ ) as continued ( $n = 20$ ). Perhaps more striking is the observation that, of the 21 plans (shown in first and second columns of **Table 4**, second row) that were sharing data on provider's

■ **Table 4.** Health Plans' Collection and Sharing of Data on Physician Race and Ethnicity, 2006 to 2010<sup>a</sup>

Health Plan Activity	No. (%)			
	Activity Present in 2006; Stopped by 2010	Activity Present in 2006; Continued in 2010	Activity Not Present in 2006; Started by 2010	No Activity in 2006 and 2010
Collection of data on race and ethnicity of physicians (n = 67)	15 (22)	20 (30)	11 (16)	21 (31)
Sharing of collected data on race and ethnicity of physicians with health plan members (n = 36)	15 (42)	6 (17)	8 (22)	7 (19)

<sup>a</sup>Data on the subset of plans that participated in both the 2006 and 2010 surveys ("same store comparison") that reflect the changes in plans' responses compared with their 2006 responses.

race/ethnicity with plan members in 2006, many more had stopped doing that by 2010 (n = 15) than continued (n = 6). We were not able to determine through this survey why such efforts were suspended.

For those plans that did share information on provider race/ethnicity with members, information on the media used by plans to share that information were available in the 2008 and 2010 surveys. The pattern of media through which plans made this information available to members was similar in the 2 surveys; the most statistically significant change over the 2 years was in providers' race/ethnicity being more likely to be available through customer services representatives in 2010 than in 2008 (z score = 4.29, P ≤ .01).

Collection of data on languages spoken by providers and staff also showed a modest increase from 2006 to 2010. Increases from 2006 to 2010 were consistent across types of other plan staff. In most subcategories of staff, the percentage of plans reporting collection of language data increased 10% to 20% across the 4 years. Collection of data on languages spoken for "all health insurance plan staff" increased by 10% (28% to 38%, z score = 3.00, P ≤ .01) during that period of time (Table 5).

Finally, the percentage of plans that reported testing or verifying language proficiency increased approximately 10% for most major types of plan employees (for example, the percentage of customer service staff tested was 29% in 2008 and 40% in 2010; z score = 2.84, P ≤ .01). The notable exception was the category of providers compared to the network providers' office staff: 5% each for providers and providers' office staff in 2008 and only 3% for providers and 5% for providers' office staff in 2010.

## DISCUSSION

Nearly half of responding plans in 2010 reported collecting data on race/ethnicity of providers, but this activity was no more frequent in 2010 than it had been in 2006, and a number

of plans that had been collecting race/ethnicity data on providers in 2006 did not continue doing that in 2008 or 2010.

The apparent decrease from 2006 to 2008 (albeit not statistically significant) was somewhat surprising, given that the collection of data on race, ethnicity, and language needs of health plan members has increased steadily for the past 10 or more years.<sup>14</sup> Collection of data about providers may be a more sensitive issue. Although the collection and publication of data on provider characteristics would seem to be an essential step to ensuring a diverse and accessible provider network for a diverse health plan membership, concerns about possible exclusions from provider networks or patients choosing against providers of specific backgrounds have raised significant challenges for health plans. Indeed, we found that 15 plans that were collecting data on providers in 2006 were not doing so in 2010. Collecting and providing these data continue to be optional activities for both health plans and providers. Based on personal conversations with health plans that collect these data (Rita Carreón, director, clinical strategies and healthcare equity, America's Health Insurance Plans, February 8-9, 2012), plans cited limitations in capturing sufficient data on their network providers among other factors such as trust and providers' concerns related to the use of the data.

Collection of data on languages spoken was more common than collection of data on race/ethnicity, probably because of existing accreditation or purchaser requirements to be able to provide services for patients who have limited English proficiency or who prefer communication in languages other than English, as well as the expressed need by plan members for interaction in languages other than English.<sup>15</sup> From 2006 to 2010, health plans expanded their collection of language data on network providers and health plan staff, were more likely to test or verify language proficiency of staff, and were more likely to share this information with plan members.

