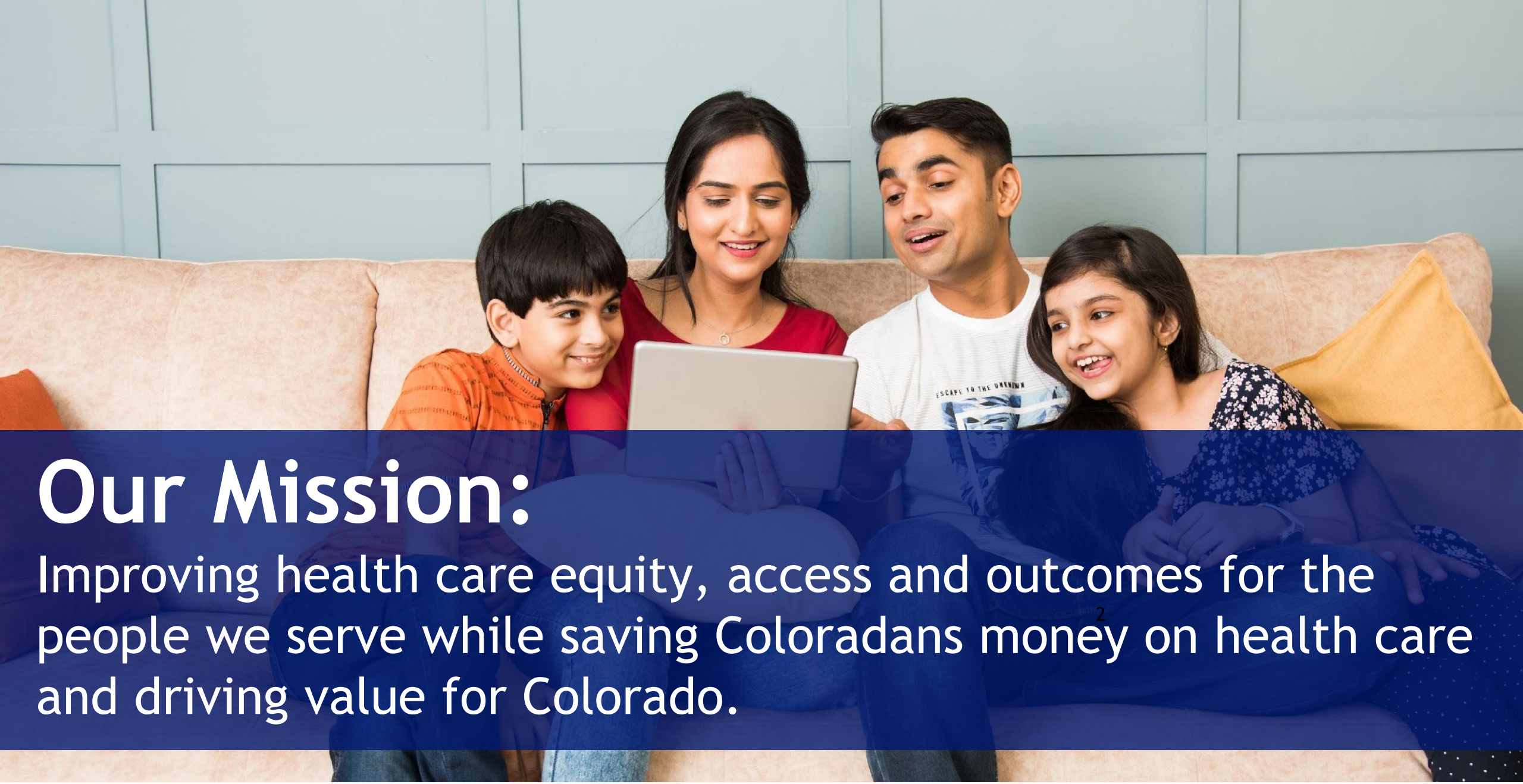
Health Equity Plan

Closing the gap to address disparities and improve health care outcomes for Health First Colorado and Child Health Plan Plus (CHP+) members

