

Department Health Equity Plan Fiscal Year 2022-23

Closing the Gap

Addressing
Disparities and
Improving
Outcomes for
Health First Colorado
(Colorado's Medicaid
program) and Child
Health Plan
Plus Members.

July 1, 2022



COLORADO

Department of Health Care
Policy & Financing

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Land Acknowledgement

We would like to acknowledge that the land we live, work, learn, and commune on is the original homelands of many tribal nations. We acknowledge the painful history of genocide and forced removal from this territory, and we honor and respect the many diverse Indigenous peoples still connected to this land on which we gather.

To learn more about territory acknowledgement, visit <https://native-land.ca/>

Executive Summary

Health disparities have long-standing historic roots in structural discrimination and systemic inequities. In 2020, the Department updated its mission to underscore its increasingly important focus on health equity. Today, the mission is to *“improve health care **equity**, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.”*

The Department is achieving this mission by applying a health equity lens across our programs and initiatives. We implemented more sophisticated data stratification analytics to identify health disparities. This informed our four focus areas:

1. COVID-19. As of the writing of this plan, COVID-19 vaccination rates show a 20%-28% gap between the general population and our members, indicating a measurable disparity for Coloradan children (20%) and adults (28%) with lower incomes.

Vaccination is the best protection against severe illness, hospitalization, and death due to COVID-19. While this gap is similar to other states across the nation, closing this disparity is of vital importance to reducing spread, hospitalizations, and deaths among Coloradans with low income. Thanks to our partners - the Colorado Department of Health & Public Environment (CDPHE), members of the disability advocacy community, Single Entry Point (SEP) agencies, Community Centered Boards (CCBs), Regional Accountable Entities (RAEs), community health centers, providers, hospitals, pharmacists, and our many other valued partners - we know that targeted outreach works, as evidenced by these results:

1. Health First Colorado (Colorado’s Medicaid program) members with disabilities have a vaccination rate approximately 22 percentage points higher than members without disabilities;
2. Homebound members have a vaccination rate almost 40 percentage points higher than their counterparts; and
3. Members of color are now vaccinated at a higher rate than white members.

Continuing to close COVID-19 vaccination disparities remains a high priority for the Department, as well as making sure that our members can access COVID-19 testing and treatment.

2. Maternity care. Health First Colorado provides health coverage for more than 40% of Colorado births. To examine maternity care quality and identify disparities, the Department conducted first-of-its-kind maternity research and reporting. The [Health First Colorado Maternity Report](#) is based on groundbreaking data and equity-designed

dashboards. The report found that preterm birth rates continue to rise and racial and ethnic disparities in maternity health outcomes persist. To address this unacceptable disparity, we established the [Maternity Advisory Council](#) to hear from members about their experiences and get their input on strategies to reduce disparities. Utilizing the Reproductive Justice (RJ) model, this organizing framework will help shape our Maternal Health Program and our approach to address maternity and perinatal health and equity. Additionally, the Department will be leveraging new federal authority available through the American Rescue Plan Act (ARPA) to extend postpartum coverage from 60 to 365 days. Maintaining coverage for new parents in this period will help reduce barriers to care and increase access to life saving and sustaining services that have impact for generations.

3. Behavioral health. Colorado, as well as around the nation, is battling immense behavioral health system challenges exacerbated by the impact of COVID-19. Between April 1, 2020 and March 31, 2021, 26.4% of Health First Colorado members had a behavioral health diagnosis. The Department continues to make investments into behavioral health a priority, increasing annual funding by over \$400 million since 2018, with a 2022-2023 FY budget of over \$1 billion. This investment has been designed to reduce disparities by increasing access to behavioral health care for Health First Colorado members with low income. This investment also supports our work to integrate administration, data and reporting for state-funded behavioral health services this upcoming fiscal year, as well as to start work on community grant funding, improve accountability and transparency, and increase opportunities for small and medium-sized providers, including those that specialize in population-specific care.

The Department is also expanding mobile crisis services and creating a new secure transport benefit, which will reduce reliance on law enforcement for community response and transportation in a behavioral health crisis. The Department also continues to expand and strengthen the behavioral health safety net network (currently represented by Community Mental Health Centers - CMHCs). Additionally, we will be supporting the implementation of a coordinated, historic and transformative behavioral health legislative package that puts people first.

4. Prevention. The saying “*an ounce of prevention is worth a pound of cure*” holds true and can save lives. The Department has worked extremely hard alongside stakeholders to increase access to prevention, primary care, and chronic care for members. Thank you to the 95,000 providers across the state who share a passion to serve Health First Colorado members. This represents a 28% increase of providers to our network over the past few years, thereby expanding access to care.

Unfortunately, having more providers isn't enough. Research shows poorer health outcomes result when a health care provider with unconscious bias and/or a lack of cultural sensitivity treats people of color, women, people with disabilities, aging adults, and LGBTQ+ people - such individuals are unheard and therefore receive less effective care. Therefore, the Department is taking proactive steps to improve outcomes, address unconscious bias through standardizing practices, address social determinants of health, bolster prevention and wellness services, and incorporate screening and counseling into chronic disease management. The Department also sees the value of including non-licensed health care providers such as peers, behavioral health aides, and community health workers to help build individual and community capacity to advance health equity.

Overall, a broad array of initiatives is needed to assure equitable health outcomes. Both the problems and solutions must be guided by our members with lived experiences. It also takes the collaboration of policymakers, industry partners, stakeholders, community leaders, and thought leaders.

This Health Equity Plan is an important step forward and outlines concrete actions the Department is taking to address health disparities in Health First Colorado and Child Health Plan *Plus*. I am confident it sets the foundation for building a better, more equitable tomorrow.



Kim Bimestefer,
Executive Director

A Call To Action: Advancing Health Equity for All

Meeting Health First Colorado and CHP+ members where they are is a fundamental principle and best practice. That is why we are striving to go into the communities we serve and bring access and opportunities to our members. The directive is clear: *working alongside our dedicated and mission-driven providers and advocates will help remove barriers to quality care and close health disparity gaps for all Coloradans.*

Effective July 1, 2022, health equity plans are now in our Accountable Care Collaborative partner RAE/MCE contracts. This important lever is foundational in achieving desired health outcomes as well as decreasing disparities for our members. In addition to targeted interventions to population needs and health priorities, listening to the lived experiences of our members and shoring up our data collection will help guide the Department's decisions and innovations to improve quality of care.

Following the lead of [Senate Bill 21-181](#), and with our partners at the Colorado Department of Public Health & Environment's (CDPHE) Office of Health Equity (OHE), and the Behavioral Health Administration (BHA), our call to action includes all stakeholders to implement this plan. Our vision and mission to create and build a health care delivery system that addresses health disparities by ensuring that everyone matters starts with us.

In the words of Reverend Dr. Martin Luther King Jr., "*The time is always right, to do what is right.*"

Seeking equity together,



Cristen Bates, MPH
Interim Medicaid Director



Tom Massey
Deputy Executive Director



Bettina Schneider
Chief Financial Officer



Peter T. Walsh, MD, MPH
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Todd Jorgensen
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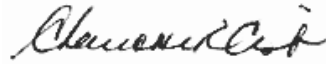
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Senate Bill 21-181 Strategic Plan Address Health Disparities

The Department partnered with the Governor's Office and the Colorado Department of Public Health & Environment (CDPHE) to pass [Senate Bill 21-181](#), which creates a shared health equity strategic plan across state agencies and provides funding and staff to implement it.

The Department, in coordination and collaboration with the Health Equity Commission (HEC), led by CDPHE and the Office of Health Equity (OHE), is developing a health equity strategic plan to address 12 health outcomes and disparity indicators in four areas: chronic diseases, injury, maternal and child health, as well as communicable diseases (COVID-19); [see Appendix I](#) for additional details. In alignment with this legislation, the Department has created a robust and comprehensive health equity plan that partners with, and works towards, addressing upstream and downstream [determinants of health](#). Ultimately, addressing health disparities and improving health outcomes for people with low income, marginalized, underrepresented, and underserved communities outlined in protected classes (race, class, age, sexual orientation, place of origin, language, disability, gender and other identities) who are enrolled in Health First Colorado and CHP+ programs.

Starting with vaccination rates (i.e., COVID-19), maternity and perinatal health, behavioral health and prevention as focus areas, the Department will explore and identify additional areas and opportunities to address in a phased approach as outlined by the Office of Health Equity.

Background

The Department of Health Care Policy & Financing (the Department) provides health coverage to Coloradans who qualify through programs such as Health First Colorado (Colorado's Medicaid program)¹ and Child Health Plan *Plus* (CHP+)². A comprehensive list of all our programs is on our [website](#).

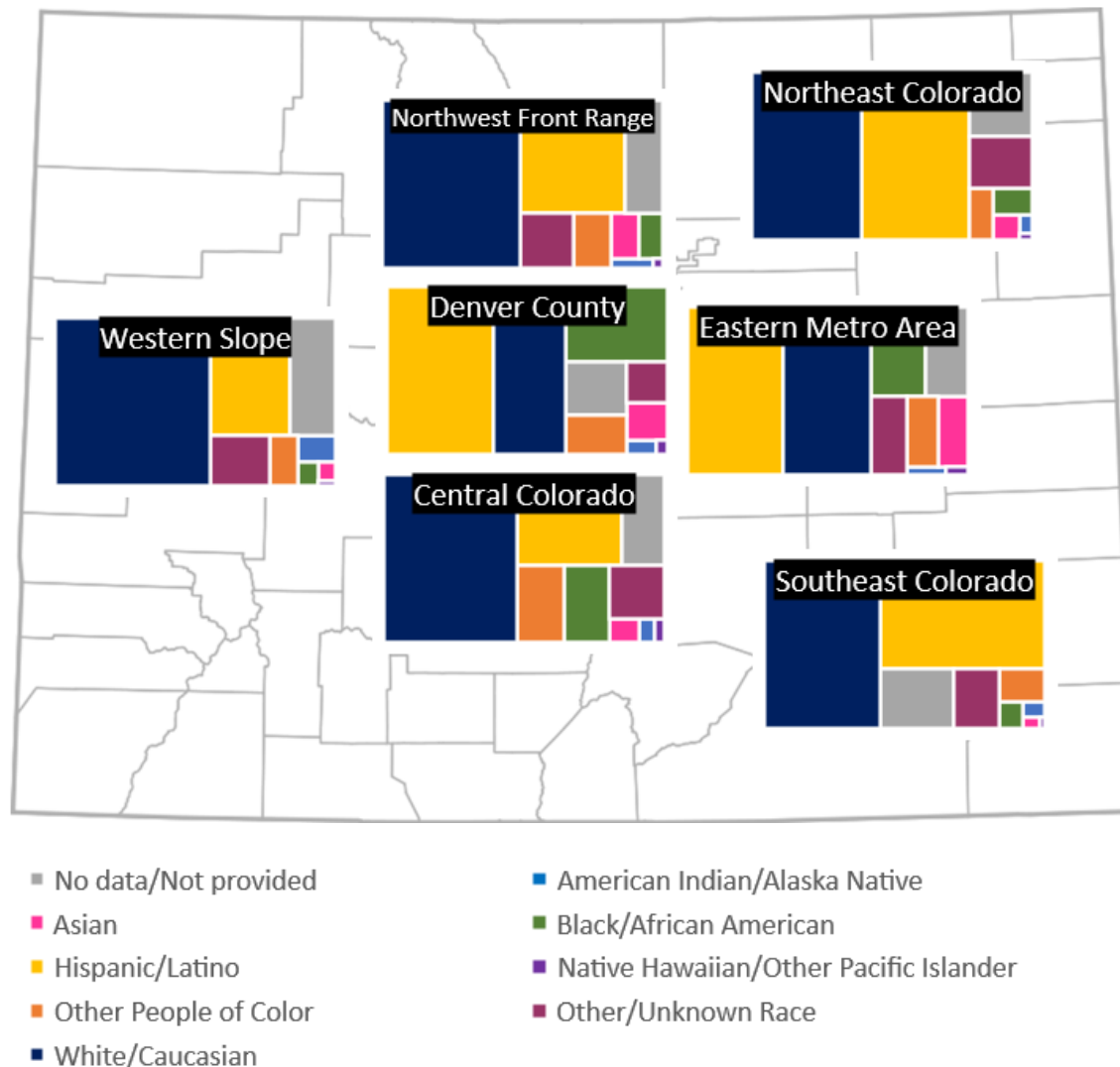
Health First Colorado covers members in every county of our state. From rural Colorado, where in many counties the enrollment is higher than the state average, to the front range. Health First Colorado covers Coloradans of all ages and abilities, as well as more than 40% of births in the state each year.

