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Bills related to Access to Care and Health Disparities

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Chairwoman Fargo, Chairman Sanchez, and honorable members of the Joint Committee on Public Health, thank you for inviting testimony from the Blue Cross Blue Shield of Massachusetts Foundation on the proposed legislation focused on access to health care and public health and on the elimination of health disparities. My name is Jarrett Barrios and I am the President of the Blue Cross Blue Shield of Massachusetts Foundation and I am here with Miriam Messinger, the Associate Director of Grantmaking and Evaluation.

Our Foundation is dedicated to expanding health care access throughout the Commonwealth, and since our inception we have dedicated \$31.6 million in total grant funding to community health centers, hospital programs, and community-based organizations throughout the state to improve access to care. We have also advanced this work through policy research, convening stakeholders and capacity building programs for health professionals and journalists.

Our foundation's focused efforts on health care disparities began in 2005, when we inaugurated a new grant area called *Closing the Gap on Racial and Ethnic Health Disparities*. Since we began that grant program area, much has changed in Massachusetts around health care access and disparities related efforts. Massachusetts now boasts the lowest uninsurance rate in the United States, due to the success of Chapter 58 of the Acts of 2006 which

reformed the health access infrastructure. While that law was primarily focused on expanding access to health care coverage it also mandated significant efforts on health care disparities, including the establishment of a Disparities Council to convene experts across sectors and established roles to support a strategy for eliminating disparities.

Despite this progress, we have not come close to the Healthy People 2010 goal of eliminating health disparities. It is clear that coverage expansions alone will not ameliorate disparities. Many of the bills before you today seek to bring us closer to these targets. Today we hope to share some of our own learning about the state of disparities in Massachusetts and about what is critical to running and sustaining successful projects to eliminate health disparities. We hope that this will both add a voice to the chorus of those saying that, particularly in challenging economic times, we cannot abandon a focus on health disparities, and assist you in deciding the relative importance of different bills before you.

I will share a few highlights from our research on these issues and then Miriam Messinger will share lessons from our grant making area to eliminate disparities.

The Foundation's contribution to data and research on disparities

The Foundation has adopted a broad disparities-related research agenda that includes:

- Monitoring the impact of Chapter 58 with public polling on insurance and usage (Blendon, Globe) and a survey of consumers (Urban Institute survey);
- Research focused on access issues in immigrant communities;
- And research on Care Beyond Coverage—barriers to care outside of insurance that persist despite the broad availability of health insurance.

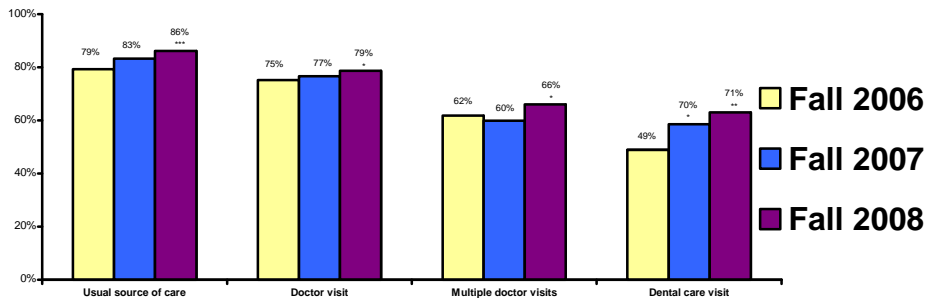
There is a great deal of good news from Chapter 58 both in terms of overall coverage rates and in reducing disparities¹:

- All residents, including low-income residents, report having less unmet need for care due to cost.

¹ Data was taken from the Massachusetts Health Reform Survey, Urban Institute and the Blue Cross Blue Shield of Massachusetts Foundation. A telephone survey was fielded in fall 2006, fall 2007 and fall 2008 of adults aged 18-64. The sample size was about 3,000 each of those years. Data was collected on insurance coverage, access to care, and the cost of obtaining care, with a focus on the low-income and uninsured. Additional information can be found at www.BlueCrossFoundation.org/Policy-and-Research.aspx

- Overall, 97.4% of Massachusetts residents have health insurance.
- Gains in access to care were greatest for lower income adults. These gains include items such as: having a usual source of care, and percent of people having one or multiple doctor or dental visits in the prior 12 months.

