Health Equity Study

STATE EMPLOYEE HEALTH PLAN

2022

Data

- State Employee Health Plan Medical and prescription drug claims between 2017 and 2020

Parameters evaluated

- Race/Ethnicity
- Income
- Job Classification
- Age
- Gender
- Socioeconomic disadvantages of neighborhoods based on the Area Deprivation Index
- Access to healthcare providers based on the Health Professional Shortage Area (HPSA) database
- Access to healthy food based on the USDA Food Access Research Atlas (FARA)
- Various chronic diseases and comorbidities
- Polypharmacy

Benchmark

The benchmarks used in this study are from the Segal data warehouse made up of nearly 100 clients with approximately two million covered lives (Medicare retirees excluded). The benchmark is adjusted to the age/sex distribution of the state health plan. The clients are a mixture of multi-employer plans and public sector plans. About 70 percent of the lives are multi-employer and the rest are public sector. The data for the state of Connecticut is NOT included in the benchmarks to avoid the plan from being benchmarked against itself.

Study Commissioned by Office of the State Comptroller

- Analysis performed by Segal Company
- Consulting on study design and recommendations provided by Health Equity Solution
- Summary findings produced by Office of the State Comptroller Staff

Findings

Race & Ethnicity

- Preventive Cancer Screenings
- Chronic Condition Compliance
- Telehealth
- Emergent Care Visits
- Diabetes Prevalence
- Treatment of Lower Back Pain

Gender

- Telehealth
- Preventive Screenings and Chronic Disease Care
- Medication Adherence

Cancer Screenings & Chronic Disease Care

The state’s Health Enhancement Program (HEP) drives significantly higher rates of compliance with recommended age-appropriate cancer screenings than seen in the general population.

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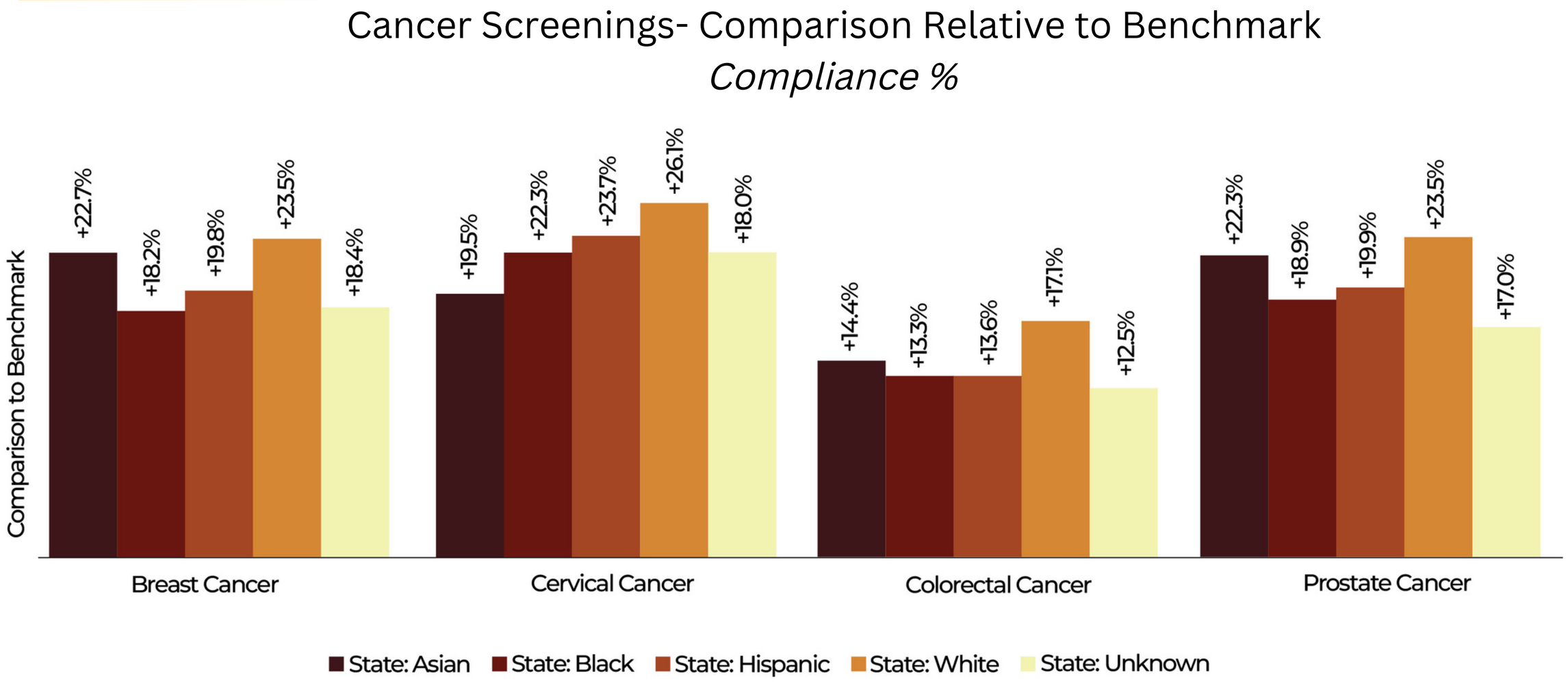
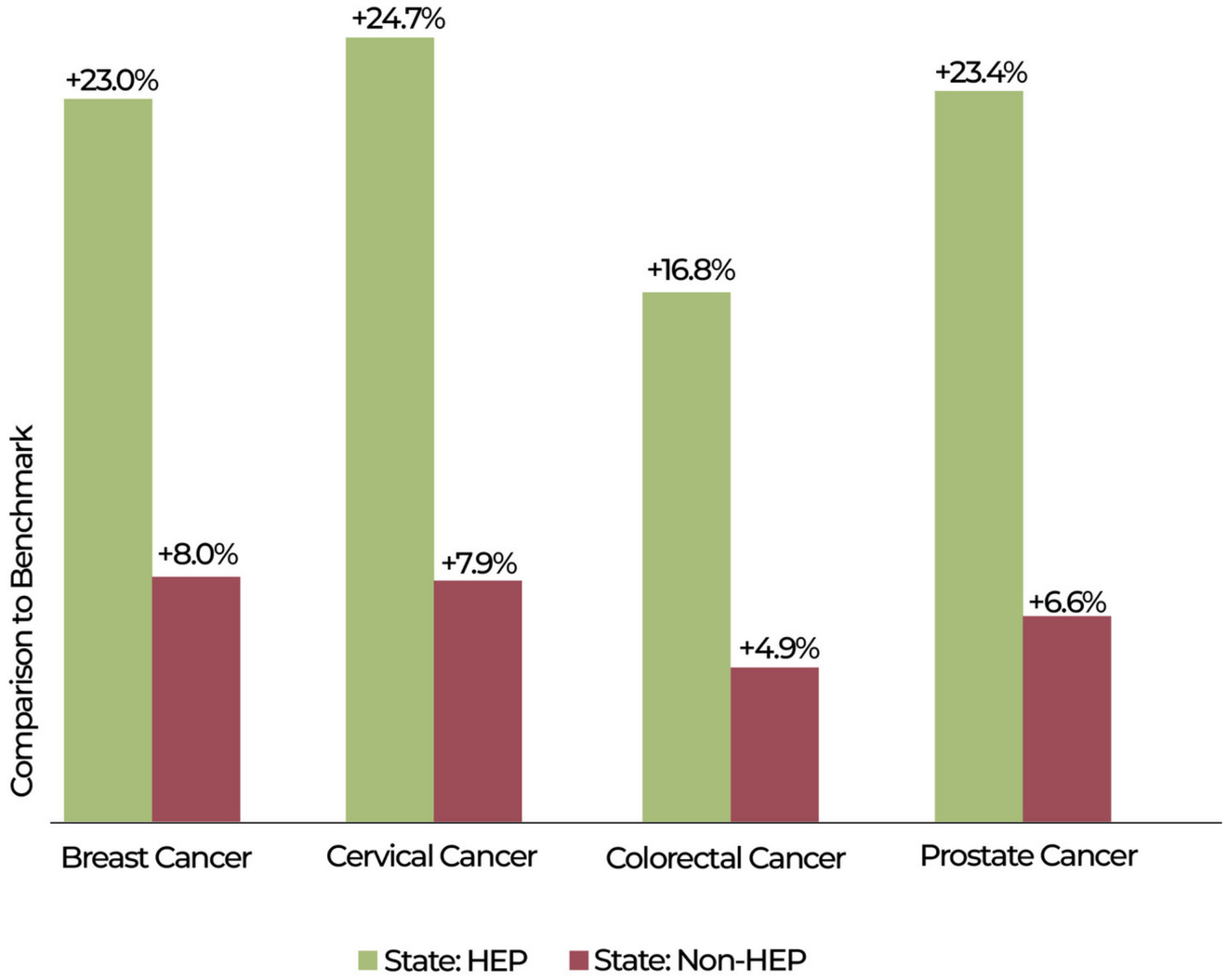
While disparities persist for Black and Hispanic members, all groups significantly outperform benchmarks.