Effective July 1, 2022

Aaron Green, MSM, MSW
Health Disparities and Equity, Diversity & Inclusion Officer
Executive Director's Office (EDO) & Office of Cost Control and Quality Improvement (CCQI)

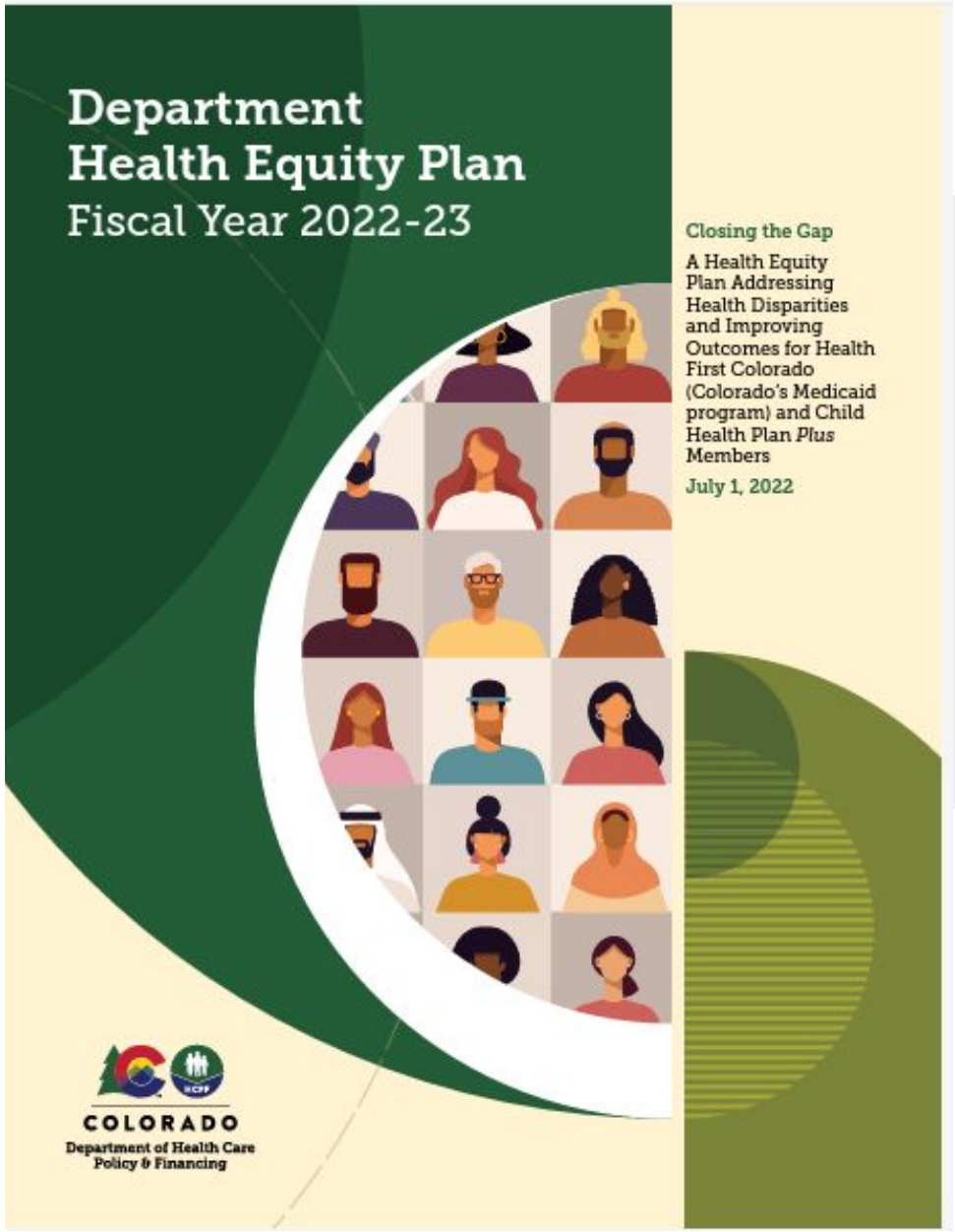


Our Mission:

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Land Acknowledgement

We would like to acknowledge that what is now Colorado includes the lands of the Ute, Arapaho, Cheyenne, Diné (di-NAY), Lakota, Apache, Puebloan nations, and many Tribes, and that the sovereign tribal governments of the Ute Mountain Ute and the Southern Ute Indian Tribes still reside in this state. These tribes are the original stewards of these natural areas. We want to take a moment to honor and respect these original stewards of the environment and their relationship with the land.