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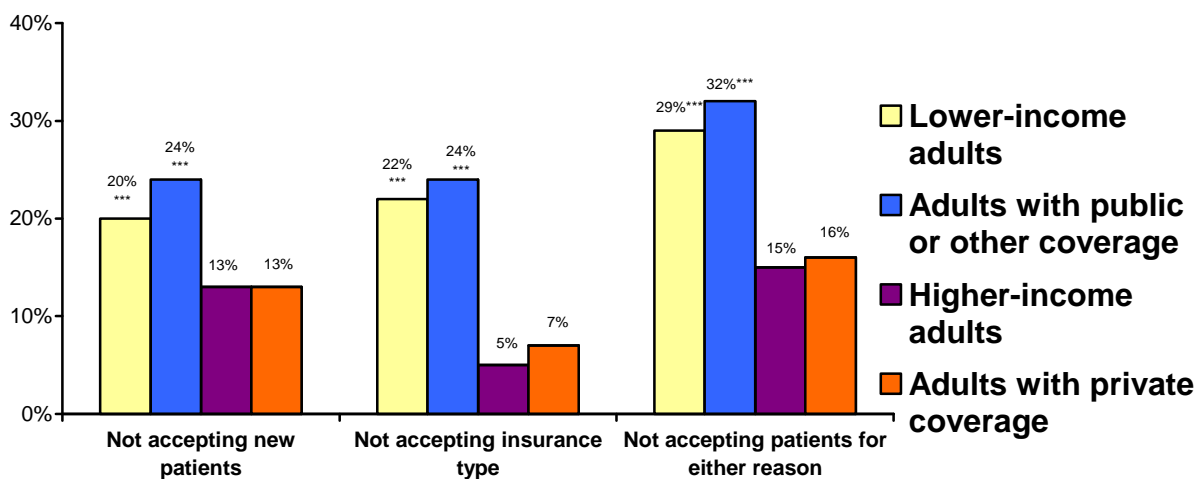


Note: *, **, *** indicate significantly different from white, non Hispanic adults at the .10, .05, .01 level, two tailed test.

However, we have also seen how some disparities persist:

- While our overall uninsurance rate is down to 2.6% statewide (DHCFP, Urban Institute, 2008) households with income of less than 300% of the Federal Poverty Level (FPL) are more likely to be uninsured than those with higher incomes. Those with incomes less than 150% of the FPL have 5.8% uninsured, nearly 30 times higher than those with incomes of 500% of FPL and higher (.2%).
- The research shows signs of strain in provider supply, particularly for those on public plans

Difficulties obtaining care in Fall 2008



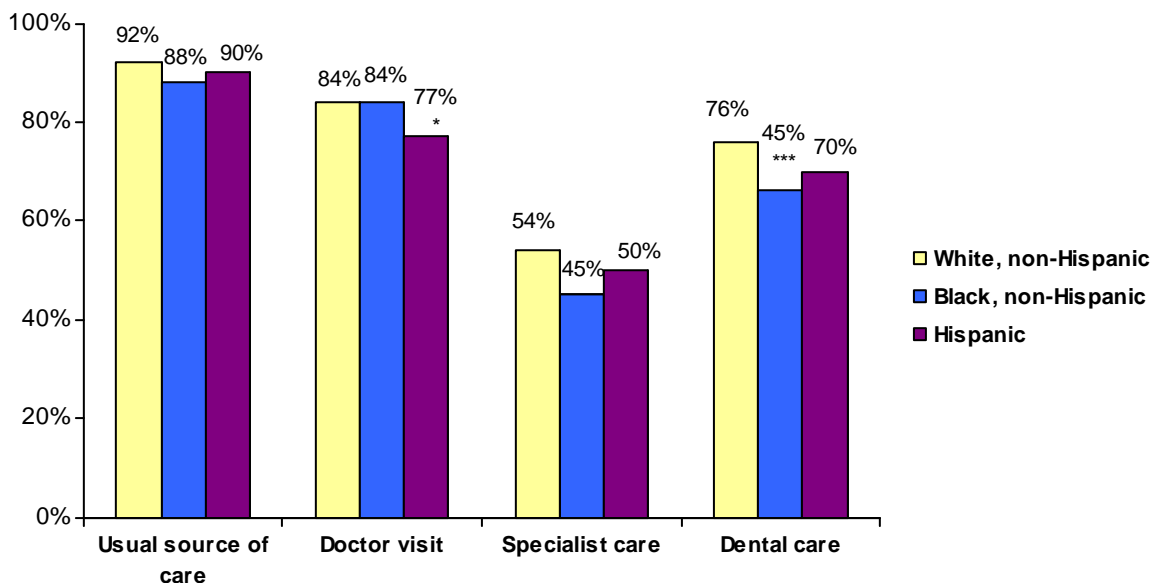
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- 1 in 5 residents overall report difficulty obtaining care because the provider they contacted was not accepting patients (either not accepting new patients or patients with that insurance type)
- 24% of those on public plans had trouble finding a provider that would accept their insurance, compared with 7% on private plans
- 10% of low income adults report unmet need due to difficulties in getting to see a provider, compared with 4% pre-reform
- Regional² and racial/ethnic variation in use of care and other access parameters are limited, but disparities bear monitoring.
 - Residents in Western and Southeast MA report more difficulties obtaining care
 - Less likely to have usual source of care (88% in SE vs. 92% Metrowest)
 - Less likely to have doctor visit (80% in Western vs. 86% in Metrowest)
 - More difficulty finding a provider who takes new patients or insurance type (26% in Western vs. 19% in Metrowest)