Preventative Cancer Screenings
(Race and Ethnicity)



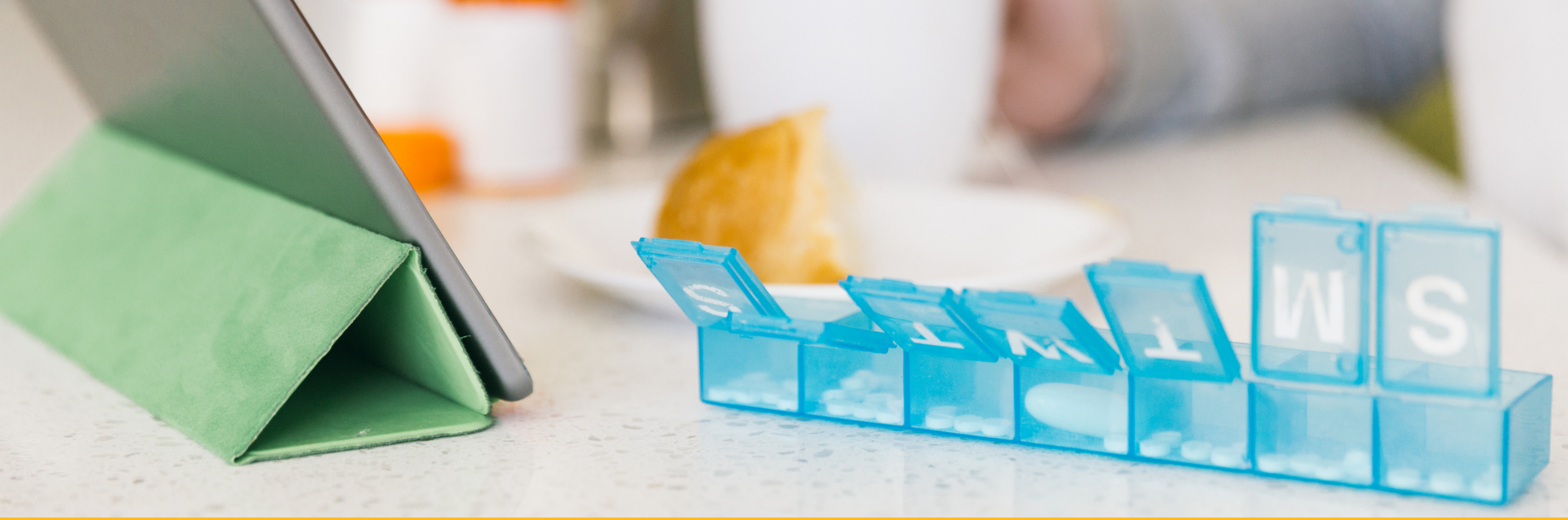
Cancer Screenings- Comparison Relative to Benchmark

Compliance %



Preventive Screening Recommendations

- Continue to support and promote the HEP program
- Expand access to HEP to other public employers through the Partnership plan
- Continue to promote the benefits of HEP and encourage broader adoption of similar programs in private sector plans, including fully insured plans
- Continue to promote cultural and linguistic appropriateness of care
- Consider leveraging community health workers to address barriers to utilization of services



Chronic Condition Management

State Plan members exceed benchmarks for nearly all utilization measures across racial and ethnic groups