¹ <https://www.healthfirstcolorado.com/>

² <https://hcpf.colorado.gov/child-health-plan-plus>



Figure 1. Health First Colorado Members by Race/Ethnicity



The map above shows Health First Colorado across Regional Accountable Entities (RAEs) and self-identified race/ethnicity of members (calendar year 2020); race/ethnicity categories are reported here as shown on the medical assistance application. Differences in race/ethnicity of members vary across regions. Northwest Front Range, Western Slope and Central Colorado, have the highest number of White/Caucasian members, with Denver County and Eastern Metro Area having the highest number of Hispanic/Latino members.

Our programs serve Coloradans with disabilities and low-income of all ages whose socioeconomic status is intrinsically linked to their state of health. Our members report 56 or more distinct primary or spoken languages; 10.8% of members self-identify as Spanish speakers, 88.0% self-identify as English speakers, and 1.2% self-

identify as speakers of another language (As of June 14, 2022). Language access is critical, and the utilization of interpretation services is a priority for our Department.

Figure 2. Health First Colorado Members by Race, including Long-Term Services and Supports (LTSS) Members with Disabilities (February 2022)

Race/Ethnicity	LTSS Members	Race Percent of Total LTSS Members	Total Members	Race Percent of Total Members	LTSS Percent of Total Members
American Indian/Alaska Native	335	0.6%	14,850	0.9%	2.3%
Asian	2,065	3.6%	38,576	2.4%	5.4%
African American	3,330	5.8%	109,631	6.9%	3.0%
Hispanic/Latino	8,068	14.1%	485,941	30.5%	1.7%
Pacific Islander	65	0.1%	5,230	0.3%	1.2%
Other People of Color	1,237	2.2%	73,302	4.6%	1.7%
Other/Unknown Race	10,369	18.1%	229,298	14.4%	4.5%
White/Caucasian	31,802	55.5%	635,846	39.9%	5.0%
February 2022 Total Members	57,271	100%	1,592,674	100%	3.6%

Thirty-nine percent (39.9%) of our members self-report that they are white, followed by 30.5% Hispanic, and 14.4% Other. We have an opportunity to ensure that those enrolling in public programs feel comfortable accurately identifying themselves so that we can more accurately report on and address disparities by community. At the same time, the percent of individuals identifying as “Other People of Color” (4.6%) is slightly below the percent of individuals identifying as African American (6.9%).

Our Department is making tremendous strides to ensure the disability community is seen and empowered to thrive. If you or a loved one acquires or is born with a disability, you will need Medicaid (unless you are independently wealthy) to get your care needs met. Private insurance does not cover the cost of long-term services and supports (LTSS). While people with disabilities comprise just a small percent of the total Health First Colorado population (57,271 or 3.6%; see Figure 2), they do represent the only marginalized group that many of us will eventually become a part of, as we age. This is because someone turning 65 today has almost a 70% chance of needing long-term care in their remaining years.

With a history of inappropriately institutionalizing people with disabilities, our Department’s investment is to continue to strengthen, enhance, and expand the availability of home and community-based services (HCBS).

According to the 2021 Colorado Health Access Survey:

- Our members are more than three times as likely to report fair or poor health compared with privately insured Coloradans.³

³ Colorado Health Institute. 2021 Colorado Health Access Survey.

- Health First Colorado members who recently gave birth were more than twice as likely to report symptoms of a possible depressive disorder compared with new parents with other health insurance types.⁴

While mental health challenges can be experienced by all populations, a survey of LGBTQIA+ Coloradans found that respondents who said they have Health First Colorado coverage self-reported a greater number of days per month where their mental health was not good compared with higher income respondents with other insurance.⁵ LGBTQIA+ Health First Colorado members who responded to the survey also indicated barriers in finding culturally appropriate care, including transportation and provider availability.

Additionally, one in four Coloradans expressed mental health needs during the pandemic, suicide rates across the nation increased by 12% between 2010 and 2020. With death rates rising the fastest among people of color, younger individuals, and people in rural communities,⁶ the Department has expanded our mental health and substance abuse services (referred to as behavioral health) to over 11,000 providers to help increase access to quality care and are working to improve crisis services for those in urgent need.

Health disparities such as these in Colorado represent loss of human life, productivity, and billions in taxpayer revenue spent on unnecessary costs. Disparities affect us all in ways we may not even realize. Our economy suffers because health disparities affect productivity. For example, Colorado employers experience \$1 billion each year in lost productivity as the result of short-term complications of diabetes, which are at a significantly higher rate among Hispanic/Latino and Black Coloradans.^{7,8,9} The true cost of health disparities goes far beyond financial concerns. The cost can even be death. The national maternal mortality rate (the number of maternal deaths) was 28.8 per 100,000 births in 2020. Black women comprised 55.3 deaths per 100,000 births, which is 2.9 times the rate of white women (19.1 deaths per 100,000 births); Hispanic women had 18.2 deaths per 100,000 births.¹⁰

⁴ Colorado Department of Public Health & Environment. Colorado Health eMoms Survey 1.1 Prevalence Estimates, 2020 Birth Cohort.

⁵ Colorado Department of Health Care Policy & Financing. Analysis of One Colorado 2018 Turning Point for LGBTQ Health.

⁶ https://www.kff.org/other/issue-brief/a-look-a-suicide-rates-ahead-of-988-launch-a-national-three-digit-suicide-prevention-hotline/?utm_medium=email&_hsmi=217297172&_hsenc=p2ANqtz--BaCmtrCT15F_P2JgIQOsQJBRjakQeAJDms-thk3De_nLN3mbvNhqfOXJvGU7yNk_NeUbszDhisYU3L1zE4ZIQJZueVw&utm_content=217297172&utm_source=hs_email

⁷ American Diabetes Association. (2020) The Burden of Diabetes in Colorado. https://diabetes.org/sites/default/files/2021-10/ADV_2021_State_Fact_sheets_Colorado.pdf

⁸ Marcondes FO, Cheng D, Alegria M, Haas JS. Are racial/ethnic minorities recently diagnosed with diabetes less likely than white individuals to receive guideline-directed diabetes preventive care? BMC Health Serv Res. 2021 Oct 25;21(1):1150. doi: 10.1186/s12913-021-07146-0. PMID: 34689778; PMCID: PMC8543926. <https://pubmed.ncbi.nlm.nih.gov/34689778/>

⁹ Diabetes and Hispanic Americans. Minority Health. US Department Of Health. <https://minorityhealth.hhs.gov/omh/browse.aspx?vl=4&lvlid=63>

¹⁰ <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf>



According to the 2021 National Health Care Quality and Disparities Report, disparities exist in these six areas¹¹ :

1. Patient safety
2. Person-centered care
3. Care coordination
4. Effective treatment
5. Healthy living
6. Health care affordability

It is critical to identify the current state of *health disparities* in these six areas in each Colorado region to appropriately allocate resources to regions with disproportionately poor clinical outcomes for our members. Providers, caregivers, and stakeholders have voiced the need to have equity-based, quality outcomes data for their region so they may begin to address Colorado's health disparities.

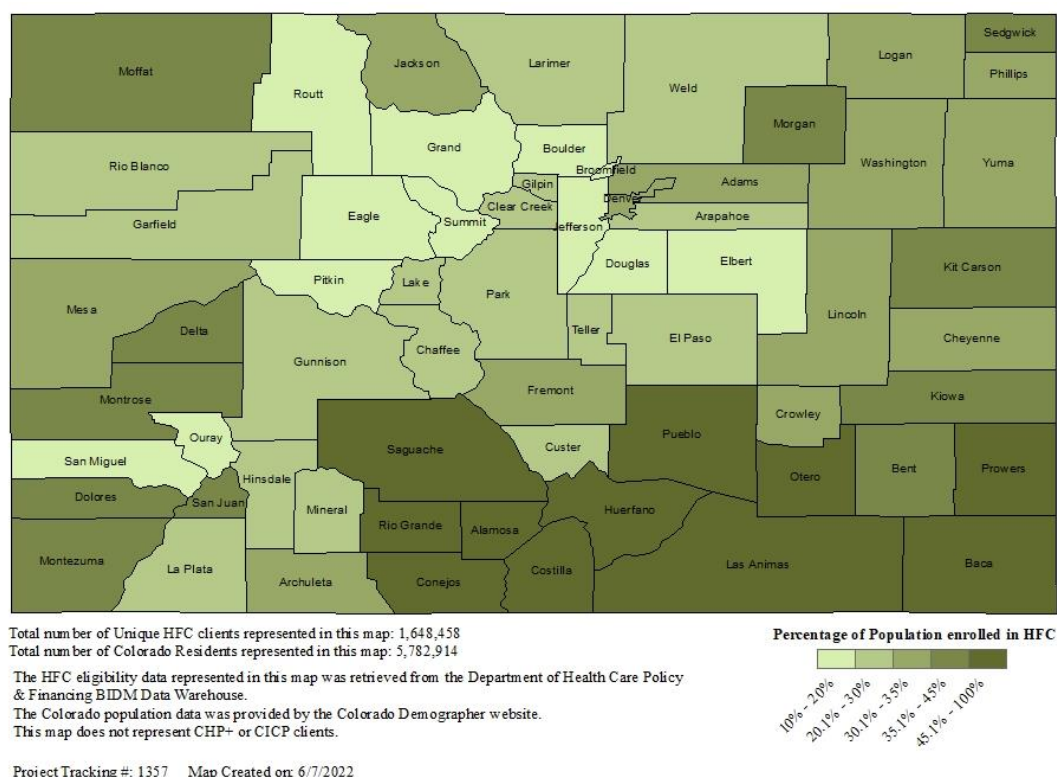
Health First Colorado plays an integral role in advancing racial and ethnic health equity - meeting the needs of all members. Research shows that children, youth, and families of color that have access to quality health care experience better long-term health outcomes.¹² For access to be meaningful, it must be affordable, equitable, person-centered, and culturally responsive. The Department will focus our efforts on not just racial and ethnic health equity, but also the intersectional identities of all impacted members (see Figure 3).

¹¹ <https://www.ahrq.gov/research/findings/nhqdr/nhqdr21/index.html>

¹² <https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/>

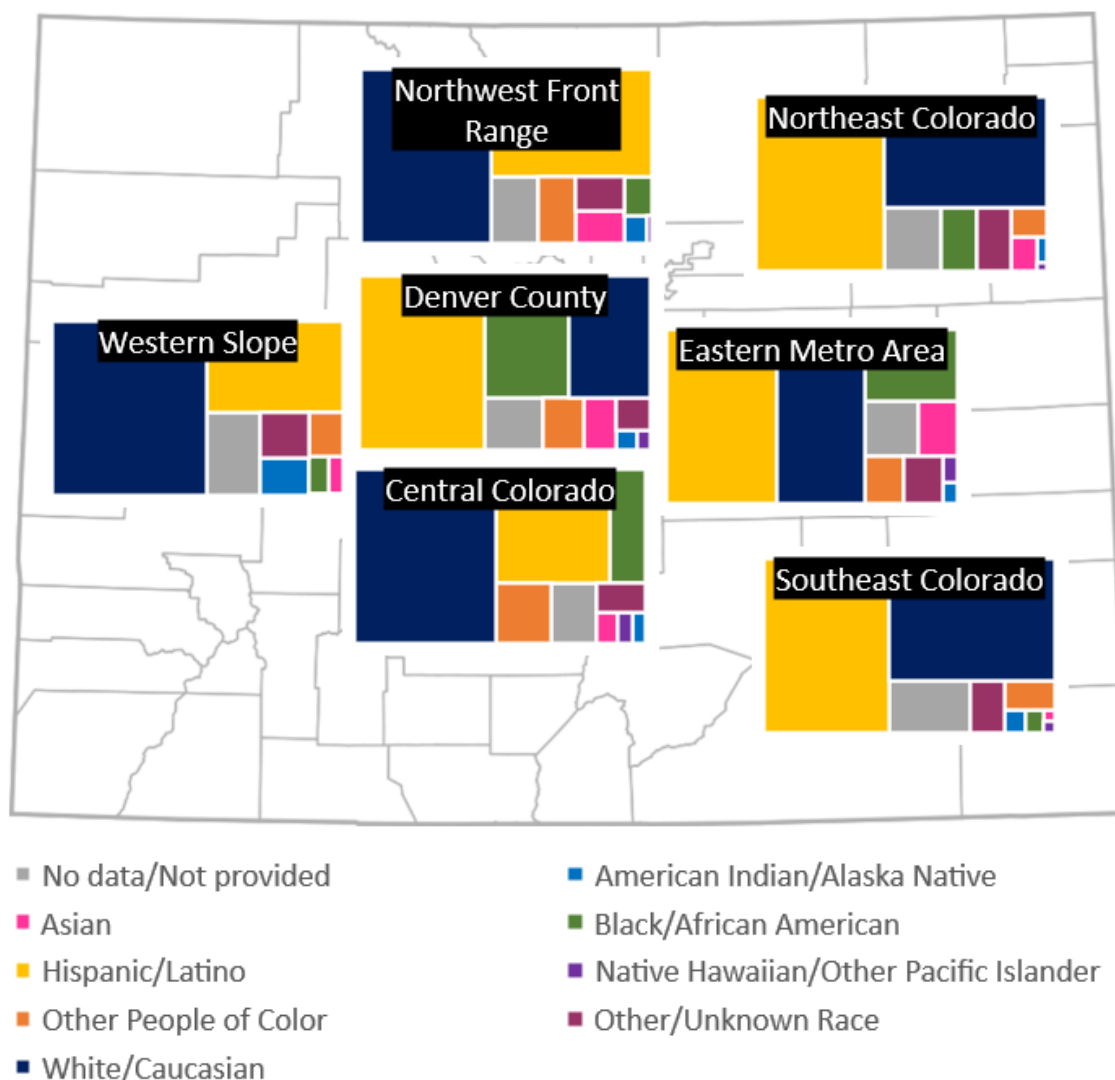


Figure 3. Percentage of Coloradans served by Health First Colorado



The map above visualizes the total percentage of Health First Colorado members enrolled at least one day of enrollment in calendar year 2020. The darker the county is shaded, the higher the percent enrolled in Health First Colorado.

