

BUILDING TOWARD RACIAL JUSTICE AND EQUITY IN HEALTH: A CALL TO ACTION





ACKNOWLEDGMENTS

This report is informed by the experiences of many patients, health care providers from a variety of practice settings, public health organizations, researchers, and community groups who generously shared their time and perspectives with AGO staff.

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INTRODUCTION

The data on racial and ethnic health care disparities in Massachusetts paint a bleak picture. In general, residents of color are less healthy and die younger than white residents. The rates of heart failure, stroke hospitalization, and diabetes-related death are significantly higher for residents of color than white residents.¹ The infant mortality rate for Black newborns in Massachusetts is twice that of white newborns.² Black women are twice as likely to die in connection with pregnancy than white women.³ The rate of HIV infection in Massachusetts is more than 6 times higher in Hispanicⁱ individuals than in white non-Hispanic individuals.⁴ Asian residents in Boston are 15 times more likely than white residents to have Hepatitis B and twice as likely to have liver cancer.⁵ These disparities are long-standing and pervasive. While gaps between white populations and communities of color have been narrowed, there are still significant racial disparities in health outcomes in communities across the state.

COVID-19 has amplified and worsened these inequities. Massachusetts residents of color have significantly higher COVID-19 infection rates, hospitalization rates, and age-adjusted death rates than white residents.^{6,7} Although they are less likely than white residents to seek mental health care, residents of color have reported higher levels of anxiety and depression since the beginning of the pandemic.⁸ They have also been more vulnerable to the economic impacts of COVID-19. Black, Hispanic, and

i. While this report describes disparities affecting both the Hispanic population (individuals who speak Spanish or trace their heritage to Spanish-speaking countries) and the Latinx population (individuals who trace their heritage to Latin American countries), we specify the population studied in cited references where appropriate. See Nicki Lisa Cole, *Difference Between Hispanic and Latino*, COURAGEOUS CONVERSATIONS (June 30, 2019), <https://courageousconversation.com/the-difference-between-hispanic-and-latino/>.

Latinx workers are more likely than white workers to hold jobs that cannot be done remotely; Latinx and Hispanic people are twice as likely to live in crowded housing as their white counterparts.⁹ Hate incidents targeted at the Asian community have increased during the pandemic.^{10, 11}

The evidence on the disparate effects of COVID-19 provides a somber reminder of the health care system's failure to equitably serve the Commonwealth's most vulnerable residents. COVID-19 also creates an urgency to address health inequities. That urgency builds on the nationwide racial justice movements that arose after the killing of George Floyd and other Black Americans—events that have shown the deadly impact of racial discrimination on the health and wellbeing of marginalized communities. Access to high-quality, affordable health care, without regard to race or ethnicity, is an issue of civil rights. The Commonwealth must set ambitious goals for swift progress toward racial justice. There is much work to do to ensure that every resident in the state has an equal opportunity for a healthy life.

Fortunately, the Commonwealth is renowned for the high quality of its health care system. The state has taken bold, effective action to address health care quality, cost, and access. Massachusetts has a history of collaboration in ensuring near-universal health insurance coverage, supporting robust safety net programs, and working to constrain health care cost growth. These efforts are models for other states. Indeed, the Commonwealth is a national leader in health policy.

The state's reputation for excellence is due in no small part to its health care institutions. These world-class institutions have shown tremendous resiliency as they work on the front lines of our response to the COVID-19 pandemic. Our academic and public health institutions have provided critical information, explanation, light, and hope on how to best address COVID-19 in our country and around the world. Our providers have saved lives across the state under extraordinary conditions. Our life sciences companies have worked tirelessly on diagnostics, therapeutics, and vaccines. And many of our insurance companies have waived cost sharing for COVID-19 care and certain important medical visits, making it easier for patients to receive the care they need.¹² Together, these institutions have proven that our health care ecosystem remains strong.

These successes cannot deflect attention from the work that remains; rather, our accomplishments should give us the confidence to reform our health care system and related parts of our community infrastructure to best address the needs of Black, Indigenous, Hispanic, and Latinx communities, and all communities of color. Although

the system works for many, it has left many others behind. Progress in the fight against health inequities requires a commitment to sustained collaboration involving our health care institutions, policymakers, public health organizations, scientists, academics, patient advocates, and community-based organizations in the drive towards fairness and equality. Massachusetts has the resources, talent, and vision to emerge from the COVID-19 crisis not only as a leader in health care, but also as a leader in health equity.

To increase the momentum of action and collaboration to advance health equity, the Massachusetts Attorney General's Office (AGO) issues this report discussing ways stakeholders should come together to address the systemic health inequities facing people of color. This report is by no means exhaustive, and we acknowledge the efforts of many others to increase the attention on health inequity. Our goal in focusing on five domains that are critical to reducing health disparities and advancing racial justice is to support concrete steps that can move us forward toward equity. The goal of this report is to build on our statewide dialogue on health equity and invite collaboration. We intend this report to launch discussion about how best to advance these priorities. We invite stakeholders to share their ideas with us.

This report begins with an overview of the disproportionate harm that COVID-19 has caused in communities of color, and then outlines actionable recommendations to advance health equity in the following areas:

1. Data for Identifying and Addressing Health Disparities: Establishing a robust and timely data foundation that is readily available to policymakers, researchers, and health care providers is the first step to understanding existing disparities and developing strategies to address them. We recommend that state agencies require health care providers and insurance carriers to improve the collection and reporting of patient race, ethnicity, and other demographic characteristics. The state should embrace a transparent and inclusive process to set measurable health equity goals and launch an annual Health Equity Hearing to measure the state's progress towards the identified equity benchmarks.
2. Equitable Distribution of Health Care Resources: Low-income communities and communities of color should have access to the same resources available to any other community in order to meet their health needs. State actors should examine new ways of ensuring that safety net providers receive fair and adequate payments for delivering care to those who need it most. We recommend that carriers reduce cost sharing during the pandemic for primary

care, behavioral health, and prescription drugs for certain chronic conditions. Legislation may be required to effectuate these changes.

3. Clinical Health Equity: Telehealth as a Tool for Expanding Equitable Access: The accelerated adoption of telehealth during the pandemic has the potential to address longstanding health care access barriers. But additional policy changes are needed to ensure that these gains are enjoyed equally by all. We must address the divide in digital access by increasing the availability of free and low-cost internet plans and devices, and make sure that underserved patients are aware of available resources. Insurers should be required to provide coverage and payment parity for telehealth services, including telephonic visits, where clinically appropriate, for the next two years. This will allow providers flexibility to determine the best method of treatment for patients, many of whom face barriers accessing in-person or video care, without forcing substantial financial trade-offs. Entities must ensure equitable access for individuals with disabilities and limited English proficiency through standardized procedures and accommodation services to minimize existing disparities in clinical care.
4. Health Care Workforce Diversity: The health care workforce does not represent the diversity of the patients it serves, and this lack of representation hurts communities of color. Policymakers, educational administrators, and health care organizations should expand affordable and inclusive educational opportunities to increase access to health professions. Anti-racist and cultural humility training should be included in medical education, licensure, and certification processes. We recommend that health care providers implement equitable standards of care to improve the patient experience and health outcomes for all. The state should support the expansion of community health worker capacity to meet the needs of underserved communities.
5. Social Determinants of Health and Root Causes of Health Disparities: The health care system alone cannot end health disparities, which are rooted in deep-seated inequities in the social, economic, and environmental conditions that are necessary for a healthy life. All stakeholders must come together to address key social determinants of health—including education, employment, housing, the environment, and violence—in order to advance statewide health equity. Local public health departments are key leaders in this work, but they need better funding and coordination. We encourage the state to explore new models to bring together regional stakeholders to address social determinants of health, such as regional health equity authorities.

GLOSSARY OF KEY TERMS

Community Health Center (CHC): Non-profit, community-based health care provider organization that offers primary and preventive health care, mental health services, and social support to anyone in need regardless of their medical status, ability to pay, culture, or ethnicity.

Community Health Worker (CHW): Trained public health workers who serve as a bridge between communities, health care systems, and state health departments.

Cultural Humility: In clinical settings, a practice in which providers are guided by patients' knowledge of their own health, are willing to bridge gaps in cultural perspectives, and deliver care directly in the diverse communities where their patients live.

Health Care Payer: A private insurance carrier or public entity (i.e. Medicaid, Medicare, Group Insurance Commission, Health Connector) that contracts or offers to arrange for, pay for, or reimburse the costs of administered health care services.

Health Care Provider: A health care practitioner, facility, group or organization that delivers and administers health care services or medical products to patients.

Health Disparities: Health differences closely linked with economic, social, or environmental disadvantage that adversely affect groups of people who have systematically experienced obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender or sexual identity, age, disability status, geographic location, or other characteristics historically linked to discrimination.

Health Inequities: Systemic, avoidable, and unjust disparities in health status and mortality rates across population groups that are rooted in underlying injustices and social and economic conditions.

Health-Related Social Needs: Immediate social and economic needs that impede an individual or family's health, well-being, or safety.

Implicit Bias: Unconscious or learned attitudes, stereotypes, and prejudices that impact an individual's understanding, actions, and decisions.

Massachusetts Health Connector: The state's marketplace for health and dental insurance where individuals and small businesses can find and compare private health insurance options, as well as qualify for lower premiums and out-of-pocket costs.

Safety Net Provider: A health care provider that predominantly delivers care and support services to the uninsured, Medicaid enrollees, and other vulnerable populations.

Social Determinants of Health: Underlying social, economic, and environmental conditions that impact population-wide health risks and outcomes.

Structural Racism: A system of advantage in structuring opportunity and assigning value on the basis of race.

Fromⁱⁱ: C. Jones (2002)¹³; E. Fee and A. Gonzalez (2017)¹⁴; J. Powell and R. Godsil (2011)¹⁵; MA Center for Health Information and Analysis (2020)¹⁶; MA Health Connector (2020)¹⁷; MA Bureau of Geographic Information (2019); U.S. Department of Health and Human Services (2010)¹⁸; U.S. Institute of Medicine (2000)¹⁹; World Health Organization (2008)²⁰; CDC Community Health Worker (CHW) Toolkit²¹; M. Tervalon and J. Murray-Garcia (1998)²².

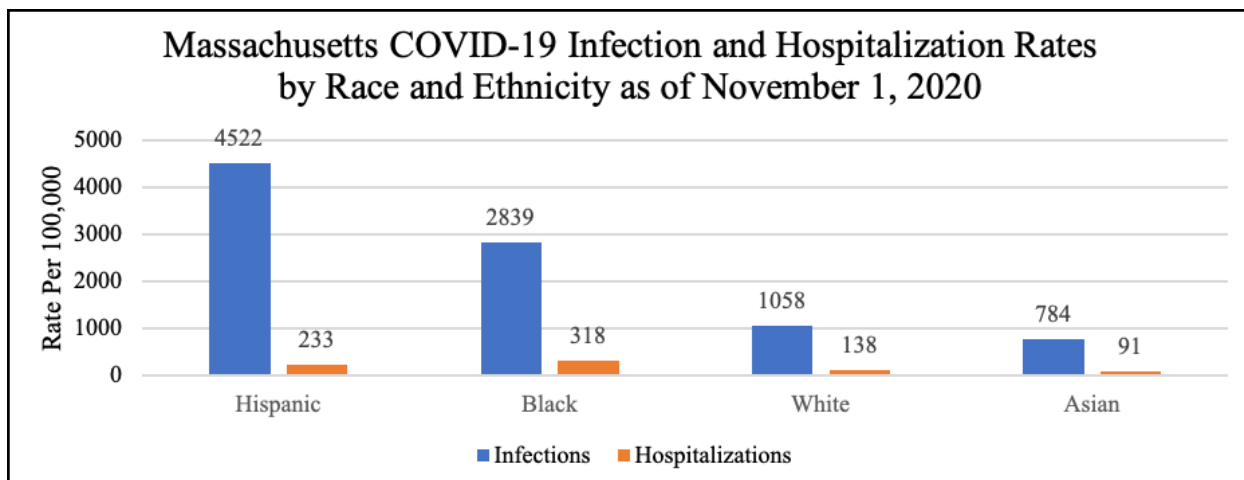
ii. This glossary was informed by tools developed by the Southern Jamaica Plain Health Center.

THE IMPACT OF COVID-19 ON COMMUNITIES OF COLOR

Communities of color have disproportionately borne the brunt of COVID-19. In comparison to white communities, they have experienced significantly higher COVID-19 infection, hospitalization, and age-adjusted mortality rates—disparities rooted in underlying inequities in social determinants of health. People of color are at risk of suffering disproportionately from the mental health crisis caused by the pandemic, and from the inability to access needed medical care, including preventive care. They are also more likely to live in the high-poverty neighborhoods that are most vulnerable to the economic effects of the virus. In these ways, COVID-19 has threatened the very fabric of these communities.

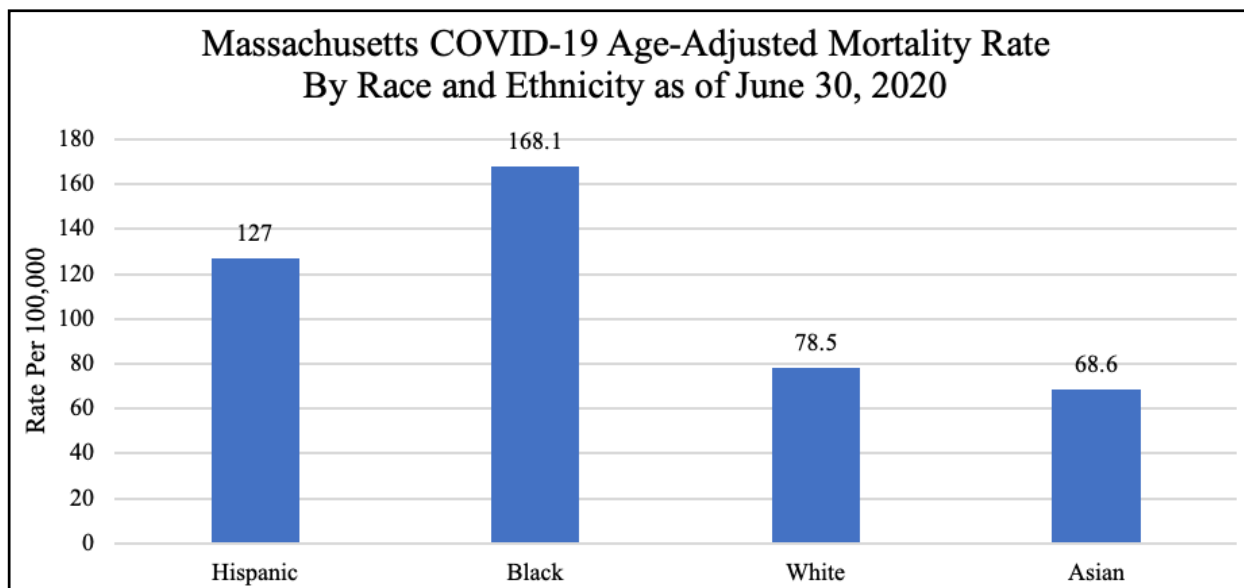
The data show striking disparities in infection, hospitalization, and age-adjusted mortality rates between white communities and communities of color. When compared with white residents, Hispanic and Black residents, respectively, are about 4.3 and 2.7 times more likely to be infected with COVID-19, and 1.7 and 2.3 times more likely to be hospitalized from the virus.





