SustiNet Health Partnership

Health Disparities & Equity Advisory Committee

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Health Disparities and Equity Committee
AFT * Connecticut – 35 Marshall Road – Rocky Hill, Connecticut
May 20, 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 ; Sharon Mierzwa (via phone); Brad Plebani; and Arvind Shaw*

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

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

Guest(s): *Kristen N. Hatcher, Esq. (CT Legal Services); and Katherine London (SustiNet Consultant – via phone)*

Marie Spivey opened the meeting by welcoming committee members, OHA staff, and the SustiNet Consultant.

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

Marie said there is no official agenda but the meeting will center on the draft template report developed by Katherine London, who stated that there are recommendations and information in the template that should have been included in the original statute. Please click **here** to see the draft template document.

Marie asked that Katharine walk the committee members through the Health Disparities and Equity Advisory Committee draft template report with members providing comments at the end. Katharine began with explaining that the first section is sparse because that is the only language that is in the current statute addressing health disparity/equity ands the second section goes into more detail with specific questions and recommendations developed by the committee members that should have been originally placed in the state statute. Section three of the template is blank because the direction of the other committee will need to be understood and assist in developing additional questions and feedback; section four is a broad direction of intersections. Katherine continued to walk throughout the document starting from the beginning:

Part I: Legislative Questions - a broad overview to say: *"The SustiNet Board shall develop an action plan for reducing and eliminating racial and ethnic health disparities. The plan shall be updated at least annually, and shall include the components described in Part II."*

Part II: Other Topics – a little more challenging because the topics are intersecting and can be moved around. The sub-topics included recommendations for a governance board, budget, data collection /report, measureable objective, provider incentives, and provider penalties.

Rafael Perez-Escamilla requested an explanation for the difference between the SustiNet Board and the SustiNet Health Plan. Katharine said the plan is the health plan where enrollees receive healthcare services and the board is made-up of individuals who develop the policy and regulations for the plan. Katherine asked the committee said who they want to serve on the board. Elizabeth Krause said it should be someone with expertise in reducing racial/ethnic health disparities. Marie said a SustiNet Board currently exists and there is a sub-committee addressing disparity; does the committee want to change to change the structure of the board to include someone to represent fully health disparity. Bonita Grubbs said the current statute is written to state that current Board of Directors terms have an expiration on

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their term and so the committee should determine to have someone appointed to serve. Rafael said that it would be good to have a consumer representative. Bonita said is there another entity to take over for the daily enrollment details into the health plan. Marie said the current Board will begin implementation (until 2014) and once a plan is in place, there will be a decision making structure; Marie feels the "new" Board should be comprised of 51% of health care services consumers. Is it necessary to recommend a change/enhancement in the structure and/or composition of the Board? The committee members agreed that this recommendation should be made because it makes a difference now allows for the formation of the community advisory committee that will be a directly aligned with the Board of the Directors for an infinite integration. Leo Canty agreed and said the current legislation should be amended to include more detailed language. Katharine had a different understanding with the role / responsibilities of the current Board that is to make a plan to recommend what is the SustiNet governance should look like: a public authority or a non-profit. Bonita said an official letter defines her role and term of service to the Board until 2014. Marie questioned the health disparities council in Massachusetts and if they received funding and recognition within the plan; Katharine responded that there are several disparity council run by several different agencies and none are connected with the exchange, all are separate in action, and intra-departmental recommendations are made. Leo supported Elizabeth's recommendation to add another board member who is an expert who knows how to effect the changes. Estela said that one member would not be enough to serve on the board because it can be difficult to continuously address and convince others to review and correct the various health disparities.; there should be enough places available to get different perspectives and to have a stronger voice. Arvind said something needs to be implemented into the design of the new Board and making it more patient-centric. Rafael said that at the end of the day the recommendations need to be of substance and give a defined direction to the new authority. Marie said health disparity and equity recommendations, structure, and objectives/measures, need to be deeply rooted throughout so that there will be an impact. The general consensus was to have recommendations that are comprehensive to the following: at least two individuals serve on the Board (at least one is a consumer), recommend plan design concepts, recommendations to institute authority/power of the disparity advisory committee, a direct link between the disparity advisory committee and the Board of Directors, integration of an action plan, culturally competent community outreach (inclusive of language, traditions, etc.), media material development (culturally competent, literacy levels, etc.), identify and apply to disparity/equity-specific grant funds, etc.