The study findings clearly have limitations. Although the response rate was reasonable for a survey of this type, we did

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■ **Table 5.** Health Plans' Collection of Language Capabilities for Plan Employees and Providers: 2006, 2008, and 2010

Type of Staff	Percentage		
	2006 (n = 156)	2008 (n = 121)	2010 (n = 126)
Clinical providers in the network	67.9	71.1	74.6
Provider office staff	32.1	35.5	40.5 <sup>a</sup>
All health plan staff	27.6	39.7	38.1 <sup>a</sup>
<b>Breakdown of responses for those plans that <i>did not</i> collect information on languages spoken for all staff (n = 112 for 2006, n = 73 for 2008, and n = 76 for 2010)</b>			
Health plan's customer service staff	55.4	60.3	69.2 <sup>a</sup>
Disease management/care management staff	18.8	31.5	44.9 <sup>a</sup>
Health plan's marketing/sales staff	19.6	23.3	32.1 <sup>a</sup>
Health plan's health promotion/wellness staff	NA	15.1	23.1
Behavioral health staff	NA	11.0	19.2
Health plan's quality improvement staff	NA	5.5	11.5
NA indicates not available.			
<sup>a</sup> The difference between the 2006 and 2010 result was significant at $P \leq .05$ .			

not have data for the complete universe of operating health plans. It is possible that the nonresponding plans were less engaged in issues related to race, ethnicity, and language data collection, so the activity reported here might overstate the level of activity for health plans in general. One might speculate that health plans serving areas with little racial, ethnic, or linguistic diversity would be less likely to invest in data collection and incorporation of data into programs and member materials; however, qualitative data from follow-up interviews on data collection issues related to plan members' race/ethnicity did not show such a relationship.<sup>16</sup> The sample size of plans did not permit a more detailed analysis of the relationship between service area demographics and activities in the area of race, ethnicity, and language data collection. We also were not able to gather information as to why a subset of health plans stopped the collection and sharing of data on physician' race and ethnicity between 2006 and 2010.

The National Committee for Quality Assurance's (NCQA's) Multicultural Healthcare Distinction Program, which includes aspects of Culturally and Linguistically Appropriate Services, has been in place since 2010.<sup>17</sup> Although this program is voluntary and therefore cannot enforce compliance through regular accreditation requirements, the NCQA has clearly sent a signal to plans working with it that collection of race, ethnicity, and language information on plan members, staff, and providers is an important, valued activity. It is not surprising, then, to see more plans reporting activity in this general area in 2010 than in 2008. Specific mention of race/ethnicity and language data collection in the ACA<sup>18</sup> and in the second stage of the Health Information Technology for

Economic and Clinical Health meaningful use standards for health information technology,<sup>19</sup> although not directed explicitly to health plans, has reinforced the message from payers and accrediting bodies that such data collection is expected and essential. Such requirements will presumably encourage physicians and other providers to report this information.

In their survey responses about uses of data, health plans indicated that they recognize demographic diversity among their members and are seeking to meet diverse needs. In some cases, the data are used in the design of programs (eg, wellness and disease management) and in the provision of information about benefits and other plan features in languages other than English. In other cases, information about race/ethnicity and languages spoken by providers that is shared with plan members presumably supports choices being made by members about where to seek care, which will be critical under the new health insurance exchanges that began accepting new enrollment October 1, 2013. The diverse makeup of healthcare providers and clinicians also allows plans to draw on their expertise, via advisory councils, in improving care for racial and ethnic populations and in developing tools and written/verbal messages to consumers. Through this variety of mechanisms, it appears that plans are expanding the ways in which they can provide culturally and linguistically appropriate services to members.

There is room for continued progress in expanding data collection efforts and increasing the availability of this information to consumers. As our nation's population continues to become more diverse, the healthcare system will need to meet the increasingly complex cultural and language needs of patients. Although additional research may be needed to

further understand the complexities of collecting data on provider networks' race and ethnicity (eg, the nature of providers' concerns, attitudes, and beliefs regarding provision of these data), there continues to be general consensus that improving the diversity of the US healthcare workforce is important for health plans and other key stakeholders to help improve access and quality for patients of all racial and ethnic backgrounds.<sup>20,21</sup> With public programs now reinforcing the need for such data on practicing physicians and other clinicians through meaningful use requirements, physicians are seeing a concerted message on the importance of reporting such information. A broader discussion within the healthcare stakeholder community on the experiences in collecting and sharing providers' race, ethnicity, and language data would be a critical step toward increasing patient-provider racial and language concordance.

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