

July 1, 2010

To: SustiNet Board of Directors

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Re: SustiNet Health Disparities and Equity Advisory Committee

Pursuant to PA 09-148, An Act Concerning the Establishment of the SustiNet Plan, we are proud to submit the report of the SustiNet Health Disparities and Equity Advisory Committee. By this transmittal, we are fulfilling the requirement under Section 4(c) of that Act.

We want to thank all the members of the Advisory Committee for their hard work in developing this report, the many generous experts who shared their wisdom with us, and to thank you for this opportunity. We also want to thank the able assistance of Katharine London, Andrew Cohen, Anya Rader Wallack, Vicki Veltri, Michael Mitchell, Marilyn Rice, and Africka Hinds-Ayala without whose assistance this report would not have been possible.

We are available to answer questions or to re-convene the Advisory Committee as needed to ensure that SustiNet is addressing disparities and equity issues in Connecticut's health care system.

Cc: House, Senate Clerks  
CT Legislative Library  
CT State Library

# HEALTH DISPARITIES AND EQUITY ADVISORY COMMITTEE FINAL REPORT TO THE SUSTINET BOARD

## 1. EXECUTIVE SUMMARY:

Research has demonstrated that vulnerable populations and groups that face social or economic disadvantages tend to experience lower quality care, reduced access, and poorer health outcomes than the general population. These problems are particularly acute among racial, ethnic, and linguistic minority groups. Health disparities can lead to higher health care costs and expensive acute care needs as people delay seeking care for preventable and treatable conditions that spiral into chronic ailments or lead to medical emergencies. Disparities persist within Connecticut's health care system, in part because disadvantaged populations face a dearth of culturally competent and coordinated medical services, as well as barriers to accessing insurance coverage.

The Health Disparities and Equity Advisory Committee asserts that an integrated and multi-disciplinary approach across all of SustiNet's proposed activities will be necessary to effectively address equity gaps and disparities within Connecticut's health care system. The Committee proposes that the SustiNet Board produce an annual action plan to reduce disparities. The plan should include strategies to change the health care system, measureable goals, and key objectives. The committee also offers specific recommendations regarding governance and membership of the SustiNet Board, creation of a Committee on Health Disparities and Equity, the collection and analysis of data on these topics and creation of measureable objectives, incentives and penalties for health care providers, strategies for communicating with people who have disabilities, and considerations about long-term care.

The Committee believes that reducing disparities under the SustiNet Plan will not only improve the quality of care for diverse populations, but may reduce costs, leading to a long lasting competitive advantage over other health insurance strategies.

## 2. PURPOSE AND MISSION

### a. SustiNet Law, direction to the Committee:

**Public Act No. 09-148: AN ACT CONCERNING THE ESTABLISHMENT OF THE SUSTINET PLAN, reads:**

Sec. 4. (c) "The board of directors shall recommend that the public authority adopt periodic action plans to achieve measurable objectives in areas that include, but are not limited to, effective management of chronic illness, preventive care, **reducing racial and ethnic disparities as related to health care and health outcomes**, and reducing the number of state residents without insurance. The board of directors shall include in its recommendations that the public authority monitor the accomplishment of such objectives and modify action plans as necessary."

### b. Members of the Health Disparities and Equity Committee:

<b><u>Dr. Rafael Perez-Escamilla</u></b> - <i>Co-Chair</i> Director, Yale School of Public Health Office of Community Health	<b><u>Dr. Marie M. Spivey</u></b> - <i>Co-Chair</i> Allied Health & Nursing Initiatives, Capital Workforce Partners
<b><u>Rev. Bonita Grubbs</u></b> - <i>Board of Directors Liaison</i> Executive Director Christian Community Action	<b><u>Estela Lopez</u></b> - <i>Board of Directors Liaison</i> Senior Program Advisor Excelencia in Education
<b><u>Yolanda Caldera-Durant</u></b> Program Director, Economic Opportunity/Health and Human Services Fairfield County Comm. Foundation	<b><u>Sharon Mierzwa</u></b> Health Equity Alliance Project Director CT Association of Directors of Health
<b><u>Leo Canty</u></b> Second Vice President AFT Connecticut	<b><u>Dr. J. Nwando Olayiwola</u></b> Chief Medical Officer, Family Physician Community Health Center, Inc.
<b><u>Grace Damio</u></b> Center Director Hispanic Health Council	<b><u>Stephanie Paulmeno, R.N.</u></b> Executive Principal & CEO Global Health Systems Consultants, LLC
<b><u>Elizabeth Krause</u></b>	<b><u>Brad Plebani, Esq.</u></b>

