



**Comments of the Connecticut Multicultural Health Partnership
on the Connecticut Healthcare Innovation Plan Draft 1.1**

November 29, 2013

The Connecticut Multicultural Health Partnership (CMHP) is an independent membership organization whose mission is to identify and address health disparities and multicultural health issues. A major focus of the CMHP is the implementation of the National Standards on Culturally and Linguistically Appropriate Services (“CLAS”) in Connecticut. The CMHP has approximately 400 members from throughout Connecticut - who represent a wide variety of health and health-related professions, as well as consumer organizations - interested in improved health outcomes for all people in Connecticut, especially racial and ethnic minorities. Our leadership, through our Executive Committee, is multiracial, multiethnic and multicultural.

We applaud the efforts to address health disparities and to achieve health equity in our state through the Connecticut Healthcare Innovation Plan Draft 1.1 (“the Plan”). The Plan is remarkable in its breadth, particularly in light of the relatively short timeframe in which it was developed. Nevertheless, these comments are made because we believe a better understanding of the needs of those people who currently experience health disparities, as well as the means necessary to address those needs, should be reflected in the Plan. **We believe that demonstrating a fuller understanding of the issues facing Connecticut residents who have experienced health disparities, as well as clearly committing to the means to address those disparities, will better establish innovation on the part of Connecticut in its proposal.** We have grouped our comments under various topics raised and addressed within the Plan itself:

CLAS Standards: While the CMHP is pleased with the desire to have providers adopt and implement the CLAS Standards¹, **the Plan evinces an apparent misunderstanding of the Enhanced CLAS Standards issued in April, 2013 by the federal Office of Minority Health.** The 2013 CLAS Standards have eliminated categorizing each of the 15 Standards as either a recommendation, mandate or guideline, which was the case with the prior 2000 Standards.

¹ See, the Plan, page 42.

Instead, the 2013 CLAS Standards promote adoption and implementation of *all* of the Standards as the most effective way to achieve health equity. “The Standards are intended to be used together, as mutually reinforcing actions, and each of the 15 Standards should be understood as an equally important guideline to advance health equity, improve quality, and help eliminate health care disparities.”²

While the CMHP fully recognizes the need for and wholly supports the Plan’s adoption of requiring healthcare providers to deliver culturally and linguistically appropriate services³, the Plan’s design in this regard simply is not enough to sincerely and truly address health disparities. **If one of the Plan’s innovations designed to persuade CMS to provide additional funding is the Plan’s approach to the CLAS Standards, it will not likely be persuasive as currently drafted.**

Additionally, the Plan’s methods for evaluating elements of the AHM model include conducting consumer experience surveys and self-reported data on provider activities and structures, through systematic surveys.⁴ This data relates to the adoption and implementation of the 2013 CLAS Standards. Although not referenced in the Plan, the CMHP has been awarded a 2 year grant from the federal Office of Minority Health that will implement a plan to address the adoption of National CLAS standards to targeted healthcare organizations. During the two year grant period, the CMHP will create a systems-change approach by increasing the adoption and implementation of the National CLAS Standards throughout Connecticut and by enhancing multicultural health partnerships that aim to address health issues within communities that experience disparities in Connecticut.

Specifically, CMHP will (a) increase organizations that will adopt the National CLAS standards by ten percent (10%) from the baseline survey respondents; (b) design and implement a baseline survey to identify existing organizations that have adopted the National CLAS standards; (c) develop/utilize curricula and resource materials on National CLAS standards; and (d) conduct statewide trainings that will increase awareness and strategies on successfully adopting the National CLAS standards. This will all be done in accordance with the Healthy People 2020 goals.⁵ As a result of this work, the following outcomes are expected:

² See, “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice”, Office of Minority Health, U.S. Department of Health and Human Services, April 2013, p. 15. (referred to hereinafter as “the CLAS Blueprint”) Available at: <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf> , p. 30.

³ See, the Plan, p. 42, as well as footnote 38 of the Plan. Of course, language appropriateness as identified in footnote 38 of the Plan is a *requirement* of federal law and thus in many instances must be provided, it is only a portion of the norms set forth in the CLAS Standards. But this alone is not enough to address health disparities, nor is it adequate solely in combination with providing culturally appropriate services.

⁴ See, the Plan, pp. 116-117.

⁵ See, U.S. Department of Health and Human Services, “Healthy People 2020”, available at <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>

- 40% or more of all participants will increase their knowledge and awareness of racial and ethnic health disparities
- 40% or more of all participants will increase their knowledge and awareness of the CLAS standards
- 40% or more of all participants will perceive increased skills in working with language interpreters

In order to demonstrate further alignment with Healthy People 2020 and the National Prevention Strategy⁶, the CMHP recommends inclusion of collaboration with the CMHP on CLAS Standards adoption goals, data metrics and implementation strategies in order to strengthen the Plan.