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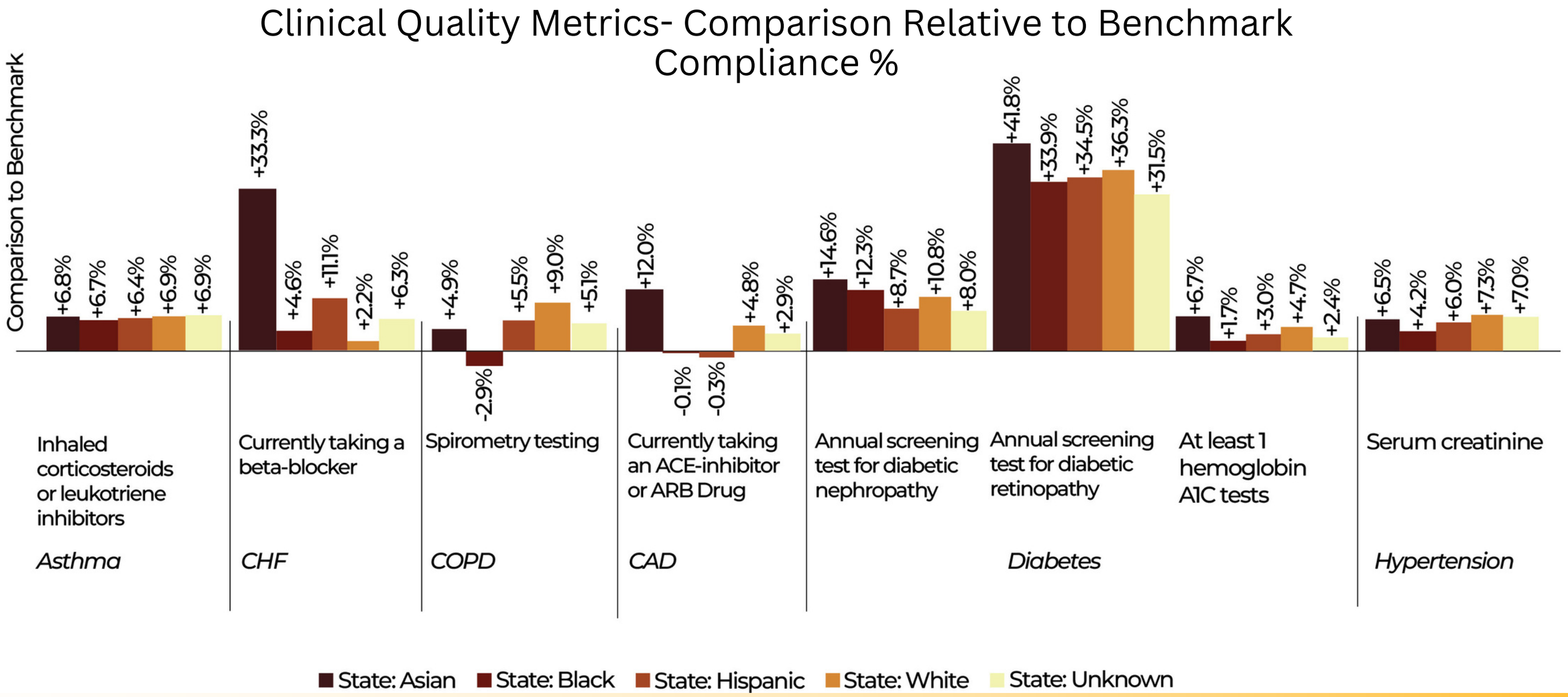
While racial and ethnic disparities are small, they should be monitored over time as further efforts to promote culturally appropriate care are undertaken

Chronic Condition Utilization

(Race and Ethnicity)



Telehealth

Race/Ethnicity

Black, Hispanic, and Asian members have lower telehealth utilization when compared to White members

Income

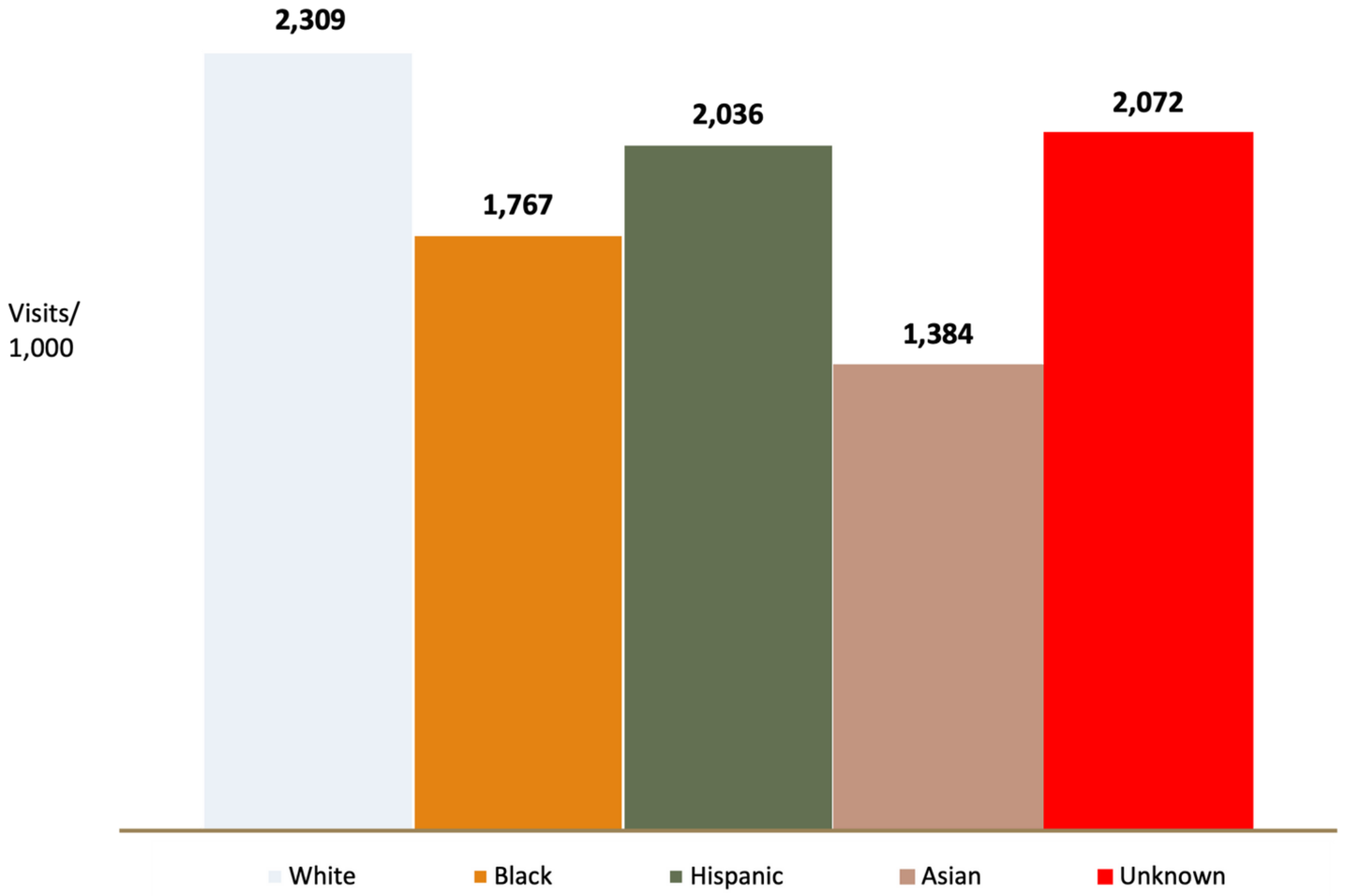
Low-income members had much lower telehealth utilization rates than high-income members

Age

Older members used telehealth less than younger members (partly explained by higher utilization of mental health services among younger members since mental health visits are both frequent and among the services to adopt telehealth most quickly and consistently.)