Senior Program Officer Connecticut Health Foundation	Attorney and Deputy Director Center for Medicare Advocacy, Inc.
<b><u>Dr. Yvette Martas</u></b> Physician Mansfield OB/GYN Associates, PC	<b><u>Arvind Shaw</u></b> Executive Director Generations Family Health Center

### **c. Methodology**

Members of this Health Disparities and Equity Advisory Committee were confirmed by the Sustinet Board of Directors. The committee's co-chairs officiated at each meeting. Board-appointed Liaisons participated in all meetings. Meetings were scheduled and held biweekly at 7:30 a.m. to complete work in a timely manner.

The Committee arranged call-in capability for members who were unable to physically attend particular meetings. Each meeting agenda included opportunities to discuss the overarching goal of eliminating health disparities and inequities. Committee members researched empirical sources of scientific evidence on barriers to access, cultural and linguistic approaches to quality care, and increasing equity of coverage and payment for health services to the uninsured. The Health Disparities and Equity Committee drafted and distributed questions to prompt each of the other committees and taskforces to set measurable objectives, track improvements, and evaluate outcomes for disparities-related measures.

All decisions were reached by consensus. Members had access to meeting minutes from the Board and all other task forces and committees.

## **3. SCOPE OF THE ISSUE**

### **a. Statement of problem:**

There is documented evidence that certain sub-populations in Connecticut have worse health outcomes than the population at large. These groups experience reduced access to culturally competent and coordinated services, often resulting in lower quality care and delayed medical treatment. Racial, ethnic, and linguistic minorities are particularly vulnerable, as are other groups that experience social and/or economic

disadvantages, such as immigrants, people with disabilities, and homeless populations.

**b. Goal:**

Develop an action plan to reduce health disparities and increase equity through the Sustinet Health Plan with the goal of improving access to care and health outcomes for ethnic, racial, and linguistic minorities, as well as other disadvantaged populations in Connecticut.

**c. Approach:**

Design the Sustinet Health Plan to systematically reduce disparities and increase equity in access, quality, processes, and health outcomes for racial, ethnic, and linguistic minorities, as well as people with disabilities and other disadvantaged groups. Promoting culturally competent and integrated care models through Sustinet will not only improve the quality of care for diverse populations, but may reduce costs, leading to a long lasting competitive advantage over other health insurance strategies.

**d. Principles:**

- (1)** The public authority shall integrate strategies for reducing and eliminating racial and ethnic disparities into every component of the Sustinet plan, including but not limited to:
  - i.** Outreach
  - ii.** Application Forms & Enrollment
  - iii.** Covered benefits, including preventive care services and interpreter services
  - iv.** Provider<sup>1</sup> networks & capacity
  - v.** Provider cultural competence standards based on national standards (established by the Joint Commission)
  - vi.** Provider payment methods and rates, and other financial incentives
  - vii.** Provider continuing education requirements
  - viii.** Enrollee communications, including education for enrollees on how to navigate the health care system
  - ix.** Enrollee appeals process
  - x.** Quality measurement and improvement

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<sup>1</sup> This document uses the term “provider” to refer to any individual or organization licensed to provide health care services.

- (2) The public authority shall describe these strategies, as well as measurable goals and objectives, in an action plan for reducing and eliminating racial and ethnic health disparities. The plan shall be updated at least annually.