From: COVID-19 Dashboard, Mass. Department of Public Health (November 2020)²³ (including infection and hospitalization numbers for Hispanics, Black/African American non-Hispanics, white non-Hispanics, and Asian non-Hispanics); U.S. Census Bureau Data²⁴ (including population estimates for Hispanic or Latino, Black or African American alone, white alone, and Asian alone)

Age-adjusted mortality data shows that Hispanic and Black residents have also borne a higher burden of COVID-19 deaths compared to white and Asian populations.²⁵ The chart below shows that, as of June 30, 2020, Hispanic and Black residents respectively had 1.6 and 2.1 times higher age-adjusted COVID-19 mortality rates than white residents. Indigenous people have been 3.3 times more likely to die from the virus than white people across the country, but Massachusetts groups Indigenous people into an “other” racial category, leading to a dangerous lack of data about this population.^{26, 27}



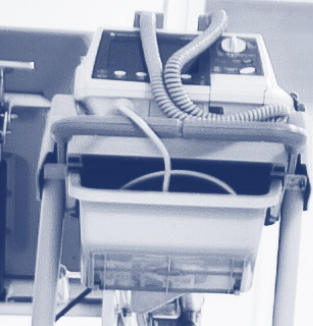
From: DPH COVID-19 Health Equity Advisory Group: Recommendations, Data Release & DPH Response, Mass. Department of Public Health (July 8, 2020)²⁸

In mid-April, amidst a surge of COVID-19 cases in Massachusetts, I called a patient who had recently tested positive to see how he was doing. This relatively stoic man described that he was doing ok. But as the conversation drew on, I could hear his wife crying in the background, suggesting she was more concerned about his health, and then I could hear his child express the same. During the conversation, he seemed increasingly short of breath, and so we arranged for him to be urgently seen in our respiratory clinic. There, we found his oxygen levels to be dangerously low, and he was immediately admitted to the hospital. I followed his hospital course everyday and his prognosis was uncertain. Thankfully, he made it out, and has begun a long road to recovery.

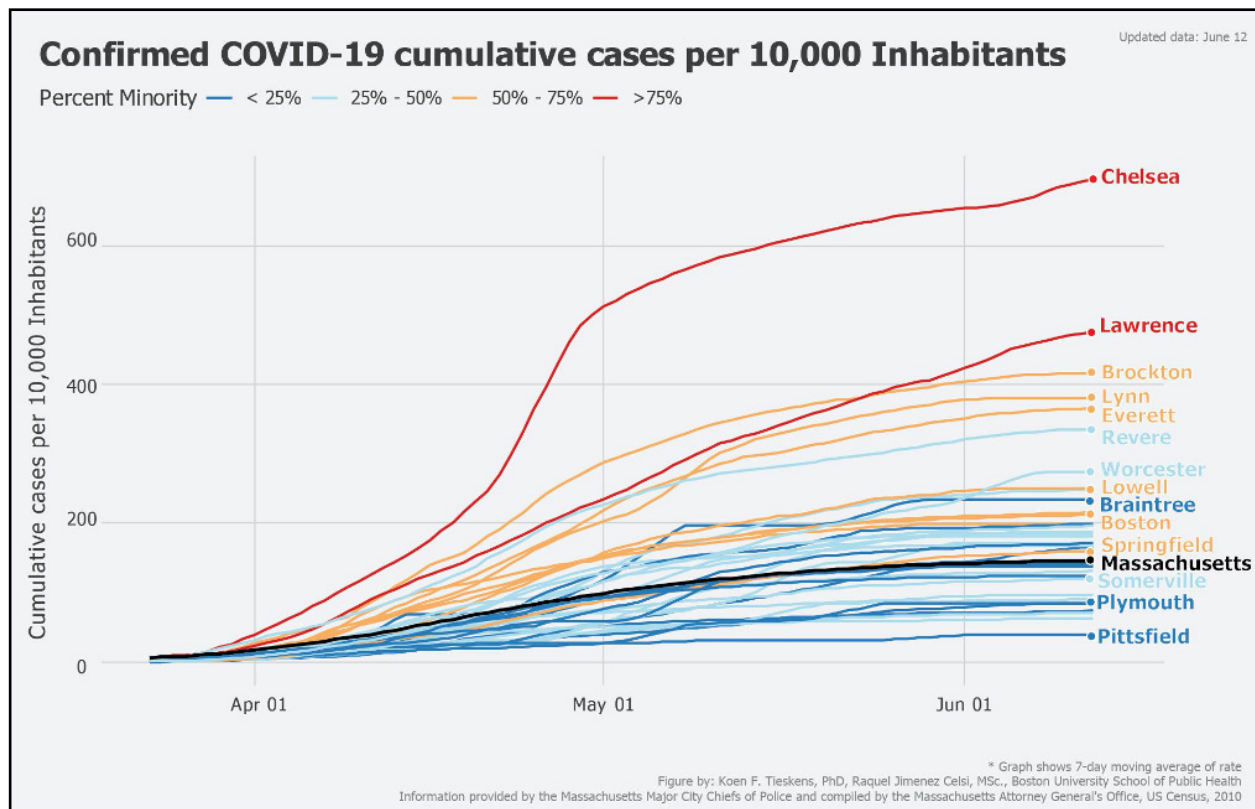
The raw suffering I have witnessed during this pandemic as a physician has been hard to bear. But I also know this pandemic is not only about a virus, but also the structures and systems that have failed us during this public health crisis. My patient lives in Chelsea, the epicenter of COVID-19 cases in Massachusetts. As a Latino man, structural racism has been among the greatest threats to his health. In many neighborhoods in Chelsea, more than 70% of community members are essential workers—who worked because they had to, even at the risk of their own health. Our housing crisis has led to high density living quarters, which increases the risk of household transmission. And people who live in Chelsea are exposed to a dangerous level of air pollution, which recent studies show increase the risk of death if infected by the coronavirus.

My patients deserve better, and their communities deserve better. Eradicating structural racism and improving health equity will not only make our society more fair and just, it will also make it more healthy.

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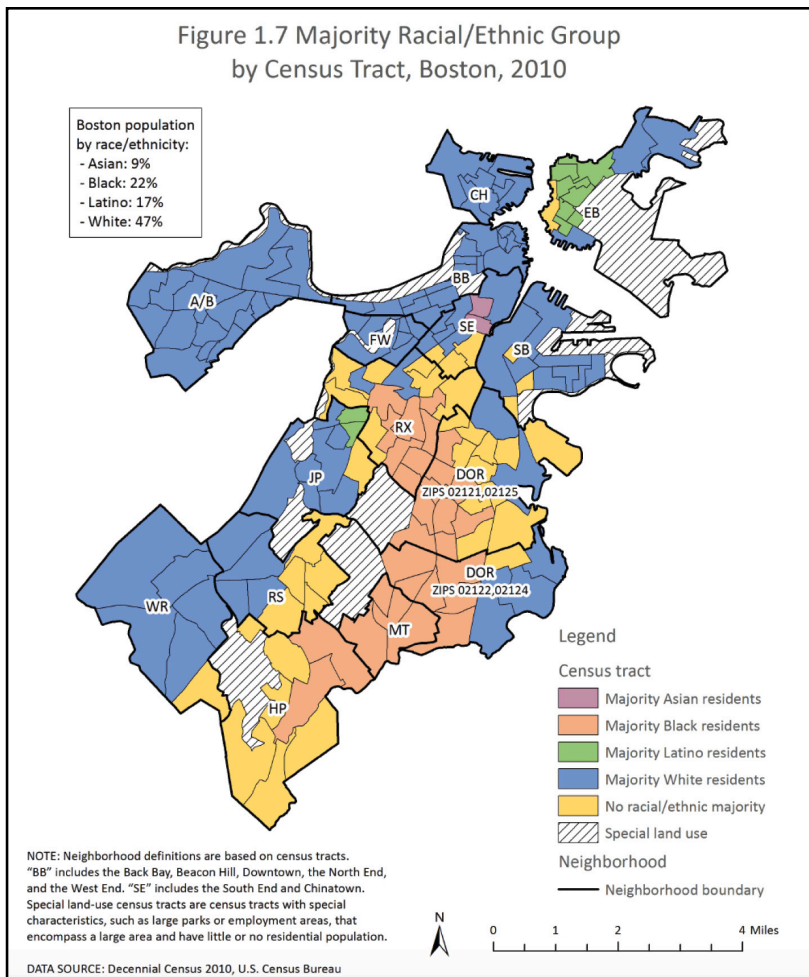


Town-level data reflects similarly striking inequities. During the initial surge in April 2020, the COVID-19 death rate was 40% higher in Massachusetts municipalities with the highest number of people of color.²⁹ An analysis of all 351 Massachusetts cities and towns found that higher percentages of Black and Latinx or Hispanic populations were associated with significantly higher rates of confirmed COVID-19 cases.³⁰ As illustrated in the graphic below, cities such as Chelsea, Lawrence, Brockton, and Everett have reported dramatically higher rates of COVID-19 than predominantly white communities across the state.



From: *Vulnerability in Massachusetts During COVID-19 Epidemic*, Boston University (June 2020)³¹

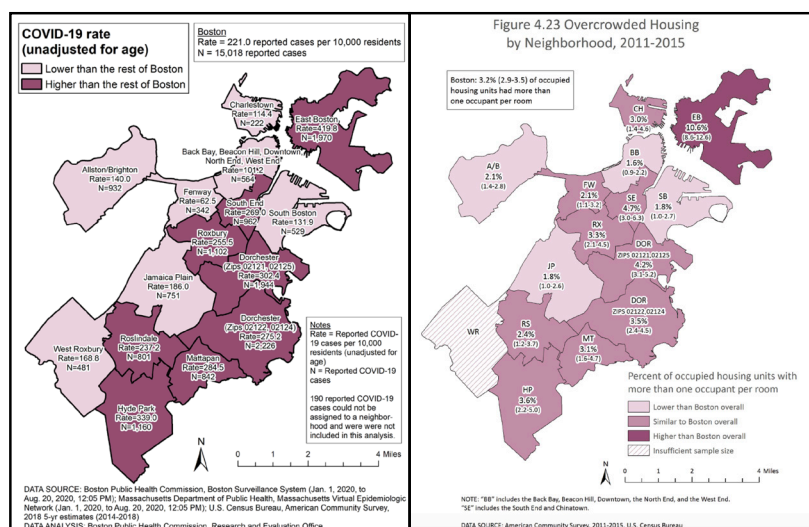
These COVID-19 disparities are driven by underlying inequities in social determinants of health, including structural racism. Communities that have been most impacted by the virus are more likely to have more essential workers, rely on public transportation, and lack the space to quarantine effectively at home.^{32, 33} In a recent report, the AGO found that sustained exposure to pollution for low-income populations and communities of color contributed to greater susceptibility to the virus.^{34, 35} In addition, changes to the federal “public charge” rule have created further barriers for immigrant families seeking to access health care, with many low-income immigrant families avoiding enrollment in Medicaid out of fear of losing access to a pathway to citizenship.³⁶ As documented in the maps on the next page, Boston neighborhoods



From: Boston Public Health Commission (2017)³⁷

that have a majority of Black or Latinx residents are more likely to live in overcrowded housing, contributing to higher rates of COVID-19 infection.

The COVID-19 pandemic is also harming residents' mental health. In the first half of 2020, about a third of Americans reported recent symptoms of anxiety and depression (compared to 11% during the same period in 2019), with people of color reporting higher levels of mental stress compared to white people.⁴⁰ As the national mental health crisis worsens, the stress on marginalized communities is compounded by the fact that Americans of color are less than half as likely as white Americans to receive mental health care.⁴¹ Black and Hispanic Americans have seen a disproportionate increase in behavioral health needs since the beginning of the pandemic, with a higher prevalence of depression, symptoms of trauma and stress-related disorders, and substance use.⁴² As of August, CDC data on suicide show stark racial disparities: while overall 10.7% of survey respondents reported having seriously considered suicide in the last month, the rates were much higher for Hispanic respondents (18.6%), non-Hispanic Black respondents (15.1%), and essential workers (21.7%).⁴³



From: Boston Public Health Commission (August 2020)³⁸; Boston Public Health Commission (February 2019)³⁹

Experts also warn of a looming secondary health crisis resulting from the pandemic that is likely to increase

the chronic and communicable disease burden in underserved communities. The steep drops in preventive care in the spring of 2020 have not yet recovered to normal levels, with mammogram and colonoscopy procedures still 33% and 23% lower than normal, respectively.⁴⁴ Childhood vaccinations for hepatitis and measles collectively dropped by 73% in April and were still 36% lower than expected in June. With low-income populations and communities of color already experiencing significant barriers to care and higher rates of chronic diseases, people of color are most likely to suffer the long-term health consequences of avoiding or delaying preventive care. In addition, these drops in preventive care and vaccination rates—as well as the fact that people of color are less likely than white people to have a regular source of care such as a primary

While many people continue working comfortably from the safety of their homes during the COVID-19 pandemic, my immigrant patients are more likely to have lost their jobs or be classified as essential workers and face an increased risk of getting the virus. In this way, the pandemic has exposed and exacerbated existing inequities among these patients. Many of my refugee patients' PTSD and anxiety have also worsened with the isolation of stay-at-home orders, compounded by increased economic and food insecurity. While immigrant and refugee patients also continue to fear arrests by ICE at or nearby hospitals, as well as information-sharing between health and government agencies, the consequences of those fears—dissuading them from seeking the care they need—have much larger, public health implications in the context of the pandemic. And, we cannot forget that many families are dealing with the trauma of having lost loved ones to COVID-19. As always, I remain in awe of my patients' resiliency but there is suffering compounded across so many levels and it has been hard to witness as a clinician.