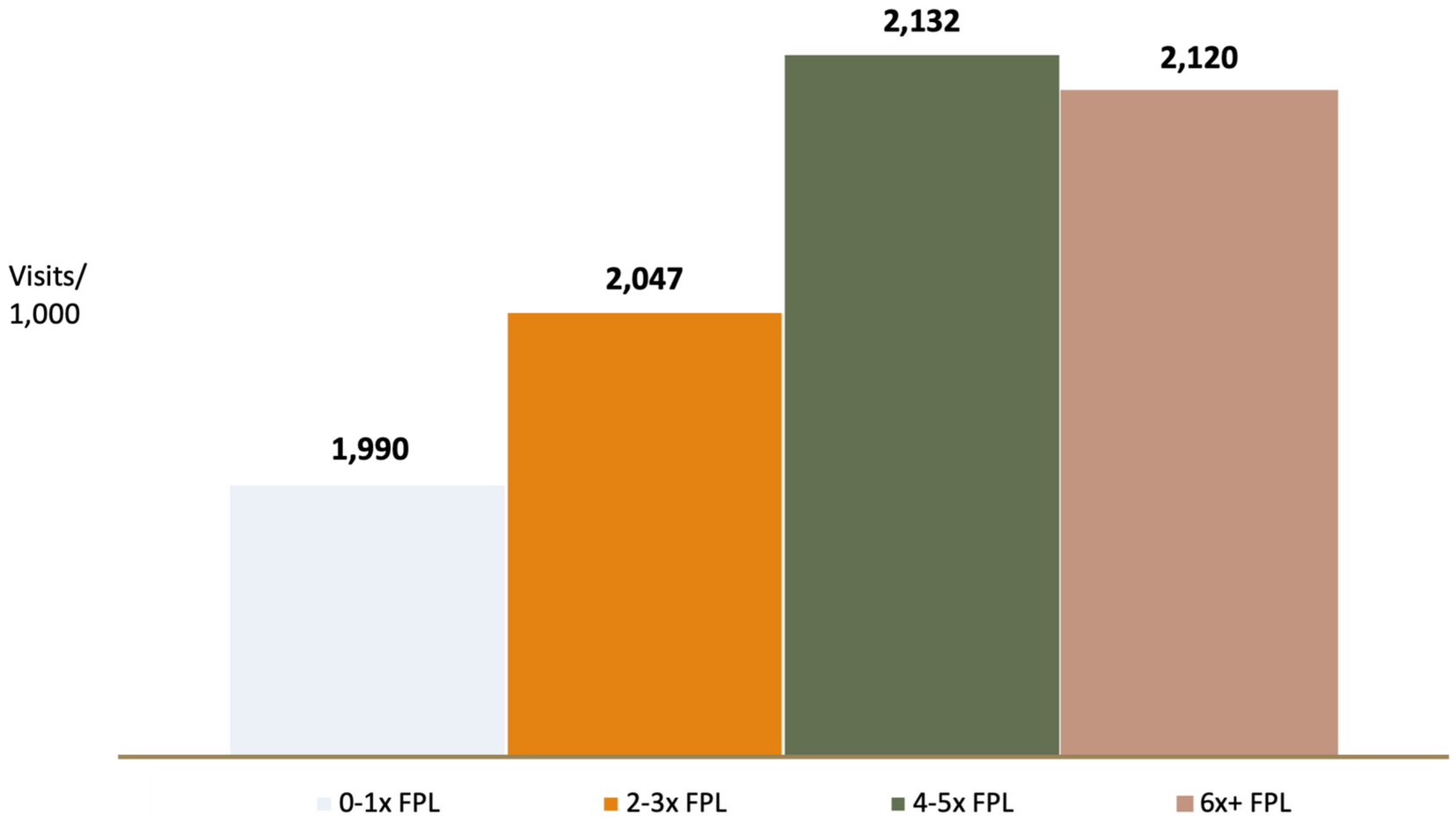
Telehealth Visits by Race/Ethnicity

Calendar Year 2020

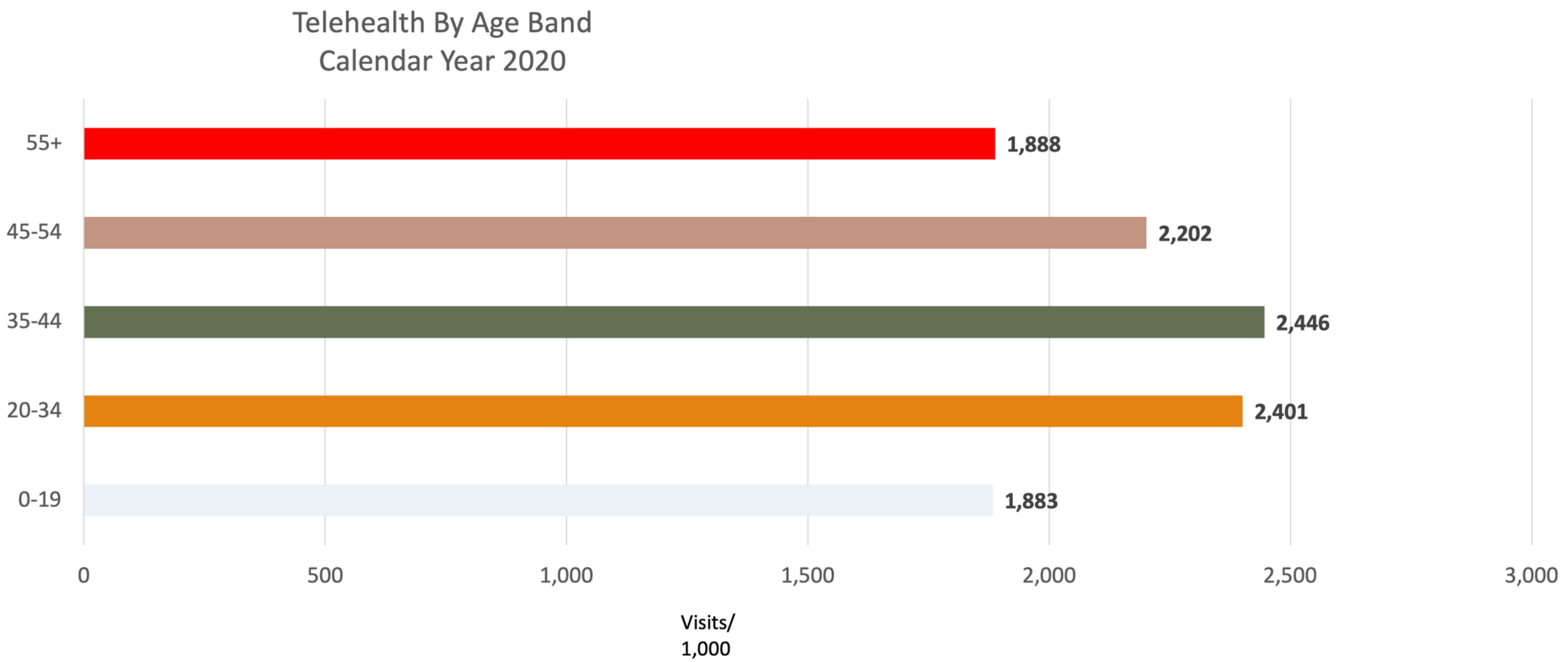


Telehealth Visits by Income

Calendar Year 2020



Telehealth Utilization



Telehealth Recommendations

Survey membership to identify barriers

- Broadband and Device Access
- Private Spaces
- Technical Support and Digital Health Literacy

