**Meeting Notes**

The eight meeting of the Social Justice & Health Disparities Working Group was held on May 6, 2021 from 3:00-4:30pm. Dr. Dora Hughes began the meeting with a brief overview of the agenda. Two speakers presented:

**C. Anneta Arno on Health Equity and Access to Care in the District**

Dr. Arno began with an overview of DC Health's five strategic priorities: 1) promote a culture of health and wellness, 2) address the social determinants of health, 3) strengthen public-private partnerships, 4) close the chasm between clinical medicine and public health, and 5) implement a data-driven outcome-oriented approach to program and policy development.

Dr. Arno reviewed key insights from the Health Equity Report for the District of Columbia 2018, which includes data from 51 statistical neighborhoods. The data presented showed that health disparities and inequities in the District are evident by race, income, and geography, and differential health outcomes persist across the life course. She noted that approximately 96% of District residents have health insurance through private or public coverage.

Dr. Arno also referenced DC Health's Health Systems Plan (2017) and Primary Care Needs Assessment (2018). Of note, they found that primary care usage is not defined by geography or travel time for Medicaid and Alliance patients, as 75% of enrollees received all care outside their Ward. There is low community-level preference amongst Medicaid and Alliance participants for local health care resources, and enrollees will travel to access care based in part on their perceptions of brand, quality, and convenience.

Key findings from the Primary Care Needs Assessment (2018) include: 1) there is sufficient primary care capacity to serve the District's residents, 2) physicians make up a high percentage of the District's primary care workforce, 3) the use of primary care is not defined by geography nor travel time for Medicaid patients, 4) there is low community-level preference for local health care resources, 5) there is low engagement with a medical home for primary care, 6) there is low utilization of primary care amongst all Medicaid enrollees, 7) there is higher than expected utilization amongst Medicaid enrollees who accessed care, 8) there is untapped Medicaid provider capacity, and 9) there are gaps in systems of care in some parts of the city.

Related recommendations include: 1) address patient perceptions of brand, quality, and convenience, 2) promote use of accessibility of medical homes, especially among women, 3) engage residents who are not accessing care, 4) promote development of systems of care that emphasize community-clinical linkages and care transitions, and ensure residents across the District can access these systems locally, 5) encourage maximizing and strategically leveraging existing provider resources to address identified and perceived gaps, 6) strengthen partnerships and systems to routinely collect, analyze, and disseminate data on access to care, 7) identify and

explore emerging issues through targeted quantitative and qualitative data collection and analyses, and 8) ensure a workforce that supports team-based care delivery.

The Mayor's FY21 budget invests $4.9 million to implement recommendations from the Mayor's Commission on Healthcare Systems and Transformation to reduce reliance on emergency care and improve health outcomes.

Dr. Arno closed her presentation by stating that to eliminate disparities in health outcomes, our collective actions must be intentional in 3 key areas: 1) access to quality health care, 2) social and structural determinants of health, and 3) structural and institutional racism.

**Destiny-Simone Ramjohn on CareFirst and BCBSA's National Health Equity Strategy**

Dr. Ramjohn began with an overview of Blue Cross Blue Shield Association's (BCBSA) National Health Equity Strategy, which intends to change the trajectory of health disparities and reimagine a more equitable healthcare system. The strategy includes: 1) collecting data to measure disparities, 2) scaling effective programs, 3) working with providers to improve outcomes and address unconscious bias, 4) leaning into partnerships at the community level, and 5) influencing policy decisions at the state and federal levels.

The multi-year strategy will focus on four conditions that disproportionately affect communities of color: maternal health, behavioral health, diabetes, and cardiovascular conditions. In 2021, CareFirst, like BCBSA, will focus first on maternal health, followed by behavioral health. BCBSA has set a goal to reduce racial disparities in maternal health by 50% in five years.

BCBSA is advancing a strategy to improve health equity in local communities across the country, related to 1) ensuring equitable access of COVID-19 vaccines, 2) making the availability of racial health disparity data a national priority, 3) establishing national focus areas and amplifying local Plan programs, and 4) integrating an equity focus into local and national network solutions.

Dr. Ramjohn then referred to the Institute for Healthcare Improvement's five core competencies needed to ensure that equity efforts are sustainable and impactful, and reviewed how CareFirst is demonstrating some of those competencies. The five core competencies are 1) make health equity a strategic priority, 2) build infrastructure to support health equity, 3) address the multiple social determinants of health, 4) eliminate racism and other forms of oppression, and 5) partner with shareholders to promote health equity.