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care physician—should raise concerns for health systems and public health authorities preparing to equitably distribute an eventual COVID-19 vaccine.⁴⁵

Massachusetts communities experiencing high rates of poverty have been especially vulnerable to the economic impact of COVID-19, due to factors such as limited vehicle access and transportation options, essential worker status, housing costs and over-crowding, and poor access to internet. Half of Latinx and Black respondents to a national survey reported experiencing significantly higher rates of economic hardship—such as being unable to pay for basic necessities and using up all or most of their savings—than white individuals.⁴⁶ Nationwide, almost twice as many Black and Latinx workers hold jobs that cannot be done remotely.⁴⁷ A Massachusetts analysis of these socioeconomic factors revealed that high-poverty communities in the state are most vulnerable to the economic effects of this crisis, and further found that this economic vulnerability is predominantly concentrated in neighborhoods of color.⁴⁸ In this study, 94% of the Boston region’s neighborhoods of color were found to have “high” economic vulnerability to the impacts of COVID-19.⁴⁹

We must come together to address these longstanding disparities in social determinants of health and health outcomes in Massachusetts. In the following sections of this report, we put forward a series of recommendations in five key domains that impact our collective progress towards health equity and racial justice. These recommendations outline the ways in which our health care institutions, policymakers, academics, patient advocates, public health institutions, and community-based organizations can take action to address systemic inequities and improve health equity in the Commonwealth.

RECOMMENDATIONS IN FIVE DOMAINS

I. DATA FOR IDENTIFYING AND ADDRESSING HEALTH DISPARITIES

COVID-19 has illustrated the importance of using demographic, geographic, and socioeconomic data to deploy resources in areas where they are needed most in an effective and timely fashion. Without complete and accurate demographic data, government agencies, health care providers,ⁱⁱⁱ and community-based organizations are hindered in their ability to identify emerging hot spots or distribute testing sites, personal protective equipment, and other resources to at-risk areas.^{50, 51} Access to consistent and robust patient demographic information allows governments, health systems, and researchers to identify and address health disparities and provide both immediate and long-term support to underserved communities.

iii. Health care providers include providers of medical, dental, behavioral health, and other health care services.

In the city of Springfield, data collection and surveillance are essential public health tools needed to monitor and address health inequity and racial injustice. As the city, and in fact, the world faces some of the most challenging health crises of our time, data surveillance is imperative to estimate the magnitude of health disparities faced by groups at greatest risk for the poorest health outcomes. The city uses data to examine relationships between risk factors and outcomes, develop interventions, and with continued monitoring, assess the effectiveness of the interventions to modify complications and improve results.

Data is also used to leverage grant funding which supports needed existing and new programs. It is a valuable resource that informs policymakers, community organizations, and residents in our shared advocacy for system change.

**SOLOE DENNIS,
DEPUTY PUBLIC HEALTH COMMISSIONER, SPRINGFIELD
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Standardized demographic data collection plays a role in improving outcomes at every point along the continuum of care, from population health management to the individual provider-patient relationship. Addressing chronic health disparities requires targeted investment in the areas of highest need; as demographic data improves, so does the precision of interventions. Some health care providers have standardized the collection of a wide range of demographic information, which allows them to identify previously hidden disparities. For example, using community-level demographic data, providers were able to identify that adult patients living in higher poverty neighborhoods were less able to prevent or control prediabetes and diabetes conditions than those living in more affluent neighborhoods.⁵² Without patient demographic information, providers may develop treatment plans that fail to consider social and economic circumstances that make it harder for individuals to attend routine appointments, afford nutritious food, or adhere to medication plans.⁵³

The quality and use of demographic data have life-and-death consequences. Many insurers and providers have built and implemented algorithms to help predict health outcomes, assist in clinical decision-making, and identify patients in need of additional care. However, algorithms widely used in health care can adversely impact disadvantaged communities if socioeconomic and demographic factors are not properly considered. For example, population health algorithms—formulas that identify patients who are likely to need additional support or services—that rely on health care spending as a proxy for patient need have been found to introduce racial bias. Longstanding unequal access to care has led to overall lower health care spending on Black patients than on white patients.⁵⁴ In addition, similar biases may affect risk-adjustment processes that are often used in determining health care payments which may result in underfunding of providers that serve low-income and marginalized communities. Users of health care data must ensure that data-driven tools do not further exacerbate existing structural inequities and health disparities.

The COVID-19 pandemic has drawn attention to the need for improved data collection and reporting on race and ethnicity. On April 8, 2020, the Massachusetts Department of Public Health (DPH) began reporting race and ethnicity data for total confirmed COVID-19 cases and deaths in Massachusetts.⁵⁵ However, at the time, over two-thirds of confirmed cases and deaths were missing race and ethnicity information. DPH issued an order instructing providers and laboratories to “make every reasonable effort to collect complete demographic information.”⁵⁶ In early June, the Legislature passed *An Act Addressing COVID-19 Data Collection and Disparities in Treatment*, requiring that DPH collect demographic information for reported COVID-19 tests, positive cases, hospitalizations, and deaths, as well as expand data collection

requirements for elder care facilities and correctional facilities.⁵⁷ The new law also requires that DPH stratify reported COVID-19 data by gender, age, race and ethnicity, city or town of residence, primary language, disability, and occupation. COVID-19 has focused attention on the need for complete, timely, and disaggregated data related to the pandemic, and we applaud the leadership of legislators and advocates who pushed for enhanced data collection practices. This law underscores a compelling need for standardized and actionable demographic data in health care that extends beyond COVID-19. The Massachusetts health care system needs data collection and publication practices targeted to identify health disparities. We recommend the following actions:

A. Standardize Reporting and Sharing of Robust Demographic Data in Health Care

Standardized and actionable demographic data is needed to improve patient and population health outcomes. *First*, we recommend that state agencies, such as the Center for Health Information and Analysis (CHIA) and DPH, require payers, providers, laboratories, and local health departments to report on patient demographics—including race and ethnicity, gender identity and sexual orientation, disability, place of residence, primary language, and occupation—when submitting data to the state on all patient events (e.g. discharge and claims data), infectious diseases, and other health conditions to allow for stratified analysis of health disparities.⁵⁸ Alignment with existing federal data collection requirements should be prioritized where possible. *Second*, the persistent gaps in basic demographic data on COVID-19 speak to the need for data collection improvements and the challenge of collecting quality demographic data.^{iv} The state should convene payers, providers, patient advocates and community members to better understand barriers to demographic data collection and to develop data collection protocols that prioritize cultural sensitivity, patient experience, and creation of actionable datasets.^{59, 60} For example, DPH could instruct health care organizations to collect and store patient demographic information as standardized variables—rather than in free-text format—to promote data completeness and to allow for rapid data sharing across health care and social service providers.⁶¹

iv As of October 28, 2020, of the 154,281 total COVID-19 cases reported in Massachusetts, 25.7% have missing or unknown race/ethnicity data. MASS. DEP'T OF PUB. HEALTH, DASHBOARD OF PUBLIC HEALTH INDICATORS 15 (2020), <https://www.mass.gov/doc/covid-19-dashboard-october-28-2020/download>.

B. Report Health Care Data by Census Tract Where Possible

To make transparent the link between disease burden and community-based socioeconomic status, policymakers and the public need access to health care data reported by census tract where possible and at least by geographic areas no larger than five-digit ZIP code. Reporting data on disease burden or vulnerability at the county or city level does not provide a granular enough understanding of areas that are most vulnerable to ongoing or emerging health issues. We recommend that DPH routinize the public reporting by census tract for all diseases and health conditions for which DPH collects data, modifying when necessary to protect individuals' privacy. In its reporting on COVID-19, we recommend that DPH report testing, cases, hospitalizations, and deaths by census tract if possible or alternatively by ZIP code so that this data can be readily linked to other available datasets on social determinants of health and demographic information. At least 17 states publish COVID-19 cases by ZIP code, and three states publish COVID-19 cases by census tract.^{62, 63} Other jurisdictions have alleviated privacy concerns through data curation methods, such as suppressing data for regions with low numbers of cases or sample sizes, or grouping cases from proximal regions.⁶⁴

C. Use Data Responsibly to Distribute Clinical and Community Resources

Payers and providers should use patient data, including data on race and ethnicity, health behaviors, living and working conditions, and other social determinants of health, to promote the equitable distribution of health care and social support services.⁶⁵ *First*, we recommend that payers and providers consider systemic inequities and socioeconomic factors when developing and implementing patient screening practices, clinical care protocols, population health management programs and data tools, and risk-adjustment formulas for payments to providers to ensure that additional biases are not embedded in these tools. *Second*, in coordination with social service agencies, schools, faith-based organizations, and other community-based partnerships, we encourage providers and local public health departments to build and maintain updated databases of available community resources and facilitate referrals for patients who require additional support around housing, food security, or other health-related social needs.

D. Harness Data to Measure Progress toward Health Equity Benchmarks

The state should embrace and build on requirements for monitoring and reporting on health equity and should establish and publicize actionable goals to demonstrate that it is committed to making forward progress on health equity. We recommend that the Health Policy Commission (HPC) partner with other state agencies focused on health equity, such as the DPH Office of Health Equity, to develop an inclusive and transparent process for setting benchmarks for demographic data collection and for achieving substantive health equity in the state. In collaboration with state agency partners, the HPC should host an annual Health Equity Hearing to measure the state's progress towards the identified equity benchmarks. The Health Equity Hearing could complement the HPC's annual health care Cost Trends Hearing with a similar format and include testimony from witness panels.

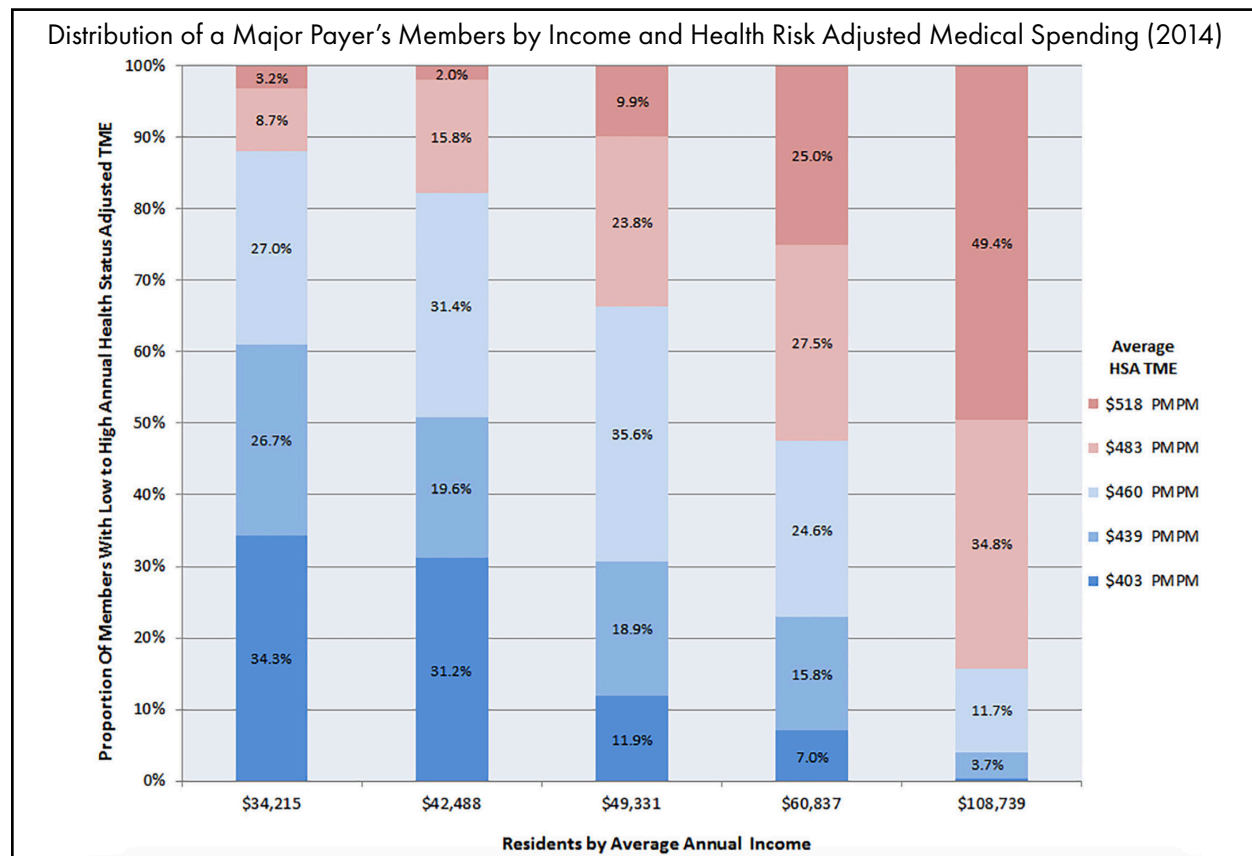
E. Prioritize Diverse Representation in Clinical Trials

Representative clinical data is an essential step to overcoming health care disparities. For clinical trials of potential treatments or vaccines to be reliable, the group of research participants must be reflective of the population that will receive the treatment. In clinical trials for COVID-19 therapies, patients of color are significantly underrepresented, which raises concerns that the study results may not be valid and may not be generalizable to the U.S. population.^{66, 67} This underrepresentation is not new; clinical trial data has historically skewed toward white male patients, who disproportionately participate in clinical trial research.⁶⁸ Ultimately, institutions should make sure that research staff and Institutional Review Boards reflect the diversity of the population to help combat the mistrust that may dissuade members of marginalized communities from participating in clinical research and ensure that diversity is considered in every part of the study design. Additionally, we recommend that pharmaceutical companies, biomedical researchers, and funders of medical research, including research into therapies and vaccines for COVID-19, work with trusted institutions and community representatives to encourage and recruit people of color as volunteers, as well as demand that clinical trials prioritize inclusion of patient populations that reflect the demographics of the pandemic.⁶⁹ Recruitment of participants of color will require sensitivity to the mistrust of the medical system, which is based on a long history of disparate and dangerous medical mistreatment.⁷⁰

II. EQUITABLE DISTRIBUTION OF HEALTH CARE RESOURCES

The disproportionate impact of COVID-19 on low-income communities and communities of color amplifies the longstanding need to change how health care spending is allocated, starting with payments to providers who care for marginalized populations. As the AGO has shown in prior reports, even among commercial insurers, health care dollars are not spent equitably across the state. Private insurers consistently spend less on health care for low-income communities relative to higher-income communities when adjusted for health needs.⁷¹

The chart below displays a payer's members by average income (from left to right) and shows the total amount spent on average to pay for health care services for those members in the blue-to-red bars. The darkest red bars at the top represent the members with the highest medical spending, after adjusting for health burden. These are individuals to whom we devote the most health care resources relative to their health need, and they are overwhelmingly members coming from the highest income communities.



