

HealthFirst Connecticut Authority

Co-Chairs
Margaret Flinter
Tom Swan



Quality, Access and Safety Workgroup

Meeting Summary

May 8th, 2008

9:00 AM, Room 1E of the LOB

The following members were present: Tom Swan, Margaret Flinter, Shanti Carter, Daren Anderson, Matt Pagano, Pat Baker, Richard Antonelli, Shawn Grunwald, Lisa Reynolds, Steve Karp, Kathleen Brandt, Wendy Furniss, Lisa Davis, Estella Lopez, Alejandro Melendez-Cooper, Victor Villagra, Bob Patricelli, Tanya Court, Jean Rexford, Jennifer Jaff, Betty Jenkins-Donahue, Maureen Smith, Mary-Alice Lee, Robert Zavoski, Arvind Shaw, and Joe Treadwell.

Margaret Flinter welcomed members to the meeting. Margaret updated the Workgroup on the progress of the HealthFirst Authority and Primary Care Access Authority. The HealthFirst Authority has begun to look at several broad reform possibilities of the healthcare system. The Authority will begin to narrow down their selections for reform in upcoming meetings.

Victor Villagra suggested that the meeting minutes from the April 10th Quality, Access and Safety Workgroup meeting reflect his position that the payer sponsored model is successful but failed to link with the provider community. He also asked that the minutes include the phrase, "a blend of payer and delivery center models would be ideal for Connecticut."

The meeting minutes were approved as amended.

Tom Swan updated the Workgroup on the activity of the HealthFirst and Primary Care Access Authorities. At the previous HealthFirst Authority meeting, the members began to look at specifics of possible proposals to the Connecticut Legislature. The goal of the Authority is to have one or two frameworks that could be used as models over the next two to three meetings. Cost-cutting strategies have also been discussed and will be investigated further. Tom Swan announced that the next HealthFirst and Primary Care Access Authority meeting would be Wednesday, May 14th, 2008. Monies have not yet been released by Legislative Management for the use of an inventory of the State's primary care facilities.

Margaret Flinter introduced James Rawlings of Yale New Haven Health Systems and the National Association for the Advancement of Colored People (NAACP) who chaired a task force that developed a report on health disparities in the African American population.

James Rawlings cited Julian Bond, the chairman of the National Board of Directors who states that “Despite improvements in health and healthcare across the board, African Americans continue to suffer significantly worse health outcomes than their white counterparts in many disease areas.”

James Rawlings explained the health status report which should be seen as a as a tool that indicates the need for the State of Connecticut to develop a comprehensive, time-phased, strategic plan to address healthcare disparities within Connecticut’s African American population.

A plan with clear goals, objectives, and timetables is necessary to address this complex problem.

Racial minorities are less likely than Whites to receive certain diagnostic and life saver procedures. Black women die of cervical cancer at twice the rate of White women. Compared to Whites, a higher percentage of Black babies die in the first year of life

The 2000 census information indicates that Connecticut’s overall population is 3,405,565, of which 2,780,355 (81.6%) are classified as White, 309,843 (9.1%) as Black or African American, 320,323 (9.4%) as Hispanic or Latino, and 82,313 (2.4%) as Asians. (Source: U. S. Census, 2000, Connecticut) The average age-adjusted death rates for prostate cancer per 100,000, during the period 1997–2001, was 66.3 for Blacks, 27.3 for Whites, and 23.7 for Hispanics. The average annual age-adjusted breast cancer mortality rates for women, during the period 1996–2000, was 33.1 for Blacks, 27.5 for Whites, and 12.4 for Hispanics. During the period 1990–1994, the crude incidence rates for invasive cervical cancer per 100,000 women were 12.8 (97 cases) for Blacks, and 8.8 (667 cases) for Whites. The average age-adjusted death rates for lung cancer per 100,000 persons, during the period 1997–2001 was 55.9 for Blacks, 50.5 for Whites, and 21.4 for Hispanics.

More Whites than Blacks have a personal doctor or provider, and go to the doctor’s office when they are sick. However, far more Blacks than Whites use the emergency room when they are ill, and are unable to get care due to cost.

Therefore, preventable hospitalization volume highlights the possibility of gaps in the primary care health system, and lack of access to health services have led to the escalation in disease severity and, ultimately, hospitalization. In FY 2004, there were more than 50,000 “preventable hospitalizations” of Connecticut residents with nearly 300,000 total patient days and total associated charges of approximately 1 billion dollars.

- During FY 2000-2004 the charges increased 46.2%.
- Minorities accounted for over half of the recent increase (FY00- FY04) in ACSC hospitalizations.
- Compared with all races combined, Blacks had higher rates for 11 of the 16 Ambulatory Care sensitive conditions (ACSCs), meaning they were more likely to be hospitalized for these conditions.