Figure 4. Pregnant People who gave birth by Race/Ethnicity by Region (Calendar Year 2020)



The map above visualizes the proportion of people within each race/ethnicity group across the seven RAE regions of Colorado who gave birth in 2020. Northwest Front Range, Western Slope and Central Colorado, have the highest number of White/Caucasian births, with Denver County, Northeast Colorado, Eastern Metro Area and Southeast Colorado having the highest Hispanic/Latino births. More detailed information for maternity will be provided in the Department's September 2022 [report](#).

Health Equity

Health equity is both an outcome and process. Health equity happens when everyone has equal opportunity to be as healthy as they can be. No one's race, ethnicity, disability, age, sexual orientation, gender identity, socioeconomic status, geography, or preferred language should negatively affect their health care. Health equity work includes removing obstacles to positive health outcomes, such as health care access barriers.

The Department embraces this definition, and with the direction of the Centers for Medicare and Medicaid Services (CMS), we are working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our members need to thrive.¹³

Improve Data to Identify Health Inequities

Health inequities are defined as systemic differences in the health status of different population groups. The Department needs accurate and up-to-date data to develop appropriate insights and action steps that address disparities. Strengthening Department data collection and therefore insights is a critical aspect of our health equity plan. Understanding that the data the Department collects is only as good as the demographics on the Health First Colorado application, the Department is planning to make recommendations to modify Health First Colorado applications to include more data on age, gender, race, ethnicity, and language, in partnership with the Colorado Department of Human Services. It is paramount that we articulate to our members the why and purpose behind requiring specific personal information. Such data would help bolster communication among agencies, partners, hospitals, and clinics, as well as eliminate rework and enable a positive impact on health outcomes.

Equitable Access & Outcomes for our Members

The Department's **health equity plan** is comprehensive and culturally-responsive, and centers on health equity, diversity, inclusion, and accessibility (HEDIA) to drive down disparities and improve access for all members. Outcomes below are aligned with CMS' health equity pillars.¹⁴

¹³ <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/equity-plan>

¹⁴ https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf

- **Critical:** Develop and identify ways to actualize coordinated care for person-centered outcomes
- Stratify data collection and align with quality of care and payment structures
- Define clear, actionable steps to address social determinants of health (SDoH)
- Develop strong partnerships with community members from ideation to implementation
- Focus on safety net provider engagement, accountability and affordability (tribal, rural, frontier, and urban)
- Identify and leverage targeted interventions based upon health disparity data among vulnerable and marginalized members and manage risk
- Ensure Coloradans maintain continuity of health coverage if they transition from Health First Colorado to other benefits or forms of coverage when the public health emergency ends
- Strengthening and stabilizing the health care workforce
- Ensuring members, including those with complex conditions and complicated life situations, have access to needed behavioral health services
- Measure success in health outcomes and cost savings
- Add health equity reports to vendor contracts
- Planning and implementation of ACC¹⁵ Phase III (Empowered Members / Member Centricity)
- Update our standards to be reflective of growing progress; all hands-on-deck approach

COVID-19 in Context: Understanding the Roots of Health Disparities

Racial disparities are associated with COVID-19 infection, morbidity, and mortality among underserved communities.¹⁶ The Department has designed the health equity plan with the flexibility to move from pandemic responsiveness to endemic management and pandemic readiness to address these disparities.

Understanding and addressing the root causes of health disparities and analyzing the negative impact of structural racism are essential to building equity in health.¹⁷ Alan Weil, the editor-in-chief of Health Affairs, wrote that “*the legacy of racism is baked into our institutions, our thinking, and our policies*”¹⁸ - and that is why we must centralize our efforts around racial and ethnic health equity. This does not preclude our efforts to negate health disparities other marginalized groups experience, but

¹⁵ <https://hcpf.colorado.gov/accphase2>

¹⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7466083/>

¹⁷ https://www.healthaffairs.org/racism-and-health?utm_source=Newsletter&utm_medium=email&utm_content=New+Journal+Issue%3A+Racism+and+Health&utm_campaign=HASU%3A+2-13-22&vgo_ee=l2EnA9cg%2BbZka22AQqzBJJVWxsT%2F5Cm5%2FK%2B1leDVXsQ%3D

¹⁸ <https://www.healthaffairs.org/racism-and-health>

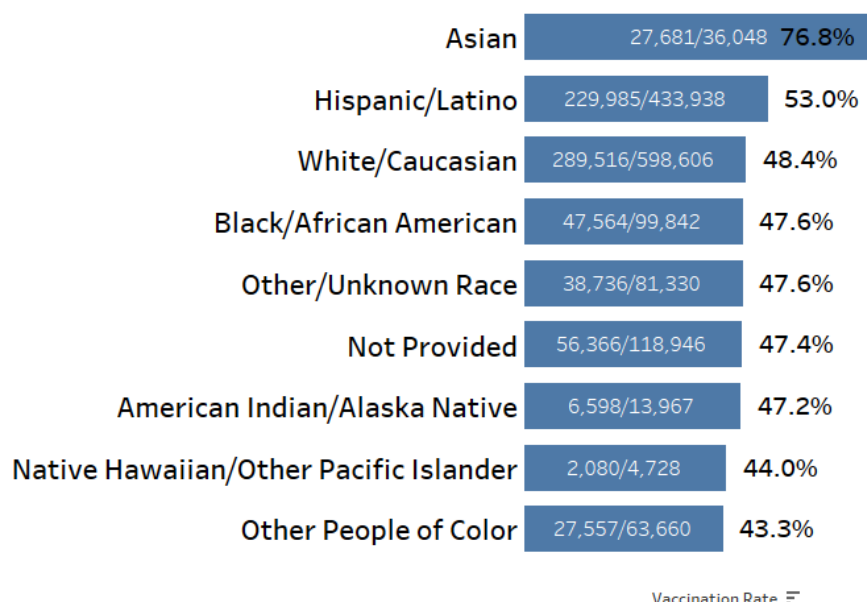


rather, it represents a starting point that specifically addresses racism as the primary driver for health disparities in this country.

Department efforts are based on health care policy-based recommendations¹⁹ to address structural and systemic racism. Not only are we providing leadership and staff training, but we are also leveraging multi-layered approaches that will deepen our understanding of the administration and structures of marginalization.²⁰ The Director for the Othering and Belonging Institute of Berkeley, John A. Powell, states that we must move our terminology from “structural racism” towards “structural racialization” - which is a “*set of processes that may generate disparities or depress life outcomes without any racist actors. It is a web without a spider.*” More plainly, communities of color were disproportionately deemed essential workers, relied on public transportation, and lived in close quarters with others. Conditions resulting from structural racialization resulted in people of color being disproportionately exposed to COVID-19 across the United States.

Understanding the underlying implications for communities of color, CDPHE and HCPF worked together with our RAEs to overcome this barrier. In addition to concerns that immunization clinics depended largely on private transportation, this disparity issue primarily impacts members with low income, more so than medium and higher income people. To address this concern, the Departments supported pop-up clinics and closely monitored racial health equity metrics to identify and address disparities.

Figure 5. COVID-19 Vaccine rate by Race/Ethnicity (age 5+ only)



¹⁹ <https://belonging.berkeley.edu/structural-racism-remedies-repository?emci=797a9200-d68d-ec11-a507-281878b83d8a&emdi=2f86412e-4b8f-ec11-a507-281878b83d8a&ceid=9279157#healthcare--public--health--and--environmental--justice>

²⁰ https://www.prrac.org/pdf/SeptOct2013PRRAC_powell.pdf

The bar chart above represents the vaccination rate within each race/ethnicity group. 76.8% of Asian members, and 53% of Hispanic/Latino members are partially or fully vaccinated at a higher rate than white members (48.4%). Data only includes Health First Colorado members age 5 and older. Data includes vaccine service dates through May 22, 2022.

Equally as important, recognizing the extraordinary efforts of our mission-driven partners working within the community, vaccinating community members in specific areas of need, is a key component of advancing health equity for all Coloradans. In addition, our Department, under the direction of the Governor's Office, is following [Colorado's Next Chapter: A Roadmap Forward](#) for the future of responding to COVID-19 as well as other future pandemics.

COVID-19 Vaccine uptake gaps between Health First Colorado/CHP+ and the general population are 19.9% for kids and 27.7% for adults as noted below (figure 6).

Figure 6. COVID-19 Vaccination Rates for Coloradans and Health First CO/CHP+ members (ages 5-19 and 20+)

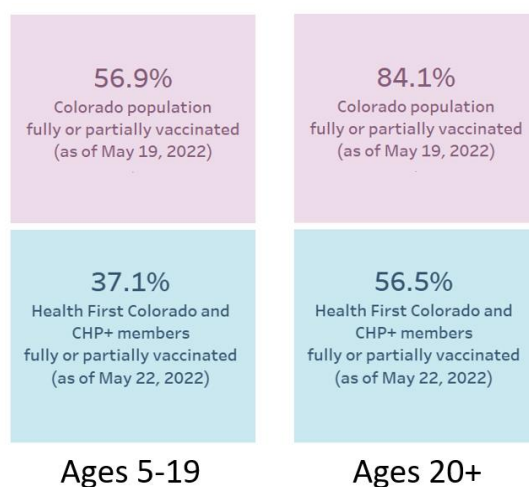
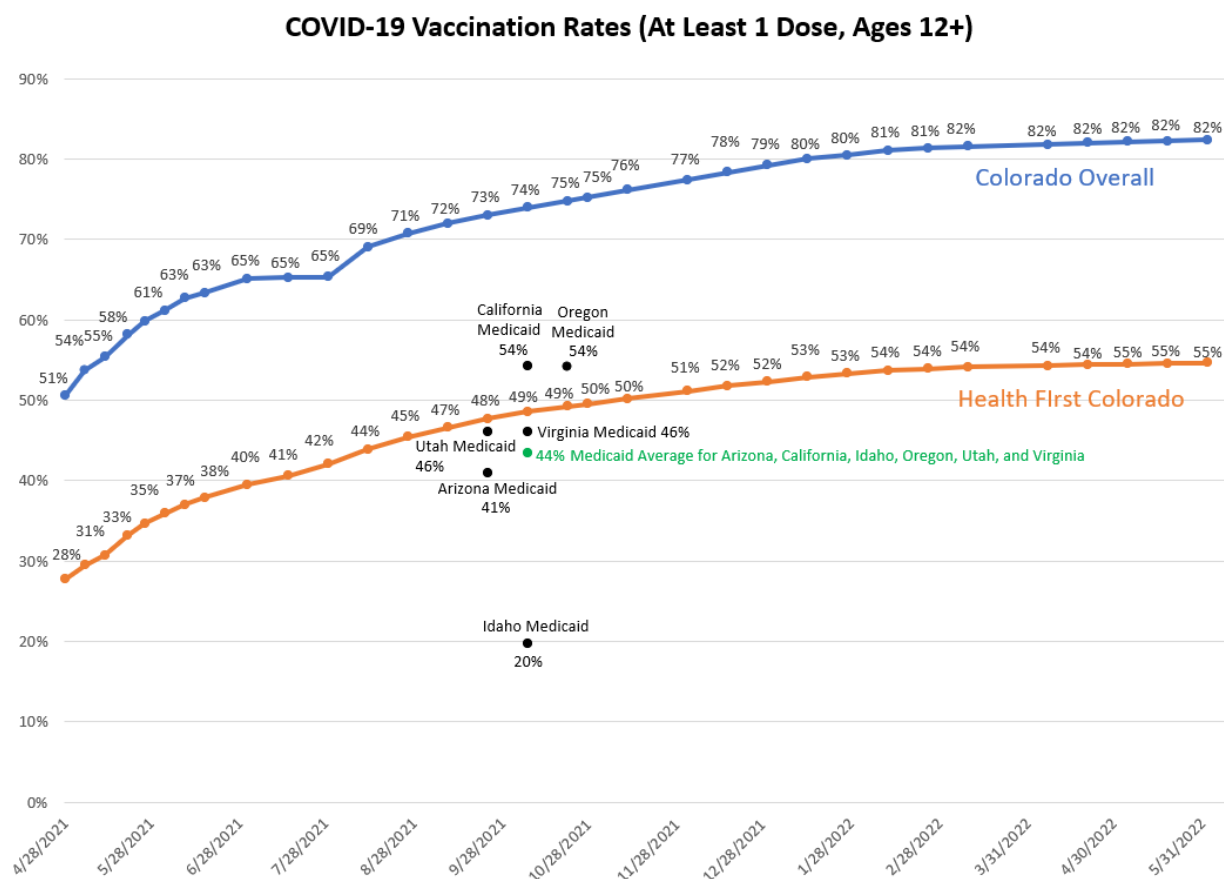