From: Massachusetts AGO Cost Trends Report (October 2016)⁷²

Resources are also inequitably distributed among health care providers, which are often categorized by the services they provide and the populations they serve. *Community hospitals*, for example, provide a wide range of medical and surgical care. *Academic medical centers*, or *teaching hospitals*, are affiliated with medical schools and have extensive research and teaching programs in addition to providing patient care. *Safety net hospitals* deliver medical and surgical care to populations that include relatively high numbers of Medicaid enrollees, patients without insurance, and other underserved patients. *Community health centers* (CHCs) provide primary and preventive health care, mental health services, and other forms of social support without regard to their patients' ability to pay, and are particularly important in providing underserved communities with access to essential services in a cost-effective manner. CHCs provide primary care to over one million Massachusetts patients who are most vulnerable to COVID-19 and chronic conditions.^{73, 74}

Safety net hospitals and CHCs play a critical role in efforts to build and maintain health equity, as they are more likely than other types of providers to care for low-income patients and patients of color. However, they often face more acute financial constraints than other providers. Many of their patients do not have private health insurance, and instead rely on Medicaid—a government program that provides reimbursement at rates significantly lower than private health insurers—or are uninsured. One estimate indicates that MassHealth, Massachusetts' combined Medicaid and Children's Health Insurance Program, pays 32% less than commercial payers.⁷⁵ As a result, safety net hospitals and CHCs typically receive less revenue per patient than providers that have smaller proportions of Medicaid patients.

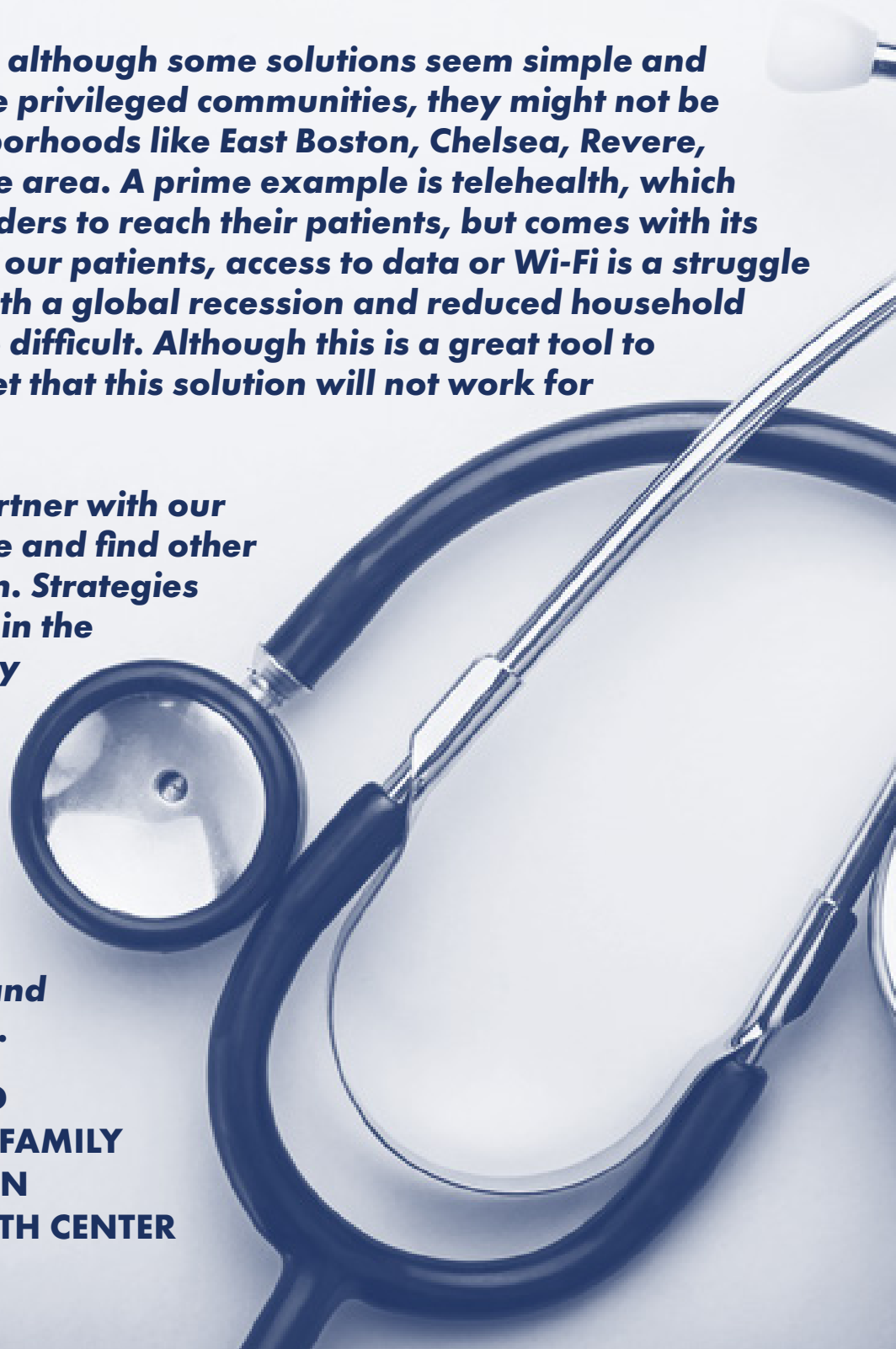
Health care providers serving different populations also face variation in the payments they receive from private insurers. Global budgets are payment arrangements where providers face financial penalties if care is too costly in comparison to a target "budget" negotiated with insurers. Significant variation in global budgets—as illustrated in the chart on the next page—means that some doctors have far more resources to take care of their patients as compared to others who care for the same number of patients in similar health.⁷⁶ The gap presented is likely understated since we know that existing algorithms for health status adjustment typically understate illness severity in diverse communities. And because public payers reimburse at lower rates than commercial payers, providers must ensure that they have a high enough share of commercially insured patients for financial survival. Yet studies have consistently shown that it is precisely the providers with the highest share of publicly-insured patients that receive the *lowest levels* of commercial payment. COVID-19 has increased the urgency of swiftly addressing this problem by reimagining how we value and pay for health care.

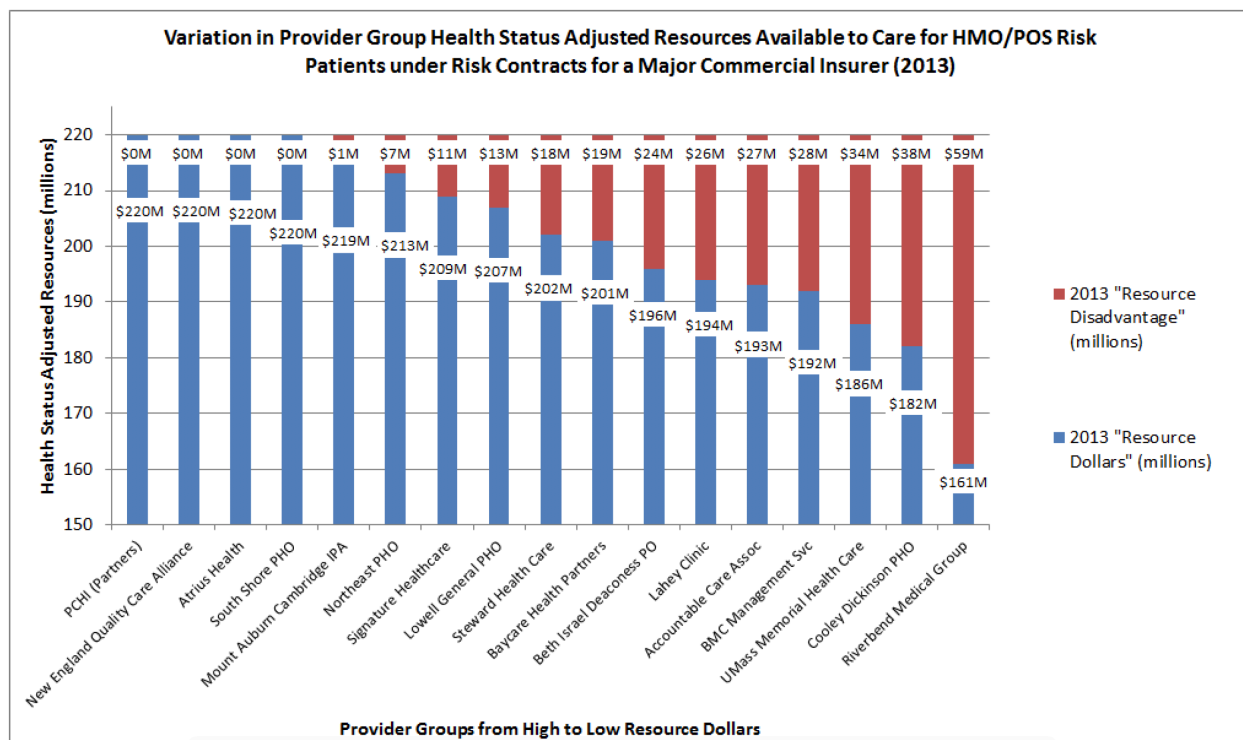
I have been working in community health centers since I finished my family medicine training nine years ago. Providing care for vulnerable communities can be quite challenging because patients are often dealing with poverty and distrust of a healthcare system that has not always looked out for their best interests. In addressing these issues, it is vital that our communities feel they have the support of people who they trust – those that have their best interests at heart and who are invested in finding solutions alongside them.

We must not forget that although some solutions seem simple and straightforward in more privileged communities, they might not be easily applied in neighborhoods like East Boston, Chelsea, Revere, and others in our service area. A prime example is telehealth, which is a great way for providers to reach their patients, but comes with its challenges. For some of our patients, access to data or Wi-Fi is a struggle at baseline, but now, with a global recession and reduced household incomes, it is even more difficult. Although this is a great tool to have, we must not forget that this solution will not work for everyone.

We must continue to partner with our communities to innovate and find other ways we can serve them. Strategies such as hiring from within the community, intentionally documenting and addressing social determinants of health, and advocating for changes in our healthcare delivery will go a long way towards building trust and keeping people healthy.

**MOTHUSI CHILUME, MD
MEDICAL DIRECTOR OF FAMILY
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NEIGHBORHOOD HEALTH CENTER**





From: Massachusetts AGO Cost Trends Report (September 2015)⁷⁷

This crisis has placed enormous strain on all Massachusetts health care providers. All providers have had to adapt to caring for COVID-19 patients while simultaneously losing significant revenue as they reduced non-COVID-19 services. Many health care providers have undertaken enormous efforts at great expense to stand up extra surge capacity and create new community testing sites. As the pandemic began to spread in the first quarter of 2020, Massachusetts hospitals reported losses of over \$2 billion.⁷⁸ CHCs and physician practices faced similar pressures as they worked to build capacity to provide COVID-19 care while their revenue from routine care fell precipitously.

While all providers faced these challenges, the challenges may have a particularly destabilizing impact for hospitals and doctors who disproportionately care for low-income communities and communities of color. These communities rely on the continued operation of their trusted health care providers, particularly where transportation or language barriers make getting care at other sites difficult, and rely heavily on MassHealth, which pays providers less than commercial plans. These providers often receive the lowest commercial payment rates for their services, are most likely to have negative margins, and are least equipped to withstand the demands of responding to a public health emergency while weathering unprecedented revenue disruptions. Persistent reliance on cross-subsidization between commercially insured and publicly insured patients to fund the health care delivery system has prevented providers who serve low-income communities and communities

of color from thriving for years. As a result, these same providers are often unable to cushion their financial losses and are forced to try to consolidate with large, high-cost physician organizations, hospital systems, or health plans to avoid financial collapse. In past reports, the AGO has found that hospital size correlates with market leverage, allowing larger and wealthier health systems to obtain higher payment rates and more favorable contract provisions. This further widens the variation in provider payments and disadvantages providers offering low-cost, high-value care to underserved communities.

Massachusetts has long understood the need to increase funding for safety net health care providers serving low-income communities while maintaining affordability for all patients, but no consensus has emerged on a path forward.⁷⁹ A solution to protect health care safety net providers must be in line with our longstanding commitment to containing overall health care costs. If costs are left unchecked, rising premiums and shrinking insurance benefits threaten to make services inaccessible to many residents. Now is the time for Massachusetts to embrace bold changes to health care financing in order to prioritize a more equitable distribution of health care funding and a robust safety net. We recommend the following actions:

A. Change State Law to Promote Equitable Provider Payment Rates

After years of study and now after bearing witness to the vulnerability of low-income communities and communities of color in a public health crisis, it is time for Massachusetts to take action to ensure that providers who serve those with greater health and social challenges are not systematically paid less than those who serve people with lesser health and social challenges, as occurs today. *First*, policymakers should examine new ways of ensuring that payment rates adequately support care for patients and communities most in need. To achieve these goals, we recommend that the state consider adapting and strengthening the Cost Growth Benchmark. This approach would modify the current system-wide Cost Growth Benchmark into a provider-specific maximum allowable commercial rate increase that is indexed to the provider's all-payer efficiency (see Recommendation D below), allowing lower paid and efficient providers more room for payment increases under the benchmark, while limiting rate increases for the highest paid providers. *Second*, as described above, the long-documented disparities in budgets for the care of patients represent systemic under-investment in the health of low-income communities and communities of color. We encourage the state

to adopt mechanisms among payers and providers to modify global budgets to operate equitably across communities and providers after adjustment for patient health status and social determinants of health, which will more closely match health care spending and resources to patient needs and incent high quality and affordable care. *Third*, the state should protect the continued viability of Massachusetts safety net hospitals and CHCs by ensuring that their state financial support (through MassHealth payments and grant funding) allows them to continue to meet the needs of underserved communities.

