ADVANCING HEALTH EQUITY FOR CONNECTICUT’S CHILDREN AND FAMILIES THROUGH HEALTH SYSTEMS TRANSFORMATION

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INTRODUCTION

Connecticut’s health statistics consistently compare well to other states. Unfortunately, these aggregate statistics mask enormous disparities in health and health care experienced by the state’s residents of color. These disparities are the result of racism and its social and economic consequences, and these disparities are largely preventable. Connecticut has already begun to alter our health systems to address the root causes of health and wellbeing. In order to mitigate the prevalent and dramatic inequities in our state, such changes must deliberately aim to reduce racial and ethnic disparities in health and wellbeing. In the pages that follow, we outline proposals for advancing health equity through health systems transformation.

Health equity means that everyone should have a fair opportunity to attain their full health potential and no one should be disadvantaged from achieving this potential. Therefore, in accordance with the World Health Organization’s definition, health equity means the absence of avoidable, unfair, and remediable differences among groups of people. Connecticut Voices for Children focuses specifically on racial and ethnic equity in health because of the vast and preventable disparities discussed above. Racial disparities in health outcomes persist when controlling for socio-economic variables and can be mitigated by alleviating the impacts of systemic racism, including, but not limited to, disparities in access to fair wages, safe and affordable housing, adequate and healthy food, and quality education.

Tracking, examining, and acknowledging inequities in our health systems is important because these inequities reduce the overall wellbeing of our state, dramatically increase unnecessary spending to treat preventable disease, and most importantly because they cause harm and shorten lives. For example, reducing inconsistencies in how people of different races and ethnicities are treated by the hospital system could result in over $1 billion in reduced spending in Connecticut, according to Connecticut’s Department of Public Health. Further, changing our systems to mitigate the impacts of racism and the disproportionate burdens faced by children of color—such as higher rates of economic hardship and increased exposure to traumatic events—can have lifelong impacts that reach across all aspects of our society. The Centers for Disease Control and Prevention estimates that preventing exposure to such burdens (sometimes called “adverse childhood events”) could mitigate half of the leading causes of death and reduce the number of adults with depression by over 40 percent.

In the last two years, a number of national policy organizations have published roadmaps to improving wellbeing through policy changes in the United States. A common theme was the complex intersection of education, economic security, housing, health, and safety. Many of the proposed solutions can only be carried out at the federal level. Further, few of these analyses focused on the role of racial disparities in wellbeing and the importance of ensuring programs, services, and systems work together to maximize resources and to ensure that the needs of whole families are met. With the aim of considering state-level possibilities for progress towards health equity, Connecticut Voices for Children chose to focus this paper on work by the Families USA’s Health Equity Task Force—a group of U.S. health policy experts dedicated to ensuring that health system reforms address inequities.
THE HEALTH EQUITY TASK FORCE produced a “Framework for Advancing Health Equity and Value” examining the impact of health systems reform on health inequities to date and making policy recommendations. The report includes 86 policy recommendations in six categories with one “overarching imperative” of inclusion. Connecticut Voices for Children examined the 56 recommendations that can be implemented at the state level to determine which were most likely to promote equity for children and families of color in Connecticut. We utilized evaluations of current programs, academic literature, and the state’s demographics and health systems structures to inform our analysis. In particular, we considered how these interventions might operate given Connecticut’s high degree of geographic and economic racial segregation and shifting demographic profile. In addition, we gathered feedback from health advocates and government stakeholders to ensure that a breadth of perspectives informed the policy recommendations. The intent of the analysis provided here is to provide concrete proposals for promoting health equity through health system transformation in Connecticut.

To promote health equity, we recommend reforming Connecticut’s health systems through an overarching emphasis on inclusiveness within the following:

1. Equity-focused payment reform
2. Equity-focused measurement
3. Integrating health systems, social services, and community-based services
4. Creating a more inclusive workforce

In the following pages, we propose strategies for advancing health equity through health systems reforms within the context of Connecticut’s current health insurance and service delivery structures. Given the long-term high impact of addressing the needs of children and the growing proportion of children of color in Connecticut, we focused on families in a number of these recommendations. Many of these proposals could be accomplished by bringing existing programs to scale or establishing sustainable support for interventions of limited scope or duration. As such, Connecticut is well-positioned to implement equity-focused health systems transformation.