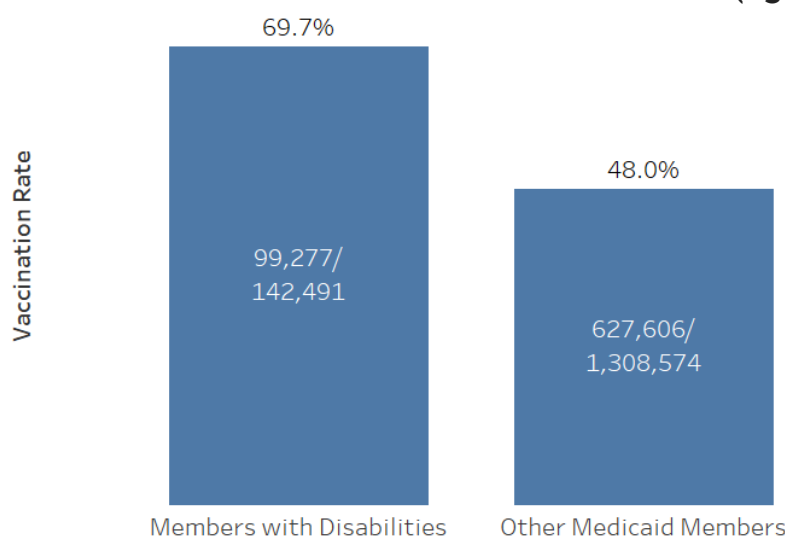
Figure 7. COVID-19 Vaccination Rates (at least 1 dose, ages 12+) versus Colorado Overall, compared to Medicaid Vaccination Rates for California, Oregon, Utah, Virginia and Arizona



*Medicaid rates for other states came from: <https://rollcall.com/2021/10/27/income-inequity-persists-in-covid-19-vaccination-rates/> Dates for these six states range from 9/17/21 - 10/20/21

The chart above highlights Health First Colorado vaccination rates (at least one dose, ages 12 and older) from April 2021 - June 2, 2022. The orange line shows Health First Colorado's steady slope increase of at least one percent (1%) per month vaccination rate.

Figure 8. COVID-19 Vaccine Rates for Members with Disabilities (Age 5+ only)



The bar graph above represents the vaccination rate within each group; 69.7% of members with disabilities are partially or fully vaccinated at a higher rate than members without disabilities (48%). Data only includes Health First Colorado members 5 and older. Data includes vaccine service dates through May 29, 2022.

As of May 22, 2022, 49.9% of Health First Colorado and CHP+ members ages 5 and older were partially or fully vaccinated. Vaccine hesitancy²¹ is not specific to Colorado, as noted in this chart. Other states have similar margins between state and member population disparity. Our members may also face additional barriers such as lack of child care, time off from work, transportation, and access. **Therefore, we have worked in close collaboration with our partners to close the gap between members and the Colorado population through the following efforts:**

Vaccine Outreach: The Department received \$14,337,696 to implement targeted vaccine outreach for two high-priority population groups: 1) members who are homebound²² and 2) populations impacted by health disparities. The Department made funds available to Single Entry Point (SEP) agencies, Community Centered Boards (CCBs), the Regional Accountable Entities (RAEs), and Managed Care Organizations (MCOs) to ensure resources were available to vaccinate these populations. These efforts led to 100% of homebound members who wanted to receive a vaccine, receiving their vaccine. This minimized the health disparity gap among racial groups within the Health First Colorado population.

²¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6515949/pdf/0650175.pdf>

²² The term "homebound" refers to people who are unable to leave their homes, and vaccines were needed to be deployed and administered in the home

Prevention, Testing, and Treatment: To incentivize Health First Colorado and CHP+ providers to vaccinate, the Department increased the COVID-19 vaccination and booster provider reimbursement rate from \$28.39 to \$61.77. There are no out-of-pocket costs or co-pays for Health First Colorado or CHP+ members. Health First Colorado and CHP+ began paying for at-home COVID-19 tests for members effective Jan. 15, 2022.²³ Each enrolled Health First Colorado member can get up to 15 free at-home tests per month from pharmacies that serve Health First Colorado. Each enrolled CHP+ member can receive up to eight tests per month. The Department has leveraged all sources to tackle the problem to close disparities in vaccination rates across race/ethnicity, including analyzing data and layering indicators, as well as focusing efforts at the micro community levels through new and existing partnerships. In addition, the RAEs and MCOs implemented the following activities and initiatives to reduce vaccination disparities:

- Identified and distributed lists of unvaccinated members to primary care medical providers (PCMPs) with messaging and, often, financial support to encourage an increase in providers offering COVID-19 vaccines to members.
- Trained care coordinators and trusted community messengers to promote accurate vaccine information and dispel myths.
- Funded promotoras (Hispanic/Latino community health workers) to outreach to members in their communities about why and how to get vaccinated.
- Supported PCMPs (especially Federally Qualified Health Centers) in diverse communities, including administrative support, supplies, and in some cases, incentive payments.
- Set up pop-up clinics in communities, often staffed with bilingual workers and paired with COVID-19-safe events.
- Funded alternative transportation options for members.
- Formed partnerships with housing partners, advocacy groups, schools, community-based organizations, local public health agencies, vaccination task forces, child care providers, radio and media groups, and faith-based organizations.
- Met contractor goals for disparity reduction, ensuring that vaccination rates between white members and members of color were within three percentage points. We are seeing a higher vaccination rate of 50.6% for members of color, in comparison to a vaccination rate of 45.9% for white members.

²³ <https://www.healthfirstcolorado.com/covid/supplies/>

Key Populations and Demographics

Our health equity plan includes the following key populations and demographics:

Table 1. Key Populations and Demographics

Racial/Ethnic Groups	Other Marginalized Groups	Geographic
American Indian/Alaska Native	Immigrants and refugees	Tribal
Asian/Asian Americans, Native Hawaiians and Pacific Islanders	LGBTQIA+ people	Rural
Black/African American	People with low income	Urban
Hispanic/Latino	People experiencing homelessness	Frontier
White	Veterans	Remote
Other People of Color	Pregnant people	Overall community environments
	Foster Care/Child Welfare	
Age	Medically Underserved	Congregate settings
Infants/Children (0-12)	People with disabilities	Jails
Youth (12-18)	People who require long-term services supports	Prisons
Adults 65 and older	Uninsured/Underinsured	Nursing Facilities

Community and Stakeholder Meetings

The Department held 12 community and stakeholder meetings over the course of several months that contributed to the development of this plan. Addressing the needs and concerns of the members we serve is a top priority. Key information and feedback was documented, and a few observations, ideas, and future areas for exploration and implementation are noted below:

Observations. Navigating health care services for non-English speakers is a challenge, as well as an opportunity to enhance demographic fields on the

medical assistance application. Stakeholders also shared insight around existing silos and the disconnect of care coordination with safety net providers; the need to recognize food, housing, and employment/workforce as all part of health care. Common sentiment was also expressed that addressing the growing number of members who have Medicare and Health First Colorado among the aging population is necessary to anticipate member needs. And finally, recognizing the obstacles of members having to physically go to a health care provider continues to be challenging. It was widely noted that it is essential that the Department and its partners continue to focus on marginalized communities that are unvaccinated, while also closing the COVID-19 vaccination gap between members and the general Colorado population.

Ideas. Increasing access among rural community clinics and hospitals to reduce the need to travel hours outside of their community for care. Improving access to long-term services and support for members in the disability community, expanding language access, transcription and transcreation services for non-English speaking members. And ultimately investing in postpartum doulas for mothers and babies to improve maternal health.

Future innovations to consider. Creating a “Right Now Fund” to expand access to emergency Medicaid for undocumented Coloradans/immigrant health is needed. Improving cultural competency and implicit bias training for health care providers treating Black, Indigenous, People of Color (BIPOC) members is needed. And leveraging technology and the ability for telehealth for virtual health care services and community health workers to go into the homes of members.



Ongoing conversations and partnership with members and community stakeholders is part of the fabric of health equity. Following the *Meaningful Community Engagement: A Conceptual Model To Advance Health Equity*²⁴ framework, it will require that we understand community preferences on **how, when, and to what** degree they want to be engaged (National Academy of Medicine, 2022). Taking the key observations, ideas and opportunities highlighted above, the Department has taken swift action by incorporating the interests, concerns, challenges and opportunities in the first-of-its-kind for the Department Health Equity Plan.

Embedding meaningful engagement starts with listening, opportunities to learn, and connecting specific interventions that clearly address disparities and inequities that impact our members. Department leadership and staff recognize community voice as a powerful vehicle to drive significant change, and are dedicated to ensuring the insight and voice of members goes from ideas to implementation.

²⁴ <https://nam.edu/assessing-meaningful-community-engagement-a-conceptual-model-to-advance-health-equity-through-transformed-systems-for-health/>

Working with and alongside the community is the most effective way to achieve progress and advance health equity. By working closely with community-based organizations and key stakeholders that represent marginalized groups/populations (i.e. African American, American Indian/Alaska Native, LGBTQIA+, disability, older adults, Hispanic/Latino, Spanish speaking, Refugee and Immigrant communities), the Department believes and affirms that transformation begins with healing, reconciliation, relationship and trust building. Most importantly, investments in efforts that are defined, initiated and owned by the community.²⁵

Figure 9. Health Equity Plan Public Meetings

 <p>Health Equity Plan Public Meetings</p> <p>HCPF is committed to ongoing and sustained health equity for all our members.</p> <p>The purpose of the health equity public meeting is to provide space for providers, members, and community stakeholders to learn about the Department Health Equity Plan, and to provide input and feedback. Our goal is to establish the current state of health equity, and strategically look at innovative ways to improve health outcomes and decrease health disparities for our members in Colorado.</p> <p>To achieve better health outcomes, stakeholder engagement is critical. Register for one of the following upcoming public meetings:</p> <ul style="list-style-type: none"> • March 31 (6-7 p.m. MDT) – Registration Link • April 14 (6-7 p.m. MDT) – Registration Link • May 3 (3-4 p.m. MDT) – Registration Link • May 17 (12-1 p.m. MDT) – Registration Link Call in number +1 720 707 2699 (Spanish Speaking Session) • June 2 (12-1 p.m. MDT) – Registration Link <p>Feedback from sessions will inform the Department health equity strategy and implementation.</p> <p>Health equity happens when everyone has equal opportunity to be as healthy as they can be. No one's race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography or preferred language should negatively affect their health care. Health equity work includes removing obstacles to health care access and positive health outcomes.</p>	 <p>Reuniones Públicas del Plan de Equidad de la Salud</p> <p>HCPF está comprometido con la equidad e igualdad en la salud continua y constante para todos nuestros miembros.</p> <p>El propósito de la reunión pública de equidad de la salud es facilitar un espacio para que los proveedores, miembros y partes interesadas de la comunidad se informen sobre el Plan de Equidad de la Salud del Departamento y aporten sus opiniones y comentarios. Nuestro objetivo es establecer el estado actual de equidad en la salud y buscar estratégicamente nuevas formas de mejorar los resultados y disminuir las desigualdades en la salud de nuestros miembros en Colorado.</p> <p>Para lograr mejores resultados de salud, es fundamental la participación de las partes interesadas. Regístrese en una de las siguientes reuniones públicas:</p> <ul style="list-style-type: none"> • 31 de marzo (6-7 p.m. MDT) – Enlace para registrarse • 14 de abril (6-7 p.m. MDT) – Enlace para registrarse • 3 de mayo (3-4 p.m. MDT) – Enlace para registrarse • 17 de mayo (12-1 p.m. MDT) – Enlace para registrarse (sesión en español) • 2 de junio (12-1 p.m. MDT) – Enlace para registrarse <p>Los comentarios de las sesiones le servirán de base al Departamento para la estrategia y aplicación de la equidad en la salud.</p> <p>La equidad en la salud se produce cuando todos tienen la misma oportunidad de estar lo más saludables posible. La raza, el origen étnico, la discapacidad, la orientación sexual, la identidad de género, el nivel socioeconómico, la geografía o el idioma preferido de cada persona no deben afectar negativamente sus cuidados de salud. El trabajo por la equidad en la salud incluye eliminar los obstáculos que impiden el acceso a los cuidados y resultados de salud positivos.</p>
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Decision-Making Through the Health Equity, Diversity, Inclusion and Accessibility (HEDIA) Lens and Framework