B. Address Cost Sharing Affordability as an Equity Priority

Massachusetts has made tremendous progress in expanding access to health insurance, but health benefit plan designs are creating a different kind of affordability barrier to care. In recent years, patient cost-sharing and premiums have increased at a faster rate than wages or inflation.⁸⁰ A lack of affordability at the doctor's office and pharmacy makes health care inaccessible for many low-income communities, communities of color, and immigrants. A 2019 survey of Massachusetts residents found that Black and Hispanic residents were more likely than white residents to face affordability issues accessing health care.⁸¹ Hispanic residents reported an unmet need for health care due to cost more frequently than any other group. Prescription drug affordability also disproportionately affects low-income communities and communities of color. Policy changes enacted due to COVID-19 have temporarily waived cost-sharing—copays and deductibles—for COVID-19 treatment, and many health insurers have waived cost-sharing for all telehealth visits in order to promote access to care during the pandemic.⁸² According to providers, this has been an unexpected lifeline for low-income patients, particularly those with high-deductible health plans, many of whom had previously foregone primary care or behavioral health care due to their unaffordable deductibles or copays, but due to the pandemic were able to reconnect with their doctors online or by phone. Pediatricians ready to see patients in person again find parents reluctant to schedule in-person appointments—not because of potential COVID-19 exposure, but because they can only afford the visit remotely due to the telehealth deductible waiver. *First*, a lack of affordable access to health care office visits puts the health of communities of color and low-income communities at risk during a time of acute medical and behavioral health risks. We recommend that carriers temporarily reduce cost-sharing for primary care and behavioral health visits during the pandemic. Legislation may be required

to effectuate this recommendation and should direct the HPC to review the equity, access, and short-term and long-term cost implications of such a change. *Second*, a lack of affordable access to prescription drugs puts individuals with uncontrolled chronic conditions—disproportionately people of color and low-income people—at higher risk for more severe complications if they contract COVID-19. We recommend that carriers temporarily reduce cost-sharing for medications for chronic conditions linked to COVID-19 complications. Legislation may also be required to effectuate this recommendation and should establish an HPC review process for those drugs to determine if prices are unreasonable or excessive, similar to the recently adopted MassHealth process. Longer-term strategies for combatting the access barriers posed by cost sharing would have implications for premium rates. We recommend that the HPC and the Connector study how best to balance these costs to promote equitable access to services.

C. Expand Flexible and Equitable Global Payments

Global budgets, when adequately and equitably funded, can be a means of promoting innovation in health care delivery that benefits underserved patients: those with chronic health conditions and whose health care is complicated by unmet health-related social needs. We recommend that the HPC set specific and ambitious targets for expanding adoption of commercial global payment contracts. Alternative payment methods have allowed clinicians and their health care delivery organizations to provide better population health services to COVID patients through identifying high-risk patients, coordinating care outside of facilities, and providing in-home services.^{v, 83} Global budgets should allow health care systems flexibility to invest in services that are critical to meeting the needs of underserved populations, such as primary care services, behavioral health services, dental services, community health workers (CHWs), data collection infrastructure, and telehealth supports. Shifting the health care system away from fee-for-service payments for individual clinical services and towards global payments will also open opportunities for community-wide interventions to address social determinants of health, such as environmental protection.

v. For example, providers participating in alternative payment methods such as global budgets during the COVID pandemic have been able to more effectively handle the COVID crisis by leveraging their value-based care infrastructures such as: care management support, triage call centers, remote patient monitoring, population health data to manage and predict cases, and claims data to understand care delivered outside the acute care setting. See *Premier Inc. Survey: Clinically Integrated Networks in Alternative Payment Models Expanded Value-Based Care Capabilities to Manage COVID-19 Surge*, PREMIER: NEWSROOM (May 13, 2020), <https://www.premierinc.com/newsroom/press-releases/premier-inc-survey-clinically-integrated-networks-in-alternative-payment-models-expanded-value-based-care-capabilities-to-manage-covid-19-surge>.

D. Transform State Reporting and Monitoring of Provider Efficiency to Include All Payers

First, we recommend that CHIA develop more comprehensive metrics for analyzing provider efficiency and promulgate updated regulations for routine data collection and reporting on these metrics. A perspective that silos commercial and public payers distorts comparisons across providers because it does not take into consideration key factors impacting providers serving low-income communities that rely on Medicaid. Given that Medicaid pays far less than most commercial insurers, providers must stretch their resources to adequately serve the needs of populations covered by both commercial and public payers. Since most people access health care services close to where they live, providers located in low-income communities are more likely to have a higher share of Medicaid enrollees in their patient mix. Comparing the “efficiency” of systems needs to take into consideration how well each one uses its aggregate resources to serve the entire population that depends on it for care. Blending all payer spending metrics—such as TME and Relative Price—would give a more accurate picture of how efficiently providers deploy the resources allocated to them to serve their communities in total. For example, if two provider groups have the same commercial TME but one has significantly more MassHealth patients, the provider with the higher MassHealth payer mix would have a much lower blended TME. This is important for evaluating how scarce health care dollars are being deployed and can inform Performance Improvement Plans, appropriate contracting goals, and policymaking. *Second*, in the interim while developing these blended efficiency metrics, we encourage CHIA to put relative price data into the context of these differential payment rates across payer type by publishing hospital payer mix data alongside its Relative Price data reports.

E. Ensure Provider Relief Funds Are Allocated Transparently and Equitably

COVID-19 has prompted significant federal and state relief payments for health care providers, but the distribution of many of these payments has not been transparent and has not been allocated based on need. *First*, the work of redistributing health care dollars fairly requires timely and complete financial reporting from health care system participants, and this need is heightened during a pandemic when expected payments are disrupted and various federal and state relief programs are available. We recommend that CHIA require transparent public

reporting from all hospitals and health systems on all relief payments received from all sources and the extent to which losses have been offset. *Second*, the bulk of the federal general distribution COVID-19 relief funding has been allocated based primarily on a provider's historic Medicare revenue.^{vi, 84} Revenue is not a neutral proxy for patient health needs, hospital financial needs, or COVID-specific impacts. As noted above, providers treating a higher share of low-income patients relying on Medicaid or who are uninsured tend to receive lower payment rates and thus are likely to have the greatest financial need. Federal provider relief funds have been distributed so far to provide more money to large hospitals that already had the most resources.⁸⁵ The state should take action to ensure that COVID-related financial assistance tracks COVID-19 burden and provider needs (such as by using Medicaid share as a proxy) by advocating for changes to the federal relief funding formula or continuing to adjust state payments to support providers left behind by federal relief efforts.⁸⁶

F. Expand Health Insurance Options Not Linked to Employment

Although addressing inequities in health care provider payment is an important step, reform is also needed on the insurance side to address disparities in access to health care for communities of color and low-income communities. People of color are less likely to have access to employer-sponsored insurance in the first place and, as discussed above, are more likely to be exposed to coronavirus due to their work in essential jobs.^{87, 88} People of color are also more likely to have lost their job and employer-sponsored health insurance during the pandemic, creating disruptions in care for themselves and their families.⁸⁹ As a result, these individuals shift to MassHealth, find coverage on the Connector, or become uninsured. The Connector is the state's health insurance marketplace, and it allows individuals and small businesses to find and compare private health insurance options. The Connector plays a critical role in providing robust and affordable insurance options to those who do not have coverage through an employer. We recommend that the state require all carriers participating on the Connector to also offer ConnectorCare plans—plans that are subsidized by the Commonwealth and offered to low-income individuals and families on the Connector—so that all consumers have a reasonable set of options and each family can select the plan that makes most sense for them. This expanded participation should be structured

vi. In addition to providing direct relief funds, the federal government provided a temporary 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage for the duration of the federal public health emergency. See Families First Coronavirus Response Act, H.R. 6201, 116th Cong. §6008 (2020) (enacted).

to allow more network options and affordable price points for the lowest income consumers shopping for insurance on the Connector. To guide consumers through these options, we encourage the state to increase its support for health insurance enrollment navigators. It will also be important for the Connector to study and report on the value to consumers of additional insurance options balanced against the potential for confusion posed by additional complexity.

G. Expand Health Insurance Options that Reward Patients for Selecting High-Value Providers

In the current market, all consumers pay higher premiums due to the fact that certain consumers choose to seek care at higher-cost health care providers. Though low-income communities are more likely to use local lower-cost, high-value hospitals, these patients end up cross-subsidizing the more expensive choices of higher-income patients in their same risk pool. For example, in the case of an employer-sponsored health plan, some of the premiums paid by lower-income employees who visit lower-cost providers will be used to pay for the care received by higher-income employees who visit higher-cost providers. We encourage payers to innovate with insurance product design to explore models where premiums vary based on the efficiency or value of the primary care provider selected by the member, in order to untangle these regressive cross-subsidies and make health care more affordable for low-income communities.⁹⁰

H. Ensure Equitable Distribution of a COVID-19 Vaccine

In the event that a COVID-19 vaccine is approved for manufacturing and distribution, it is critical that the state design and implement a coordinated and equitable vaccination strategy to ensure access to underserved communities, at-risk populations, and essential workers. On October 16, 2020, DPH released an Interim Draft of its COVID-19 Vaccination Plan, which proposes a three-phase vaccination effort: Phase 1, during which DPH would supply doses to health care personnel likely to be exposed to or treat people with COVID-19, people at increased risk for severe illness from COVID-19, and other essential workers; Phase 2, during which DPH would begin to provide doses for the broader population; and Phase 3, during which DPH would have enough doses for all residents. The Interim Plan affirmed DPH's commitment to ensuring equitable access to the vaccine and set forth the agency's communications strategy for building vaccine confidence and dispelling vaccine misinformation.⁹¹ The final Vaccination Plan should

reaffirm and explicate DPH's commitment to equity. *First*, we recommend that the Vaccination Plan make clear that DPH will ensure an equitable distribution of doses by race and ethnicity during each of the first two Phases, and not just during Phase 3. An equitable allocation framework will be critical during these early Phases when the supply of the vaccine is expected to fall far short of the needs of health care and essential workers, at-risk individuals, and many others. *Second*, the final Vaccination Plan should provide for collection of data on the race and ethnicity of all vaccine recipients and include a commitment that DPH will use this data to assess whether distribution efforts are adequately reaching low-income populations and communities of color.

III. CLINICAL HEALTH EQUITY: TELEHEALTH AS A TOOL FOR EXPANDING EQUITABLE ACCESS

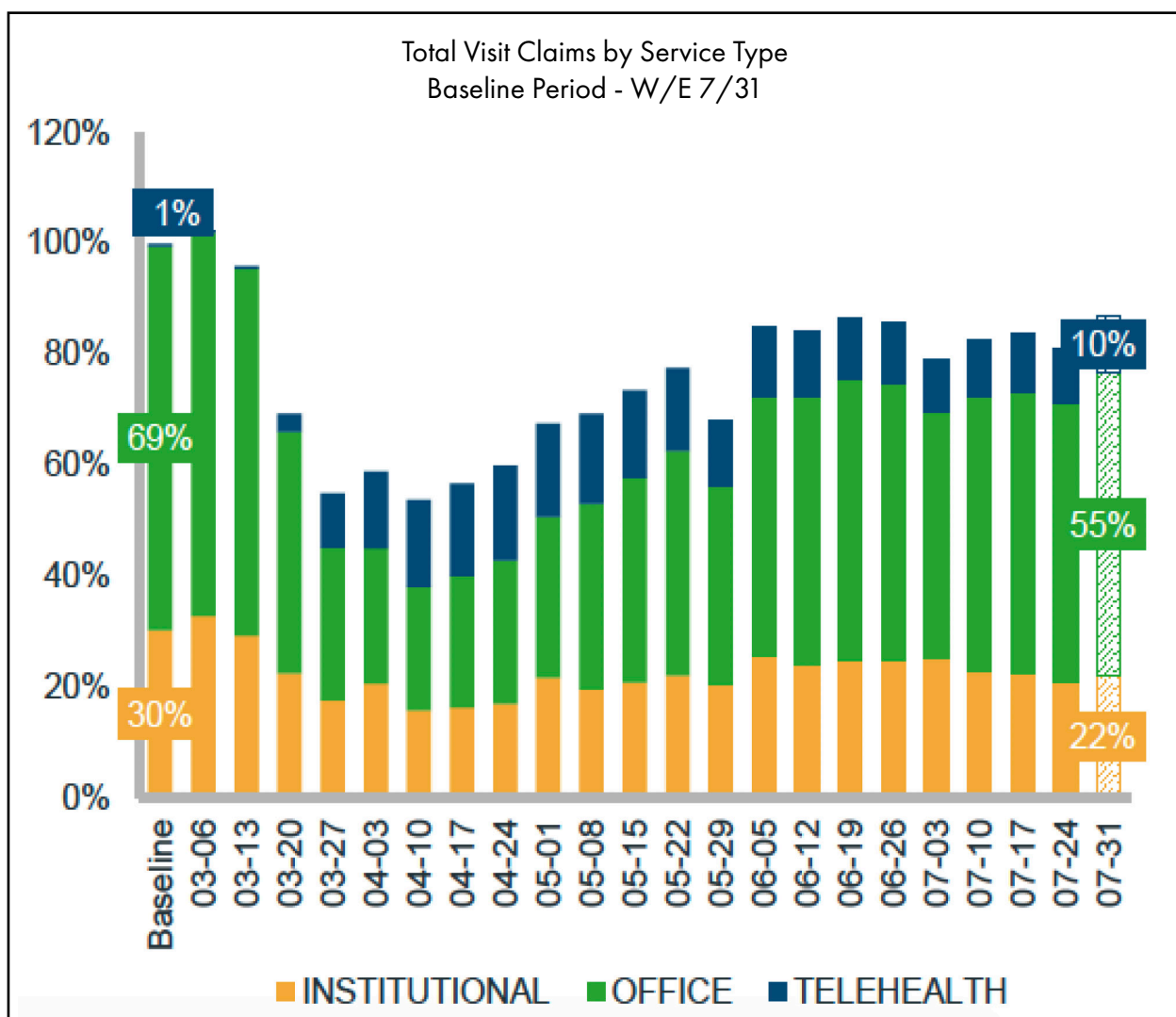
Health care services, even before the COVID-19 pandemic, were nearly inaccessible for many patients. In-person clinical care is accessible for those who live close to hospitals or clinics, have enough sick time accrued to cover needed appointments, and have reliable transportation. As community care settings close and consolidate, communities of color, as well as rural residents, are often left behind and forced to travel considerable distances for care and take time away from work, often without pay.