Possible actions

(focus areas dependent on results of survey)

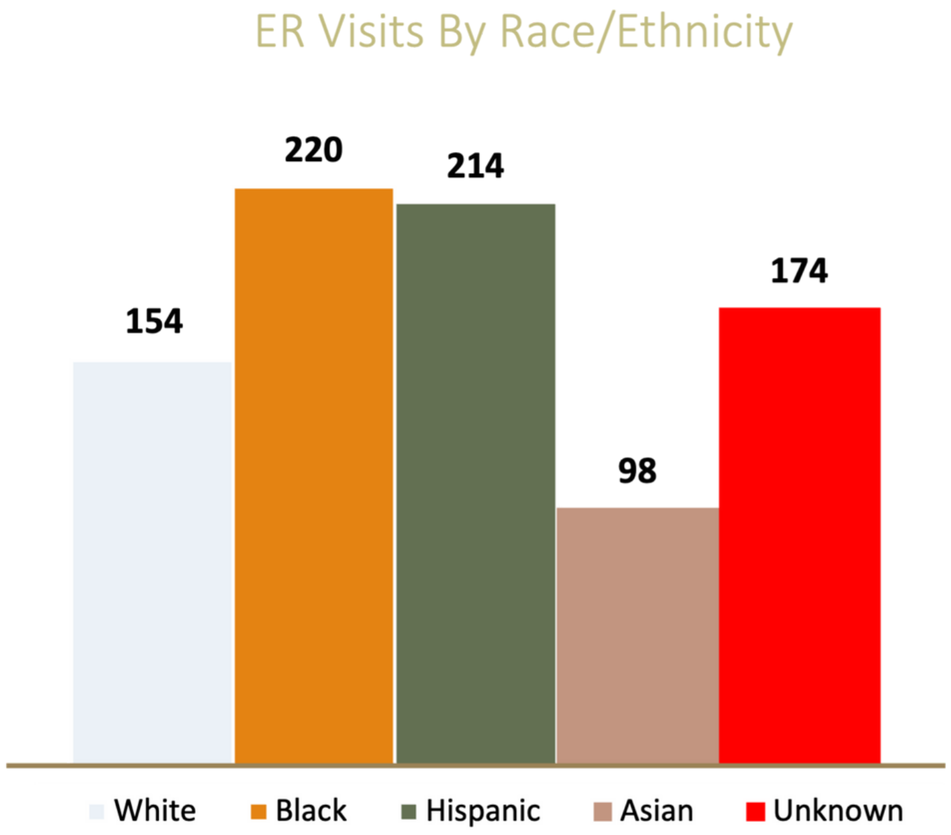
- Provide broadband and device access to members who require them
- Promote telehealth options and availability to segments of membership that underutilizes service
- Expand telehealth services to cover more areas of care (health monitoring, complex and chronic diseases, etc.)
- Address disparities in established provider relationships
- Improve access to care, both physical and virtual in socioeconomically disadvantaged neighborhoods
- Ensure telehealth is an option but not a requirement for receiving care

Emergent Care Visits

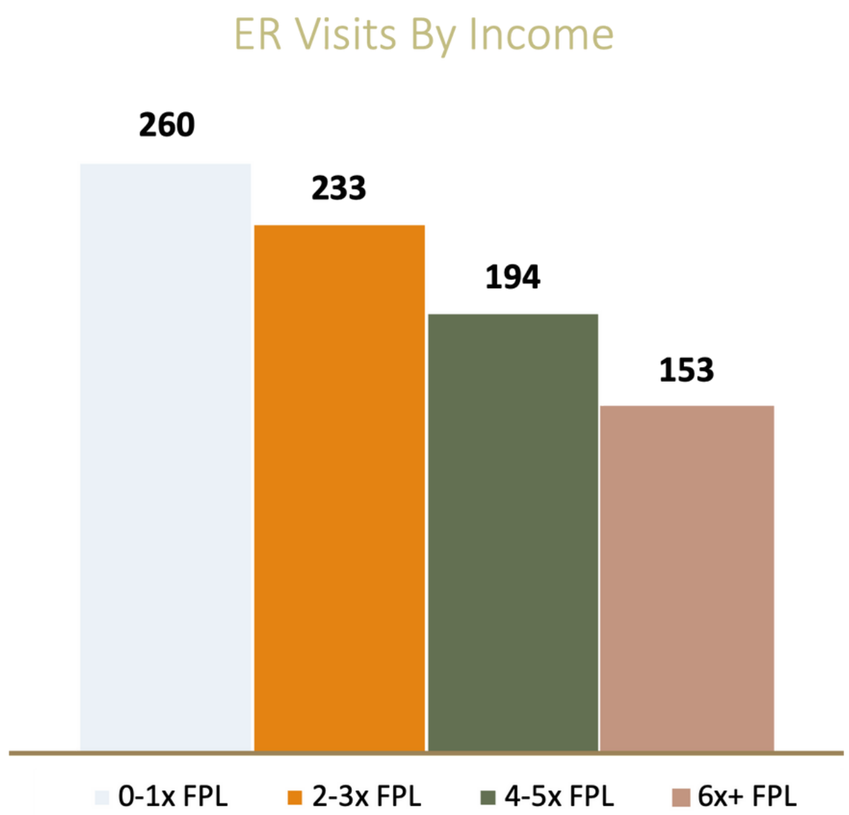
Emergent Care Visits

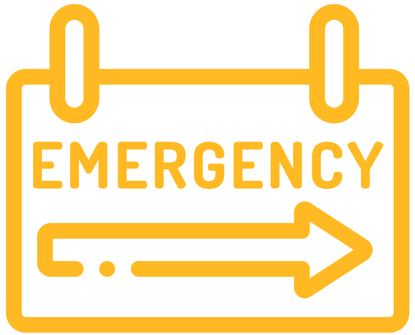
- Significant disparities were found between racial and ethnic groups in terms of emergent visits
  - Blacks and Hispanic members were significantly more likely to utilize the emergency room (ER) and less likely to receive preventive visits
  - Higher ER utilization was also correlated to lower income levels and a higher area deprivation index and lack of provider adequacy

Emergent Care Visits



Visits/1000





Emergent Care Recommendations

Survey membership and review provider adequacy to identify primary causes for reliance on emergency department care

- Care avoidance due to concerns about quality of care or cost
- Lack of relationship with primary care provider
- Convenience of ER compared to other options, etc.