Governor Jared Polis' landmark Executive Order (EO) D 2020 175²⁶ empowered state departments to prioritize the operationalization of equity, diversity, and inclusion (EDI) efforts. The Department also is prioritizing accessibility along with EDI (EDIA). Our Department has made intentional and strategic changes to embed EDIA into the fabric of our organization. We updated our Department mission statement in 2020 to

²⁵ Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies

²⁶ <https://www.colorado.gov/governor/sites/default/files/inline-files/D%202020%20175%20Equity%2C%20Diversity%2C%20and%20Inclusion%20for%20the%20State%20of%20Colorado.pdf>

include health equity: *Improving health care equity and outcomes for the people we serve while driving value and affordability for Colorado and Coloradans.*²⁷

In addition to our mission statement, our Department added a sixth strategic pillar for fiscal year 2022-23, which incorporates EDIA. Today, our Department pillars include: Member Health, Care Access, Operational Excellence & Customer Service, Medicaid Cost Control, Affordability Leadership and Employee Engagement & Satisfaction. This sixth priority includes investments in EDIA to help all our employees thrive. These pillars are the framework that the Department employs to categorize, manage and monitor our work.

The Department firmly believes that health equity is not hard work, but **heart work**. Connecting our full selves, mind, body, and spirit, is the essence of equity, and our leadership and staff are not only committed, but are actively engaged in this process. In launching our health equity plan, the Department's approach was informed by these equity approaches, models, and frameworks:

- Government Alliance on Race and Equity (GARE) Framework²⁸
- Race Forward: From Seed to Harvest Model²⁹
- National Council on Disability Health Equity Framework³⁰
- A.O.R.T.A. Health Equity Framework³¹
- Other evidence-based and promising practice frameworks.

As an active member of the Government Alliance on Race and Equity (GARE)³², our methodology stems from the *Seed to Harvest*³³ concept, a process and a set of questions we plan to operationalize in creating our health equity ecosystem.

As health equity advances, taking the tools crafted by the GARE and listening sessions from community stakeholders, we developed The A.O.R.T.A. Framework: Awareness, Opportunities, Reconciliation, Trust Building and Action (see *Appendix D: Table 4*), integrating the theory of change model of visualizing, normalizing, organizing and operationalizing. The A.O.R.T.A. framework is a home-grown tool, which follows our Department's **Core Values and Guiding Principles**: Person-Centeredness, Accountability, Continuous Improvement, Employee Engagement, Equity, Diversity, Inclusion and Accessibility, Integrity and Transparency (see *Appendix D; Table 4*).

²⁷ <https://hcpf.colorado.gov/about-us>

²⁸ <https://www.racialequityalliance.org/about/our-approach/>

²⁹ https://www.raceforward.org/system/files/RaceForward_RET_FromSeedsToHarvestforCollaborativeGovernance_2021.pdf

³⁰ https://ncd.gov/sites/default/files/NCD_Health_Equity_Framework.pdf

³¹ <https://docs.google.com/presentation/d/1HND5OfDmLVcNvjz65w8v6Y1RB7TzS-plIMRtAosEkwl/edit?usp=sharing>

³² <https://www.racialequityalliance.org/>

³³ https://www.raceforward.org/system/files/RaceForward_RET_FromSeedsToHarvestforCollaborativeGovernance_2021.pdf

Health Equity Priorities and Core Projects

Over the course of several months, the Department met with its partners, the community and stakeholders, which contributed to this plan, and table 2 below outlines health equity priorities and core projects for the 2022-23 fiscal year. Included in the Governor's Wildly Important Goals (WIGs) and Health Cabinet WIGs to close health disparities, our Department plans to increase Health First Colorado members being served by primary care providers in Alternative Payment Model 2 by June 30, 2023. This value based payment program supports improved patient outcomes, reduced disparities and increased affordability.

Table 2. Target Area Initiatives to Close Disparity Gaps (COVID-19, Maternity and Perinatal Health, Behavioral Health and Prevention)

Key Term Definitions

- **Short-term Goals:** Activities or projects to accomplish in the near future (i.e. 12 months or less)
- **Long-Term Goals:** More than 12 months, requiring additional time and planning
- **Status**
 - **Completed:** finished, ended, concluded
 - **Approaching completion:** Coming near to completion/final stages
 - **In progress:** in the course of being done or carried out
 - **In development:** In the research, planning or design stage
 - **Consider:** Taking into account the possibility of an idea, concept, policy or practice towards developing

Focus Area: COVID-19 Vaccinations	Status/ Timeframe	Accountability
Short-Term Projects		
Collaborate with Health First Colorado Primary Care Providers to eliminate barriers to COVID-19 vaccination rates <ul style="list-style-type: none"> ■ Identify which PCMPs are owned by systems, required under HB22-1401 to vaccinate and work with CDPHE to ensure vaccination compliance. ■ Monitor PCMP vaccination rates against attributed members. ■ Identify which PCMPs are FQHCs, determine vaccination rate for 	In progress	CMO, EDI Officer, COVID-19 Vaccine Task Force

attributed members, and ensure focus on Health First Colorado member vaccinations to close gaps.		
Monitor RAE compliance against submitted strategies to address COVID-19 vaccination rates. Identify barriers and create plans to further address barriers with a focus on these target populations: <ul style="list-style-type: none"> ■ Pediatric Health First Colorado members age 11 and under. ■ High-risk members, those in congregate care settings (i.e., homeless shelters, correctional care settings, out-of-home placements/child welfare, residential care, etc.). ■ BIPOC members and/or communities with high unvaccinated rates. 	In progress	CMO, Deputy Chief Administrative Officer, Vaccine Coordination Team, ACC Director, ACC Program Management Section Manager
Collaborate with congregant-setting providers to ensure a Health First Colorado member vaccination rate above 85% and that each provider is compliant with the CDPHE vaccination distribution requirements, as defined in rule.	In progress	CMO, Deputy Chief Administrative Officer, Vaccine Coordination Team, ACC Director, ACC Program Management Section Manager
Continue to collaborate with CDPHE on outreach activities.	In progress	CMO, Deputy Chief Administrative Officer, Vaccine Coordination Team, ACC Program Management Section Manager
Long-Term Projects		
Determine additional strategies needed to close the COVID-19 vaccination disparity equal to the overall Colorado population and Health First Colorado/CHP+ vaccination disparity.	In progress	CMO, Deputy Chief Administrative Officer, Vaccine Coordination Team

Focus Area: Maternity and Perinatal Health	Status/ Timeframe	Accountability
Short-Term Projects		
<p>Evolve the Department's Health First Colorado Maternity Alternative Payment Model (APM).</p> <ul style="list-style-type: none"> ■ Ensure the equity framework is utilized in developing a new alternative payment model (APM) during this fiscal year's stakeholder meetings. ■ Evaluate the effectiveness of the framework for the current maternity bundle efforts. ■ Finalize the recommendation for the next generation maternity APM, ensuring focus on CMS core measure collection, assessment and health equity stratification. 	In progress	Medicaid Director, CMO, Payment Reform Section Manager, CFO
<p>Document the experience of Black, Indigenous, People of Color (BIPOC) birthing people to increase maternity health disparity drivers and insights, by:</p> <ul style="list-style-type: none"> ■ Collecting Maternity Advisory Committee (MAC) stories, with identified barriers to care and other contributors to disparities, for Maternity Report 2.0. ■ Using the Department's 2021 Maternity Report, emerging insights, and the above MAC aggregated insights, create a qualitative report framework and plan to address maternity disparities (see maternity long-term projects). 	In progress	Maternal Child Health Manager, Quality, DAS
<p>365 Days of Postpartum Coverage. Implement SB21-194, which provides the Department with authority to ensure all members receive a full year (instead of 60 days) of postpartum coverage.</p>	July 1, 2022	Maternal Child Health Manager, Eligibility Division Director

Expanded Population Coverage for Family Planning Services. Implement SB21-009 and SB21-025 which support family planning and coverage for undocumented Coloradans to reduce the incidence of unintended pregnancy, which reduces adverse perinatal and neonatal outcomes.	July 1, 2022	Maternal Child Health Manager, Eligibility Division Director, Medicaid Director, CMO
Long-Term Projects		
Maternity Health Equity Plan. Develop and implement a Maternity Equity Plan that addresses maternal morbidity in Black, Indigenous, People of Color (BIPOC) communities.	In progress with deadline of July 1, 2023	Medicaid Director, Maternal Child Health Manager, Health Programs Office, EDI Officer
Leverage the Hospital Quality Incentive Payment (HQIP) Program³⁴ - Hospital incentive program focused on maternal health, patient safety and patient experience measures. Includes measures on Maternal Depression and Anxiety, Maternal Emergencies, Zero Suicide, and Racial and Ethnic Disparities.	In progress	Special Finance Project Manager
Leverage HTP. Improve hospital care by tying CHASE fee-funded hospital payments to quality-based initiatives through the Hospital Transformation Program ³⁵ (HTP) - HTP rewards the closing of health disparities by improving patient outcomes, demonstrating community engagement and improving health outcomes over time. The Department will disaggregate data, and hospitals will focus on health equity as part of their required continuous learning and improvement in HTP and the Department will evaluate program performance with data disaggregated by race, ethnicity, and primary language spoken whenever possible.	In progress	Special Finance Project Manager

³⁴ <https://hcpf.colorado.gov/sites/hcpf/files/2022%20CO%20HQIP%20Measure%20Detail%20Revisions%202.24.22.pdf>

³⁵ <https://hcpf.colorado.gov/colorado-hospital-transformation-program>

Focus Area: Behavioral Health	Status/ Timeframe	Accountability
Short-Term Projects		
Increased the Health First Colorado behavioral health network to more than 11,000 active behavioral health providers.	In progress	Medicaid Director
Create a report that identifies those providers who are enrolled but not seeing patients, and create outreach to identify why.	In progress	Medicaid Operations Office provider relations team, Medicaid Director, RAE management team
Behavioral health community grants and training. Provide Behavioral Health community grants to expand behavioral health capacity specific to community members' needs with culturally relevant service access, availability, and delivery.	In progress	Medicaid Director, Health Program Office
Alternative Payment Model (APM). Ensure the equity framework is utilized in developing a new alternative payment model (APM) and value measures during this interval and evaluate the effectiveness of the framework in current behavioral health efforts.	In progress	Medicaid Director, Chief Medical Officer, Chief Financial Officer
Long-Term Projects		
Work with sister departments to expand broadband and telehealth in rural communities to improve tele-behavioral health care access and reduce reluctance to seek care due to stigma.	In progress	Health Information Office Director, Medicaid Director, Cost Control & Quality Improvement Director, Research and Analysis Manager
Expand behavioral health mobile crisis benefit and develop secure transportation benefit to reduce reliance on law enforcement and ensure equitable access to services, which will require providers to	In progress	Medicaid Director, Health Program Office

become proficient in procedures for crisis response and transport for individuals with disabilities, individuals who are deaf/hard of hearing, and individuals who are non-English speaking or non-English proficient.		
Focus Area: Prevention	Status/ Timeframe	Accountability
Short-Term Projects		
Improve Diabetes A1C control in populations at risk by: <ul style="list-style-type: none"> Analyze data in collaboration with RAE/MCO partners to identify disparities (race/ethnicity, age, gender, language, disability) and identify priority populations Inventory the percent of members with diabetes enrolled in RAE diabetes programs Continue to improve data quality by increasing access to provider lab data and improving provider documentation of services provided and level of disease control Collaborate with FQHCs to develop Diabetes self-management education (DSME) program opportunities to improve patient health equity through evidence based medicine 	In progress	Benefits team, Health Program Office, Data Analytics, Quality
Create the initiatives to increase well child visits. Include initiatives to address priority populations.	In progress	Child Cross-Team Matrix, Quality, DAS
Long-Term Projects		
Identify Social Risk Factors (SRF) through the lens of social determinants of health and develop predictive analytics tools to gather appropriate data for social needs to promote health equity (i.e., housing insecurity and quality, food insecurity, unmet needs for utility	In progress	CMO, EDI Officer, Medicaid Director, Data Analytics, Research and Analysis Manager

assistance, interpersonal violence, and unmet transportation needs). ^{36,37}		
Work with OeHI and state partners to release and review the Request for Proposals (RFP) that will procure a partner to implement the 2nd Phase of the Prescriber Tool, which allows providers and case management to better address social determinants of health for Health First Colorado members.	In progress	OeHI, HIO leadership, CCQI leadership, CMO, EDI Officer
Work with providers and advocates to collect data to better screen for whole-person service needs and identify disparities related to upstream and downstream determinants. Align with 12 Indicators* outlined by the Office of Health Equity (CDPHE); and develop a phased strategy and approach to address the health outcomes and disparity indicators outlined in Appendix I. *Maternity and Child Health, Chronic Disease (i.e., Diabetes), and COVID-19 are currently underway in Department plan	In development	CMO, EDI Officer, Medicaid Director, Data Analytics Director, Quality Performance Manager