² Analysis of 6 regions in the state: Metrowest, Boston, Central, Northeast, Southeast, and Western

- Racial/ethnic minorities report more difficulty in some areas of care

Racial and Ethnic Differences in Health Care Access and Use



Note: *, **, *** indicate significantly different from white, non Hispanic adults at the .10, .05, .01 level, two tailed test.

- No apparent disparities in usual source of care, overall unmet need, provider availability, and affordability
- Hispanics report getting less care and more unmet need
 - 77% report having a physician visit vs. 84% white
 - 13% report not getting needed preventive care screenings vs. 5% white
- Black residents report receiving less dental care (66% vs. 76% white, along with Hispanics at 70%), less access to specialists (45% vs. 54%) and more unmet prescriptions need
- The vast majority of Massachusetts residents surveyed reported having a personal health care provider. However, a significantly lower percentage of blacks (84%), Hispanics (76%) and Asians (86%) reported having a personal health care provider compared to whites (90%).

Note: The race/ethnicity data is not available for comparison in 2006 or 2007.

Research focused on access issues in immigrant communities. We also undertook research with a specific focus on immigrants for three reasons: 1) we see wide differentials in level of coverage in different immigrant communities; 2) we knew there were built in obstacles in Chapter 58 for unauthorized immigrants and 3) beyond immigration status, we know there are significant access barriers related to “health literacy” at the system, plan and individual level—things like cultural competent care delivery, lack of familiarity with the system, or even fear of the system.

There are many barriers to conducting effective research with immigrant groups. Therefore, less is known about this population, although we do know they suffer higher uninsurance rates and other access barriers. Furthermore, we hear that immigrant populations who have fear of exposing themselves to any public entities may defer care, and only seek out care in an emergency situation. So, we committed to community based participatory research, partnering with community based organizations to do the outreach and interviewing, relying on them for their relationships, the trust they have in the community.

A few highlights of what we have found.

- The need for medical interpretation remains for many immigrant populations as they access care, and many organizations that we work with, particularly health centers, struggle to ensure that there are consistent and certified medical interpreters available. This is often difficult to ensure, however, given capacity and resources available throughout the state and within the health care system.
- Anti-immigrant sentiment from community members in certain parts of the state also serves as a barrier to immigrant populations in search of care or social services that can help themselves and their families better adjust to their new residence.
- The limited health coverage options available to immigrant populations are often lacking in the types of services that they cover, thus leading to further complications around medical debt and the ability to obtain needed services.

Reports on research conducted amongst Portuguese speaking immigrants and another study of Dominicans and Brazilians will be available later this summer. We see confirmation of barriers for immigrant communities as well as vastly different rates of coverage depending on the

immigrant community. The study by Enrico Marcelli was based on innovative sampling and included the collection of bio medical assays which will allow for some study of stress and its impact on health amongst immigrants and migrant workers.

Care Beyond Coverage

Even with the good news from Health Reform, looking forward we need to drive the percentages up for those with access to care, ensure that the insurance and care is affordable and increase the cultural competence of providers, decreasing disparities in treatment by race, ethnicity, income and immigrant status.