New! Dept. Health Equity Plan

- Applied health equity lens across all programs and initiatives
- Stratifying data analytics to identify disparities
- Health Equity Plans in RAE/MCE contracts effective. 7.1.22
- Aligned with Governors Executive Order 175, SB21-181, CDPHE/OHE to address health disparities
- Internal EDIA work (over 25 events) for staff

Focused efforts around vaccinations (COVID-19), maternity and perinatal health, behavioral health and prevention

- Ongoing effort to close COVID-19 vaccination disparity gap
- Maternity research and reporting
- Behavioral health investments and transformation
- Increase access to prevention and expansion of quality care

Background

- In alignment with SB 21-181, HCPF partnered with the Governor's Office, CDPHE, and OHE
- 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) and Child Health Plan *Plus* (CHP+). 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.
- First-of-its-Kind Health Equity Plan is now live!

By The Numbers

- Our programs serve Coloradans with disabilities and low-income of all ages whose socioeconomic status is intrinsically linked to their state of health.
- 1 in 4 Coloradans (1.6 Million)
- 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
  - 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

What are health and health care disparities?

- **Health and health care disparities refer to differences in health and health care between groups that stem from broader inequities.**
- There are multiple definitions of health disparities. Healthy People 2020 defines a health disparity as, "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" and notes that disparities, "adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."
- The Centers for Disease Control and Prevention (CDC) identifies health disparities as, "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."
- A health care disparity typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care. The terms "health inequality" and "inequity" also are used to refer to disparities.
- Racism, which CDC defines as the structures, policies, practices, and norms that assign value and determine opportunities based on the way people look or the color of their skin, results in conditions that unfairly advantage some and disadvantage others, placing people of color at greater risk for poor health outcomes.

Source: Kaiser Family Foundation

Disparities exist in 6 areas:

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

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.

Key Populations and Demographics

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

Health Equity Community Engagement

External lever: Stakeholder Engagement (Members, Providers, Partners)

- Engaged stakeholders in meaningful dialogue, feedback, grassroots strategy
- Town halls, listening sessions
- Completed 12 public meetings Jan-June
- Health Equity Website CO.gov/HCPF/health-equity

Targeted and intentional conversations, input from stakeholders across all of Colorado

- Members with lived experience (Member Experience Advisory Council)
- Regional Accountable Entities (RAEs), Managed Care Entities (MCE's)
- Ongoing Community stakeholders from all intersectional identities
  - African American, American Indian/Alaska Native, LGBTQIA+, Disability, Non-English speakers, Immigrants, Refugees and more!

7/19/22 Annual Stakeholder recap

Annual Stakeholder Webinar on 7/19 was very successful - great feedback. With about 700 stakeholders voting:

- **Most opportunistic focus areas they wanted HCPF focused on included:** behavioral health, which got 33% of the votes. 15% voted for HCBS transformation, and 10% voted for advancing health equity and Value Based Payments.
- **The audience's top concerns were:** 38% voted on growing the healthcare workforce. 33% listed the balance between inflation, provider rates, workforce access, and Medicaid affordability. Last, 22% were most concerned about continuous member coverage following the end of the PHE.
- **Of our 6 pillars, the stakeholders said the most important were:** 35% voted for care access (which parallels the health care workforce concern), 29% said Affordability for ALL Coloradans