Telehealth is one way to create more accessible clinical care. Telehealth eliminates the time and cost of travel and allows those with limited mobility to access care more easily. During the COVID-19 pandemic, the state quickly overcame longstanding barriers to widespread adoption of telehealth services—including limited health plan coverage, low rates of reimbursement, and technological barriers. Although telehealth is an opportunity to increase access to care, government entities and health systems must ensure that the expansion of telehealth does not worsen existing health disparities by leaving behind low-income, older, rural, and non-English speaking residents.⁹²

On March 15, 2020, Governor Baker ordered health care providers to postpone non-essential, non-emergency elective invasive procedures and office visits to mitigate the spread of the virus and conserve capacity for COVID-19 prevention and treatment.⁹³ In order to offer patients continued access to health care services, the state issued requirements that all insurance carriers cover clinically appropriate, medically necessary services delivered via telehealth by an in-network provider.⁹⁴ The order provided that there would be no specific requirements imposed on the technology used to provide services, and the payment rate for telehealth services with in-network providers would be no lower than the payment rate for in-person services. At the federal level, the Office for Civil Rights at the Department of Health and Human Services issued a notification of enforcement discretion, allowing providers to use telehealth technology even if it was not HIPAA-compliant during the COVID-19 emergency.⁹⁵

Though telehealth has long been heralded as a safe way to deliver certain medical and behavioral health services, virtual care has been especially critical in maintaining continuity of care, preserving patient-provider relationships, and providing convenient access and support at a time when individuals are encouraged to stay home to prevent

the spread of COVID-19.^{96, 97} HPC data, presented in the chart below, show that as in-person visits to emergency departments, hospitals, and physician offices dramatically declined in April 2020, the rates of telehealth visits increased significantly.⁹⁸ Between January and April 2020, CHCs reported that monthly telehealth visits for medical services increased from 506 to over 83,000 and monthly telehealth visits for behavioral health rose from 517 to 22,000. Providers have taken significant steps to redesign their care delivery in a manner that is safe and convenient for both the patient and the care team. Without in-person visits, providers have used Remote Patient Monitoring (RPM) technologies, such as wearable tools and smartphone apps, to monitor patients' COVID-19 symptoms in real time, as well as to track vital signs and medication adherence for patients with chronic diseases.⁹⁹



From: Massachusetts Health Policy Commission (September 2020)¹⁰⁰

Changes to telehealth regulations have also been vital to meet the surge in demand for behavioral health care. Through virtual care, patients can receive safe behavioral

health treatment in a manner that reduces stigma, and individuals with substance use disorders have increased options to access prescriptions, psychotherapy, and support groups.^{101, 102} Some private insurers have responded to the increased need for behavioral health services during the pandemic by waiving cost sharing for in-office or telehealth visits from primary care providers, including behavioral health treatment.^{103, 104} Providers have noted that for their low-income patients with high deductible health plans, these telehealth cost sharing waivers have led to significant increases in access to primary health and behavioral health care, where these patients were avoiding care before the pandemic due to unaffordable deductibles.

Though the use of telehealth expanded rapidly in the early months of COVID-19, national and state data shows that telehealth utilization has steadily declined as outpatient visits stabilized through July 2020.^{105, 106} As of September 2020, telehealth continues to represent about 10% of total claims, as compared to 1% of claims at the February 2020 baseline, showing that even as in-office restrictions have eased, patients and physicians remain interested in using this method of care. However, telehealth adoption and implementation may not be easily sustained at this level.^{107, 108} Many providers lack the infrastructure, funding, training, and capacity to deliver and support telehealth services. This is especially true for providers who disproportionately serve low-income communities and communities of color, like CHCs.

Widespread and equitable use of telehealth and RPM tools is further hampered by the digital divide in the state. Geographic, economic, and other barriers create gaps in access to telecommunication and information technology.^{109, 110} Marginalized racial and ethnic groups, older adults, low-income families, and individuals with disabilities, limited English-proficiency (LEP), and limited health literacy are least likely to have access to the internet and compatible devices.¹¹¹ In addition, though telehealth has the potential to expand access beyond urban regions, rural communities have historically lacked access to fast and reliable internet.¹¹² Poor internet service contributes to negative health outcomes by restricting individuals' ability to access online health information and services. Inadequate internet access can also hamper access to school, work, and other aspects of daily life that have moved online, leading to measurable behavioral health impacts, such as increased stress, anxiety, and feelings of isolation.¹¹³ An analysis of Massachusetts cities found that as many as 30% of households in high-poverty census tracts either do not have an internet subscription or do not have access to a computer, smartphone, or other similar electronic device. These conditions make these communities even more vulnerable to economic disruptions brought on by COVID-19.¹¹⁴ Affordability is also a significant barrier to internet access, with the Federal Communications Commission (FCC) reporting that

Covid-19 and Racism are the two deadliest viruses in America. As a breast cancer survivor, and a peer health educator working with immigrants and refugees, I am keenly aware of the cultural and linguistic barriers that reduce Asian Americans' use of preventive care, and sometimes result in misdiagnosis and death. I see the health effects of social determinants on a daily basis. Rapid growth of the Asian American population, and its heterogeneity, combine with scarcity of data and a model minority myth to create a public health problem that is not widely recognized. Health disparities in the Asian American communities include higher rates of tuberculosis, hepatitis B, various cancers and gambling addictions, as compared with other racial groups.

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FOUNDER OF THE ASIAN BREAST CANCER
PROJECT AND THE EXECUTIVE DIRECTOR
OF ASIAN WOMEN FOR HEALTH**

almost half of Massachusetts residents do not have access to low-priced internet (costing \$60 or less each month).¹¹⁵

The pandemic was the catalyst for widespread telehealth adoption, but sustaining telehealth services can promote accessible health care and address longstanding barriers to services. Advocates have long understood that telehealth could bring medical care to underrepresented populations, especially in rural regions. Forced to quickly transition to telehealth, many providers are more equipped to provide virtual services than ever before and perhaps more than they ever thought possible. Telehealth can save individuals time and money, avoiding long travel times and missed work hours and providing easier medical care to those with limited mobility. The quick adoption of telehealth provides a lens to the future of integrated care and the potential for more accessible medical consultations in the future. To ensure equity, the benefits of telehealth must be accessible for all patients in Massachusetts. In addition, to ensure that all patients in Massachusetts are receiving safe, effective, and high-value care, health care stakeholders must study the effectiveness of telehealth and its impact on outcomes across clinical service lines and adjust clinical policies and payment rates accordingly based on evidence. We recommend the following actions:

A. Address the Digital Divide

Stakeholders must take action to reduce the digital divide in Massachusetts to ensure that underserved patients have equitable access to telehealth services. *First*, we recommend that policymakers and telecommunications companies increase the availability of free and low-cost internet plans and devices in underserved areas by expanding state grant programs, subsidies, and public-private partnerships and by advocating for federal funding to increase internet access to low-income areas.¹¹⁶

Drawing on the experiences of existing programs, such as the Massachusetts Broadband Institute's Last Mile and Broadband Extension programs and the Lifeline Services program, we encourage the state to provide low-income localities and families with the necessary funding to develop infrastructure and reduce monthly costs.^{117, 118} *Second*, we recommend that health care providers and community-based organizations pursue grants similar to the FCC's COVID-19 and Connected Care Pilot programs to continue the expansion of broadband services. The federal Health Resources and Services Administration and other grant-makers continue to offer grants to pursue telehealth expansion, and these grants can be used to expand broadband services and to improve access to remote behavioral health care services.^{119, 120} *Third*, health care providers and payers should be accountable for ensuring underserved patients are not left behind by telehealth. We encourage providers and payers to routinely screen patients for unmet connectivity needs and inform all low-income patients about Lifeline plans offered by telecommunications companies and opportunities to receive subsidized internet plans or devices.

B. Mandate Coverage and Rate Parity for Telephonic and Video Visits Where Clinically Appropriate

Historically, lack of coverage and low reimbursement for telehealth services have been significant barriers to the adoption of telehealth services by health care providers. Providers faced strong financial incentives to see patients in person whenever possible, since reimbursements for the same visit provided by video or telephone would be reimbursed at a lower rate or not at all. Providers' increased willingness to deliver care via telehealth—due in no small part to the payment parity requirement—represents a significant increase in access for patients facing transportation, employment, childcare, or other barriers to receiving in-person care. The telehealth coverage and payment parity ordered by Governor Baker will expire when the COVID-19 state of emergency ends.^{121, 122} *First*, we recommend that the state enact a policy that requires coverage and payment parity across all

carriers for telehealth services over the next two years, which will allow providers flexibility to determine the best method of treatment for patients, virtual or in-person, without having to factor in substantial financial trade-offs. The policy should ensure payment parity between telephonic, video, and in-person visits, where clinically appropriate. Coverage for telephonic visits is essential in low-income and underserved communities as many patients do not have the technology to allow telehealth visits with video, and many elderly patients are not comfortable enough with technology to participate in video telehealth visits.^{123, 124} Parity should not include limitations that would present barriers to equitable access to telehealth services, such as location requirements or service line restrictions. Insurers should be prohibited from imposing prior authorization and cost sharing requirements solely because care is provided through a telehealth mechanism. *Second*, we recommend that DPH and HPC collaborate on comprehensive and transparent analyses regarding quality of care and the equity implications of discontinuing payment parity for telehealth. These analyses should inform the decision of whether to continue to mandate payment parity in the long term.

C. Activate Trusted Community-Based Providers to Build Digital Health Literacy

Underserved populations, especially low-income, non-English speaking, and elderly residents are at risk of being left behind in the accelerated movement to telehealth services without concerted strategies to build digital literacy (i.e., the ability to use information and communication technologies to find, evaluate, create, and communicate information).¹²⁵ Community-based providers, such as CHCs and CHWs, can facilitate telehealth access by providing culturally tailored information and leveraging trusted relationships with underserved populations.¹²⁶ Consistent with their longstanding mission to increase community capacity, we encourage CHCs to offer trainings to build digital literacy skills, including how to access telehealth platforms and online patient portals. CHC sites could also be used to train individuals with chronic conditions to use RPM tools.

D. Ensure Access to Telehealth for Individuals with Disabilities and Limited English Proficiency (LEP)

Disabled and LEP individuals often face barriers that prevent them from accessing telehealth services. *First*, Massachusetts should adopt uniform guidelines for

providers on how to best facilitate access to telehealth services for disabled and LEP individuals.¹²⁷ Specifically, a statewide mandate that telehealth services comply with the World Wide Web Consortium's Web Content Accessibility Guidelines 2.0 would facilitate increased access to telehealth services for both disabled and LEP individuals. These guidelines are designed to ensure the accessibility of text, images, sound, and other web content. For example, the guidelines require that text alternatives be provided for non-text content, which allows the content to be easily converted into large print for the visually impaired, braille for blind individuals, and other languages for those who do not understand English. *Second*, health care institutions must have standardized procedures to determine what accommodation services are needed (e.g., multilingual interpreters) before a telehealth encounter and to ensure that providers proactively make patients aware of accommodations and interpreter services that are available. DPH has developed a *Guide to Language Needs Assessments*, which requires that hospitals complete language needs assessments to evaluate the needs of LEP individuals in their communities and the accessibility of their facilities.¹²⁸ We recommend that DPH create a similar tool for all providers to assess translation needs for telehealth services based on the populations they serve. *Third*, providers need training on how to use technology to serve disabled and LEP patients.¹²⁹ Providers should receive training on how to use telehealth platforms, including features such as captioning and other forms of assistive technology, and should understand the technology (e.g., websites or apps) that works best for their disabled and LEP patients.¹³⁰

E. Promote Equitable Access to Technology for Chronic Disease Management

For patients with disabilities or chronic health conditions such as diabetes or depression, telehealth services can be tailored according to individual patient needs and can be an opportunity for high-value and accessible care.¹³¹ Chronic conditions and disabilities require regular treatment and effective self-management and disproportionately affect low-income communities of color.¹³² RPM tools, such as smart blood pressure monitors and weight scales, can enable care teams to track chronic conditions and prevent adverse outcomes and readmissions, especially while social distancing recommendations are in effect.¹³³ By overlaying real-time vital signs from RPMs, patient health records, and patient demographic information, providers can develop a more complete and holistic view of individual and population health risks. *First*, the effectiveness of RPMs depends on their economic feasibility, mode of connectivity, patient digital literacy and cognitive

ability, and trust in the provider-patient relationship and technology.¹³⁴ As such, it is important that providers receive adequate reimbursement for RPM implementation and utilization. *Second*, providers and medical device manufacturers must ensure that RPMs offer a user-friendly interface, translate into multiple languages, and include accessibility features for patients with disabilities.¹³⁵