Next Steps

Following state and federal health equity guidance, the Department, in collaboration with our partners and stakeholders, is committed to addressing health disparities in pursuit of our mission and our quest to make a Colorado that Works for All of Us. In an effort to provide full transparency and accountability, the Department will provide updates and information sharing through the Health Equity Task Force. Our goal is to explore, collect data, and identify additional strategies and gaps for targeted approaches, focusing on maternity and perinatal health, and other focus areas.

³⁶

<https://www.healthaffairs.org/doi/10.1377/forefront.20191025.776011/#:~:text=In%20an%20effort%20to%20address,utility%20assistance%2C%20interpersonal%20violence%2C%20and>

³⁷ <https://www.shvs.org/resource/developing-a-social-risk-factor-screening-measure/>

Deliverables

- Health Equity Task Force, Starting July 1, 2022
 - Initial planning sessions scheduled
 - July 13, 2022, 11 a.m.-1 p.m. [Virtual Zoom Link](#)
 - Aug. 31, 2022, 11 a.m.-1 p.m. [Virtual Zoom Link](#)
 - Sept. 28, 2022, 11 a.m.-1 p.m. [Virtual Zoom Link](#)
- Annual Department Health Equity Report, due fiscal year 2023-24
- Health Equity Plans added to RAE/MCE contract requirements effective July 1, 2022; due to the Department July 31, 2023

Resources and Toolkits

- [Addressing Health Equity in Public Health Practice](#)
- [Advancing Health Equity Through Alternative Payment Models](#)
- [American Medical Association Equity Strategic Plan](#)
- [Building Racial Equity into the Walls of Minnesota Medicaid](#)
- [CMS Behavioral Health Strategy](#)
- [CMS Health Equity Pillars](#)
- [CMS Paving the Way to Equity 2015-2021 Report](#)
- [Colorado Diversity and Inclusion Measure - Hospital Transformation Program](#)
- [Colorado Equity Alliance Tools and Resources](#)
- [Developing a Social Risk Factor Screening Measure](#)
- [From Seed to Harvest: A Toolkit for Racial Equity Strategies](#)
- [Health Care Policy & Financing A.O.R.T.A. Health Equity Framework](#)
- [Health Disparities and Aging](#)
- [Health Equity Measurement in Medicaid](#)
- [Health Equity Tracker](#)
- [HealthLeaders Equity Measures in 5 Steps](#)
- [Implicit Bias](#)
- [Inclusive Language](#)
- [LGBTQIA+ Health Equity](#)
- [Minority Population Profiles](#)
 - [Black/African American](#)
 - [American Indian/Alaska Native](#)
 - [Asian American](#)
 - [Hispanic/Latino](#)
 - [Native Hawaiian/Other Pacific Islander](#)
- [National Council on Disability Health Equity Framework](#)
- [Office of Health Equity](#)
- [Race Equity and Inclusion Action Guide](#)

- [Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography](#)
- [Racism and Health](#)
- [Reducing Racial Disparities in Health Care by Confronting Racism](#)
- [Shared Decision-Making](#)
- [Solving Health Disparities Road Map](#)
- [Training Health Professionals to Understand Implicit Bias linked to Racial and Ethnicity-Based Discrimination, and the Implications for Health Equity](#)

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Health Care Policy & Financing, Closing the gap: A Health Equity Plan Addressing Health Disparities and Improving Outcomes for Health First Colorado (Colorado's Medicaid program) and Child Health Plan *Plus* (CHP+) Members (2022).

For more information or to provide feedback, please email inquiries to Aaron Green, Health Disparities and Equity, Diversity & Inclusion Officer, at Aaron.Green@state.co.us

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Health Care Policy & Financing
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<https://hcpf.colorado.gov/health-equity>



Appendices

Appendix A: Additional Health Equity Priorities

The below table identifies additional projects and priorities the Department will consider based on resources and feasibility in the next fiscal year.

Project Description	Status/ Timeframe	Accountability
Short-Term Projects		
Develop and implement Affinity groups (Employee Resource Groups) to harness cultural and institutional knowledge among diverse HCPF staff to inform health equity efforts.	In progress	EDI Officer
Improve access to quality care by developing a quality performance improvement and quality strategy that includes quality, affordability ³⁸ and equity.	In progress	CMO, EDI Officer, Quality Performance Manager, Quality and Affordability Advisor
Long-Term Projects		
Develop Health Equity Action Plans (see Appendix G) that are tied to reportable data metrics using EDI filters (Age, Gender, Language, Race, Ethnicity currently available) to lessen disparity gaps in the following areas: <ul style="list-style-type: none"> • Care of Acute and Chronic Conditions • Primary Care Access and Preventive Care • COVID-19 • Behavioral Health Care • Maternal and Perinatal Health <i>(See Table 2: Target Area Initiatives for more details)</i>	In progress	CMO, EDI Officer, Medicaid Director, RAEs/MCEs
Improve the medical assistance application. Develop a concept document outlining evidence-based recommendations for changes to the	In progress	CMO, EDI Officer, Medicaid Director, Medicaid Operations

³⁸ <https://hcpf.colorado.gov/affordability>

current state of the medical assistance application to include important data elements for health disparity reporting.		Officer, Eligibility Division Director, CDHS
Implement an Accessibility Adoption Plan outlined in House Bill 21-1110 - Accessibility for All ³⁹ Support internal workgroup focusing on HB21-1110 Implementation/ Dept. compliance	In progress	EDI Officer, Accessibility Officer, Health Information Office
Financial incentives to close disparity gaps. Complete development of the process for identification of key metrics for health equity, access, quality of care, and cost metrics that provides the Department with the ability to incentivize providers to implement and support changes that improve health equity (measure selection committee process).	In development	CCQI Director, CMO, EDI Officer, ACC Director, Quality Performance Manager

Appendix B: GARE Theory of Change

Our Department’s health equity methodology is based on the Government Alliance on Race and Equity⁴⁰ (GARE). The GARE six-part strategic approach organizational theory of change: visualize, normalize, organize, and operationalize. As we center our collective efforts around racial equity, while also prioritizing and *“integrating the voices and ideas of people and communities experiencing great injustice and historically excluded, exploited, and deprived of needed resources such as people of color, women, people with disabilities, LGBTQ, and those in rural and urban communities alike”* (American Medical Association⁴¹, 2021, p. 5).

³⁹ https://leg.colorado.gov/sites/default/files/2021a_1110_signed.pdf

⁴⁰ <https://www.racialequityalliance.org/wp-content/uploads/2018/05/1-052018-GARE-Comms-Guide-v1-1.pdf>

⁴¹ <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>

Table 3. GARE Theory of Change, six-part approach

Normalize	Organize	Operationalize
<p>Use a racial equity framework: Jurisdictions must use a racial equity framework that clearly articulates our vision for racial equity and the differences between individual, institutional, and structural racism—as well as implicit and explicit bias. It is important that staff—across the breadth and depth of a jurisdiction—develop a shared understanding of these concepts.</p>	<p>Build organizational capacity: Jurisdictions need to be committed to the breadth and depth of institutional transformation so that impacts are sustainable. While elected leaders and other top officials are a critical part, change takes place on the ground. We must build infrastructure that creates racial equity experts and teams throughout local and regional government.</p>	<p>Implement racial equity tools: Racial inequities are neither natural nor random—they have been created and sustained over time. Inequities will not disappear on their own; tools must be used to change the policies, programs, and practices that perpetuate inequities.</p>
Normalize	Organize	Operationalize
<p>Operate with urgency and accountability: While it is often believed that change is hard and takes time, we have seen repeatedly that when we prioritize change and act with urgency, change is embraced and can occur quickly. The most effective path to accountability comes from creating clear action plans with built-in institutional accountability mechanisms. Collectively, we must create greater urgency and public will in order to achieve racial equity.</p>	<p>Partner with other institutions and communities: The work of government on racial equity is necessary but not sufficient. To achieve racial equity, government must work in partnership with communities and other institutions to achieve meaningful results.</p>	<p>Be data-driven: Measurement must take place at two levels— first, to measure the success of specific programmatic and policy changes, and second, to develop baselines, set goals, and measure progress towards goals. It is critical that jurisdictions use data in this manner for accountability.</p>

Appendix C: Social Determinants of Health (SDoH)

Social Determinants of Health



Leaning into racial equity, we must crosswalk into social determinants of health. SDoH and the social structures directly impact health outcomes, and it is essential that we align with our CDPHE/OHE partners and create thoughtful, strategic and deliberate solutions to address upstream and downstream determinants.⁴²

SDoH are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” The [social determinants of health](#)⁴³ include economic stability, neighborhood and built environment, health care access and quality, education access and quality, social and community context.

⁴² <https://www.ama-assn.org/delivering-care/health-equity/3-key-upstream-factors-drive-health-inequities>

⁴³ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>

Appendix D: Health Equity Lens

Table 4. Health Equity, Diversity, Inclusion and Accessibility Lens & Framework

Health Equity Lens & Framework				
The Five I's of Health Equity, Diversity, Inclusion and Accessibility (HEDIA)				
Innovation	Intent	Interaction	Impact	Implementation
A.O.R.T.A. Framework Pillars and Principles				
Awareness	Opportunity	Reconciliation	Trust Building	Action
<ul style="list-style-type: none"> - Organizational readiness - Education - Training - Upstream SDoH - Address disparities 	<ul style="list-style-type: none"> - Knowledge - Best practices - Areas of improvement - Partnerships - Growth mindset 	<ul style="list-style-type: none"> - Storytelling - Racial healing - Member experience (tribal, urban, frontier, rural) 	<ul style="list-style-type: none"> - Relational - Fostering truth - Alliance building - Sustained - Safety net⁴⁴ - Shared power 	<ul style="list-style-type: none"> - Quality data driven - Performance metrics - Targeted investments - Policy - Affordability and cost saving
Person-centeredness				
Accountability	Transparency	Engagement	Integrity	Continuous Improvement

To operationalize and embed Health Equity, Diversity, Inclusion and Accessibility (HEDIA), we will run each decision and initiative through an *HEDIA Lens* with the following questions⁴⁵:

- How are people from different underserved groups affected by this issue?
- What does the data tell us? What is missing from the data?
- If this policy is adopted, who is burdened most and who benefits most?
- If this policy is adopted, what are the health inequities, barriers or negative outcomes involved in the problem being examined?
- How can we ensure that this policy results in inclusive and equitable solutions?
- How can those most adversely affected by the issue be actively involved in solving it?
- How will the proposed policy, practice or decision be perceived by each group?

⁴⁴ <https://www.frameworksinstitute.org/issues/human-services/>

⁴⁵ Adapted from Annie E. Casey Racial Equity Toolkit

- If funding is involved, how do we ensure equitable distribution of resources across geographic areas?

Additional HEDIA questions to consider:

- Historically, how has our use of data impacted disenfranchised communities we seek to serve? How does this decision address this?
- What must we do differently to center equity and access?