How do the Policy Domains Identified by the Health Equity Task Force Apply to Connecticut? Policy analysis and recommendations

An overarching need for inclusive systems and processes

Health reform efforts have the potential to improve health equity dramatically, yet evaluations of early models suggest a risk that reforms may widen racial and ethnic disparities in health unless equity is thoughtfully and measurably embedded. Avoiding the risk of harm requires including communities of color in the decision-making process from design through evaluation and throughout the life-cycle of interventions. Meaningful inclusion of people of color who have lived experience of structural racism and navigating health systems ensures that the perspectives and needs of those disproportionately impacted by social risk are taken into account as changes to health systems are planned, evaluated, and updated. In other words, inclusiveness means that diverse experiences and points of view are more likely to be considered and, as a result, that subsequent changes are more likely to promote health equity.
Connecticut’s state agencies have made a number of efforts to include consumer perspectives in health systems. For example, each of the Medicaid Administrative Services Organizations has an active consumer advisory council. Further, the Office of Health Strategy has a consumer outreach strategy and the State Innovation Model employed a stakeholder engagement strategy in establishing its workgroups. Yet, stakeholders in Connecticut have echoed the Families USA Health Equity Task Force’s emphasis on the need to create health reform systems and processes that are more inclusive. Conversations both formal and informal with consumer advocates in Connecticut suggest concern about imbalances in their numbers, decision-making power, and resources to support participation as compared to representatives of health systems payers and providers. The Health Equity Task Force’s “Framework” and discussion with Connecticut consumer advocates produced the following recommendations, which should be embedded in each of the proposals in subsequent sections of this paper.

This overarching need for inclusiveness can be addressed through:

- greater transparency throughout project design, implementation, and evaluation;
- including community representatives as early as possible and throughout the course of any initiative;
- funding affected groups to engage in dissemination and translation of information;
- funding community groups to sustain engagement in the development, evaluation, and evolution of health systems;
- being mindful of diversity across underrepresented communities (a representative from one community of color cannot represent all communities of color);
- being mindful of intersectionality or complex identities and diversity within communities;
- being mindful of power dynamics and the balance of perspectives so that input from community members is not lost in the greater volume of input from payers and providers; and
- structuring processes to remove barriers to participation including technical assistance, transportation, and the timing and location of meetings.

I. Equity-focused payment reform

Changing how health services are paid for has the potential both to motivate health systems to address the root causes of health disparities and to unintentionally harm underserved populations. For example, when a payment model rewards outcomes (such as reduced emergency room visits) but fails to adequately adjust for risk related to both social and clinical circumstances, safety net providers may be penalized due to the higher risks experienced by the people they serve. By centering equity in payment reform structures and methods, it is possible to safeguard against harm and promote racial equity in health outcomes.

In their most basic forms, both fee-for-service and per-person (or capitated) payments fail to incentivize quality or improved outcomes. Fee-for-service incentivizes increasing the quantity of services that have billable codes, while capitation incentivizes less spending per visit. Proponents of fee-for-service say it ensures that higher risk patients are not turned away and that the billing process generates more robust data. Proponents of managed care or capitated payments argue that this model allows providers the flexibility to address social needs. Ultimately, because they focus on volume or costs, neither payment model incentivizes quality, access, or outcomes. Payment models that employ a mix of payment methods and quality assurance metrics are now widespread and have the potential to incentivize better care and better health. For example, a recent evaluation of Oregon’s health reform efforts, which focus on equity, found evidence of improvements in access to quality care.

Payment reforms can require providers to deliver care that addresses each person in a holistic and responsive manner by collaborating with community-based service providers and integrating medical, behavioral, and oral health. Linking payments to robust process and quality measures safeguards against any attempt to save money by denying services or accepting only the simplest cases and helps providers track gaps in progress so that they can then assess and address the underlying causes of health disparities.
For many years, pediatric primary care providers have noted the importance of addressing social determinants of health\(^{26}\) such as asthma triggers in the home, ensuring that a family has enough food, or addressing a parent’s mental health needs. Despite acknowledging the importance of such factors on a child’s health and wellbeing, our current systems still mostly pay for the volume of patient visits or the volume of billable services performed. This structure makes it difficult to take the steps necessary to prevent future hardship by addressing the child’s needs by, for example, coordinating access to pest control to help manage asthma or identifying a mental health provider for a parent who is experiencing depression.\(^{27}\)

Connecticut’s Medicaid programs are grounded in a fee-for-service structure while employing several alternative payment models, including: per-encounter payments for community health centers, bundling of maternal health services provided by physicians, reimbursement for certain care coordination strategies to Administrative Services Organizations (ASOs),\(^{28}\) enhanced fee-for-service payments and quality performance and improvement incentives to providers participating in Patient Centered Medical Homes (PCMH), and advanced per-member payments for care coordination for some participants in a primary care shared savings program known as Patient Centered Medical Homes Plus (PCMH+).\(^{29}\)

