Public Comment for the Quality Council meeting

Dear members of the Quality Council,

My name is Dashni Sathasivam. Thank you for the opportunity to publicly comment on behalf of Health Equity Solutions (HES), where I serve as Manager of Policy and Outreach. HES is a nonprofit organization with a statewide focus on promoting policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

I spoke at the last Council meeting in support of adding a measure assessing the completeness of the race, ethnicity, language, and disability status (RELD) data being collected in addition to stratification of specific measures by RELD. I appreciate that completeness is a topic of discussion in today's agenda. In addition to OHS's response, please note that while RELD collection must include an 'decline to answer' option, there are evidence-based ways to improve completeness of these fields. Improvement does not mean an expectation of 100% completeness; yet, efforts such as tailoring how questions are asked, explaining why questions are asked, and training those who are asking these questions can lead to improvement. Benchmarking RELD completeness is foundational to moving RELD data collection towards best practices.

Regarding the overall discussion of the equity measures, it is imperative to understand that equity measures should never exclusively focus on "best-performing" and "worst-performing race/ethnicity." Equity means reducing gaps between minoritized and majoritized groups. So, disparities are quantified by comparing minoritized groups to a reference group, which is the majoritized group or the population as a whole. Furthermore, the phrasing of this note implies that racial/ethnic groups are "performing better or worse," when the health care system's performance is the issue.

A recent *Developing Health Equity Measures* report prepared by RAND and released under the Office of the Assistant Secretary for Planning and Evaluation (ASPE) aggregates the leading frameworks and features of health equity measures in the field. They defined a health equity measurement approach as "an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients." Based on this report, we recommend incorporating an approach similar to Minnesota's Healthcare Disparities Report, which uses the overall state average to benchmark disparities.

Finally, we recommend measures included in the Medicaid Transparency Board report be considered as health equity health status measures, including, for example, life expectancy. Years of potential life gained can also be calculated using reliable and regularly published data. Other health status measures can be used to benchmark health equity by stratifying health status measures by race and ethnicity. Health Equity Solutions can share sources, if helpful.

As always, we are grateful for the Quality Council's intentional focus on embedding equity into this work. Thank you for the opportunity to comment.

Sincerely,

Dashni

Dashni Sathasivam, MPH