Estela noted that any recommendations made should be listed, reasonable, understandable / implementable, and have a solid impact on the population and the community. Elizabeth said there should be a healthcare dashboard with indicators. Brad Plebani said that there should be a recommendation for an appeals process that is easy to access and culturally competent as to not have a disparate impact on racial and ethnic minorities.

Kristen Hatcher provided information about the appeals process and will forward information to Katharine for the template. Arvind said the appeals information should be a part of the data collection and reporting process and included as a measurable objective. Rafael and Brad agreed that the SustiNet health Plan shall include a disparity/ equity committee charged with reducing healthcare disparities among varying races/ethnicities. Bonita said the committee should be a standing committee; Katharine included that the co-chairs of the standing committee will serve on the SustiNet Board of Directors.

Yolanda Caldera-Durant questioned the language for cultural outreach and its status within the priority of the recommendations. Katharine said a new section will be developed to address the cultural outreach. Elizabeth recommends that the word "integration" is laced throughout the document and all recommendations.

Marie said the appeals process should go into data collection reporting and measurable objectives. Arvind stated the SustiNet Board shall assess current data to document disparities and identify gaps in disparity needed to address disparity and inclusive of the appeals process. Leo said that there should set goals and develop an evaluation component. An evaluation component is included within the template and will be made public.

Discussion continued around the template document to enhance the current recommendations, add new recommendations, consider another draft for circulation before the June 1, 2010 Board of Directors meeting. Bonita question what will happen if the Board does not have the resources to complete the recommendations, especially data collection. Estela responded that the Board must secure the resource to complete the work of the recommendations and commission studies where needed the most; information is available but not integrated in an acceptable format. Maries stated that partnerships are essential and to eliminate the current fragmentation among the different data collection groups. Leo pointed out that the savings is contingent upon doing the overall process better with the implementation of the programs and the solid recommendations. Katharine said the federal health reform law includes several grants that are specific to health disparity reduction.

Marie began discussion of the Pay-for-Performance (PFP) for providers stating that it should assist to keep the provider within the practice but at the same time ensuring quality of care. Arvind asked that "Provider" be defined; Katharine stated that it is used broadly for anyone who provides healthcare services. Marie said a *provider* is anyone who has been commissioned or hired by a member of the plan to provide health care in the broad sense (Mental, emotional, physical, etc) and holistically to improve health status. Brad said in the Medicare world, *provider* is defined as any person or entity contracted with Medicare to provide healthcare services to a Medicare beneficiary. Arvind

questioned if there is no specialized healthcare provider within a specific area, such as no cardiologist who accepts a certain patient population within a specific city. The question is how the resources are mapped within a region to alleviate the disproportionate burden on the provider and patient. Africka offered an example of Medicaid providers not signing up to be providers because of the pay-scale for services, especially dentists; a Medicaid provider voluntarily signs up to provide services.

Marie and Katharine agreed to finish up the draft template with the noted additions to get out to everyone for final review by May 22, 2010. Katharine will add the questions sent to the other committees into the template. Bonita reiterated that the recommendations will go before the Board on June 1, 2010 with feedback to each committee/taskforce on or by June 8, 2010 with a final report submitted to the legislature by July 1, 2010. Please be advised that the HDE Committee will remain operational after July 1, 2010 to be called upon by the Board as needed to complete a final report due January 1, 2011.

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

Meeting was adjourned.

The next meeting is scheduled for Monday, June 7, 2010 at the Legislative Office Building – Room 1B at 1:00pm.

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