The Office of Health Strategy and the Department of Social Services embrace racial equity as a priority. Further, primary care providers participating in PCMH+ are required to meet culturally and linguistically appropriate services (CLAS) standards, increase care coordination efforts, and improve behavioral health integration. Yet, the state’s current payment models, including PCMH+, do not embed racial equity in risk adjustment or evaluation. Overall, PCMH+ quality monitoring from 2018 showed greater improvements in quality in PCMH+ practices than in PCMH practices on seven of the eleven shared quality metrics and “credible savings” in four of 14 participating entities.\(^{30}\) No quality metrics for PCMH+ were analyzed for racial disparities in quality or utilization; so, it is not possible to evaluate the program’s impact on health equity. The Office of Health Strategy has also sought opportunities to work with private insurers, hospitals, and health care providers to move towards whole-person care, some of which are discussed below.

In 2019, Connecticut’s Pediatric Primary Care Payment Reform study group concluded: “Payment reform itself is not the goal; the health and well-being of children is. The key question is how to pay for care in a way that ensures an integrated, innovative system.”\(^{31}\) This group highlighted the needs of children because their relatively low cost to health systems means that children are often excluded from payment models, yet the conclusion applies to the health and well-being of Connecticut’s entire population.

Recommendations for centering equity in payment reform:

1. **Incorporate input from communities of color in the planning, implementation, and evaluation of payment reforms.**\(^{32}\) Medicaid enrollees are both more likely to be negatively affected by social and economic factors and more likely to be people of color than the state’s general population.\(^{33}\) As noted throughout this report, meaningful inclusion of the people served by health reform interventions is key to ensuring that the intended results are achieved and unintended results are avoided.

2. **Future payment models in Medicaid and private health insurance plans in Connecticut should incorporate social factors in risk adjustment and use equity measures in cost and quality incentives.**\(^{34}\) Incorporating racial equity in risk adjustment and the evaluation of and incentives tied to payment models will avoid situations in which providers are rewarded for serving higher income, healthier populations. Evaluation metrics could require large provider groups to have a plan for reducing disparities and to track their progress on this plan, further embedding equity in health systems. To date, Connecticut’s PCMH and PCMH+ payment models have not incorporated social risks and have cited the poor quality and availability of such data.\(^{35}\) Race and ethnicity data is collected at enrollment by Medicaid and some private insurers, but is not required or collected in a uniform manner.\(^{36}\) The Community Clinical Integration Program (CCIP) under the State Innovation Model demonstrated the feasibility of collecting granular race and
ethnicity data in Connecticut—a practice already in place in several other states. Further, work underway in Oregon and Minnesota and recommendations from the Yale Center for Outcomes Research and Evaluation lay the groundwork for developing robust health equity measures for payment models. A plan to improve social risk and race/ethnicity data collection and utilization should be established with a timeline for including this data in future waves of existing payment models as well as in additional payment models such as the hospital readmission rate reduction and behavioral health value-based payment models currently in planning phases.

3. **Ensure that payment reform efforts prioritize quality, access, and equity.** Many early payment reform efforts in other states have focused on reducing spending and improving quality, in that order. To promote equity in health outcomes, people must have access to quality care and to care that takes their social, economic, and environmental circumstances into account. When payment models prioritize savings over outcomes and fail to intentionally target equity, they may widen disparities and worsen outcomes. Connecticut has recognized that as people gain access to preventive care and are connected with services that meet their social needs, outcomes will improve and long-term costs are likely to decrease. This approach should be supported with transparent evaluations of whether or not the goals of improving outcomes and decreasing disparities are being met. Future payment reform efforts in Connecticut across payers should rely on more robust quality metrics incorporating equity. As the State Innovation Model work comes to a close, the Office of Health Strategy could be tasked with coordinating cross-payer and cross-agency collaborations to meet this goal.

4. **Utilize fee-for-service billing codes to incentivize services that are underutilized.** Singling out underutilized services for fee-for-service codes can serve to track improvements and incentivize providers to increase utilization. Connecticut has used payment enhancements for behavioral and developmental screening for children to increase screening in primary care. While follow-up for children who need additional evaluation or services has not yet been analyzed, increases in screening rates are dramatic. This model could be judiciously applied to other services to incentivize changes in how health providers deliver services. It is key that such incentives be linked to outcomes—for example, by tracking referral after a positive screening for behavioral health needs, as planned, or tracking emergency department utilization for behavioral health services.