## **e. Definitions**

### **1) Health disparities:**

Health disparities refer to the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care, that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, and geographic area of residence. Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantages." (Stratton, Hynes and Nepaul, "Issue Brief: Defining Health Disparities." Hartford, CT: Connecticut Department of Public Health, 2007).

### **2) Health care equity:**

"A common definition of equity in the public health literature is that the primary determinant in the use of services should be the need for them. Other factors such as income, race, location of residence and so forth should not play an important role in selecting who receives care and who does not." (Berman P., Sisler D. G. and Habicht J.-P. "Equity in public sector primary health care: the role of service organisation in Indonesia." *Econ. Der. Cultural Change*, 31, 771, 1989.)

Or

'A health disparity (inequality) is a particular type of [unfavorable] difference in health or in the most important influences on health that ...disadvantaged social groups systematically experience...' (Braveman, P. "Health disparities and health equity: Concepts and measurement." *Annual Review of Public Health*, 27, 167–194, 2006).

Equity in Health: “The absence of potentially remediable, systematic differences on one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups.”

(<http://www.equityhealthj.com/content/1/1/1>, from the International Society for Equity in Health).

### **3) Cultural competency:**

“Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards A Culturally Competent System of Care Volume I. Washington, DC: Georgetown <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>)

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### **4) Health care access:**

“Degree to which people are able to obtain appropriate care from the health care system in a timely manner” (IOM 2006, from: Perez- Escamilla, Rafael. “Health Care Access among Latinos: Implications for Social and Health Care Reforms.” Journal of Hispanic Higher Education, Vol. 9, No. 1, 43-60 (2010).

### **5) Vulnerable populations:**

Groups of people "made vulnerable by their financial circumstances or place of residence; health, age, or functional or developmental status; or ability to communicate effectively...[and] personal characteristics, such as race, ethnicity, and sex," including “populations whose vulnerability is due to chronic or terminal disease or disability” [Final Report of the President's Advisory Commission on Consumer Protection and

Quality in the Health Care Industry, cited by the Agency for Healthcare Research and Quality (AHRQ), <http://www.ahrq.gov/news/press/vulnpr.htm>].

#### **6) Socially disadvantaged population:**

“Socially disadvantaged groups [are] those that have low [socio-economic status] or belong to an ethnoracial minority ... [In health care] social disadvantage [is] related to patient, provider, and health system factors that can affect self-management and provider management and ultimately manifest as clinical outcomes.” (Glazier RH, Bajcar J, Kennie NR, Willson K. “A systematic review of interventions to improve diabetes care in socially disadvantaged populations.” *Diabetes Care* 2006;29:1675-88.)

### **4. RECOMMENDATIONS**

Socially disadvantaged people are more likely to become ill and die prematurely. They are also more likely to delay seeking needed care until a health care problem becomes dire, which is often the most expensive moment to provide medical treatment. In Connecticut, there is great pent-up need for health services among many disadvantaged sub-populations due to lack of health insurance, limited access to care, discrimination, and the need for the medical profession to adjust its methods of providing health care to accommodate a multiplicity of cultural, ethnic and linguistic differences in population groups throughout the state.

Beyond expanding insurance coverage – which will occur after 2014 as the state implements federal health reform – the state’s greatest opportunity for increasing access to and quality of care is to reduce disparities and achieve greater equity across the state. The Committee notes, however, that treating everyone the same way will not create equity. In fact, treating everyone the same elides that certain populations, particularly the most vulnerable among us, have much greater health care needs than other people who are healthier or have more resources. Those with the greatest needs may require extra attention and support to improve their health access and outcomes.

The Committee believes that, in the long term, reducing disparities, increasing equity, and promoting better coordinated and culturally competent care for everyone will help to slow rising health care costs.