Quality Data Management

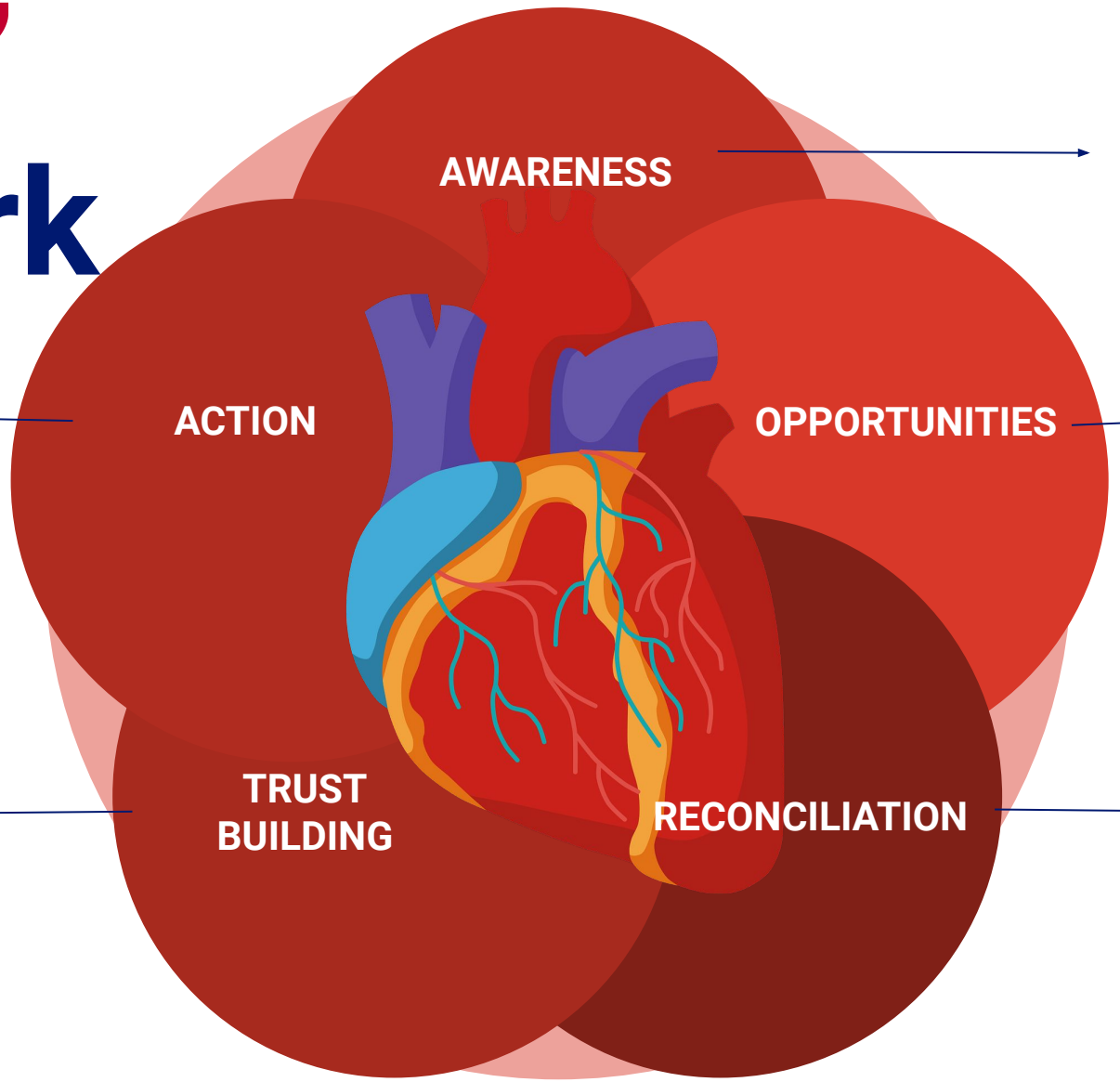
Quality dashboards focused on disparity metrics and performance measures

- Develop robust dashboards that stratify data
- Provide current or most updated disparity data
- Embed health equity lens in metric deliverables & analytics

Stratify data by race/ethnicity, gender, language, geography, disability and other available identifiers

- Quality data
- Centers for Medicare and Medicaid Services (CMS) Core Measures
- Department goals and measurements
- Changes to Medicaid application; Access to data