5. **Require providers participating in payment models to adhere to equity-focused care delivery reforms (for example, collaborating with community based services and engaging with community health workers).** Requiring medical providers to change the culture and process of practice by incorporating changes that address social determinants of health and boost cultural competence can improve outcomes for underserved populations. Connecticut has a robust PCMH structure. However, PCMH and PCMH+ do not go far enough in requiring connections to community-based services or in incentivizing community-based supports. Such efforts are lagging in our state’s hospitals and large advanced networks of service providers as well. While PCMH+ requires providers to have a list of community-based partners, coordination with these partners is not tracked or tied to quality measures. PCMH, PCMH+, and ASO contracts incentivize care coordination for specific conditions; yet, the ability of care coordinators to go beyond traditional health systems and mitigate barriers to health may be limited by their scope of work. Community health workers based in communities can help people navigate barriers to services and supports and address cultural gaps through a combination of lived experience and knowledge of local resources. Community-clinical integration is covered in greater detail below.

6. **Encourage Medicaid to take full advantage of opportunities to fund supportive housing and housing-first models.** Connecticut is in the process of launching a Medicaid supportive housing program (including pre-tenancy and tenancy-sustaining services) for Medicaid enrollees who have experienced homelessness and incurred high medical claims in the prior year. This cross-agency collaboration is a promising example of data matching and cross-sector budgeting. We recommend that equity be embedded in the project’s design and that results be carefully evaluated for potential expansion to other populations. While interventions for people with less complex medical needs are unlikely to generate short-term savings, housing stability has long-term implications for the health and wellbeing of less cost-intensive populations—including children and their families.

7. **Remove regulatory and administrative barriers (including barriers related to electronic health records and billing) to integrating physical, behavioral, and oral health care.** Despite the state’s robust medical home models, significant barriers to addressing the needs of the whole person and effectively coordinating care remain. Medical home policy should enable and incentivize a system in which one health “home”
is responsible for coordinating a person’s primary, specialty, oral, behavioral, and physical health care as well as linking to education, disease management, and social supports. Connecticut has the infrastructure to do this through existing efforts to connect children and families to non-medical services such as the Child Development Infoline and condition-specific efforts such as those conducted under the Prevention Services Initiative. Additional progress requires addressing regulatory and reimbursement-related barriers, including barriers to home visiting programs and to telehealth consultations and services, in some circumstances.

II. Equity-focused measurement

Data is collected and used to evaluate processes, outcomes, patient experience, and the efficiency of health care interventions. Measures determine how payments are made, how levels of risk are calculated for certain reimbursement models, which patients are identified for specific interventions, and how resources are distributed. In order to promote health equity, states must collect, report on, and evaluate health services data stratified by race and ethnicity. Without information about which populations utilize services and experience various health outcomes, it is impossible to measure progress towards health equity.

In 2018, Connecticut Voices for Children’s survey of health-related data sets that included race or ethnicity data found that while this data was widely collected, the poor quality and availability of the data limited its usefulness. Standardizing Connecticut’s collection and utilization of race, ethnicity, and language data is crucial to meaningfully advance health equity in the state. Algorithms used to target care to high-risk populations, determine payments, and improve access will continue to exacerbate racial disparities unless they take into account that barriers lead to lower rates of utilization by people of color. Efforts at “race blind” measures can obscure the lived experience of being a person of color. The following recommendations aim to embed meaningful evaluation of race equity in our state’s health systems, while noting that context and cultural competence are vital when using race and ethnicity measures to make decisions at all levels of the health system—from individual treatment plans to statewide policy. Further, each of these recommendations assumes that the robust privacy protections already in place will continue to be respected and that the best practices of allowing individuals to self-identify or choose not to do so will be followed.

Recommendations for equity-focused measurement:

1. Require all health organizations, and especially participants in alternative payment models across payers to stratify data by race, ethnicity, and language (as well as gender and other characteristics that may be collected, such as sexual orientation). As noted above, some organizations and payers in Connecticut and in several other states already consider demographically stratified data. However, the collection and utilization of race, ethnicity, and language data in Connecticut is inconsistent. “Report cards” created by the Medicaid ASOs and by the Department of Children and Families include data stratified by race, ethnicity, and gender, but the quality of the data and how it is being used to address disparities are unclear. The collection of granular race ethnicity data and guidelines for using this data to promote health equity were included in the CCIP. This effort included a subset of PCMH+ participant providers and proved the feasibility of collecting this data using electronic health records systems in a uniform and useful manner. Further, such efforts are in line with federal guidelines and recommendations.