Addressing the health needs of chronically ill patients through integrated care models will be particularly important in this regard. However, the Committee also acknowledges that treatment of widespread, unaddressed health care needs among vulnerable and disadvantaged people will require significant up-front investment from the State and federal government. A financial and operational commitment to outreach among hard-to-reach populations will be crucial to bring as many people as possible into a more culturally competent health care system and realize the benefits of integrated and coordinated care delivery.

Given on-going state budget problems, the fiscal health of Connecticut may determine the success or failure of the Board's efforts. Ultimately, SustiNet's success will depend on substantial legislative involvement, as well as committed leadership from the Governor, state agencies, and advocates.

From prevention and health care quality, to workforce development and medical homes, health disparities remain an overarching problem within each substantive area. A multi-tiered approach will be necessary to address this problem holistically through SustiNet. The Committee's specific recommendations are as follows.

### **1) Governance of SustiNet**

- a) The public authority governing board shall include at least two enrollees in the SustiNet plan.
- b) The public authority governing board shall reflect the diversity of SustiNet plan enrollees in terms of race, ethnicity, gender and age (>18).
- c) The public authority governing board shall include at least two individuals who have expertise in reducing health disparities.
- d) The public authority governing board shall establish a Community Advisory Committee comprised of SustiNet enrollees to provide consumer input on policy decisions.
- e) The public authority governing board shall establish a Committee on Health Disparities and Equity that is dedicated to reducing and eliminating racial and ethnic disparities in health care access, utilization, quality of care, and health outcomes under SustiNet. Member(s) of the public authority's governing board who have expertise in reducing disparities shall chair the committee.

## **2) Responsibilities of the Committee on Health Disparities and Equity:**

- a) Assuring the integration of culturally competent, quality improvement objectives into the policies of the SustiNet Plan.
- b) Allocating funding dedicated to reducing disparities for uses including conducting studies and providing grants to provider organizations for improvement.
- c) Commissioning studies, as described in Data and Reporting (below).
- d) Identifying and approving measures of disparities for use by the SustiNet Plan in improvement efforts.
- e) Recommending specific measures to eliminate barriers to care for inclusion in a Pay for Performance incentive system.
- f) Reviewing the set of benefits covered by the SustiNet Plan and recommending changes that would assist in reducing disparities.
- g) The Committee shall undertake a study of the return on investment (ROI) of Connecticut's potential and actual spending on programs and initiatives that reduce disparities.

## **3) Budget**

The public authority shall seek and allocate funding dedicated to reducing and eliminating health disparities.

## **4) Data Collection and Use**

- a) All SustiNet plan data intake systems and data storage systems shall include member race, ethnicity & language (in addition to age, gender, and other demographic data) in order to be able to track disparities in health outcomes. Data systems shall enable coding of multiple races and ethnicities for a single individual.
- b) The SustiNet Plan shall provide one integrated system for all plan data in real time, to the extent feasible.
- c) The committee shall assess current data to document disparities and identifying gaps in data needed to fully assess disparities.
- d) The committee shall commission studies to document disparities by population group and by provider organization, as well as the cost-effectiveness of improvement efforts.
- e) The committee shall evaluate improvement efforts, establish a feedback loop based on rapid responses, and report its findings publicly.

## **5) Measurable objectives in reducing racial and ethnic disparities**

- a) The public authority/committee shall establish specific, written, measurable goals for reducing and eliminating racial and ethnic disparities in health access, utilization, quality of care and health outcomes.
- b) These measures shall use life cycle approach and shall include appropriate measures for all age groups and for both genders.
- c) Improvement measures shall include, but not be limited to, standard measures for best practices in management of chronic physical and mental health conditions (e.g. diabetes, asthma, cardiovascular disease, and depression), use of preventive care services, use of preventive dental care services, and reductions in avoidable hospitalizations, re-admissions and emergency visits.
- d) The Sustinet Plan should start with some initial measures based on current data and knowledge and expand the list of measures over time. The committee should establish short-term, medium-term, and long-term objectives and recommendations.
- e) The public authority shall report racial and ethnic disparities in health access, utilization, quality of care and health outcomes by geographic area and by provider or organization, where feasible. The Board/committee shall provide information data to each provider organization comparing its performance to benchmarks and to other providers.
- f) The public authority shall provide guidance to providers on specific actions that providers shall take to reduce disparities.
- g) Providers shall have an opportunity to review their own data and take corrective action before results are made public.