Appendix E: The A.O.R.T.A. Health Equity Framework

Table 5. The A.O.R.T.A. Health Equity Framework in Practice⁴⁶

<u>A.O.R.T.A. in Practice</u>	
Awareness	<p>Health disparities are everyone’s problem⁴⁷. Acknowledgement of historical and present day discriminatory practices and policies that widen disproportionate and disparate health outcomes is vital.</p> <p>Disrupt: The interruption of event, activity or process (individual or system) that is reinforcing health inequities across marginalized groups, communities and/or populations</p> <p>Key Strategies, Activities and Resources:</p> <ul style="list-style-type: none"> ■ Organizational readiness (motivation, capacity, intervention-specific) ■ Education ■ Training ■ Upstream social determinants of health (economic, social, political) ■ Address disparities <ul style="list-style-type: none"> ○ Through exploration and data collection, identify key disparity gaps in health outcomes (diabetes, well-child checks, post-partum, etc.) <p>Timeline: Monthly check-in mechanisms to drive self-awareness and organizational awareness</p>

⁴⁶ <https://docs.google.com/presentation/d/1HND5OfDmLVcNvjz65w8v6Y1RB7TzS-plIMRtAosEkwl/edit?usp=sharing>

⁴⁷ Cooper, L. (2021). Why are health disparities everyone’s problem? Johns Hopkins University Press: Baltimore

Opportunities	<p>Disrupt: The status quo or organizational operations that do not support learning and growth opportunities that center health inequities</p> <p>Key Strategies, Activities and Resources:</p> <ul style="list-style-type: none"> ■ Knowledge <ul style="list-style-type: none"> ○ Leadership, management and staff enhance their health disparity literacy and increase information and skills required to advance health equity ■ Best practices <ul style="list-style-type: none"> ○ Vulnerability, seeking health equity, engaging stakeholders in efforts that demonstrate efficiency ■ Areas of improvement - tending to gaps or deficiencies in program areas that are hindering program for marginalized populations ■ Partnerships - alliance building with communities that are historically underserved ■ Growth mindset - solution-focused, goal oriented and action-driven <p>Timeline: Monthly</p>
Reconciliation	<p>Defer: Always defer to the expertise, knowledge, wisdom, and richness of the community. By using a community-reconciliation approach, restorative justice is central to revitalization and reconnection with our members (source: Community Reconciliation)</p> <p>Key Strategies, Activities and Resources:</p> <ul style="list-style-type: none"> ■ Storytelling <ul style="list-style-type: none"> ○ As community ○ Force of change ○ Form of engagement (Source: Wired) ■ Racial healing <ul style="list-style-type: none"> ○ Recognize and name past and current traumas and experiences ○ Changing the narrative ○ Deficit to asset-based ■ Member experience (tribal, urban, frontier, rural) <p>Timeline: Ongoing</p>
Trust Building	<p>“Trust, as defined by organizational scholars, is our willingness to be vulnerable to the actions of others because we believe they have good intentions and will behave well toward us. In</p>

	<p>other words, we let others have power over us because we think they won't hurt us and will in fact help us." Sandra J. Sicher and Shalene Gupta</p> <p>Demand: Recognize the definition of authentic trust building, and following these four essential elements adapted from Creating A Bond of Trust Tool:</p> <ul style="list-style-type: none"> ■ Expertise: What are your special skills? ■ Good will: What are our intentions? Are they positive? How is it being expressed? ■ Reliability: Do we live up to our promises? What promises did we break? ■ Authenticity: Are we acting from a place of openness and vulnerability? <p>Key Strategies, Activities and Resources:</p> <ul style="list-style-type: none"> ■ Relational ■ Fostering truth (honoring lived experiences from members of the community) ■ Alliance building ■ Sustained (long term) ■ Safety net (coordinated care) ■ Shared power <p>Timeline: Time to heal and build trust is based on the community; we show up and remain consistent</p>
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Action	<p>Demand: Taking action and moving towards sustainable change</p> <p>Key Strategies, Activities and Resources:</p> <ul style="list-style-type: none"> ■ Quality data driven: up-to-date, disciplined and stratified ■ Performance metrics (contractors identify areas) ■ Targeted investments - population areas ■ Policy and legislative levers ■ Affordability and cost saving <p>Focusing on following the immediate steps of: Preparation, research/information gathering, research findings, plan development and implementation, reporting and evaluation (as outlined by the Racial Equity Alliance action planning tool)</p> <p>Timeline: Ongoing</p>
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Appendix F: The Five I's

Table 6. The 5 I's of Health Equity, Diversity, Inclusion and Accessibility (HEDIA)

Innovation	Introduce new ideas and methods for target populations to close health disparity gaps
Intent	Center our goals, purpose and aims in clarity and in good faith
Interaction	Engage members and partners (key stakeholders) from the beginning
Impact	Discuss intended and unintended consequences
Implementation	Create a plan that is inclusive, accessible and transparent for all members



Appendix G: Action Plans

We will use the next fiscal year to explore gaps in health outcomes for our members. We will collaborate with stakeholders to identify priority populations and to begin to identify appropriate strategies and targeted interventions to reduce disparities. Each action plan will follow the below criteria:

- Identify health disparities and priority populations
- Define goals
- Determine needs/resources
- Monitor and evaluate progress

These action plans will drive steps to close identified gaps in the health of our members and provide the Department access points to further our efforts for **targeted universalism**⁴⁸. Targeted universalism is a framework outlined by the Othering and Belonging Institute, which highlights the premise that we recognize differences within groups and populations and develop targeted strategies to achieve our universal goal of health equity for all members.

The Department followed the process below (Figure 10) for identifying health disparities. These plans have been adapted from the CMS Disparities Impact Statement template.⁴⁹ There are four focus areas: prevention, COVID-19, maternity, and behavioral health. Department leadership has selected these areas as strategic priorities, which extend beyond equity efforts. Within each focus area, EDI staff collaborated with internal subject matter experts to identify areas of potential disparities that are measurable through data and have feasible intervention opportunities. Whenever possible, metrics align with CMS Core measures.⁵⁰

In the first year of the plan, the Department will collaborate with RAEs, MCOs, and partners to disaggregate data by race/ethnicity, age, gender, language, and disability with the goal of understanding which populations should be priorities. There may be additional ways to identify priority populations, such as identifying members with unmet social needs. This year one goal of improving data quality and analysis capabilities is foundational to all future health equity work. As time allows, the Department will begin identifying and implementing targeted interventions in partnership with stakeholders. These goals and actions are aligned with **CMS Strategic Pillar Health Equity Goals**⁵¹, and will become more sophisticated over

⁴⁸ https://belonging.berkeley.edu/sites/default/files/targeted_universalism_primer.pdf?file=1&force=1

⁴⁹ <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf>

⁵⁰ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures>

⁵¹ https://www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf



time as the Department and its partners expand the collective capacity to analyze data, improve data quality, and build on the knowledge of what works and what does not work.

Figure 10. Simplified Process Model for Developing Equity Action Plans

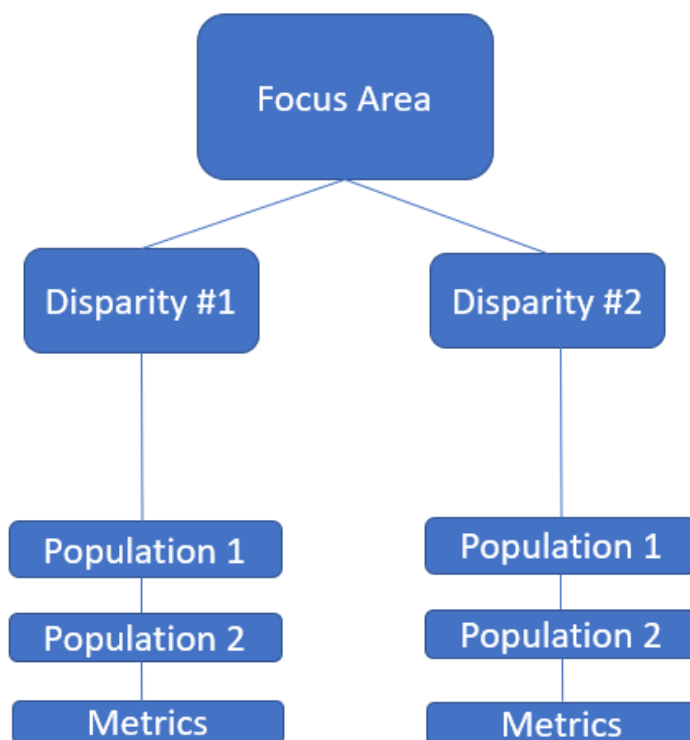


Table 7 below outlines the high level objectives of the equity action plans.

No.	Priority Area	Disparity Topic	Priority Population	Short-Term Goals	Metric
1	Population Health	Diabetes	To be determined after data disaggregation	(1) Disaggregate data (2) Improve data quality with labs (3) Partner with FQHCs to identify opportunities	Core Measure NQF 0059: Comprehensive Diabetes Care, Hemoglobin A1c Poor Control >9%
2	Population Health	Well-child visits	To be determined after data disaggregation Child welfare to be considered	(1) Disaggregate data (2) Collaborate with CDHS to improve data and better identify preventive visits (3) Explore opportunities for behavioral health prevention	(1) Core Measure NQF 1392: Well-child Visits in the first 30 months of life (2) Core Measure NQF 1516: Child and Adolescent Well-care Visits (ages 3-21)
3a	Prevention/ Population	Childhood immunization	To be determined	(1) Disaggregate data (2) Identify priority	Core Measure NQF 0038: Childhood

	Health	status	after data disaggregation	populations and next steps for action in partnership with RAEs, MCOs, and others	Immunization Status
3b	Prevention/Population Health	Immunization for adolescents	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	Core Measure NQF 1407: Immunizations for Adolescents
3c	COVID-19	Vaccination	Older adults	(1) Collaborate with RAEs, CMAs, and partners to outreach and vaccinate adults ages 50 and older (2) Explore CMS approval to increase payment for vaccinations	10% increase in booster vaccination rate
4	Behavioral Health	Appointment follow up post-ED for mental health	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	Core Measure NQF 3489: Follow-up after Emergency Department Visit for Mental Illness
5	Behavioral Health	Appointment follow up post-ED for SUD	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	Core Measure NQF 3488: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
6	Behavioral Health	Hospitalizations for mental health emergencies	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness
7	Behavioral Health	Depression screenings	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	HEDIS measure DSF: Depression Screening and Follow-up
8	Maternal Health	Prenatal access to care	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH)
9	Maternal Health	Postpartum access to care	To be determined after data disaggregation	(1) Disaggregate data (2) Identify priority populations and next steps for action in partnership with RAEs, MCOs, and others	Core Measure NQF 1517: Post-partum Care (PPC-AD)

Appendix H: Regional Accountable Entities and Managed Care Entities Health Equity Inventory

The Department is committed to creating a high-performing, cost-effective Health First Colorado and Child Health Plan *Plus* system that delivers quality services and improves the health of Coloradans. By leveraging our partnerships with our service delivery providers through the Accountable Care Collaborative (ACC)⁵², our Regional Accountable Entities (RAEs) and Managed Care Entities (MCEs) play an important role in dismantling barriers to health care. Our RAE/MCEs have actively engaged in efforts and collaborations to ensure access, quality care, and affordability for all our members.

Table 8. Regional Accountable Entities (RAE) and Managed Care Entities (MCE) Health Equity Inventory.

Note: Information provided is brief and high-level; a more detailed health equity plan for each contractor will be provided to the Department by July 31, 2023.