2. Incentivize or require collection of patient social and behavioral risk data through payment reforms across payers and include this data in electronic health information exchanges. Early efforts to collect social and behavioral risk data were included in the CCIP, but collection was limited in scope. Provider presentations to the Healthcare Innovation Steering Committee suggested variation in success with this aspect of the program and in understanding how to use the data once it was collected. Lessons learned from this project could inform future endeavors, including the proposed Health Enhancement Communities, which are expected to share data and goals across participating health and community based service providers. Successful data collection projects in other states also offer opportunities for learning and improving Connecticut’s collection and utilization of social risk and demographic data. This recommendation should be included in the Office of Health Strategy’s ongoing health information technology efforts, including work to establish a statewide health information exchange.
3. Streamline eligibility determinations through information sharing (for example, across SNAP, Medicaid, WIC, etc.) and share information to support whole-person services. Connecticut is among the roughly half of U.S. states that have not yet adopted federal options to link information across social services program applications. Adopting these regulatory options allows residents of the state to submit the required information once for multiple programs or to link applications using a single login. At present, an application through the Connect database for one program will suggest other services for which an applicant may be eligible, but individual application, verification, and renewal processes are used for each program. When systems are connected, data remains protected and private, while administrative processes are streamlined. Individuals should retain the choice of which applications to submit. Early results from the first year of PCMH+ and focus groups recently conducted by Connecticut Voices for Children and Health Equity Solutions found that while Connecticut has high rates of automatic renewal for Medicaid, gaps in coverage and disenrollment due to administrative burden are likely widespread. Aligning and streamlining eligibility determinations would require investment in technological solutions and has the potential to both improve access to services and reduce unnecessary losses of coverage.

4. Increase the number of disparities-sensitive and health equity measures reported across payers and develop additional measures in identified gaps. Shared metrics help to embed equity in delivery systems. A recent update of the “Framework for Child Health Services” by two Connecticut-based organizations recommends outcome measures for consideration in payment reform. Embedding equity in outcome measures can improve reporting and evaluation of progress towards health equity. Sharing data across sectors and government agencies can improve the likelihood of tracking outcomes and having meaningful measures of child wellbeing. For example, education data is a strong indicator of child wellbeing and multi-generational data is particularly important to tracking early childhood interventions. The Help Me Grow National Center, which is headquartered in the state and coordinates the efforts of over 30 affiliate sites across the nation, has been a pioneer in establishing shared metrics across sectors and utilizing health promotion measures to evaluate progress. Health Enhancement Communities (proposed cross-sector, place-based collaboratives with a focus on child wellbeing) and alternative payment models offer opportunities to leverage these measures to both identify preventable disparities in health outcomes and ensure that equity is incorporated in how health systems design interventions and measure their progress.

5. Prioritize the inclusion of health equity measures in core measure sets used by various initiatives and the addition of these measures when others are decommissioned. A number of initiatives have laid the groundwork for including evidence-based measures of disparities, health promotion metrics, and social risk factors. Among these, work done by the National Academies of Sciences, Engineering and Medicine, State Health and Value Strategies, and the National Quality Forum, all point to practical means of including equity measures in core measure sets. Further, work done at the state level by the Quality Council (formed with consumer inclusion as part of the State Innovation Model) and Yale Center for Outcomes Research and Evaluation offers recommendations for establishing disparity measures in Connecticut. While it will take some effort to identify and implement the most appropriate measures to evaluate progress towards eliminating racial disparities in health, the state should have a concrete plan and timeline for doing so.

6. Incorporate decreases in health disparities into payment models, including bonus payments for exceptional progress. Any payment model should include robust quality measures and safeguards to ensure access. In addition, models should be designed to promote health equity and reward progress towards that goal on specific measures. For example, Health Enhancement Community models propose that communities work toward shared goals including reducing exposure to adverse childhood events, healthy weight, and fitness. These collaborations are often led by hospitals or health departments and, thus, may contribute to health system transformation. Evaluations of these goals should consider disparities in service utilization and outcomes and reward progress towards reducing inequities.
III. Integrating health systems, social services, and community-based services

While health systems are increasingly attuned to and held accountable for socioeconomic, environmental, and behavioral contributors to health, our current health systems do not incentivize providers to develop the robust community partnerships that can keep people healthy and prevent unnecessary illness and hardship. Further, incentives to provide whole-person care may lead to health systems replicating the work of community partners rather than leveraging the expertise and cultural competence of existing community-based organizations and community health workers.\(^{82}\)