The CMHP also agrees with the intent to require healthcare providers to incorporate clinical recommendations for disparity populations. However, we are concerned with the modifier “as available”.⁷ **In order to make the Plan truly innovative, clinical recommendations for disparity populations should be developed in a comprehensive fashion so that all healthcare providers can use the recommendation for populations who, up until now, have been neglected by the healthcare system.**

Attribution of Consumers to Providers: The proper choice of a primary care physician is important to assure that members are receptive to the receipt of healthcare. It is unlikely that a person who is not fond of a primary care physician to whom s/he is assigned will receive the necessary preventive care services that are designed to lower costs. Yet the Plan proposes to assign members to the provider who has given them most of their primary care during a defined reporting period. If a member selects another primary care physician, that selection can be overridden by a payer. This is not a reasonable option. With the increase of the Medicaid population, under the Affordable Care Act Medicaid expansion, large numbers of persons who were previously denied access to the healthcare system will enter the system. These people will mostly be persons from racial and ethnic minority groups. As the plan itself notes: “[A] significant number of minorities remain self-insured or uninsured.” They are likely to be unfamiliar with even the basics of accessing healthcare and negotiating their way through the healthcare system, a task that can be daunting to even the most experienced and most educated residents of Connecticut. In fact, it is possible they will not ever before have used a primary care physician. This renders the proposed method for assigning consumers to a primary care physician virtually meaningless. But even if this were not true, **consumers must be given the**

⁶ See, National Prevention Council, Office of the Surgeon General, “National Prevention Strategy: America’s Plan for Better Health and Wellness, June 2011, available at <http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf>

⁷ See, the Plan, p. 44

choice of who will be their primary care physician. No other method will assure the proper development of a patient/doctor relationship, continued utilization of preventive care on the part of the member, and appropriate coordination of care by the physician. Elsewhere⁸, the Plan desires to have each person be an active participant in management of his/her own health by creating “a true working partnership...between the individual and their provider”.⁹ However, the proposed method of attribution of consumers to providers works at cross purposes to this goal.

The CMHP approves of the Plan’s strategy to “educate consumers on why they should choose a PCP, how to select a PCP, how care may differ if they select an AMH, and how to make the best use of this new approach to primary care”.¹⁰ **These educational efforts must also include how to negotiate the health care system (for example, when to contact a primary care physician, what to do with a referral for diagnostic tests or specialty care, the importance of following up with prescribed medications, etc.).**

The plan’s consideration of populations who have unique healthcare needs is excellent. One example cited in the plan is “people with complex health conditions”.¹¹ Many of these people will be racial and ethnic minorities, who experience higher rates of chronic medical conditions, including multiple chronic conditions, than other populations.¹² For many, these chronic conditions have never been treated, except when they have become acute, because of lack of access to the health care system. Thus, if health disparities are to be properly addressed, this is a critical aspect of the plan.

Community Health Improvement

The CMHP is enthusiastic about the establishment of Health Enhancement Communities (HEC) on a pilot basis.¹³ We hope that once the pilots have been conducted and evaluated, that they will be expanded to account for as many of those who experience health disparities as possible throughout the state. One concern, however, is the emphasis on adverse risk selection and the need to create financial incentives solely for healthcare providers. **No mention is made of the financial needs of the community based organizations that will be called upon to fully participate in the HECs.** It is critically important that this be addressed. Already hard pressed community organizations - most of which are not-for-profit – can ill afford to be asked to do

⁸ See, the Plan, p. 59.

⁹ Id., p, 59 and 60.

¹⁰ See, the Plan, p. 45.

¹¹ See, the Plan, p. 49.

^{12,12} See, e.g., Easing the Burden: Using Health Care Reform to Address Racial and Ethnic Disparities in Health Care for the Chronically Ill, Center for American Progress, available at

<http://www.americanprogress.org/issues/healthcare/report/2010/12/16/8793/easing-the-burden/>

¹³ See, the Plan, p. 51.

more with less. Similarly, the Certified Community-Based Practice Support Entity proposal, makes no clear reference to how the community organizations pulled into the network of the entity would be reimbursed for their services, except to “explore the potential use of existing programmatic state funds and grants as a starting point”.¹⁴ Moreover, the Value-Based Payment Strategy set forth in the Plan does not address this issue either.¹⁵ Again, **it important that this not mean asking community organizations to perform important preventive healthcare support functions, without sufficient funding to do so. To fail to do so will be a prescription for lack of success.**

Consumer Incentives to Encourage Healthy Lifestyles and Effective Self-management