## **6) Incentives to providers for reducing disparities**

- a) The public authority shall budget for incentives to providers for identifying and reducing disparities in their diverse patient population groups.
- b) The committee shall provide grant funding to provider and community-based healthcare organizations to provide initial funding to establish programs to reduce disparities.
- c) The Sustinet Plan shall establish a Pay for Performance (P4P) system to reward providers for reductions in racial and ethnic disparities in health access, utilization, quality of care and health outcomes.

- d) The P4P system should reward providers for improvement as well as for meeting benchmarks.
- e) The P4P system should reward providers for having an effective plan in place for preventing illness, as well as improving health status.
- f) The P4P system should specifically reward providers for caring for patients with the most complex and least well-controlled conditions.
- g) The P4P system should expect providers to receive cross-cultural training within regular professional development sessions for providers and staff.
- h) The P4P system should reward home care and other long-term care providers for providing patients and families with education on healthcare coverage and on navigating the healthcare system.

## **7) Penalties for providers failing to take action to reduce disparities**

- a) The public authority/committee shall require participating providers to submit a corrective action plan, describing in detail the actions that the provider will take to reduce disparities.
- b) Providers that do not make progress toward reducing disparities, defined as achieving specified benchmarks within a specified timeframe, may be removed from the plan network.

## **8) Special considerations for people with disabilities.** The Sustinet plan shall make accommodations for people with disabilities, which shall include the following:

- a) Provide computer-assisted real time translation (CART) or viable real time transcriptions (VRT) where applicable.
- b) Develop print materials in easy to read, low literacy, picture and symbol formats.
- c) Provide materials in alternative formats (e.g., audiotape, Braille, enlarged print).
- d) Take varied approaches to share information with individuals who experience cognitive disabilities.
- e) Develop materials that have been tested for specific cultural, ethnic and linguistic groups.
- f) Conduct outreach through ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals).

- i. Provide translations of legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications), signage, health education materials, and public awareness materials and campaigns.

## **9) Long Term Care**

- a) Cultural differences can create difficulties for older adults and their caregivers in receiving needed services and care. Long term care providers must develop methods of recruiting, retaining and managing a workforce that mirrors the diverse population of older adults and those with disabilities requiring health care services both in long term care facilities and in home care.
- b) If the Board decided that the Sustinet Plan would include individuals who are dually eligible for Medicare and Medicaid (low income individuals with disabilities and elders over age 65), then
- c) Our committee would recommend strategies for reducing and eliminating disparities in long-term care, including providing education and training on cultural competence standards to caregivers.

## **10) Intersecting Issues (topics that overlap with other committees)**

- a) Health Information Technology
  - i. All Sustinet plan forms, data intake systems and data storage systems shall include member race, ethnicity & language preference (in addition to age, gender, and other demographic data), which can then be used as a measurement tool to monitor racial/ethnic health disparities. Data systems shall enable coding of multiple races and ethnicities for a single individual.
  - ii. The Sustinet Plan shall provide one integrated system for all plan data in real time, to the extent feasible.
- b) Care Delivery and Medical Home
  - i. The Sustinet plan should include cultural competence standards for Medical Homes.
  - ii. Establish and continuously improve culturally competent coordination of healthcare services across the continuum of care.