The next research challenge for the Foundation is to look at access-related issues beyond coverage. Our preliminary research has shown that culturally competent care delivery, medical debt, and related issues that can be predictors of disparate levels and access and health outcomes are significant barriers in a “near universal” care environment. Many of these barriers, not surprisingly, exhibit disparities between communities. One of our five focus areas is on achieving equity and several of the others, including medical debt, affect poor and people of color communities disproportionately.

Foundation’s grantmaking work in this area

From 2005-2008, the Foundation supported nine projects in our Closing the Gap on Racial and Ethnic Health Disparities grant area. The projects spanned disease area (asthma, cardiovascular, mental health access, AIDS), group (immigrant teens, African American adults, Asian children, Latino adults) and geography around Massachusetts. The stated goal of these grants was to fund interesting projects that reduced the instances of inequities, gaps and inconsistencies throughout the continuum of care by promoting access to culturally appropriate care and equal availability and utilization of services for specific racial and ethnic groups experiencing disparities in health care outcomes.

The Foundation supported interventions that sought to address the issue through patient-focused solutions, adjustments in provider/clinician processes and behaviors, and systemic and operational changes.

Let me share two examples and then some common lessons and quality improvement or policy ideas that emerged from the three year program:

1. **Holyoke Health Center focused on cardiovascular disease in Latino patients.** For individuals, there was a focus on chronic disease self-management techniques paired with group support and hands-on learning. Several participants talked about losing more than 20 pounds and the importance of nutrition and exercise classes in Spanish and peer support. At the provider level, they focused on hiring bicultural and bilingual staff as well as cultural competence training for others. On a systems level, the health center initiated smoking cessation efforts into every visit, implemented culturally geared group classes in weight loss, nutrition and exercise, created multidisciplinary teams for “wrap around” services and enhanced the EMR to include the holistic measures of impact.

2. **Alliance for Inclusion and Prevention.** Their goal was for children to feel and perform better in school and family life. They proposed enhancing access to culturally competent and school-based mental health services for refugee youth and youth of color suffering violence-related trauma. We saw the following changes:
 - a. On the individual level: access to convenient and appropriate services for more than 100 children and their families in five Dorchester schools. The schools reported improvements in school climate and reductions in disruptive behavior in classrooms.
 - b. Important system changes and lessons include:
 - i. Fee for service paid for all but \$4,000 of a mental health provider’s full time salary.
 - ii. School based services led to greatly enhanced communication between providers and teachers and between providers and family (aided by an evening clinic).
 - iii. On site services also meant that there were virtually no missed appointments.

While two years of implementation funding is not sufficient to demonstrate improved medical outcomes, these projects did point to some promising strategies. Through the nine projects, we identified quality improvement measures that are likely to positively impact disparities.

- Bilingual and culturally competent services

- The use of community health workers (CHWs) and other models to span the health delivery-community gap and to help address the issues not best suited to the doctor's office such as exercise, other behavior change, and barriers to effective self care.
- Bilingual/bicultural staff
- Chronic Disease Self Management programs, classes and education, especially those that are tailored to the language or needs of a specific community, may enhance the likelihood of individual behavior change.
- Hands on interventions—don't just talk about healthy eating in a 12 minute doctor visit; rather, walk clients through the supermarket, do a cooking/eating class; show junk food.
- Programs by and specifically tailored to the audience: ask the consumers what will reduce the barriers to either seeking care or following protocols
- Coordination of services (for example, gynecologists at health centers coordinating with the delivery unit at the major hospital serving their patients)
- Consider alternative care delivery models, group visits, case managers, and disease program "champions." These strategies were usually more culturally sensitive although there are challenges as well including reimbursement and financing.
- Utilize Electronic Medical Record systems to track disparities and to support providers using best practices during each client visit
- Attention to upstream issues. For example, if you care about disparities in birth outcomes, you might have prenatal care visits include questionnaires and services related to housing, food access and domestic violence. You would also want to coordinate health and housing services.

With several of these proposed improvements, there will be a need to push for ways to finance the services such as CHWs, group classes, community outreach and advocacy work, smoking cessation classes. In a time of fiscal challenges we need to look at whether these are more cost effective ways to address the disparities and then advocate for reimbursement.

Three of the major shifts for the disparity elimination grants we awarded in 2008 relate to expanding our understanding of health disparities, their impact and root causes.

