# SustiNet Health Partnership

## Health Disparities & Equity Advisory Committee

**Co-Chairs**
Marie Spivey
Rafael Perez-Escamilla

**Board of Directors Liaisons**
Bonita Grubbs
Estela Lopez

**Phone:**
866.466.4446

**Facsimile**
860.297.3992

**E-Mail**
SustiNet@CT.Gov

Post Office Box 1543
Hartford, CT 06144-1543
www.ct.gov/SustiNet

**Health Disparities and Equity Committee**
**AFT * Connecticut – 35 Marshall Road – Rocky Hill, Connecticut**
**April 19, 2010 at 7:30 a.m.**
**Regular Meeting Minutes**

**Committee Attendees:** *Marie Spivey; Co-chair; Rafael Perez-Escamilla Co-chair; Yolanda Caldera-Durant; Leo Canty; Bonita Grubbs; Elizabeth Krause; Estela Lopez; Brad Pelbani; and Arvind Shaw*

**Office of the Healthcare Advocate:** *Africka S. Hinds-Ayala*

**Absent:** *Grace Damio; Yvette Martas; Sharon Mierzwa; J. Nwando Olayiwola; and Stephanie Paulmeno*

**Guests:** *Kristen N. Hatcher, Esq. (CT Legal Services)*

Marie Spivey opened the meeting by welcoming committee members and the Office of the Healthcare Advocate staff.

Marie requested that all present in person and via phone introduce themselves.

The April 6, 2010 meeting minutes were approved by all present, with one noted correction for Maritza Rosado's place of employment to be Eastern Area Health Education Centers and not Danbury Hospital.

Marie asked Estela Lopez to provide a report on the SustiNet Board of Directors Retreat Meeting held April 14, 2010. Estela said the retreat was a good opportunity for the various committees and taskforces to communicate about their progress, as well as to determine what is needed from the other committees/taskforces. . Estela stated that, as a follow up to the retreat, Stan Dorn sent an email about the questions and key indicators to be included in the report template that will be sent to all SustiNet committees and taskforces for completion. Estela suggested that the other committees give oral presentations because it becomes a recorded document that allows the audience to understand the rationale behind the report and ensures that health disparity and equity are being address in the planning and execution of the work. Marie stated that it will be difficult to do all presentations in a timely fashion, but if the drafts are disseminated prior to the meeting, there could be direction for a much shorter presentation to be given by each committee/task force.

Rafael Perez-Escamilla questioned if the committee will focuses solely on racial and ethnic disparity or will the group look at other attributes of disparity to bring about awareness. Estela reminded the group that the majority of research being conducted is done with white male-subjects, therefore the committee must be mindful of manageable social justice indicators and use the committee work as an opportunity to transition into greater areas that are doable and reflects the spirit of the work. In past meetings the committee has discussed the need to include racial, ethnic, cultural, linguistic, gender, sexual preference, and disability challenges in our recommendations.

Brad Plebani stated that an insurance health plan design does only two things: provides coverage for services, and pays for the coverage of those services provided. The question for SustiNet is to determine how this is all done, what will be covered, and how. The suggestion of the "pay-for-performance" Brad referenced is "…not good because it can increase health disparities"; there must be an appeal system that is informative and easy to use by the consumer. Arvind Shaw stated that the committee just recently started a truthful review of health disparity and we should develop an evaluation piece to incorporate into the health plan design.

Elizabeth Krause responded that "pay-for-performance" can be specifically designed to reduce disparity. Arvind said that the "pay-for-performance" model must make risk adjustments for certain environmental factors that can place providers at a disadvantage (i.e., Smoke stacks in Bridgeport increase incidence of asthma in the community that must be addressed by providers versus providers in the suburbs who do not have to contend with the same issues or numbers). Brad explained from his perspective the "pay-for-performance" that he referenced does not consider those who have gone without insurance (of any kind) for long periods of time, therefore, does not take into account the historical nature of the individual with the outcomes and measures. Estela said that it falls to providing the proper education and consider the "value-added" concept, where the outcome may not be perfect, but there was some value-added to the quality of life for the individual. Marie said that there is the potential for losing money on wrap-around services, so it is important to treat participants in the plan holistically and perform an evaluation from the perspective of the provider and the patient. Rafael said that Massachusetts Chapter 58 Legislation contains four provisions within their health care law that addresses health disparity and equity. The four provisions are cited below are from Minority Health Initiatives at Families USA – "Confronting Disparities while Reforming Health Care: A Look at Massachusetts" (January 2008)

- ***Section 160*** *calls for the creation of an ongoing* ***Health Disparities Council*** *that is charged with developing recommendations on several minority health issues, including workforce diversity, disparate disease rates among communities of color, and social determinants of health.*
- ***Section 16 L. (a)*** *calls for the creation of a* ***Health Care Quality and Cost Council****, which will focus on health care quality issues with the goals of lowering costs, improving health care quality, and reducing disparities.*
- ***Section 13B*** *develops standards for* ***Hospital Performance and Rate Increases****, with a specific stipulation regarding hospital rate increases being based on quality issues such as reducing racial and ethnic health disparities.*
- ***Section 110*** *requires a* ***Community Health Worker Study*** *to be conducted by the Public Health Department to determine the effectiveness of community health workers in reducing racial and ethnic health disparities.*