IV. HEALTH CARE WORKFORCE DIVERSITY

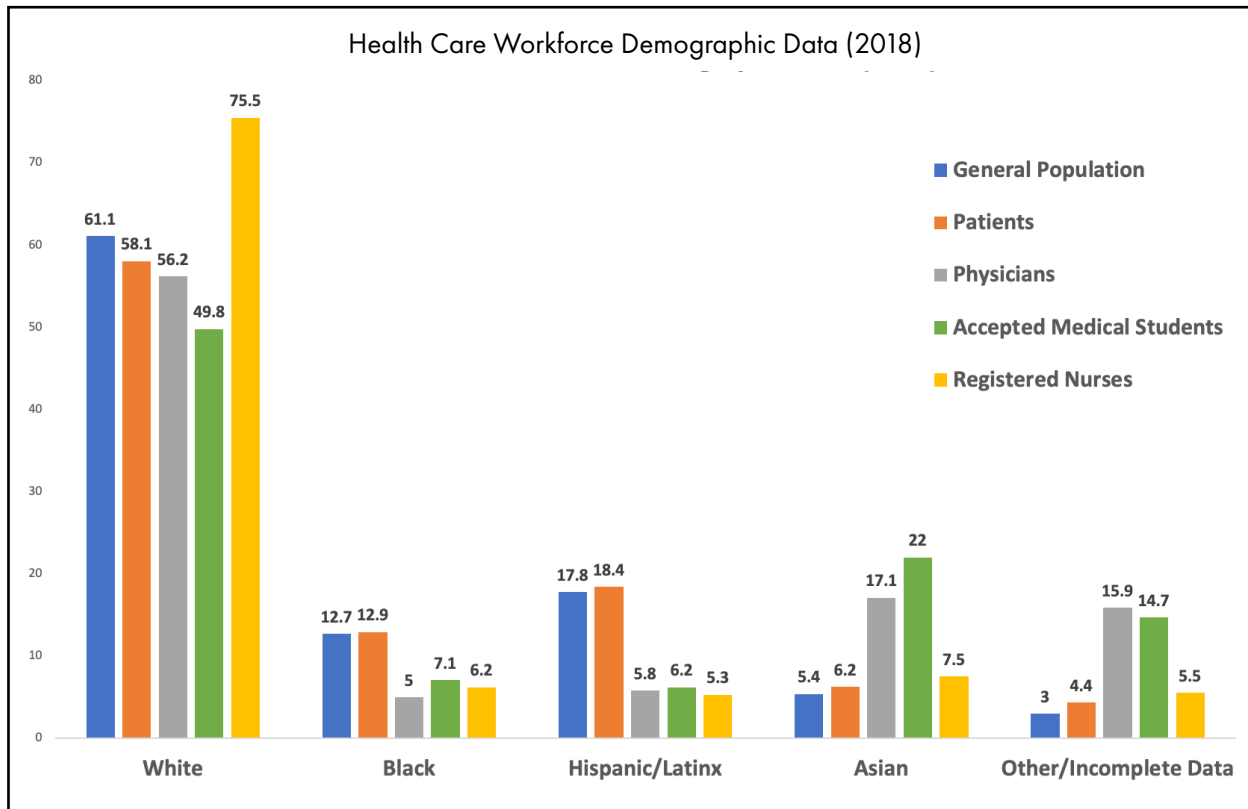
The pandemic's disproportionate impact on communities of color has illuminated the urgent need to address a longstanding lack of diversity in the health care workforce and the resulting impact on the health outcomes in communities of color. The evidence, described in more detail below, indicates that cultural humility helps doctors to provide better care to patients of color. Further efforts are needed to increase both the diversity and the capacity of the health care workforce—efforts that will require a rethinking of education, workforce development, and health care provision for currently marginalized communities. Because health care and social assistance workers constitute nearly one-fifth of the Massachusetts workforce, building a more equitable health care workforce will mean addressing inequities not only in health care but in a large segment of the economy as a whole.¹³⁶

Demographic data of health care providers and hospital leadership in the United States reveal deep inequities in the health care workforce compared to the patients they serve. As shown in the chart below, despite Black Americans representing 12.7% of the nation's population, as recently as 2018 only 5% of all physicians were Black.¹³⁷
¹³⁸ For nurses, there is a similar lack of diversity: 6.2% of all nurses in the United States

I learned so much as a young girl at my grandmother's house. A house full of family and friends which meant you couldn't help but overhear tons of stories. I vividly remember sitting on my grandparents' front steps and listening to one of my uncles talk about doctors and how he doesn't trust them. He had not sought treatment for years, if ever, for anything and didn't plan to. His mistrust, as a black man, passed down from generations before him. He referenced others that he knew that had negative experiences from doctors or went into the hospital but did not come home. I was very close with my grandmother, and I remember her complaining of aches and pains, especially in her knees. I remember her sitting on her porch towards the end of her life and rubbing her knees, wincing in pain. She never saw a doctor for her pain.

**ANONYMOUS PATIENT
EAST LONGMEADOW, MA**

are Black, while just 5.3% are Hispanic or Latinx.¹³⁹ Hospital leadership is even less diverse, with all individuals of color combined holding just 14% of all positions on hospital boards in 2015 and just 11% of all hospital leadership positions in 2015.¹⁴⁰ Even at lower levels of leadership, hospitals are significantly less diverse than the country's workforce as a whole, with under-represented groups holding only 19% of first and mid-management positions in 2015.¹⁴¹ Without intervention these inequities are not likely to narrow as incoming classes of medical students largely resemble the existing physician workforce.¹⁴²



From: U.S. Census Bureau,¹⁴³ NCHS,¹⁴⁴ AAMC,^{145, 146} *Journal of Nursing Regulation*^{vii, 147}

Note: Due to data limitations, physician data in the "Hispanic/Latinx" category include only Hispanic physicians.

This lack of diversity in the health care workforce poses real risks for the health outcomes of people of color. Two different studies have found that in mental health services and preventive care, Black patients are more satisfied with the quality of care and are more willing to seek out treatment for additional health problems when treated by a Black health care provider.^{148, 149} One of the studies found that pairing Black men with Black physicians could help reduce cardiovascular mortality among Black men by 19 percent, as increased communication and trust led to greater willingness to undergo invasive screenings.¹⁵⁰ Another study found that Black infants experience poorer health outcomes than white infants regardless of who treats them. But while Black babies

vii. Nursing demographic data was collected between August 28, 2017 and January 15, 2018.

were three times more likely to die in the hospital than white babies when cared for by white doctors, the mortality rate was halved when Black babies were cared for by Black doctors.¹⁵¹ Diversifying our physician workforce is a matter of life and death. The literature suggests that these disparities may be caused by implicit biases, a lack of empathy towards and identification with patients of color among white physicians, as well as a lack of cultural humility among health care providers and hospital leadership which, if left unaddressed, can lead to hospitals not having the staff or resources to properly communicate with and treat the individuals that they serve.^{152, 153}

Diversifying the health care workforce will take time. Part of this work includes expanding the types of health care professionals involved in patient care to include diverse teams of community-based health professionals such as CHWs, recovery coaches, health insurance enrollment navigators, and care coordinators. The CHW workforce in Massachusetts is more diverse and representative of patient populations than other health care professions—over half of CHWs are people of color and speak multiple languages.¹⁵⁴ As a result, CHWs are able to form trusted relationships with the communities they serve and improve health outcomes and reduce disparities for a wide array of conditions.¹⁵⁵ Expanding the community-based health workforce will also enhance the breadth of expertise and intervention designs and subsequently improve individual and community health status and health outcomes. For example, by meeting patients at times and locations most convenient to them to discuss immediate health goals in addition to barriers to attaining those goals, CHWs in Boston have been effective at lowering emergency department visits and decreasing office no-show rates—ensuring that people in marginalized communities can access the cost-effective resources they need to improve their health by counteracting negative social determinants of health like housing or food insecurity, inadequate access to transportation, or lack of childcare.¹⁵⁶ On the whole, CHWs improve outcomes for the treatment of chronic diseases and increase patient knowledge and understanding of disease.¹⁵⁷ Individual CHW initiatives have been shown to reduce hospital admissions, increase communication between health care providers and patients, and increase access to primary care for the populations served.¹⁵⁸ Furthermore, the intervention of CHWs has been shown to improve health outcomes while simultaneously reducing Medicaid expenditures.¹⁵⁹

A provider workforce that is diverse, both in the types of clinical and non-clinical health care professionals and in terms of race and ethnicity, is particularly important to meeting the behavioral health needs of underserved communities. Although Massachusetts has a robust behavioral health workforce, access to care is still restricted because about half of mental health care providers do not accept

MassHealth and, as of 2014, fewer than half of all psychiatrists in the Northeast accepted private health insurance.^{160, 161} This creates a system in which individuals seeking behavioral health treatment may be forced to pay out of pocket or forgo treatment entirely—a choice for lower income individuals that may not be a real choice at all. Creating incentives for qualified providers with varying levels of licensure to participate in MassHealth may help diversify the ranks of behavioral health clinicians available to serve all communities.

Building a health care workforce that can meet the needs of individuals of color will entail diversifying and expanding the health care workforce. We recommend the following actions:

A. Increase Health Care Workforce Diversity through Expanded Educational Opportunities

1. Focus on Upstream Educational Inequities: Educational inequities limit access to higher education and careers in health care for individuals of color. School funding mechanisms that allocate greater funding amounts to lower-income localities, like our newly updated Chapter 70 formula, help address these inequities and, among other things, better prepare students of color to pursue jobs in health care.¹⁶² We recommend that policymakers continue to pursue policy solutions that address educational inequities and keep students on track for graduation and beyond.
2. Make Higher Education Accessible and Affordable: Creating a diverse health care workforce with the capacity to meet the needs of communities of color will require both targeted early outreach and expanded educational opportunities for students of color. *First*, the state should expand upon existing efforts to create health care workforce pipelines with initiatives that provide health care-specific STEM instruction at public secondary schools through partnerships with local community colleges and universities. Models such as the Massachusetts Department of Higher Education's STEM Starter Academy are key to supporting the success of underrepresented community college students in STEM education.¹⁶³ These partnerships could expand opportunities for low-income students and students of color by offering no-cost college credits for completed courses. *Second*, we recommend that the state create a pilot program to assess the feasibility of reducing or eliminating tuition for graduate-level health care programs modeled after New York University.¹⁶⁴

3. Re-Think Admissions and Curriculum: To ensure the development of a health care workforce that can address the needs of communities of color, graduate-level health care programs should embrace reforms to existing admissions processes that fail to account for upstream educational inequities. *First*, we recommend that educational administrators consider shifting away from entrance exam-focused admissions and towards more holistic admissions processes for Massachusetts public graduate programs in health care.¹⁶⁵ Test scores should be used only to measure and identify minimum competency, not as a core differentiator between qualified applicants.¹⁶⁶ *Second*, we encourage administrators to build on efforts to develop anti-racist curricula, structures, and institutional cultures that invest in and support the growth and development of all students.^{167, 168}

B. Promote Equitable Development of Health Care Workforce Diversity and Capacity

1. Prioritize Equity in Health Care Leadership: We recommend that health care providers develop and publicize plans to ensure that leadership in health care service organizations is diverse and inclusive of the backgrounds represented in the communities served.
2. Build Equity Among University Faculty and Staff: We encourage educational administrators to implement aggressive measures for faculty recruitment, retention, and promotion, as well as recognize and counteract the implicit biases of faculty and staff, as evidenced in multiple levels of the educational system.^{169, 170} Administrators should also broaden the understanding of what realizing equity and diversity will entail for university faculty and leadership.¹⁷¹
3. Undertake Licensure and Certification Reform: We recommend that policymakers ensure the inclusion of anti-racist and cultural humility components in medical education, licensure, and certification processes in order to combat explicit and implicit biases.¹⁷² Policymakers should also ensure that licensure and certification requirements for health care jobs are necessary to the safe and effective performance of the jobs and do not act as barriers to exclude qualified candidates, such as individuals educated abroad in health care fields whose abilities and expertise are currently underutilized in Massachusetts. Creation of new licensed health care roles can increase cost-effective access to needed services for low-income communities while opening an accessible pathway to employment in health care.

4. Create Equitable Standards of Care: In an effort to immediately address health disparities for individuals and communities of color, we encourage providers to increase their efforts to develop policies, procedures, and practices that they can implement in the near term to reduce disparities in quality of care and patient experience. Examples include provider training in cultural humility, increased use of patient advocates from underserved communities, and deployment of patient satisfaction surveys to better understand the experiences of underserved populations.

C. Build Community-Based Health Workforce Capacity to Meet Needs of Underserved Populations

1. Fund a Community Health Worker Corps: The state should support the creation of a CHW corps that is paid a living wage and is trained to provide culturally and linguistically competent care and support, address social determinants of health, and increase access to high-value, low-cost health care resources.¹⁷³
¹⁷⁴ Funding sources might include federal or philanthropic funds. Local boards of health could administer the CHW corps, allowing communities to have the stability and flexibility to create a CHW workforce in the manner most effective for them—from publicly administered programs to public-private partnerships building on an existing provider infrastructure.
2. Meet Chronic and Acute Behavioral Health Needs: By deploying a CHW corps trained to deliver behavioral health services, the state can significantly increase access to culturally appropriate, evidence-based treatment options, ranging from cognitive behavioral therapy to community-based youth violence prevention programs.¹⁷⁵ With training in crisis response, CHWs with the proper cultural competencies, language skills, and technical skills could respond to acute behavioral health needs in ways that provide more appropriate support for this need than police intervention, which can lead to fear, violence, criminal justice involvement, and incarceration.

V. SOCIAL DETERMINANTS OF HEALTH AND ROOT CAUSES OF HEALTH DISPARITIES

The recommendations set forth in the previous sections of this report seek to catalyze action in and relating to the health care system to address longstanding disparities and inequities in health outcomes. However, the health care system alone cannot address the underlying causes of health disparities, and these strategies alone will not achieve health equity. Though it is critical that all residents have access to affordable, high-quality health care, studies show that clinical care accounts for only a modest percentage of health outcomes.¹⁷⁶ Rather, research indicates that underlying social determinants of health—or the social, economic, and environmental conditions in a community—play a much larger role in determining population-wide health risks and outcomes.