First, we broadened our definition of disparities. While racial and ethnic differences should remain at the core of any effort to eliminate disparities, and racism is one of the causal factors identified in disparate outcomes, groups defined by other factors see significant

disparities as well. These groups include people with disabilities, gay, lesbian, bisexual and transgender people, poor people and immigrants. House Bill H2116 and Senate Bill S0858 seek to shine the light on disparities for people with disabilities.

- individuals affected by persistent mental illness or developmental disability live an average life span that is 25 years shorter than the general population; they experience twice the degree of burden associated with chronic illness and six times the number of role-impaired days.

- US and Massachusetts studies show higher rates of day-to-day discrimination for GLBT identified individuals which is shown to have harmful effects on indicators of psychiatric morbidity.

Second, we moved from funding provider centered initiatives to collaboratives that pair providers with community stakeholders. That move was an acknowledgement of the central role played by social determinants of health and recognizing that successful efforts to eliminate health disparities are likely to include significant work outside of the health delivery system. House Bill H2093 asks that EOHHS evaluate the impact of these social determinants of health, including employment, racism and education on health outcomes.

And third, we are supporting the ability for consumers to have a legitimate voice in defining these efforts. Their perspective is essential to the capacity for understanding and addressing the barriers to effective access and care and for perspective on the root causes and most promising interventions. We currently fund 11 planning grants in our new three year funding round to eliminate disparities. These grantees are forming coalitions, ensuring that the voice of the affected community is at the table to help construct the projects, and are gathering in a quarterly statewide Learning Community to support their work.

One project, run by AIDS Action Committee is comprised of a group of HIV positive women of color working with doctors to transform the culture of care at MGH and other institutions to lead to earlier entry into care and reduce the horrific rates of increased mortality for women of color with HIV/AIDS.

Another project, Live Well Springfield, is bringing together a coalition that crosses traditional silos (school, community organizations, health care and others) to reduce obesity amongst African Americans and Latinos in Springfield.

A third, led by ServiceNet, is working with affected community members, support people and doctors to create health care that supports behavior changes in nutrition and exercise for people with severe mental illness in Western MA.

In an environment where sociodemographic data is central to our approach, those crafting solutions must widen their list of partners and of possible interventions to areas beyond care and coverage. A grant program such as that highlighted in Senate Bill S0811 aims to promote this kind of community based problem solving.

Collaboration with State and Local Partners

Our grantmaking in this area has brought us to collaborate and build relationships with numerous stakeholders dedicated to eliminating disparities around the state. These include, but are not limited to, the Disparities Solution Center, an informal network of funders (including Metrowest Community Health Foundation, the Cavu Foundation, DPH and the BPHC), advocacy organizations, and academic entities. It is important that this kind of networking continue. The Office for Health Equity promises to be a central actor for sharing knowledge and the best solutions for these entrenched disparities.

An Office of Health Equity (supported by Senate Bill S0810) is not a unitary solution but it offers many benefits. The Office could be a place to:

- centralize knowledge, share successes and challenges, and develop ideas to undo challenges;
- promote successful models with other providers and payers;
- convene consumers, policy makers, funders, practitioners and payers for broader conversation;
- address upstream issues, such as education and environment.

The Office of Health Equity has the power to work across issue and department—more in line with a social determinants approach and, ultimately, with a greater likelihood of success.

Conclusion

The Foundation has experienced a significant return on its investment in our undoing disparities work. We offer these lessons to the Committee for your consideration and use.

We have found the following to be critical elements for programs attempting to eliminate health disparities:

- **Community voice** in defining problems and creating solutions.
- **Coalition building** to bring together key stakeholders from community agencies, government, and local businesses.
- **Focus on System and Provider changes** more than individual behavior change.
- **Adopt a learning approach** in the work—we need to learn from each other, work across silos and include frequent feedback loops and evaluation.
- **Community education** about disparities and root causes is critical to building support for ending these present day civil rights violations.
- **Utilize a social determinants approach**—if we do not begin to look upstream and ensure that all our residents live in healthy and vibrant communities than our best programs will always be full.

There are also critical data lessons to draw upon:

- Ensure adequate sample size and methodology to collect data from groups that often are undersampled but experience greater disparities
- Collect race and ethnicity data, as well as data on English language use and education and other elements so that we can assess whether care and outcomes are becoming more equitable.

A government body such as the Office of Health Equity would take us a long way in collecting and analyzing data, bringing people together to learn and share successes, and coordinating efforts to eliminate disparities.