Connecting health systems and the people they serve to community-based supports can address the root causes of illness and injury, which are largely non-medical in nature. In order to promote health equity, such efforts should include the perspectives of affected families and individuals from planning through evaluation and revision of interventions. Further, these collaborations must be grounded in evidence and evaluated for their impact on health equity and specifically on equity in health outcomes. Given that people of color are often not represented in academic research, careful evaluation and planned redesign should be incorporated into programs that aim to address root causes and for which the evidence base may not yet be established.\(^{83}\)

Recommendations for building robust and well-resourced community partnerships:

1. Require Medicaid ASOs and all advanced networks to include communities of color in governance structures, decision-making councils, and community/consumer advisory boards and strengthen the requirements for including community members in the community health needs assessment (CHNA) process and community benefit program implementation.\(^{84}\) Opportunities to better include people of color in decision-making bodies vary among organizations and issues. For example, Connecticut’s ASOs have consumer advisory councils that are reported to be diverse in composition; yet, the state’s Council on Medical Assistance Program Oversight includes minimal consumer representation and lacks racial/ethnic diversity in its current form.\(^{85}\)

Connecticut’s statute codifying community benefit requirements for hospitals and managed care organizations requires “meaningful participation” from communities within the institution’s service area.\(^{86}\) However, the statutory requirements are less specific than those in surrounding states.\(^{87}\) Connecticut’s Office of Health Strategy has recently been noted for holding providers accountable in certificate of need agreements.\(^{88}\) This work could be codified, scaled, and more explicitly applied to promote health equity. Further, we suggest including people of color on committees or councils that determine “medical necessity” and identify “preferred” treatments or medications. Meaningful engagement with communities of color, including funding community groups to enable participation, could ensure that racial equity is prioritized in the CHNA process and in hospital and network structures more generally.

2. Require providers participating in alternative payment initiatives to contract with community based organizations for social services, outreach, education, assessment, and follow up.\(^{89}\) Connecticut is home to a myriad of excellent, if under-resourced, community based organizations including early childhood home visiting programs, community health worker initiatives, and efforts to prevent involvement in the child welfare system.\(^{90}\) Partnerships between health systems and community-based organizations mean less concentration of health care spending, improved cultural competency, and a higher likelihood of accurately identifying and addressing people’s needs.\(^{91}\)

3. Require Connecticut’s Medicaid Office and Office of Health Strategy to develop, pilot, and scale models requiring significant engagement with community-based organizations.\(^{92}\) As noted above in the recommendations to embed equity in new payment models, significant opportunities exist for collaboration between health systems and the communities they serve. Community-based organizations are widespread in Connecticut, but these organizations are often small and lack the resources and information technology infrastructure to effectively collaborate with health systems.\(^{93}\) Hospitals and provider networks could improve the health outcomes of the people they serve by partnering with and investing in community-based organizations, including by collaborating with community health workers and other lay health professionals who work in and with community centers, faith-based organizations, schools, food banks, and other existing community efforts. Home visiting programs also
offer opportunities for collaboration on interventions shown to improve outcomes. Engagement with community-based organizations will require flexible or blended funding streams to ensure sustainability.

4. **Require all hospitals to meet community benefit requirements.** Connecticut could leverage the Certificate of Need (CON) process and/or statutory changes to require all hospitals to meet community benefit requirements regardless of tax-exempt status. This would build on the Office of Health Strategy’s recent efforts to embed accountability in the CON process, as noted above. Over 25 states, including neighboring states, have more stringent approaches to community benefit, demonstrating that this is feasible. One approach might be to make participation in Medicaid Disproportionate Share Hospital payments contingent on meeting community benefit standards.

5. **Require that all hospitals invest a minimum percentage of community benefit in programs targeted to address the root causes of health disparities.** Given Connecticut’s extreme health disparities, community benefit programs should be targeted to mitigate the social, environmental, and economic causes of these disparities. The Office of Health Strategy could be tasked with aligning data collection and evaluation of the programs funded with community benefit dollar to ensure transparency, accountability, and a focus on mitigating racial disparities in health.

6. **Establish IT hubs for community-based organizations and incentivize the sharing of existing infrastructure to improve coordination between health systems and community-based organizations and maximize resources.** Technology is particularly important to facilitate information sharing between health systems and community-based organizations. Privacy must be protected as required by existing federal laws, while enabling systems to facilitate communication between organizations. Prevention services initiatives through the State Innovation Model found technological solutions crucial to streamlining collaborations. Further, efforts to capture referral to community-based services through CCIP showed success in incorporating software that facilitates community collaboration into electronic health records systems. Connecticut’s health information technology efforts and Health Enhancement Communities, now in a planning phase, could incorporate lessons learned from these initiatives.

