HEALTH EQUITY SOLUTIONS

53 Oak Street
Hartford, CT 06106
860-461-7637

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Office of Health Strategy
Via email: tina.hyde@ct.gov

Dear Director Veltri,

Health Equity Solutions (HES) is grateful for the opportunity to comment on the Office of Health Strategy's (OHS) Roadmap for Strengthening and Sustaining Primary Care (Roadmap) that will inform the development of the state's primary care infrastructure. We recognize the critical role of primary health care in preventing and mitigating disparate health outcomes. We also acknowledge the need to strengthen the state's infrastructure to address systemic barriers to improve health systems' capacity to provide high-quality, accessible, culturally and linguistically appropriate, and equitable opportunities to health for all residents, particularly people of color.

The Roadmap identifies equitable care as a priority objective driving these efforts to strengthen the system. To further embed health equity into these processes and practices outlined in the Roadmap, we respectfully submit the following comments for your consideration:

Center equity as a criteria of payment models and measure progress towards equity: We cannot overstate the importance of a health system that intentionally and specifically centers health equity and racial equity. While HES agrees that the existing fee-for-service (FFS) landscape is insufficient to address the social and economic drivers of health needed to advance equity, the ***adoption of alternative payment models must incorporate a robust health equity strategy***. Payment Model Parameter #4 states that OHS's Quality Council is tasked with developing the core measure set; however, the existing equity-focused measures adopted by the Council are limited and narrow. They include an obesity measure (only for non-Hispanic Black and non-Hispanic white populations) and stratification of certain measures of the core set by race and ethnicity. Health equity metrics is a rapidly developing field and we ask that OHS commit to addressing the existing gaps in these quality measures by outlining a clear, ongoing process for curating and implementing state-level health equity metrics. This commitment and process would help to ensure that the adoption of alternative payments has the desired impact on equity. ***We respectfully request that the Roadmap implementation plan include planned activities to develop an expanded health equity measure set***, such as those reported in other states, which would be piloted to assess and reward meaningful progress towards health equity by payers and practices. See, for example, efforts in Minnesota, Oregon, and Rhode Island.

Further Core Practice Team Function #7 requires care to be culturally and linguistically competent, which we support. For practices to be accountable for demonstrating cultural and linguistic competencies ***we recommend payment models be required to report on a standard set of CLAS metrics and monitor the quality of data***. Cultural and linguistic competency can be monitored through formal practice recognition or completing trainings in cultural humility or similar programs. A recent report by the Office of the Assistant Secretary for Planning and Evaluation identified six cross-cutting measures to assess an organization's performance on culturally and linguistically appropriate services (CLAS standards) (Table 3.1). Data quality can be monitored by evaluating the completeness of social and demographic data collection.

In sum, we ask that OHS assess additional health equity metrics for adoption to ensure robust benchmarking of health equity in the delivery of primary care.

Prioritize monitoring of risk-adjusted payments for adverse impact: Risk adjustment-based methodologies, particularly those that do not incorporate social risk, can lead to inequities for people of color. Risk adjustment based on traditional medical risk scores amplifies underutilization and underdiagnosis, particularly among communities of color. Age adjustment has an increased risk of discounting the higher risk of chronic disease experienced at younger ages by people of color. Incorporating social risk adjustment is complex and requires improvements in data collection. The Roadmap's Payment Model Parameter #1 makes clear that OHS will pursue risk-adjusted payments based on age, gender, and clinical complexity despite these significant limitations. Thus, ***we request that OHS explicitly require active monitoring of all risk-adjustment in Payment Model Parameter #3 and test any algorithms used to allocate services or attribute patients to a practice for bias.*** In addition, ***we recommend including monitoring of risk adjustment in the Roadmap monitoring and evaluation plan***. Careful monitoring can safeguard against exacerbating inequities and allow models to be adjusted to address any such concerns.

Integrate community-based supports and organizations: Core Practice Team Function #4b states that "embedded non-clinical care coordination personnel…may be physically located full or part-time at the practice site or should the practice site not afford sufficient physical space, physically located elsewhere." Community health workers (CHWs) are an example of embedded non-clinical care coordination personnel. This definition could be read to exclude CHWs working under community-based organizations that contract with formal clinical sites. To support the inclusion of both non-clinical workers working within formal clinical settings and those working for community-based organizations, ***we request that OHS clarify the definition of "embedded" to encompass non-clinical health workers across all settings and contractual arrangements*** as this is significant to the CHW workforce's advancement and sustainability.

In addition, the roadmap does not cover collaborations with community-based organizations. Community-clinical connections can have enormous impact on disparities by bridging gaps between patients and clinicians and meeting people where they live, work, pray, and play with the support they need to get or stay as healthy as possible. ***We recommend incentivizing and monitoring such community-clinical collaborations*** rather than focusing exclusively on clinic-based services.

Thank you for taking the time to consider our comments to the Roadmap. We fully support advancing a primary care infrastructure that centers health equity and responds to the health and social needs of communities of color in Connecticut and believe this is possible with these recommendations.

Sincerely,

Dashni Sathasivam

Dashni Sathasivam, MPH
Manager of Policy & Outreach
Health Equity Solutions

Karen Siegel, MPH
Director of Policy
Health Equity Solutions