Further analysis of ACSC across both the state and local level by urban, suburban and rural areas confirmed the severity of the issues.

- In many cases not only did the incidence of admissions reflect to a threefold difference compared to the general population.
- Also in many cases the average age of hospitalization for the same condition reflected a 5 years delta and in many cases a 10 years delta on average for African Americans for the same condition compared to the general population.

According to the Centers of Disease Control (CDC) and Prevention, 77% of African-American women and 62% of African-American men are overweight while only 47% of White women and 62% of White men are overweight which explains why African Americans lead in many statistics for obesity related conditions

- Black men will be facing an epidemic of diabetes by the year 2050.
- Most diabetics can control their illness through diet and lifestyle changes; but left untreated can progress to a more serious state.
- Approximately 12% of all African American men age 20 years or older have diabetes, however, more than 30% do not know it.
- The average African American born today has over a 50% chance of developing diabetes in his or her lifetime.
- With it's complications – blindness, amputations, heart attack, stroke, kidney failure and impotence – diabetes is the 5th leading cause of death in America.
- African Americans are 1.5 to 2.5 times more likely to have a limb amputated than are others with diabetes.

African Americans are twice as likely to have high blood pressure and four times as likely to die from it.

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999).

Sociocultural factors are a root cause of healthcare disparities because they have an impact on health beliefs, behaviors, and treatment

These factors affect: variation in symptom presentation, expectations of care, bias, mistrust, prejudice, stereotyping and, ability to maneuver within the system.

James Rawlings made several suggestions to the Authority:

Legislative policies and bills are currently not reviewed by an independent entity to determine their potential disproportionate impact on all citizens. An example of this would have been the significant impact on lower body amputations caused by limiting podiatric access to SAGA recipients at risk for diabetes complications.

All legislative policies and bills should be vetted through the proposed Office of Minority Health in order to prevent any disproportionate impact on any minority group, thereby avoiding and or minimizing any future health inequity legislation.

Each year the Department of Public Health reports on the health status of Connecticut citizens and the health inequities that exist within the state. It is clear that there is little coordination with the agency charged with providing access and programs (Department of Social Services) and the agency charged with monitoring and safeguarding health status (Department of Public Health). These departments should be consolidated to improve delivery of services and reduce current and long-term healthcare costs to this State.

There is a significant lack of coordination, accountability, and a cohesive plan for coordinating the various public and private initiatives to address the myriad concerns facing minority health. An Office of Minority Health must be established to address minority health issues and healthcare inequities and launch many of the recommendations cited in this report.

The IOM report states that the lack of inclusion of minorities in teaching settings directly impacts inequities within the healthcare system. Currently, accountability for minority inclusion, within this state, does not reside within any office of our state government. Academic medical centers and other teaching facilities must be fully engaged in developing a diverse workforce in this state, with a strong emphasis on the training of future doctors and other care providers. The issue of minority clinical staff must be included in any effort to reduce and/or eliminate inequities in health care.

Licenses and approvals are not linked to impact programs that address disparity objectives. The State of Connecticut should use its power and influence to establish quantifiable goals that address disparity objectives in health care.

Currently, licenses are approved are not tied to any state plan. Two examples where access is a significant state issue are childhood obesity and the emerging adult sickle cell crisis. The State of Connecticut should incorporate accountability within new/expansion programs in order to address this well documented and emerging disparities issue

Currently, the Department of Public Health does not collect ethnic and racial demographics beyond the broad African American and Hispanic categories. The absence of subgroup data may adversely impact demographic analyses and assessments. Change the data collection procedures to include subgroup data.

The absence of health partnerships at the local level reduces healthcare effectiveness. Establish new partnerships with local governing bodies and local NAACP branches in order to reduce healthcare inequities. Individuals, families, and neighborhoods have to be held accountable to close the gaps noted in this Health Status Report.

Currently, the cost of certain health care that is avoidable and preventable often is caused by health inequities. The cost of “loss of productive days” is enormous and creates an unnecessary expense for many employers. The Connecticut Business & Industry Association (CBIA) should invest in health

prevention and promotion in order to reduce costs and increase economic profitability and development. This would also help CT realize the full economic potential of its workforce.

Currently Managed Care Organization (MCO) contracts do not include a “pay-for-performance” provision, which will impact asthma care and childhood obesity situations. Establish a “pay-for-performance” provision in MCO contracts.

Margaret Flinter introduced Estella Lopez for the purposes of a presentation.

Estella Lopez offered a presentation on the health profile of the Latino population in Connecticut.

- The state’s Latino population is growing at a dramatic rate.
- Latinos are now the largest minority group in Connecticut — 10.9% of the state’s population.
- Latinos are almost 11% of the State’s population and have the highest poverty and unemployment rate of any ethnic group in the State.
- Latinos experience the highest poverty rate & the highest unemployment rate of any ethnic group in the state. (23% of all Latinos are living below the poverty level; per capita income of \$18,126).
- The Latino population is young, with a median age of 31.4 years, and nearly 40% are under 20 years of age.
- Only 32% of Latino residents age 25 or older have a high school diploma.