IV. **Creating a More Inclusive workforce**

The health care workforce does not represent the demographics of the US population and in some sectors is inadequate to meet the need for services. At the same time, about 20 percent of people of color report avoiding medical care for fear of facing discrimination. Further, people of color who join the primary care workforce are more likely to work in underserved communities.

In Connecticut, the State Innovation Model planning process highlighted projected increases in demand for primary care and a workforce shortage that could be alleviated through optimal utilization of mid-level practitioners. This analysis also noted that the health services workforce in Connecticut is disproportionately over age 55, suggesting an upcoming wave of retirements, particularly among doctors and nurses. The challenge of a shortage of primary care and prevention practitioners presents opportunities to diversify the health systems workforce to better represent Connecticut’s population.

Recommendations for growing a more inclusive health care workforce:

1. **Expand K-12 programs that ensure academic readiness and entryways into health care professions for people from underrepresented groups.** Connecticut is home to many learning opportunities, from medical schools to community colleges, providing training for a broad spectrum of health care employment opportunities. Ensuring that children and youth from underrepresented communities are aware of, prepared for, and have the resources to enter and complete these programs could both alleviate projected workforce shortages and diversify the health care workforce in Connecticut.

2. **Increase financial incentives (such as loan forgiveness) for health care providers from underrepresented groups.** Education-related debt can deter individuals from seeking careers requiring licensure or certification. Given the enormous wealth gap faced by people of color in the United States, such incentives are important to increase access to health systems careers for people of color.
3. **Require state licensing boards, health care systems, and health care organizations to collect and report demographic data on licensees, staff, and board members.** Connecticut’s Department of Public Health collects demographic data on many applications for licensure and certification, but does not publicly report this data. Data on the representativeness of health systems leadership and employees is not publicly available.

4. **Provide financial incentives (including through payment reforms) for organizations to hire and retain organizational leaders, board members, and providers from the communities they serve and from underrepresented groups.** Workforce diversity is key to increasing access to culturally competent care and increasing the likelihood that the needs of underrepresented groups are better represented in decision-making.

5. **Remove regulatory and reimbursement-related barriers for employing community health workers (including doulas, home visitors, and peer support team members).** In 2019, Connecticut’s General Assembly codified a certification process for community health workers. Ensuring that certification covers a broad definition of community health workers—including doulas, peer support staff, and individuals with lived experience in the communities they serve—will help to expand the reach of health and social services systems. Connecticut’s Medicaid program and some health care providers already utilize peer support and community health workers for select behavioral health interventions and intensive care management. The use of community health workers should be scaled to additional populations, providers, and payers. Establishing funding streams and reimbursement mechanisms for employing community health workers will ensure sustainability.

6. **Require or incentivize Medicaid ASOs (or the providers with whom they contract) to make community health workers and community-based care available and establish guidelines for the time such workers spend in the community, minimum range of services they provide, and ratio of community health workers to enrollees.** Community-based services are inherently positioned to address cultural and health literacy barriers to care. As noted above, the state is home to several community health worker initiatives and these recommendations are intended to scale this work and strengthen its impact on health equity. Community health workers should be based in the communities they serve, ideally employed by community-based organizations, and have both clear scopes of work (to prevent burnout and maximize expertise) and the flexibility to meet people where they are and connect them to the support they need.

Adjust state policies regarding the scope of practice, licensing, and regulations and adjust reimbursement rates to allow more mid-level providers to practice to the full extent of their ability across payers. Shortages of health professionals disproportionately impact people of color and people living in lower-income neighborhoods. Multiple possibilities exist for engaging mid-level professionals to address unmet need for health services while diversifying the workforce. For example, Connecticut could join other states in leveraging dental therapists to increase diversity in dentistry and improve access to dental services.
Conclusion

In addition to the health systems reform proposals evaluated here, a number of organizations have published frameworks for reducing poverty and promoting health equity in the past two years, and we would be remiss to omit their recommendations for broader, cross-systems reforms.\textsuperscript{118} Among the proposals that Connecticut could adopt at the state level but has not yet implemented, are the following: increasing the earned income tax credit (EITC),\textsuperscript{119} implementing a state-level child tax credit, increasing access to the child care and development fund, increasing payments through the Supplemental Nutrition Assistance Plan (SNAP), expanding social supports to more non-citizens, and establishing universal pre-kindergarten.