Arvind stated that with "pay-for-performance" we should place the money on the table to ensure we get what we pay for, for example the Mayo Clinic should meet a certain set of conditions, such as more outreach to disadvantaged populations, perform a specified number of services, etc. to be considered a level one facility and receive payment. Rafael supported this concept and stated that in many provider institutions (hospitals) there are separate services and/or programs for the same disease, but the program/service received depends on the type of insurance held by the individual (Medicaid v. Private). Leo Canty stressed that all of the discussion thus far pushes back onto data collection and how the committee really does need to take into account the community demographics and environments; there is a need to look at the contributory factors that can disadvantage providers and incorporate into data collection. Brad said that there needs to be a strong record about data collection. Rafael questioned the types of incentive systems that have made a difference. Leo stated that outside of the various healthcare systems there are a number of agencies that have data on the books. Marie said the Commission on Health Equity's Policy Committee has interviewed two state agencies and is scheduled to interview several more via legislative mandate. The Commission will also entertain the idea of bringing all the state's commissioners to the table for candid discussion to share their policies, procedures, objectives and plans to eliminate health disparities for the sake of consistency across the agencies.

Brad posed a question to Elizabeth regarding social services impact, but Elizabeth stated that the best answer would come from Sharon Mierzwa. Rafael suggested that the group commission a study to determine types of data collection, incentive systems, etc. to include as recommendations into the report.

Arvind spoke of how providers and patients treat pain management/narcotics with regard to one provider do not take away the medication if another provider prescribed it and both participants (physicians and patients) in care believe it is acceptable for pain medication to be self-managed by the patient. This can be curbed by being more candid in the approach to self-management and allow the primary care physician spend adequate time with the patient. Arvind continued with the sentiment that with the longer visitation the physician can take the opportunity to explain the evaluation of care to the patient, complete their own evaluation form regarding care of the patient, and record current data that will assist in tracking disparity and equity.

Rafael expressed that with regard to health insurance reform and care, Massachusetts is ahead of Connecticut and has the ability to collect data on who has insurance and who does not. Brad stated that although they [Massachusetts] are ahead their plan does not have "teeth" with regard to setting rates and goals for their health insurance care plans and disparity reduction. Bonita said there needs to be a state-level discussion on results based accountability; there are a number of councils that do institute accountability.

Yolanda Caldera-Durant provided on brief report on the conference all with Camille Watson, the Health Disparities Policy Coordinator at Health Care for All (Massachusetts). Yolanda said that the city funded the project to ensure health disparity reduction and increase oh health equity; approximately eleven committee members were on the call. Marie suggested a webinar with MA to determine what has and has not worked. Rafael said that the committee should develop five key questions ahead of time. Estela said that indicators need to be defined so that the questions are more pointed and specific areas of concern are better addressed.

Marie said the April 13, 2010 conference call with the Preventative Healthcare Advisory Committee and Childhood/Adult Obesity Taskforce was productive. Both groups will forward a draft of there reports to the HDE for feedback.

The focus of the Health Disparities and Equity Committee was the theme discussed throughout the meeting discussion. There will be ongoing communication with the SustiNet Board of Directors, committees, and taskforces to ensure that there are proper resources to increase equity within the SustiNet Healthcare Plan and definitive way(s) to reduce/eliminate health disparity.

The committee will look at several dates to set-up webinars to learn about the Massachusetts Health Plan, Cultural Competency Training, Patient-Centered Medical Home, and the Joint Center of Political and Economic Studies (Brian Smedley). Elizabeth suggested taking a step back to review the best way to track information with regard to cultural competency. Yolanda said that the Cultural Competency Provider Training has completed training for 110 interpreters and that the training is necessary because it offers two things: 1 a path to get to better care and the understanding of the individual patient; and, 2. interpreters going forward with their educational accomplishments to become higher-level health care providers.

With regard to resources to compile information and begin report recommendations, it was expressed that no committee or taskforce has completed a report to date. There are several drafts that will be forthcoming. There was discussion of having a HDE committee retreat and/or a several hour working-session to develop the indicators, list resources, etc. There was some expression for concern that there is not a set template for committee use at this time taking the work from a broad perspective to a more narrow that can be quantifiable. Bonita said it is important for us to define where we are going and how to get there. Rafael reiterated the three important concepts that we might adopt as referenced in the Massachusetts Plan:

1. SustiNet should develop a system of incentives to reduce health disparity and increase health equity;
2. The Legislature could create an Authority that will enforce recommendations and adherence to incentivize programs; and
3. Continuous tracking of process outcome indicators must be in place.

There was no unfinished business to be addressed by the committee.

The next meeting is scheduled for Friday, April 30, 2010 at AFT-Connecticut beginning at 7:30am.

Meeting was adjourned.