Many racial and ethnic minorities reside in neighborhoods without access to fresh fruits and vegetables and other healthy foods. This is a result of an absence of food stores selling such products and poor transportation within the state to permit convenient travel to stores that do sell them. These so-called “food deserts” also tend to have large numbers of fast food restaurants, which offer inexpensive, less-than-healthy food. The result, in terms of an individual’s health, is predictable: poorer health and health outcomes for residents of those neighborhoods. As it is described in the Plan, the NuVal program¹⁶ will have no impact on residents of these neighborhoods. And while, attempting to harness the SNAP program may be able to reach some in these neighborhoods (hopefully in spite of recent federal cuts to the SNAP program), there still must be access to healthy food. The people in these neighborhoods need to have food brought to them and/ or they need better transportation to get to where healthy food is sold. Therefore, **the state should include and involve the Connecticut Department of Transportation, the Connecticut Department of Economic and Community Development, and the Connecticut Department of Agriculture in addressing and resolving these issues. Similarly, as to the question of access to healthcare providers¹⁷, the Connecticut Department of Transportation should be involved in this effort. This methodology aligns with the HHS National Prevention Strategy by engaging partners across disciplines, sectors, and institutions in an effort to change the way communities conceptualize and solve problems, enhance implementation of innovative strategies, and improve individual and community well-being.**

While financial incentives may prove useful among some groups in Connecticut, for many populations who experience health disparities, financial resources are scarce. Healthy foods cost more than unhealthy foods, which in large part explains the proliferation of fast food restaurants in communities whose residents experience health disparities. Other incentives must be created,

¹⁴ See, the Plan, p. 55.

¹⁵ See, the Plan, pp.70-73.

¹⁶ See, the Plan, p. 65-66.

¹⁷ See, the Plan, p. 66-67.

if this Plan is to be truly innovative. Other locales in the country, such as Philadelphia and New York, have begun to figure out successful ways to encourage healthy eating among low income communities.¹⁸ **The CMHP recommends that the Plan include a proposal to hold listening sessions to hear what people in communities in Connecticut that experience health disparities, especially racial and ethnic minority communities, to learn what are the true barriers to healthy eating, receipt of preventive care and meeting wellness goals. Only then will the Plan be capable of offering incentives that will work to end health disparities in our state.**

Lastly, the CMHP heartily endorses the establishment of an Equity and Access Council.¹⁹ As the healthcare system changes, it is important that no one get “lost in the shuffle”. **Historically, racial and ethnic minorities frequently have been thought about last and least. The proposal for a Health and Access Council, if properly implemented and given “teeth”, will help to assure that history does not repeat itself.**

Health Information Technology

The Plan sets forth the use of technology for consumer empowerment. “Payers will provide consumers with access to portal that offer customized guidance and shared decision aids...] Providers will employ secure e-communications and use e-consults to increase consumers’ access to specialty care.”²⁰ Elsewhere, the Plan envisions developing curricula designed to educate consumers about their role in a new healthcare delivery model.²¹ Among the racial and ethnic populations in Connecticut are numbers of people with no easy access to the internet²² and low levels of literacy, including health literacy.²³ Therefore, **while the CMHP agrees that health information technology is an important innovation for improving health outcomes, special care should be taken to assure that those without access to such technology or with low levels of literacy are offered other means to participate in this new delivery system.**

¹⁸ See, for example, the work in Philadelphia and elsewhere of The Food Trust, <http://thefoodtrust.org/>

¹⁹ See, the Plan, p/ 67.

²⁰ See, the Plan, p. 76 and 79..

²¹ See, the Plan, p. 62.

²² “The Bridgeport MSA ranks No. 1 when it comes to the unequal distribution of wealth, according to a Stanford University study that looked at income segregation in American cities. That gap is reflected in the broadband map. The urban core of the city suffers from biting poverty and low rates of broadband subscribership, while the outer suburbs show sky-high incomes and correspondingly high rates of broadband subscribership. Wealthier households subscribe at a rate of 80 percent to 100 percent, while low-income areas of the city, some exceeding a 50 percent poverty rate, subscribe at a rate of 40 percent to 60 percent. “ Center for Public Integrity, “Poverty Stretches the Digital Divide”, March 2013, available at <http://www.publicintegrity.org/2012/03/23/8486/poverty-stretches-digital-divide>

²³ “[M]ore than half of the adults in many of Connecticut’s cities function at the two lowest levels of literacy. In the city of Hartford, 73% of adults are functionally illiterate; in New Haven, 57%; in New London, 50%; and in Bridgeport, 68%; in Waterbury, 56%. Hands on Hartford, “Literacy and Learning”, available at http://www.handsonhartford.org/Issues_Literacy_and_Learning

Conclusion

The CMHP appreciates the opportunity to comment on Draft 1.1 of the Connecticut Healthcare Innovation Plan. We hope that our recommendations will be heeded. The Plan proposes major changes to the healthcare system in Connecticut that have the potential to have broad application to residents of our state. Therefore it must be done carefully, comprehensively and well. This is particularly so for those who historically have been excluded from enjoying the full benefits of the healthcare system. The CMHP looks forward to assisting in any way possible to improve the Plan and health and health outcomes for all those in Connecticut who experience health disparities.