Latinos are playing and will continue to play an increasingly important role in the economic and social progress of Connecticut.

- The Latino population is young, with a median age of 31.4 years, and nearly 40% are under 20 years of age.
- Only 32% of Latino residents age 25 or older have a high school diploma. This is due to the population centers of Latinos in Connecticut.

The health inequities experienced during critical stages of the life cycle dramatically reflect the failure of our public health and socioeconomic systems to protect the health of those most vulnerable.

- Prenatal Care – highest lack of, or late prenatal care
- Teen pregnancy – highest percentage of teen births, 16.8%
- 36% of Hispanic adults are uninsured
- Less likely to have prescription and dental coverage or seek needed medical care for a non-emergency illness

- Pediatric asthma rates are 11% for Latinos, compared to 9% for African Americans and 8% for non-Latino Whites.
- Latinos have a 60% higher mortality rate for diabetes and 40% higher mortality rate due to diabetes-related illnesses than non-Latino Whites.
- Obesity rates of CT Latina females (25.5%) are significantly higher than those of White, non – Latina females (16.9%)
- Among the leading causes of death, unintentional injury and HIV are the number 1 and 2 causes of premature mortality for Latinos

A Profile of Latino Health in Connecticut documents pervasive health inequities experienced by Latinos and represents an urgent call to action. The problem at hand is enormous, reflective of systemic root causes that must be addressed through decisive policy change.

- **Poverty**
For real, long-term change in the health status of Latinos to occur, opportunities for livable wage must be created.
- **Cross Cultural Barriers**
There is still much work to be done for Connecticut’s health care system to assure that its care providers are skilled in working effectively with diverse populations. A critical need is the commitment of time and resources to assure a profound training that gets at the fundamental issues at hand and facilitates authentic change.
- **Language Barriers**
Medical interpretation is a necessary and affordable step towards solving the urgent problem of language barriers within health care settings.
- **Health Care Coverage**
Universal Health Care Coverage is an essential step towards solving the health inequities experienced by Latinos in Connecticut.
- **Health Literacy**
Health literacy is critical to elevating the capacity for Latino communities throughout the state to effectively navigate health systems, adhere to health guidance and care for themselves adequately.

Margaret Flinter introduced Tanya Court of the Fairfield Business Council and Health Policy Specialist.

Tanya Court presented the Connecticut Health Scorecard which has been produced by the Fairfield Business Council. That report found similar health disparities as had been reported by the previous two speakers. Information is also difficult to retrieve. Workforce issues have an impact on healthcare in Connecticut. Registered nurses receive a lot of attention in Connecticut because of the shortage, but there are shortages of other healthcare workers as well including CAT-scan and MRI technicians, pharmacists, pharmacy technicians, physical therapists, physical therapy assistants, and medical assistants.

One of the ten essential public health functions is assurance of a competent public health and personal health workforce. However, the Connecticut Department of Public Health cannot tell you how many doctors or nurses are practicing in Connecticut or in what fields. The online licensing system may be able to provide valuable data on workforce needs. Comprehensive healthcare reform is not possible without an adequate workforce. This means the workforce must be competent and culturally diverse. Connecticut healthcare system turns away huge numbers of students because we do not have the capacity to train them.

Other issues include lack of clinical placements, need for classroom and laboratory space, a lengthy academic approval process for getting new programs in, and a lack of the required science, math, and English skills required to succeed in college, university nursing and allied health. Connecticut needs to do a better job of keeping young qualified workers in the area. A lack of infrastructure to train immigrants is another problem. We need facilities that will help provide foreign healthcare workers the necessary training in English. There is also a need for more men, Blacks and Hispanics in the healthcare workforce. There needs to be a partnership that coordinates the region's healthcare workforce development efforts. Creation of web-based centralized clinical placement systems would be useful. This would increase the number of available clinical placement slots, would decrease the time spent working on arranging clinical placements, and would provide an early alert system when clinical sites become available. The Fairfield Business Council suggested that a regional pilot be instituted using software used by eleven other states. The program would offer scholarships in exchange for service in Connecticut. This would be the equivalent of an Apollo project in Connecticut Nursing. Another suggestion is the development of a centralized resource for immigrants with foreign healthcare credentials to help them find opportunities to upgrade their skills in healthcare. We must also look at expanding the availability of nursing and allied health distance learning. An online transfer student information system would make it easier for students to enter the States healthcare system and workforce. Additionally, salaries for community college nursing faculty need to be addressed. Finally, data needs to be made available with regard to the healthcare workforce and the progress that programs are making in alleviating the current problems should be tracked using whatever data system is created.