Improve quality of care for Black, Hispanic, and other members of color and low-income plan members

- Make it easier for members to elect providers with a shared experience by including race, ethnicity, sexual orientation, and gender identity in provider lookup tools
- Implement equity-focused quality measures and incentives
- Move toward contractual relationships that incent provider groups to take a more active role in addressing social determinants of health and focus on addressing inequities
- Require or encourage providers to adhere to culturally and linguistically appropriate services and to participate in implicit bias, health equity, and/or cultural humility trainings as part of continuing educations requirements.

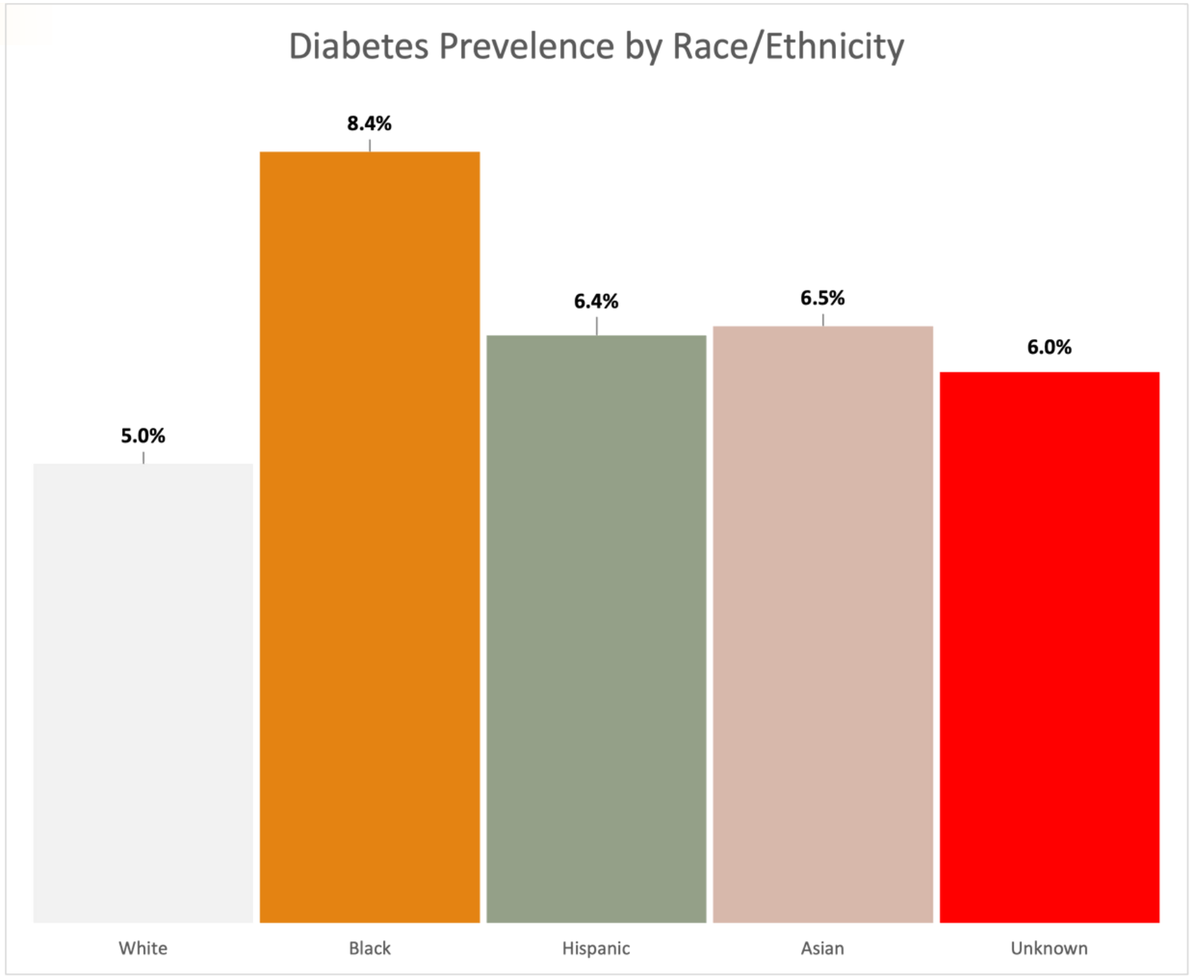
Expand accesses to equitable, preventive-focused services

- Increase use of community health workers for targeted interventions and to help members address social determinants of health
- Targeted interventions for those with or at risk of developing chronic diseases

Diabetes Prevalence

- Diabetes prevalence is higher among Black, Hispanic, and Asian members than White members
- Enrollees who had diabetes and lived in the areas with the highest Area Deprivation Index (ADI) had higher hospital and ER utilization, suggesting they are experiencing more severe complications of diabetes and may have less access to preventive care or alternative care settings