- iii. Develop chronic disease self-management programs that are similar to those created by the Stanford Patient Education Research Center:

<http://patienteducation.stanford.edu/programs/>.

c) Health Care Quality

- i. The SustiNet Plan shall establish a Pay for Performance (P4P) system to reward providers for reductions in racial and ethnic disparities in health access, utilization, quality of care and health outcomes. The P4P system should reward providers for improvement as well as for meeting benchmarks. The P4P system should reward providers for having an effective plan in place for preventing illness, as well as improving health status.
- ii. The SustiNet payment system, whether capitation or fee for service, should reward providers for treating the most complex patients.
- iii. The SustiNet payment system should include strategies for paying for interpreter services.
- iv. The SustiNet plan should include the standards for measuring systemic cultural competence used by the Joint Commission

d) Health Care Workforce

*"Increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits." [Institute of Medicine, Feb. 5, 2004].*

- i. The SustiNet Plan shall require providers to receive ongoing cultural and linguistic competence training using effective training modules.
- ii. Culturally competent health care providers offer health care organizations a valuable opportunity to devote limited health care resources to the best possible use. Culturally competent means of care delivery will produce a twofold benefit: outcomes will improve, and this improvement may encourage some members to seek more preventive care and thus reduce their reliance on costly emergency care. (The Permanente Journal, Winter,

2000, Vol. 4, No. 1)

e) Preventive Care

- i. Define measurable objectives to determine progress in the elimination of health disparities/inequities relative to prevention.
- ii. Track improvements to ensure that Sustinet is making a difference in the elimination of health disparities/inequities relative to prevention.

f) Obesity

- i. Define measurable objectives to determine progress in the elimination of health disparities/inequities relative to the issue of obesity.
- ii. Track improvements to ensure that Sustinet is making a difference in the elimination of health disparities/inequities relative to the issue of obesity.

g) Tobacco Use

- i. Define measurable objectives to determine progress in the elimination of health disparities/inequities relative to the issue of tobacco and smoking cessation.
- ii. Track improvements to ensure that Sustinet is making a difference to eliminate health disparities/inequities relative to the issue of tobacco and smoking cessation.

## **5. UNKNOWN/UNRESOLVED ISSUES SUCH AS:**

**1) Federal funding opportunities:** The federal Patient Protection and Affordable Care Act (PPACA) includes several funding opportunities that address disparities and equity issues, including the following. The Sustinet Board should consider which funding opportunities would be most beneficial for Connecticut.

- a) Incentives to prevent chronic diseases in Medicaid populations (Sec. 4108): Provide grants to states to implement incentive programs to help individuals quit smoking, control/reduce weight, lower cholesterol and blood pressure, avoid diabetes, and address co-morbidities. Test approaches that may be scalable. Funding: \$100m for five year period beginning on Jan 1, 2011.

- b) Community Transformation Grants (Sec. 4201): Grants for implementation, evaluation, and dissemination of evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Funding: appropriations for FYs 2010-2014.
- c) Wellness Demonstration (Sec. 4206): Establishes pilot programs in 10 states by July 2014 to implement, evaluate, and disseminate evidence-based community preventive health activities to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. Expands demonstrations in 2017 if effective.
- d) Data collection about disparities (sec. 4302): Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment).
- e) Alternative dental health care providers demonstration project (Sec. 5304): Establishes programs that train or employ alternative dental health care providers to increase access to dental health care services in rural and other underserved communities. 15 projects begin no later than 2 years after enactment. Funding: Each grant will be at least \$4m over five years.
- f) Grants for cultural competency, prevention, public health and working with individuals with disabilities (Sec. 5307): Grants for development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. Funding: necessary appropriations authorized for FYs 2010-2015.