Mary-Alice Lee asked about a report ten years ago provided by the Department of Public Health (DPH) that dealt with healthcare disparities. That is a report that is worth repeating on a regular basis. She asked if DPH planned to update that report.

Lisa Davis responded that she was unsure if there was a plan to update the report. Lisa Davis reported serving on a health disparities workgroup that has found similarly discouraging information.

Richard Antonelli reported that his partnership with the Hispanic Health Council is working to develop a city-wide program in children's health around care coordination. Even with massive funding, there would need to be family partnership health literacy cultural competency for the partnership to be effective. The same partnership may not need the same coordination to be successful in another part of the state. There is no "one-size-fits-all," solution to our problems.

Maureen Smith reported that she had asked James Rawlings how he views disparity from a mental health perspective. He responded that we have not reached that point yet. We need to pay attention to our mental health delivery system and we need to be committed to fixing it.

Estella Lopez commented that in the Latino community also has not reached mental health parity. There is a lack of support and access. When immigrants come to this country they often bring practices that are healthy. Those practices should be preserved.

Pat Baker informed the Workgroup that most people of color do not get mental health services until they enter the juvenile justice system. There are three variables driving the disparity of mental health services; social determinants, access, and the delivery system. The challenge of the Workgroup is to determine how to affect systems change that can affect those outcomes.

Tanya Court reminded the Workgroup that there needs to be ethical considerations of healthcare reform.

Victor Villagra asked Estella Lopez about underreporting in the statistics she presented.

Estella Lopez answered that there is limited data available.

Daren Anderson suggested that the Workgroup should consider what the causes of health disparities are. Once the Workgroup decides what the cause is, it will be possible to recommend a solution. Daren Anderson expressed his belief that providing access to quality health care, most if not all of the disparities will disappear.

Pat Baker responded to Daren by citing a study that showed that access alone may not solve the problem of healthcare disparities.

Tom Swan briefly described the healthcare reform options that had been presented to the HealthFirst Authority. The five options that were presented were: 1.) Universal entitlement to primary care or coverage, with insurance purchased for inpatient care only. 2.) Regionally organized networks of care (possibly building on / extending Charter Oak). 3.) Insurance-Choice System. 4.) Bolstered Employment-Based system. 5.) Universal entitlement to publicly financed coverage.

Jean Rexford discussed the lack of creativity that was used in developing the healthcare reform options. Jean Rexford suggested that the patients, healthcare consumers and residents of Connecticut should be the drivers of care.

Tom Swan responded to Jean and said that was a legitimate concern. The policy proposal that is presented to the Legislature may not be one of the five proposals that have been presented. The five policy proposals were offered as a way of establishing a framework and strategies that may move the discussion forward and help move towards a proposal to the Legislature.

Jennifer Jaff agreed with Jean Rexford that the cost cutting issues should be the core issues.

Tom Swan suggested that the concepts raised by Jennifer Jaff are not mutually exclusive. The cost cutting issues and the healthcare policy options must both be explored.

Robert Patricelli commented on the healthcare proposals and offered his appreciation that there would be effort into looking at the proposals of the health insurance policy council. The pooling concept has not been explored enough by the policy council. There should be an exploration of the potential of

creating an entity that could serve as a market organizer for individuals and small groups. The correct way of creating a pooling plan is probably not by starting with the state employee benefit program. Other groups should have the opportunity to have some choice with regard to the benefit package and approach. Finally, the Health Insurance Policy Council did not deal with organizing regional networks of care as much as the HealthFirst Authority and Quality Access and Safety Workgroup have. It is difficult to legislate such a system, but important to discuss such a system. One way to induce the provider community into joining the management of chronic care cases would be to provide tort reform protection for the providers who operate within the system.

Victor Villagra agreed with Jean Rexford that there must be more creativity used when developing a better system of healthcare. As the healthcare consumer becomes more capable of engaging intelligently in their own healthcare conditions, we will see better quality, better outcomes and lower costs of care. The other problem with the healthcare proposals as they have been presented is the lack of explanation of what the reform will do to change the structure of the delivery system.

Mary Alice Lee commented that the reform proposals do not include anything that addresses the specific conditions that Connecticut faces such as income inequality, imbalance in specialists and primary care providers, and a high un-insurance rate in the Hispanic community.

Steve Carp suggested that cultural and linguistic competency should be listed under design options.

Richard Antonelli clarified that the Quality, Access and Safety Workgroup should put forward the best possible measurable health care system.

Lisa Reynolds asked the Authority to look at the five healthcare proposals as drafts. One element that does not belong in the proposals is the tort reform protection that was proposed by Robert Patricelli.

Jennifer Jaff asked the Workgroup to use the information that has been presented so far to begin to start writing a proposal to the Legislature.

The Meeting adjourned at 11:15 AM.