Equity is embedded in how CareFirst thinks about its five-year vision to drive transformation of the healthcare experience with and for members and communities. Community Health and Social Impact Investments (CHSI Investments) focus on six areas, including economic inclusion, educational opportunity, behavioral health, chronic conditions, accessible and affordable high-quality care, and social responsibility and impact.

From 2015-2019, CareFirst invested $10.9 million to address social determinants of health in the District. CareFirst's 2020 investments supported the health, social, and economic needs of District residents as a result of COVID-19 in addition to supporting access to quality, affordable health care services. Dr. Ramjohn concluded with a brief overview of CareFirst's recent diabetes work. In 2021, CareFirst will invest $10.5 million to address the root causes of diabetes, especially the economic, environmental, and social conditions that shape unequal health outcomes.

**<u>Presentation Discussion</u>**

Dr. Hughes asked if Dr. Ramjohn could review the work they are doing with providers to tackle unconscious bias. Dr. Ramjohn said that this year all patient centered medical home providers are expected to complete cultural competency training within the first half of the performance year and implement an approach to serve diverse populations in the second half of the year. They are not currently mandating cultural competency training for other providers.

Mila Kofman noted that CareFirst changed their benefit structure to cover insulin and diabetes supplies at no cost to the patient, and asked what CareFirst is doing to study the impact of that change and if they plan to expand that program for other services diabetics may need. Dr. Ramjohn said that although they have not had much time for observation, through member outreach they have heard that eliminating those economic barriers is positively impacting their enrollees. Collette Chichester added that there is a robust evaluation component, but they are not at the point yet where they can report outcome data.

Dr. Hughes asked for more information about CareFirst's plan to address maternal health and disparities in mental and behavioral health. Dr. Ramjohn gave one example of how they are a seed investor in a Baltimore City Health Department initiative called B'More for Healthy Babies that has demonstrated a 35% reduction in infant mortality over the past decade. Related to behavioral health, they are looking at a range of initiatives including investing in racial trauma informed care, imbedding behavioral providers in its primary care network, expanding telehealth opportunities, and exploring culturally competent care with organizations.

**<u>Review and Discussion of Preliminary Recommendations</u>**

Dr. Hughes asked if there were any thoughts on potential recommendations as drafted in "Focus Area 3: Ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District," specifically the recommendation "review clinical algorithms and diagnostic tools for biases and inaccuracies and update appropriately." Collette Chichester emphasized the importance of defining the purpose of reporting requirements and what the data will be used for. Dr. Hughes responded that for relevant recommendations, we should include a list of potential uses of the reports and allow DISB and other colleagues to weigh in.

Dr. Hughes then asked for comments on “Focus Area 2: Eliminate health outcome disparities for communities of color in the District.” Janice Davis noted that she appreciated the recommendation related to the “modification of insurance design for DC Health Link standard plans to eliminate cost sharing…” and said it would be good to also consider the cost of medical devices.

Finally, Dr. Hughes asked for comments on “Focus Area 1: Expand access to providers and health systems for communities of color in the District.” She noted that in light of Dr. Arno’s presentation, the first potential recommendation, “provide incentives for both primary care and specialist physicians to practice in underserved areas in DC” may need to be reconsidered Pamela Riley noted there is a lot to be done to eliminate barriers to access and encourage appropriate utilization, and that providing scholarships may not be the best use of DCHBX resources. Colette Chichester commented that perhaps the attention should be focused on attracting quality health care providers to underserved areas. She asked if they have done analysis on preferred brands, and Dr. Arno said they do not have specific data related to brand preference.

Diane Lewis asked Dr. Arno if they have had an opportunity to conduct a focus group with residents of Wards 5, 7, and 8 related to their utilization of providers, and Dr. Arno said they have a number of opportunities moving forward to acquire this type of information.

**<u>Attendees</u>**

Dora Hughes
Helen Mittmann
C. Anneta Arno
Destiny-Simone Ramjohn
Mila Kofman
Diane Lewis
Cara James
Debra Curtis
Purvee Kempf
MaryBeth Senkewicz
Ciana Creighton
Colette Chichester
Allison Mangiaracino
Karima Woods
Philip Barlow
Howard Liebers
Paul Spiedell
Janice Davis

Chikarlo Leak
Daniel Wilson
Yulondra Barlow
Pamela Riley
Tricia Quinn