- g) Grants to promote the community health workforce (Sec. 5313): Promote positive health behaviors and outcomes for medically underserved communities and chronically ill populations through the use of community health workers. Encourage CHW programs to collaborate with academic institutions and one-stop delivery systems, as well as outcomes-based payment systems. Funding: Appropriations as necessary for FYs 2010-2014.
- h) Supporting area health education centers (Sec. 5403): Promote infrastructure development and point-of-service maintenance, particularly for medical schools. Funding: \$125m for FY 2010-2014; not less than \$250,000 per AHEC annually; limited to 12 years for a program and 6 years for a center. Grants for health professionals working in underserved communities: Improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources. Funding: \$5m for each FY 2010 through 2014.
- i) Community-based collaborative care network program (Sec. 10333): Grants for community-based collaborative care networks (consortium of health care providers with a joint governance structure) to provide comprehensive coordinated and integrated health care services for low-income populations, including: outreach and enrollment, patient navigation and care coordination, case management, transportation, expanded capacity for tele-health or after-hour services. Funding: appropriations as necessary for FYs 2011-2015.
- j) Office of Minority Health (Sec. 10334): Assure improved health status of racial and ethnic minorities by developing measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Evaluate community outreach activities, language services, workforce cultural competency. Funding: As necessary for FY 2011-2016.
- k) Centers of Excellence for Depression (Sec. 10410): Establish (not more than) 30 national centers of excellence for depression by September 30, 2016 to engage in activities related to the treatment of depressive disorders. Non-federal contributions

must be 1 of every 5 dollars spent on the project. Funding: \$100m for each FY 2011-2015, \$150m for each FY 2016-2020. Allocation to each center may be no more than \$5m except for the coordinating center which may receive up to \$10m.

- l) State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations (Sec. 10501): Grants for health care providers who treat a high percentage of medically underserved populations or other special populations. The program cannot be established under the state Medicaid program. Recruit students most likely to practice in medically underserved areas, particularly rural communities; provide rural-focused training and experience, and increase the number of recent allopathic and osteopathic medical school graduates. Funding: \$4m for FYs 2010-2013.
- m) Grants for community-based diabetes prevention programs (Sec. 10501): Establish a national diabetes prevention program targeted at adults at high risk for diabetes to eliminate the preventable burden of diabetes. Funding: appropriations as necessary, FYs 2010-2014.

## **2) Connecticut Commission on Health Equity**

- a) Connecticut Commission on Health Equity (Public Act 08-171): Established and sustainable partnerships with this Commission will facilitate linkages with other state, local and federal entities to assure support of integrated approaches to maintain Connecticut's model of healthcare to eliminate health disparities and inequities within our state.

## **6. ADDITIONAL MATERIALS**

**2009 National Healthcare Quality & Disparities Reports, US Agency for Healthcare Research and Quality** (AHRQ), Publication No. 10-0004 and 10-0003, March 2010.

For the seventh year in a row, the Agency for Healthcare Research and Quality (AHRQ) has produced the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR). These reports measure trends in effectiveness of care, patient safety, timeliness of care,

patient centeredness, and efficiency of care. The reports present, in chart form, the latest available findings on quality of and access to health care. <http://www.ahrq.gov/qual/qdr09.htm>

### **The Connecticut Health Disparities Project, Connecticut Department of Public Health**

The Connecticut Health Disparities Project, Connecticut Department of Public Health, Hartford, Connecticut, January 2009.

[http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct\\_healthdisparitiesreport.pdf](http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf)

### **Health Disparities & Health Care Access: Definitions & Recommendations**

Rafael Pérez-Escamilla, PhD, Professor of Epidemiology & Public Health, Yale School of Public Health, March 1, 2010.

[http://www.ct.gov/sustinet/lib/sustinet/committeeinformation/healthequity/health\\_disparities\\_health\\_care\\_access.pdf](http://www.ct.gov/sustinet/lib/sustinet/committeeinformation/healthequity/health_disparities_health_care_access.pdf)

### **Racial and Ethnic Disparities in Access to Health Insurance and Health Care**

From the Kaiser Commission on Medicaid and the Uninsured: Racial and ethnic groups in the United States continue to experience major differences in health status compared to the majority white population. Although many factors affect health status, the lack of health insurance and other barriers to obtaining health services markedly diminish minorities' use of both preventive services and medical treatments. This report, produced in collaboration with the UCLA Center for Health Policy Research, examines health insurance coverage and access to physician services among African Americans, Latinos, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives. By pooling national survey data over two years, information about particular minority subgroups is also provided.

<http://www.kff.org/uninsured/1525-index.cfm>