Diabetes Prevalence by Race/Ethnicity



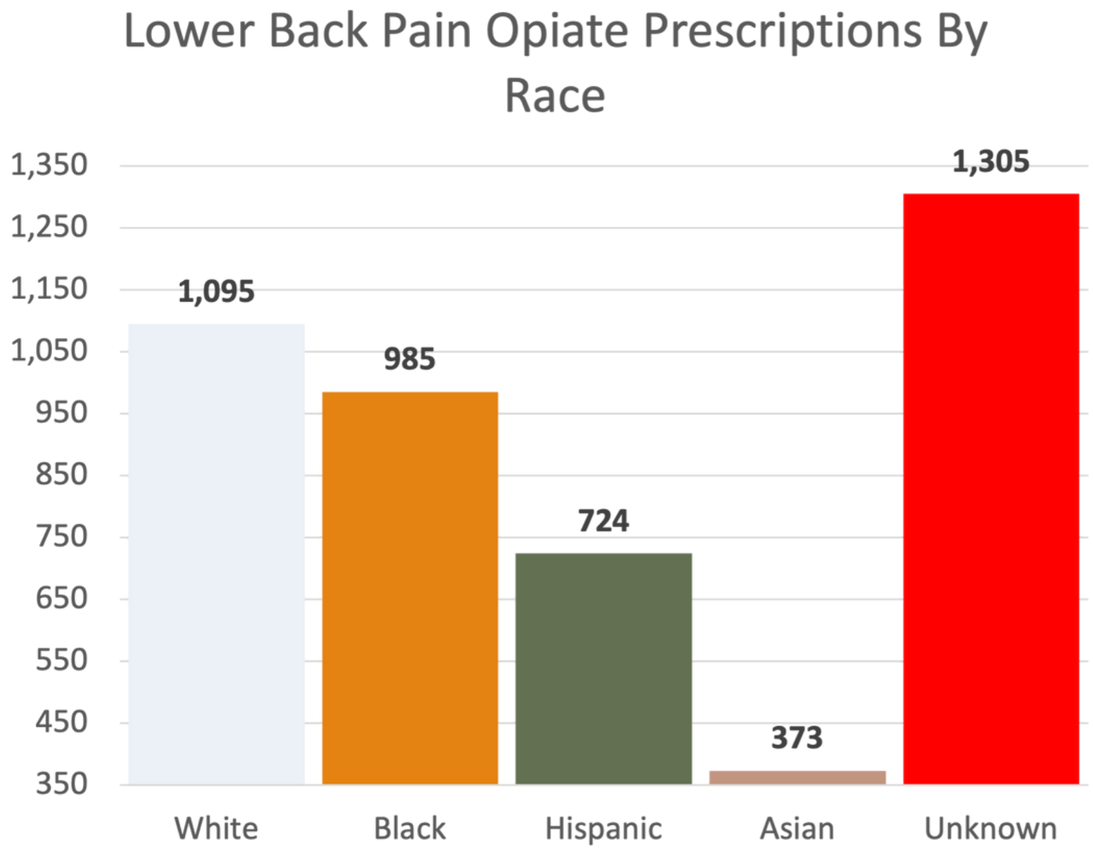
Visits/1000

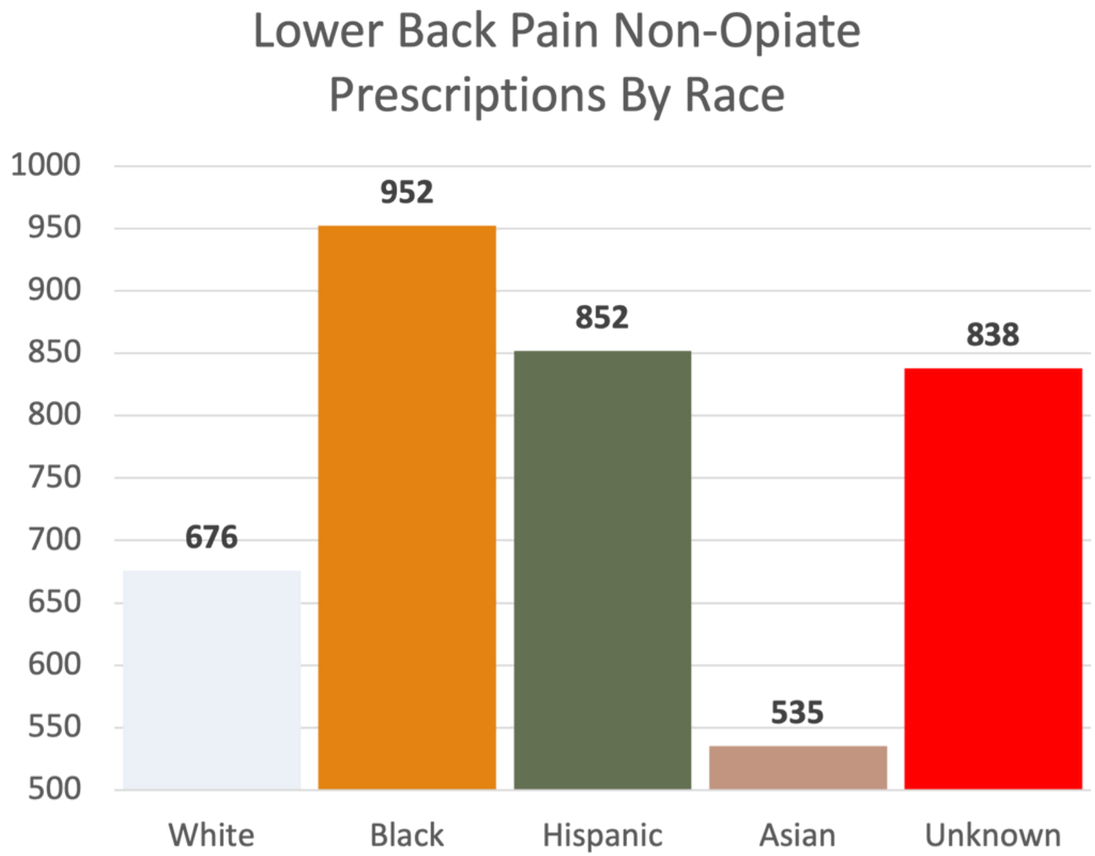
Diabetes Prevalence Recommendations

- Diversify communication platforms used to inform members of the availability of programs or services available for managing or preventing diabetes and highlighting that they are zero cost.
- Ensure lifestyle coaches have been trained in health equity, implicit bias, or cultural humility to ensure culturally appropriate care.
- Gather data from members on barriers to participation and consider additional options such as CHW-based diabetes interventions.
- Broadly support efforts to promote healthy environments such as healthy food policies, green spaces, and improved public transportation.

Lower Back Pain Treatment

Lower Back Pain Treatment Findings





White members were the most likely to receive opiate prescriptions while Black members were the most likely to receive non-opiate pain medications.

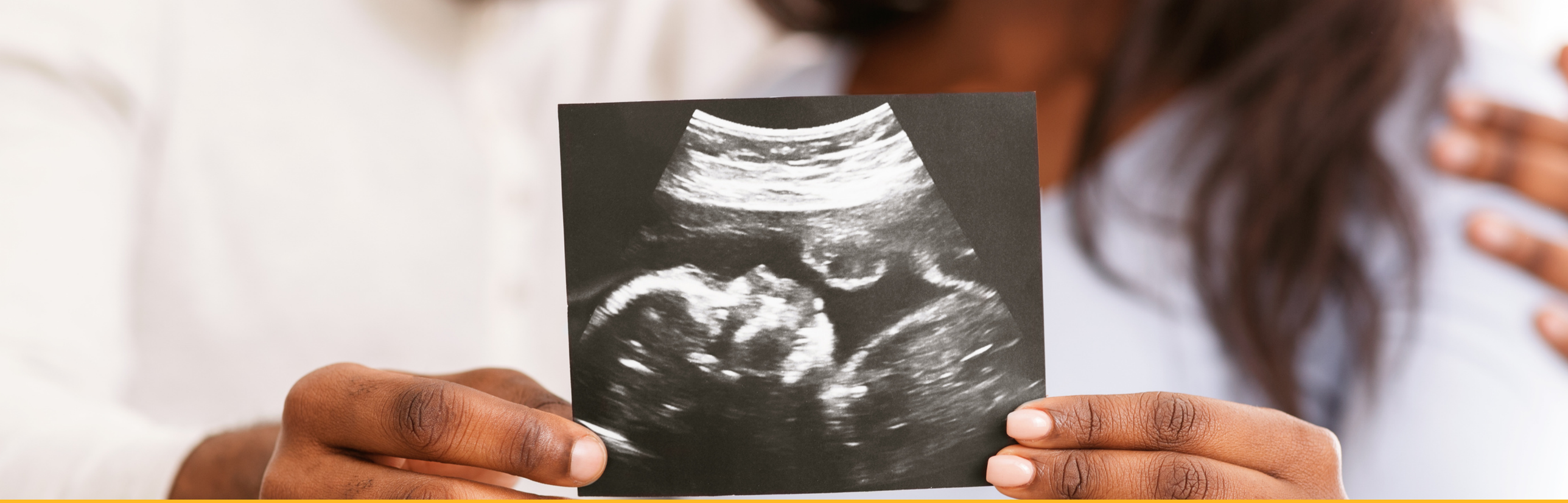
Lower Back Pain Treatment Recommendations