Entity	Health Equity Inventory
Denver Health Medical Plan ⁵³ (DHMP) and MCO CHP+	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: Stratification of key quality and outcome metrics by demographic. To determine if there is a measurable inequity in health outcomes, DHMP is developing dashboards in Tableau® to break down metrics by key demographic categories (e.g., race and ethnicity, gender, etc.) providing a view of potential disparity and the ability to filter at the member level to perform outreach. ■ Health Equity Inventory Activity 2: Epic Social Determinants of Health (SDoH) Wheel. Social Determinants of Health (SDoH) wheel in EPIC collects data for assessment and review of related data. Upon implementation, we plan to integrate the data into either the risk stratification tool or a Tableau® dashboard to have a complete picture on the challenges facing our members, this includes factors like income, social support, tobacco use, alcohol use, food and security, and potentially more accurate data on race, ethnicity, and language. The goal is to have

⁵² <https://hcpf.colorado.gov/accphase2>

⁵³ <https://www.denverhealth.org/>

	<p>the ability to look at our membership and pinpoint areas of focus.</p> <ul style="list-style-type: none"> ■ Health Equity Inventory Activity 3: Interventions to focus on conditions with identified inequities in outcomes for Black, Indigenous, People of Color (BIPOC) members. Examples include but are not limited to: <ul style="list-style-type: none"> ○ Control of blood pressure for African Americans ○ Low birth weight among African Americans ○ A1C control for Hispanics <p>Serving the following counties: Arapahoe, Adams, Denver, and Jefferson. (Automatic enrollment is Denver County only)</p>
<p>RAE 1 Rocky Mountain Health Plans & Limited Managed Care Capitation Initiative Rocky Prime⁵⁴</p>	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: Value-Based Payment: Enhanced behavioral health rates for providers who serve underserved populations (people of color, people who speak a non-English language including ASL, people who identify as LGBTIA+, people who live in rural and frontier areas with limited resources) ■ Health Equity Inventory Activity 2: Focused work with Hispanic/Latino and American Indian/Alaska Native Native American populations; Promotores - outreach in Mesa, Eagle and Grand counties; culturally responsive behavioral services (curriculum implementation); Clifton - access to care, social connectedness, Social Determinants of Health (food, housing, transportation, social connection); Member Advisory Council for Spanish-speaking members (coming soon); funding support for navigator for Ute Mountain Ute ■ Health Equity Inventory Activity 3: Focused work in the disability community; development and offering of training for providers to serve people with co-occurring disorders; financial support for Independent Living Centers, Social Determinants of Health; CCDC co-facilitated Member Advisory Councils, membership

⁵⁴ <https://www.rmhp.org/>

	<p>includes people from the disability community; funding support for disability community in the Ute Mountain Ute resources; internal DEI Council</p> <p>Serving the following counties: Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit.</p>
MCO: Rocky Mountain Health Plans CHP+	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: Provider Focus <ul style="list-style-type: none"> ● Starting in June 2022, practitioners will start attesting to activities related to diversity, equity and inclusion during the annually. This information collection will inform where future educational offerings and programs are needed to support our network as it pertains to health disparities. ● Enhanced behavioral health rates for providers who serve underserved populations (people of color, people who speak a non-English language including American Sign Language, people who identify as LGBTIA+, people who live in rural and frontier areas with limited resources) ■ Health Equity Inventory Activity 2- Internal DEI Council <ul style="list-style-type: none"> ● Internal DEI Council was created to support an inclusive internal culture and increase knowledge about health equity issues ● Ongoing internal activities such as monthly awareness newsletters to staff ● Internal moves to external/community <ul style="list-style-type: none"> ❖ Examples - Clifton volunteer work ❖ Examples - Grand County Resettlement Program ● Sub-workgroup working on the Pursuit of Health Equity NCQA Accreditation ■ Health Equity Inventory Activity 3-Provider Educational Offerings <ul style="list-style-type: none"> ● Deaf and hard of hearing training ● Applying the Health Equity Lens to People with Disabilities ● Care Equity project ● Structural Competence and Cultural Humility to Address Disparities and Inequities

	<ul style="list-style-type: none"> • Behavioral Health Skills Training <ul style="list-style-type: none"> ❖ Native Americans and Behavioral Health ❖ LGBTQ+ Health ❖ Working with People with Disabilities <p>Serving the following counties: Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco. Starting July 1, 2022: Delta, Ouray, and San Miguel.</p>
RAE 2 Northeast Health Partners, LLC ⁵⁵ (NHP)	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: COVID-19 Vaccinations: NHP led all RAEs in vaccine delivery and continues to conduct vaccine outreach and delivery to minority, homebound, and frontier populations ■ Health Equity Inventory Activity 2: EDI Training and Education: NHP provides monthly Equity, Diversity, and Inclusion Roundtable discussions for regional providers ■ Health Equity Inventory Activity 3: Regional Health Equity Needs Assessment: NHP is contracting with an external entity to assess regional needs to support strategic initiatives based on member voices ■ NHP's approach to program development is data-driven, based on root causes, and targeted to address problems. To help support efforts around Health Equity, Diversity, and Inclusion, NHP is currently building dashboards to explore performance measures across various demographic groups. This effort aligns with state direction as noted through PIAC and Performance Measurement and Member Engagement (PMME) committees and will further enable NHP to develop targeted programs to reduce performance gaps for our members. <p>Serving the following counties: Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, and Yuma.</p>

⁵⁵ <https://www.northeasthealthpartners.org/>

<p>RAE 3 & 5 Colorado Access⁵⁶ and CHP+ Managed Care Organization</p>	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: <ul style="list-style-type: none"> ■ Broad Strategy: Utilize existing datasets to identify disparities, and create specific programming to address disparities <ul style="list-style-type: none"> ▪ Specific Initiative: Data-informed Culturally Sensitive COVID-19 Vaccination Outreach ■ Overall goals of the Specific Initiative: (1) Increase COVID-19 Vaccination rates for eligible Child Health Plan <i>Plus</i> (CHP+) members and their families and (2) reduce vaccine disparity rate between eligible CHP+ members and the general population ■ Initiative Description: Existing vaccination, race/ethnicity, and related information were used to identify racial disparities in COVID-19 vaccinations, and specific programming was designed for specific subpopulations including Black, Indigenous, People of Color members and mothers of color, and rural populations. Colorado Access has continued to operate population and member-level interventions including digital engagement via SMS text (or direct mail for members with non-valid phone numbers) and partnering with cultural brokers in the community and local public health agencies to hold culturally responsive vaccine events/clinics. ■ Health Equity Inventory Activity 2: <ul style="list-style-type: none"> ■ Broad Strategy: Engage the Community in a Design/Innovation Challenge <ul style="list-style-type: none"> ▪ Specific Initiative: High Risk Maternity - Black Maternal Health ■ Overall goals of the Specific Initiative: (1) Engage leaders and community members with lived experience to create culturally relevant care, and (2) improve outcomes for Black birthing health in our community /address inequities (such as, low birth weight and high
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⁵⁶ <https://www.coaccess.com/>

	<p>infant mortality, systemic racism, lack of access to birth workers/doulas, and more).</p> <ul style="list-style-type: none"> ■ Initiative Description: The Design Challenge captured voices of 30+ organizations and 13 community members, and 80% of participants identified as Black/African American with lived experience. The collaboration culminated in community-led strategies that affect CHP+ members, including the Online Community Resource Hub and the Mental Health Community Fund. The online resource is intended to provide a "sacred, community space" for the community to share resources, information, and support for Black birthing families. ■ Health Equity Inventory Activity 3: <ul style="list-style-type: none"> ■ Broad Strategy: Support provider partners with resources and support networks to deliver culturally responsive care <ul style="list-style-type: none"> ▪ Specific Initiatives: Learning Management System to provide on-demand access to training resources, DE&I Community of Practice, and Health Equity Task Force ■ Overall goal of the Specific Initiatives: (1) Increase a level of knowledge of culturally responsive care for CO Access provider networks and (2) engage community-based partners, providers, and DE&I leaders of health organizations to gather best practices, exchange resources to address culturally relevant and affirming health care training and identify strategies to further advance health care equity. ■ Initiative Description: CO Access has invested in provider-facing training tools that use existing top level culturally responsive practices to train providers. Additionally, CO Access convenes two stakeholder forums to (1) identify best practices and share resources to implement Diversity, Equity, and Inclusion initiatives within partner health care
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	<p>organizations serving CHP+ and RAE members, and (2) gather ideas to advance health care equity and culturally responsive care.</p> <p>RAE 3 serving the following counties: Adams, Arapahoe, Douglas, and Elbert.</p> <p>RAE 5 CHP+ MCO serving the following counties: Adams, Alamosa, Arapahoe, Baca, Bent, Boulder, Broomfield, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Douglas, Eagle, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Kiowa, Larimer, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Sedgwick, Saguache, Summit, Teller, Washington, Weld, Yuma, (Kit Carson to be added in July 2022)</p>
RAE 4 Health Colorado, Inc. ⁵⁷	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: COVID-19 vaccination rate gap closure through a collaborative regional task force model: <i>Intervention Aims:</i> Continuing the work from the COVID-19 vaccination response plan, Health Colorado, Inc. (HCI) is committed to reducing disparities in COVID-19 vaccination rates and accessibility of COVID-19 therapeutics for Health First Colorado members in Region 4 using a collaborative task force model. ■ Health Equity Inventory Activity 2: LGBTQIA2S+ workgroup and health promotion and education collaboration with Southern Colorado Equity Alliance (SCEA); <i>Intervention Aims:</i> Health Colorado, Inc. (HCI) is dedicated to advancing health equity for lesbian, gay, bisexual, transgender, and queer and/or questioning, intersex, asexual, two-spirit (LGBTQIA2S+) members in our region. ■ Health Equity Inventory Activity 3: Black, Indigenous and People of Color (BIPOC) maternal care and postpartum health gap analysis and needs assessment; <i>Intervention Aims:</i> Health Colorado, Inc. (HCI) recognizes that there are systemic inequities in

⁵⁷ <https://www.healthcoloradorae.com/>

	<p>maternal and postpartum care for Black, Indigenous and People of Color (BIPOC). HCI will engage in a maternal care and postpartum gap analysis and needs assessment for Region 4.</p> <p>Serving the following counties: Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Pueblo, Prowers, Rio Grande, and Saguache.</p>
RAE 6 & 7 Colorado Community Health Alliance, LLC ⁵⁸	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: Solidify CCHA’s strategic Equity, Diversity and Inclusion (EDI) vision and action planning for staff, providers and community organizations in order to enhance outcomes and access for Health First Colorado members. ■ Health Equity Inventory Activity 2: Identify regionally-based community partners and leaders to maximize community voice and engagement as we work towards a shared vision of ensuring equitable opportunities for members. ■ Health Equity Inventory Activity 3: Seek opportunities to advance health equity efforts in our community by providing funding to key community stakeholders and leaders. <p>RAE 6 serving the following counties: Boulder, Broomfield, Clear Creek, Gilpin, and Jefferson.</p> <p>RAE 7 serving the following counties: El Paso, Park, and Teller.</p>
Kaiser ⁵⁹ CHP+ (KPCO)	<ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: Social Determinants of Health Screening - Since April 2021 we have been screening for Social Determinants of Health at well visits, starting at three clinics and will have expanded to all clinics by August 2022. This workflow asks eight questions to assess our members’ level of social risk in four domains of social health (food, financial strain, transportation, and housing) and asks if they have needs if they would like someone

⁵⁸ <https://www.cchacares.com/>

⁵⁹ <https://healthy.kaiserpermanente.org/colorado/front-door>

	<p>to outreach to help. Anyone who answers yes to the outreach question is automatically connected to one of our community specialists to further assess and connect the members with community benefits for which they might qualify.</p> <ul style="list-style-type: none"> ■ Health Equity Inventory Activity 1: Belong at KP Training for Providers and Staff - Part 1 helps providers and staff understand and disrupt bias through simple everyday behavior changes by giving tools to think and act more intentionally. Part 2 helps providers and staff gain a common understanding of systemic racism and the inequities across a wide variety of health and economic outcomes. Part 3 is for providers and helps address mitigating bias in care delivery. ■ Health Equity Inventory Activity 1: “Real Conversations” are special lunch sessions led by many different faces within Kaiser CHP+ to discuss issues around Equity, Inclusivity, Diversity work and highlight the experiences of various groups of folks. <p>Serving the following counties: Arapahoe, Adams, Boulder, Broomfield, Denver, Douglas, and Jefferson.</p>
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Appendix I: Office of Health Equity (OHE) Health Outcomes/Disparities

Outlined in the forthcoming health inequities report by the [Office of Health Equity](#) (OHE), the Department will also identify and address the following health outcomes and disparities, in a phased approach:

Table 9. Office of Health Equity: Health Outcomes/Disparity Indicators

Health outcomes/disparities highlighted in health inequities report	
Chronic diseases	Injury
<ul style="list-style-type: none">• Cancers (all-site, lung, colorectal, prostate, breast)• Heart disease• Cerebrovascular disease• Diabetes• Liver disease/cirrhosis	<ul style="list-style-type: none">Unintentional<ul style="list-style-type: none">• Drug-related overdose• Motor vehicle accidentsIntentional<ul style="list-style-type: none">• Suicide• Homicide/Legal Intervention
Maternal and child health	Communicable disease ⁶⁰
<ul style="list-style-type: none">• Maternal mortality• Infant mortality• Teen birth	<ul style="list-style-type: none">• COVID-19• Human Immunodeficiency Virus (HIV)/AIDS

Note: These outcomes and disparities will be considered in addition to other factors in the development of Department priorities and action plans.

⁶⁰ **Communicable diseases** are defined as infectious or transmissible diseases such as chicken pox/shingles, Hepatitis B, Hepatitis C, HIV/AIDS, Influenza, Mumps