Connecticut has the infrastructure and resources to reform our health systems so that they address the root causes of racial disparities in health outcomes. The solutions proposed here are grounded in evidence and rooted in the practical circumstances of the state’s existing systems. Nearly all of these recommendations build on existing state-level interventions and research and could be carried out through cross-sector collaboration with existing entities and programs. Deliberately targeting health disparities is necessary to the future wellbeing of the state and implementing these recommendations has the potential to ensure that Connecticut’s reputation as a healthy state applies to all of its residents.
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10. Note: The Health Equity Task Force's “Framework” defines equity broadly. This paper centers racial and ethnic equity with attention to intersectionality due to the significant impact of racism on health outcomes in our state and in the United States more generally.

11. See “Framework’s” “Overarching Imperative.” Inclusiveness should be integral to all health equity policies.


13. Anecdotal accounts suggest that these councils are relatively racially/ethnically diverse.


15. In addition to dissatisfaction expressed at Healthcare Innovation Steering Committee meetings, additional information was shared when we sought feedback on this paper from stakeholders prior to publication.


17. Safety net providers include community health centers, hospitals located in low-income areas, and other health systems that serve a population with a substantial share of low-income or underrepresented people.


21. While legal provisions limit the percentage of revenue that insurers can keep, the incentive to increase overall spending (and, therefore, the total amount earned by retaining the allowable percentage) remains. Quality measures and regulations constrain the income incentives for all payment systems.


28. HUSKY Health contracts with four Administrative Services Organizations (ASOs), which coordinate and administer the medical, behavioral, and oral health and transportation services.

29. Connecticut’s Medicaid programs have a self-insured, managed fee-for service structure. The PCMH+ shared savings are “upside only” and result in distribution of projected savings between the state and the participating entities. Any losses would be absorbed by the state.

30. The participating entities with “credible savings” had spending that was less than expected based on prior year claims after adjusting for medical risk. CT Department of Social Services. (2019) “MAPOC Care Management Committee Shared Savings Results Webinar December 2019.” Retrieved from: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/CMCPCMHplusWave2Yr1QMSSWebinar1242019.pdf?la=en

31. Ibid

32. For the Health Equity Task Force’s related recommendation, see recommendation 1.1D in the “Framework.”


34. See “Framework” recommendations 1.1A and 1.1B

35. PCMH+ Wave 3 workgroup meeting in December 2018; see also Council on Medical Assistance Plan Oversight meeting on December 13, 2019. Recording available at: http://www.ctn.state.ct.us/ctnplayer.asp?odID=16964


40. See “Framework” recommendation 1.3

42. Data provided by the Department of Social Services to the Behavioral Health Plan Implementation Advisory Board workgroup on screening and fiscal mapping.


44. See “Framework” recommendation 1.2A


47. See “Framework” recommendation 1.2E


49. For examples of the intersection between housing and health for children see: https://www.rwjf.org/en/library/collections/housing-and-health.html and for Connecticut-specific information see the Open Communities Alliance: https://www.ctoca.org/

50. See “Framework” recommendation 1.3D


52. For a summary of the Prevention Services Initiative see the Healthcare Innovation Steering Committee meeting presentation from November 2019: https://portal.ct.gov/-/media/OHS/SIM/HISC/2019/11-14-19/Presentation_HISC_20191114-Final.pdf


57. See “Framework” recommendation 5.1A


62. For example, the “meaningful use” proposals for electronic health records include reducing disparities as a priority; see: https://www.cdc.gov/ehrmeaningfuluse/introduction.html

63. See “Framework” recommendation 5.2B and 5.2C


66. See “Framework” recommendation 5.2D


69. Medical homes are now informed of renewal dates as a strategy for reducing gaps in coverage for PCMH+ participants.


73. See “Framework” recommendation 5.3A and 5.3D


76. See “Framework” recommendation 5.3E and 5.3F


89. See “Framework” recommendation 3.1C

90. See: United Way 211: https://www.211ct.org/ for a directory of services


92. See “Framework” recommendation 3.1F


95. See “Framework” recommendation 3.2A and 3.2B


97. See “Framework” recommendation 3.2C

98. See “Framework” recommendation 3.3A and 3.3B


105. See “Framework” recommendation 6.1A

106. See “Framework” recommendation 6.1B


109. See “Framework” recommendation 6.1D, 6.1E, and 6.1G

110. See “Framework” recommendation 6.1F


112. See “Framework” recommendation 6.2A and 6.2B

113. See “Framework” recommendation 6.2C


115. See “Framework” recommendation 6.3A, 6.3B, 6.3C, and 6.3D