Fundamentally, inequities in community health are linked with historical segregation of residential housing along racial lines.¹⁷⁷ With over 40% of the Boston population living in segregated areas, it is important to recognize that the legacy of racial segregation worsens conditions in communities of color, as it has for generations, and continues to contribute to disproportionate poor health outcomes and other disparities.¹⁷⁸

Over the years, studies have illustrated the impact of various social determinants of health on disease burden, quality of life, and life expectancy in communities of color.^{179, 180, 181} In Massachusetts, lower household income and socioeconomic status are correlated with an increase in diabetes, cardiovascular disease, and mental illness, resulting in disproportionate rates of chronic disease in Black and Hispanic communities.¹⁸² Poor environmental conditions in low-income areas, such as air pollution and lack of green spaces, contribute to higher rates of asthma and respiratory disease in populations of color.¹⁸³ Housing instability and homelessness are disproportionately experienced by communities of color and are associated with a variety of physical and mental health issues, infectious diseases, chronic health conditions, and increased mortality.^{184, 185} In Massachusetts, the high volume of evictions expected now that the state eviction moratorium has expired further endangers communities of color where evictions are highest and perpetuates the dangerous health effects of housing instability and homelessness.¹⁸⁶ Incarceration contributes to poorer health outcomes and increased chronic health problems in incarcerated individuals—disproportionately people of color.¹⁸⁷ Cascading effects of mass incarceration can have lasting negative impacts on the health and well-being of formerly incarcerated individuals and their families for generations.^{188, 189} The cumulative effect of decades of public policies and social practices that have kept

communities of color from acquiring and maintaining the resources to live healthy lives continue to threaten the health of these communities, and the health care system alone cannot address these embedded structural inequities.

Racism is itself a powerful determinant of health and a public health crisis. There is an abundance of evidence of the negative impact of racism on health and well-being.¹⁹⁰,¹⁹¹ Individuals absorb and internalize the racist and discriminatory messages, both implicit and explicit, that permeate our society.¹⁹² For people of color, this prolonged exposure to racism and discrimination increases stress hormones that lead to increases in blood pressure and heart rate.¹⁹³ According to the “weathering” hypothesis, chronic exposure to these prolonged levels of stress can damage bodily systems, increasing

I have been working as a midwife for 18 years, serving women and their families in Springfield and the Pioneer Valley for most of that time. In those nearly two decades, I have never seen black and brown women more afraid for themselves and their babies. It is no longer a secret that black women are four times more likely than our white counterparts to die during the childbearing years, nor that our babies are less likely to survive until their first birthdays. While these disparities have historically been minimized by citing genetic or biologic predispositions and differences in rates of poverty, education level, or access to healthcare, the truth is that racism, not race, is killing black women and babies in the United States.

Our work as healthcare providers, healthcare systems, and a nation will not be done until my daughters and all black and brown women and girls have the same chance of surviving pregnancy, cervical or breast cancer as their white counterparts. Access to safe healthcare, including birth, is a basic human right. The time to stand up for black and brown women and babies is now.

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vulnerability to chronic health conditions and contributing to signs of early physiologic aging among African Americans.^{194, 195} Chronic stress induced by racial discrimination has been associated with cardiovascular complications, obesity, inflammatory reactions that predispose individuals to chronic disease, and general wear and tear on the body.^{196, 197} In addition, prolonged experience of internalized racial discrimination contributes to negative mental health outcomes such as depression, substance use disorders, and sleep disturbances.¹⁹⁸ Some communities have found it helpful to make formal declarations that racism is a public health emergency, but the practical effect of such declarations vary.^{viii, 199} Awareness and acknowledgement of racism as a health crisis must inform our action plans to address health inequities.

Preventing or reducing these health disparities—and those exacerbated by the COVID-19 pandemic—are precisely the aims of a robust public health government infrastructure. Massachusetts has an unusual and highly localized public health infrastructure. Eight county governments were fully abolished in the late 1990s; since then, only a few of the remaining six county government units have designated county health departments or councils.²⁰⁰ This has resulted in a fragmented public health system with 351 local boards of health. Among these municipalities, there are 16 shared service arrangements, leaving 235 freestanding local public health authorities.²⁰¹ More populous areas have developed successful public health coalitions, but of the 105 towns with a population below 5,000, nearly 80% of local boards of health do not have a single full-time staff member.^{202, 203}

Local boards of health in Massachusetts, particularly in low-income communities and communities of color, face challenges in obtaining resources to address unmet health-related social needs. Most boards rely primarily on fees and property taxes for funding; there is not a dedicated state funding source. Currently, the only source of state funding for local boards of health is provided in Unrestricted General Government Aid for Massachusetts cities and towns.^{204, 205} Massachusetts spends only \$65 per resident on public health and has seen a decrease in staffing over the last decade.^{ix, 206}

viii. Wisconsin, Nevada, Minnesota, Michigan, Arizona, and many cities, including some in Massachusetts, have declared racism a public health crisis and have taken steps to refocus on shaping policy to target and eradicate systemic racism. See *Declarations of Racism as a Public Health Issue*, AM. PUB. HEALTH ASS'N, <https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations> (last visited Nov. 2, 2020). For example, along with her executive order, Michigan Governor Whitmer directed the Department of Health and Human Services to work in partnership with all state departments and agencies to undertake specific strategies to combat racism as a public health crisis and the resulting health inequities. E.g., OFFICE GOVERNOR GRETCHEN WHITMER, EXEC. DIRECTIVE NO. 2020-9, ADDRESSING RACISM AS A PUBLIC HEALTH CRISIS (2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90704-535748--,00.html.

ix. Total health care expenditure per resident in 2018 was \$8,827 (including all public and private sources). *Performance of the Massachusetts Health Care System: Annual Report October 2019*, CENTER FOR HEALTH INFORMATION AND ANALYSIS, <https://www.chiamass.gov/assets/2019-annual-report/2019-Annual-Report.pdf>.

In response to COVID-19, local boards of health have been charged with managing contact tracing, expanding community testing, collecting and reporting COVID-19 data, enforcing quarantine and safety guidelines, and providing guidance on school reopening plans.²⁰⁷ These boards are expected to rapidly implement changes as Executive Orders are introduced and amended. Massachusetts' response to COVID-19 has exposed the fact that historical underinvestment in public health has resulted in a system reliant on health care providers to perform public health functions or coordinate social support services. This is the result of decades of shifting investment away from public health and towards health care. Underinvestment in public health not only threatens our capacity to respond to the this and future pandemics, but also makes it harder to maintain existing health programs for underserved populations amid the crisis.

Our current highly localized and underfunded approach to public health presents an opportunity to rebuild the state's public health infrastructure and reimagine regionalized approaches to ensuring progress towards reducing health disparities and achieving health equity. We offer the following recommendations:

A. Invest in Social Determinants of Health to Address Root Causes of Disparities

Health care institutions alone cannot address the disproportionately worse health outcomes in populations of color. We must make significant investments in key social determinants of health—including education, employment, housing, and the environment—in order to advance statewide health equity. *First*, we recommend that policymakers examine how state resources aimed at improving social determinants of health are distributed across the state and be willing to consider how state funds can be better targeted towards upstream social services to address the root causes of health inequity. *Second*, health care providers and payers should support programs and interventions in the communities they serve that directly address the root causes of poor health outcomes and connect those in need to social services to address health-related social needs. Strategic investments in social determinants of health can significantly change the way in which health care is delivered and improve health outcomes for disadvantaged populations.²⁰⁸ *Third*, hospitals that play an anchor role in their communities—large organizations with significant influence on their local economies—should leverage their economic power and human and intellectual resources to support a health equity mission.²⁰⁹ Many Massachusetts hospitals are already using their employment, purchasing,

Clearly COVID-19 has widened the health inequity gap among our Latinx and Black populations. In Worcester, Massachusetts the inequities are overwhelming; food insecurity, unemployment, the technology divide, transportation, uncertainty navigating the health care system, housing insecurity and affordability to name a few. There is no question about it, these social determinants of health challenges are enormous and seemingly insurmountable —this is not business as usual. Nevertheless, this pandemic has created opportunities. We have seen the community and service providers rally together to address COVID-19 related inequities. For example, there is an extremely strong and concerted effort among the Worcester Together Coalition which includes a range of focused, target area Working Groups.

By the same token, our community has come together to address this problem—we are seeing shared responsibility, shared-ownership and interest in collaborative problem solving. Everyone has something to contribute to being part of the solution. And, the community wants to be part of the solution. This united approach, in fact, is the only way we will make headway by working through these multi-sectoral partnerships and having the people that are most impacted being engaged, listened to, and part of developing strategies and solutions. As health care systems, it is imperative that we have a comprehensive approach that utilizes our internal resources and those outside of the hospital walls. As we have been doing our COVID-19 educational outreach and the Stop the Spread Testing, we have seen the importance of meeting people where they are at, and directly providing a point of contact and clear communication and outreach to vulnerable groups. Through this effort the community is participating and contributing to the solution.

**MONICA LOWELL,
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and investment strategies to build community capacity, wealth, and housing, and all hospitals should evaluate what they could accomplish with an anchor mission strategy. Hospitals should work alongside other anchor organizations in their communities to implement coordinated anchor strategies.²¹⁰ *Fourth*, state agencies and other public purchasing authorities should consider how they can act to increase equity through hiring and purchasing decisions.

B. Expand Capacity of and Coordination Across Local Public Health Departments

Without sufficient capacity or improved coordination, local public health departments cannot adequately address health inequities or respond to the COVID-19 pandemic. We recommend that the state expand the capacity of and coordination among local public health departments. We agree with the recommendations of the Commonwealth's Special Commission on Local and Regional Public Health in 2019, and support the adoption of minimum public health standards to ensure that all residents benefit from a core set of public health services.²¹¹ Though some municipalities will not be able to fully expand services independently, local public health departments should be encouraged to collaborate with surrounding jurisdictions to meet service and workforce standards. This infrastructural transformation should be supported with funding that reflects each local public health department's population demographics and size, as well as socioeconomic conditions. Specifically, funding should be allocated towards programs aimed at accelerating public health workforce cultural competency, diversity, expertise and efficiency.²¹²

C. Explore New Regional Health Equity Infrastructure

Massachusetts should commit to a regional infrastructure necessary to building healthy communities in a coordinated way. The state should explore new cross-sector models for regional health equity authorities that act as chief health equity strategists for a region in the state^x (such as, for example, the six regions defined by the Executive Office of Health and Human Services).²¹³ These authorities should convene residents and stakeholders to assess and track community needs and conditions, form partnerships across sectors, maximize investments, and ensure an

x. Although in 1992 DPH created regional infrastructure for community needs assessment and community engagement through the Community Health Network Areas, limited funding and authority led many of these entities to become inactive.

equity focus in regional pandemic response. Though these authorities could take many different forms, they must be adequately resourced and must ensure that communities are represented in regional decision-making. These authorities should be responsible for identified services, such as:

1. Assessing regional health needs and resources: Existing community health needs assessments at the local public health department or hospital level are inconsistent in quality and often lack connection to broader regional health planning. Regional health equity authorities could sponsor coalition-based and community-driven needs assessments in a defined region to identify shared priorities for investment.^{xi} Some hospitals, payers, and community groups have already begun collaborating to conduct regional Community Health Needs Assessments that inform a coordinated strategy for planning and implementation of Community Benefits programs. Regional authorities would help health care providers maintain databases of community-based resources and capacity for patients who require additional support meeting health-related social needs.
2. Prioritizing regional needs in health care delivery system: The regional authority would use its health assessments to provide input on health care system facility expansion and investment plans, including through the Determination of Need^{xii} process, to ensure that changes to the delivery system meet the priority needs identified in the assessment.
3. Reviewing land use and environmental decisions: The regional authority would participate in health impact assessments and regulatory reviews related to significant proposed land use decisions and environmental permitting and siting decisions in the region that may affect public health.
4. Bringing health equity perspective to housing and transportation planning: Decisions about investment in affordable housing and public transportation capacity affect long-term community health and should include input from regional equity authorities.
5. Anchoring innovative strategies to address social determinants of health:
Emerging ideas for how to catalyze action to address social determinants

xi. The AGO's Community Benefit Guidelines already encourage collaboration among charitable health organizations in performing community health needs assessments, and the regional approach is also consistent with Internal Revenue Service requirements. See I.R.C. § 501(r)(3).

xii. *Determination of Need*, MASS. DEP'T PUB. HEALTH, <https://www.mass.gov/determination-of-need-don> (last visited Oct. 28, 2020).

of health often require anchor organizations with capacity. For example, researchers have developed a model to use collaborative financing across all stakeholders who stand to benefit from improvements in community health to correct for underinvestment in social determinants of health—but this model requires a trusted broker to gather confidential bids from stakeholders and assess if an initiative should be funded.²¹⁴

For a regional health equity infrastructure to be effective, the state should explore innovative funding options and allocate adequate funding. One such option is a public-private partnership in which federal and state funds are combined to support programs designed and implemented with the involvement of community organizations.²¹⁵ Under this scenario, hospitals and payers could allocate Community Benefits funds towards collectively supporting the infrastructure needed to establish and maintain these authorities, as well as actively participating in regional health needs assessments.²¹⁶

CONCLUSION

COVID-19 should serve as a call to action for stakeholders across the Commonwealth to take meaningful steps towards achieving health equity. Though our health care institutions are national leaders in patient care, research, and innovation, our health care system too often leaves behind patients of color. By taking action in the five domains highlighted in this report—the collection and use of demographic data, the equitable distribution of health care resources, use of telehealth to improve access to care, health care workforce diversity, and strategic investment in social determinants of health—we can improve the health of Massachusetts’ communities of color and build towards equity in health. COVID-19 has shown us that these actions cannot wait. The Commonwealth should set ambitious goals to make immediate progress in each domain. This report is intended to enhance dialogue and collaboration. We welcome discussion about these recommendations and invite stakeholders to bring us their ideas about new approaches and strategies to promote health equity. The AGO stands ready to work with policymakers, providers, payers, community leaders, patients, and other stakeholders to ensure that all Massachusetts residents, regardless of race or ethnicity, have access to affordable, safe, quality health care.

ENDNOTES

- 1 MASS. DEP'T OF PUB. HEALTH, 2017 MASSACHUSETTS STATE HEALTH ASSESSMENT 252-255 (2017), https://www.mass.gov/files/documents/2017/10/03/MA%20SHA_Final_All_100217_Version2%20reduced%20size%208.pdf.
- 2 *Id.* at 53.
- 3 *Id.* at 67-68.
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CREDITS

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