- The findings indicate potential racial and ethnic bias in opioid prescription patterns.
- Generally, the plan seeks to encourage limited use of opioid treatments for all types of pain including lower back pain, with an increased focus on alternative interventions; however, treatment patterns should be consistent by race.
- The state plan should track and measure lower back pain treatment by race and encourage providers to be consistent in their treatment patterns across racial and ethnic groups by reporting provider performance.
- In addition, the state plan may assess opioid and other prescription rates by race and ethnicity to monitor for and address disparities in treatment for pain, behavioral health conditions, and other disparity-prone prescription rates.

Gender

Gender Findings

- Gender is available in the claims and enrollment data as binary (i.e., male or female).
- Female members have higher average risk scores than male members (1.098 for females and .877 for males in 2020).
  - While pregnancy and birth account for some of the excess risk as does the 1.6 year difference in average age, the primary driver of this difference is the higher utilization among female members.
- Female members are 66% more likely to use telehealth than male members, 25% more likely to use urgent care services but only 8% more likely to use the emergency room.
  - This is evidence that female members are more likely to use the health care system proactively than male members due to both reproductive health care and societal/cultural care seeking norms. (2,3)
- Female members fill more prescriptions (11,297 per 1,000) than male members (9,125 per 1,000).
  - Some of this difference can be attributed to gender-specific prescriptions (i.e., birth control) but, as noted above, this is also indicative of higher overall utilization by female members.
- **Male and female members had very similar utilization on most chronic disease care gap metrics, such as nephropathy and retinopathy screening for diabetics.**
- Female members were far less likely to adhere to medication regimens for chronic diseases.
  - For example, male members with coronary artery disease (CAD) had a usage rate of 84.5% for statins compared to 64.1% for female members with CAD. This disparity in medication compliance was consistently observed regardless of the condition and drug. It is likely this is correlated with differing experiences of side effects.



Pregnancy and Birth

Pregnancy and Birth

Background

- National studies have found significantly higher rates of severe birth-related morbidity (adverse events) for birthing people living in predominantly Black communities (two times higher) and birthing people living in predominantly Hispanic communities (1/3 higher) than birthing people living in predominantly White communities.* Pregnancy and birth related deaths are consistently and exponentially higher for Black birthing people than the state average.
- Causes for the variation in outcomes include:**
  - Access to quality health care
  - Prevalence of health conditions that increase maternal risks
  - Variation in the quality of care provided
  - Variation in other social determinants of health

*Racial Disparities in Maternal Health and Mortality (bcbs.com)
**09-15-Racial-Disparities-in-Maternal-Health.pdf (usccr.gov)

Pregnancy and Birth Findings

- This study reviewed the prevalence of maternal morbidity across racial and ethnic groups in the following areas:
  - Preeclampsia
  - Gestational diabetes
  - Miscarriages
  - Pre-term delivery
- In general, the total incidence across all populations was very low, as a result the statistical significance of identified variation is also low. However, in several areas the findings are directionally consistent with national studies, indicating that disparities likely exist in the study population.

Pregnancy and Birth Findings

	Prevalence - % of Females of Childbearing Age											
	White		Black		Hisp		Asian		Other & Unk		Total	
Miscarriages	304	0.4%	109	0.6%	70	0.5%	27	0.9%	370	0.4%	880	0.4%
Pre-term labor and delivery	171	0.2%	69	0.3%	46	0.3%	11	0.3%	244	0.3%	541	0.3%
Gestational diabetes	274	0.4%	82	0.4%	68	0.5%	35	0.8%	337	0.4%	796	0.4%
Preeclampsia	172	0.2%	71	0.4%	30	0.3%	12	0.3%	215	0.3%	500	0.3%

Pregnancy and Birth Recommendations

- Change the reimbursement structure for maternal care to encourage improvements in the health of birthing people and infants
  - Require such reimbursement structures to stratify quality metrics by race and ethnicity and incent reductions in disparities
  - Provide access to doula and CHW supports during pregnancy, birth, and the postpartum period
  - Require the state health plan and Medicaid to institute such reimbursement models utilizing the same quality metrics, eventually require all commercially fully insured plans to do the same

Data Collection

Data Collection

Race and ethnicity data is collected for approximately 80% of state employees, but no data is currently collected for dependents or Partnership plan members. The lack of race and ethnicity data is a limiting factor in evaluating disparities in the plan.

Data Collection Recommendations

- Complying with PA 21-35 by expanding race and ethnicity categories, allowing individuals to select one or more racial and ethnic designations, and allowing individuals to write in identities not available on the standard list.
- Collecting race and ethnicity data for dependents and partnership plan members.
- Clearly explaining on forms and/or training staff who collect REL data to note that the purpose of collecting such data is to identify and address inequities at the population level.
- Combining questions on race and ethnicity for ease of understanding.
- Collect sexual orientation and gender identity data beyond a male/female binary, to identify and address disparities experienced by LGBTQ+ members and people with intersecting identities.
- Leveraging data collected by providers via Anthem and/or the statewide health information exchange (HIE).
- Incorporate REL data into the State Plan’s data warehouse and build standard reporting functions to track disparities.

State Plan Current Initiatives and Opportunities Related to Health Equity

Opportunities for Intervention

- Include health equity measures in Primary Care Initiative contracts and mutually share race and ethnicity data
- Require vendors to collect race and ethnicity data when enrolling members (Digital MSK, Diabetes Management, etc.)
- Survey populations who experience disparities to identify challenges that reduce Telehealth utilization and increase ER utilization – determine ways to address such issues
- Collect race and ethnicity data from Partnership groups
- Work with DAS to adjust CORE tables to include more detailed race and ethnicity categories and expand collection of data for dependents
- Target communications to populations who experience disparities, particularly for diabetes management and prevention programs where incidence is higher
- Routinely evaluate progress towards equity