"AORTA"
Health Equity
Framework



AWARENESS
- Historical context and current systemic racism and discrimination
- Systemic analysis
- Education and training
- Upstream: Social Determinants of Health

OPPORTUNITIES
- Knowledge
- Best Practices & Models
- Partnerships
- Innovation
- Policy and practice changes to address disparities

RECONCILIATION
- Storytelling
- Racial healing
- Assets framing of resistance and triumph
- Member experience driven

ACTION
- Quality Data driven
- Performance measures
  - Forward focused
  - Targeted impact
- Affordability and cost savings

TRUST BUILDING
- Fostering truth
- Alliance Building
- Humility, vulnerability
- Naming past and present harms/trauma
- Time

The AORTA health equity framework is centered on the key components of visualizing, normalizing, organizing and operationalizing racial equity approach (from the Government Alliance on Race & Equity) A Cycle of Practice and Learning

HEALTH EQUITY LENS

The Five I's of Equity, Diversity, Inclusion & Accessibility (EDIA)

Innovation	Intent	Interaction	Impact	Implementation

AORTA Framework Pillars and Principles

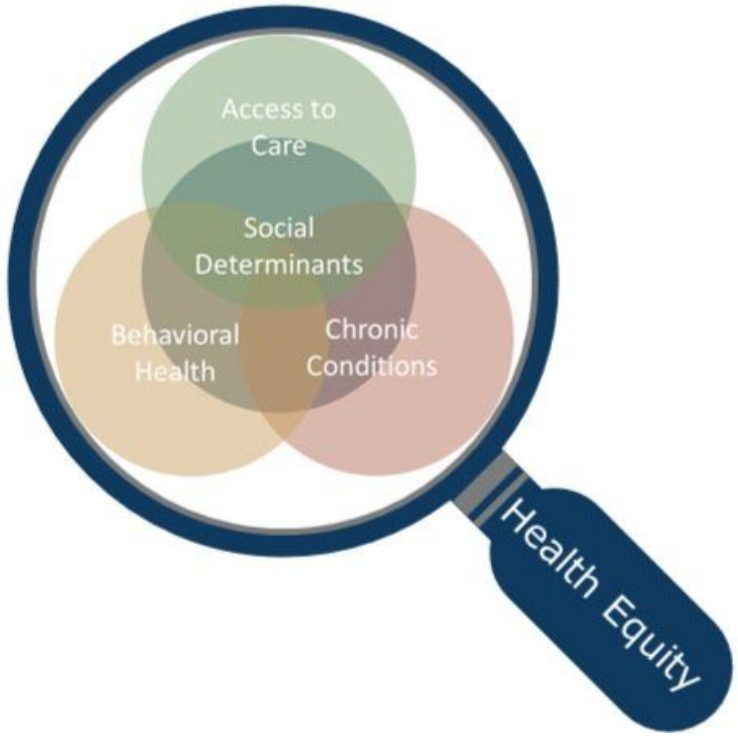
AWARENESS	OPPORTUNITY	RECONCILIATION	TRUST BUILDING	ACTION
■ Organizational readiness ■ Education ■ Training ■ Upstream SDOH ■ Address disparities	■ Knowledge ■ Best practices ■ Areas of improvement ■ Partnerships ■ Growth mindset	■ Storytelling ■ Racial healing ■ Member experience (tribal, urban, frontier, rural)	■ Relational ■ Fostering truth ■ Alliance building ■ Sustained ■ Safety net ■ Shared power	■ Quality data driven ■ Performance metrics ■ Targeted investments ■ Affordability and cost saving

PERSON-CENTEREDNESS

ACCOUNTABILITY	TRANSPARENCY	ENGAGEMENT	INTEGRITY	CONTINUOUS IMPROVEMENT

THE AORTA HEALTH EQUITY FRAMEWORK IS THE FOUNDATION OF OUR PRACTICE

Health Equity Lens



Run each decision through an *Equity, Diversity, and Inclusion Lens* with the following questions:

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

Additional EDI 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?

Adopted from Annie E. Casey Foundation Racial Equity Toolkit

Department Short and Long Term Projects / Initiatives

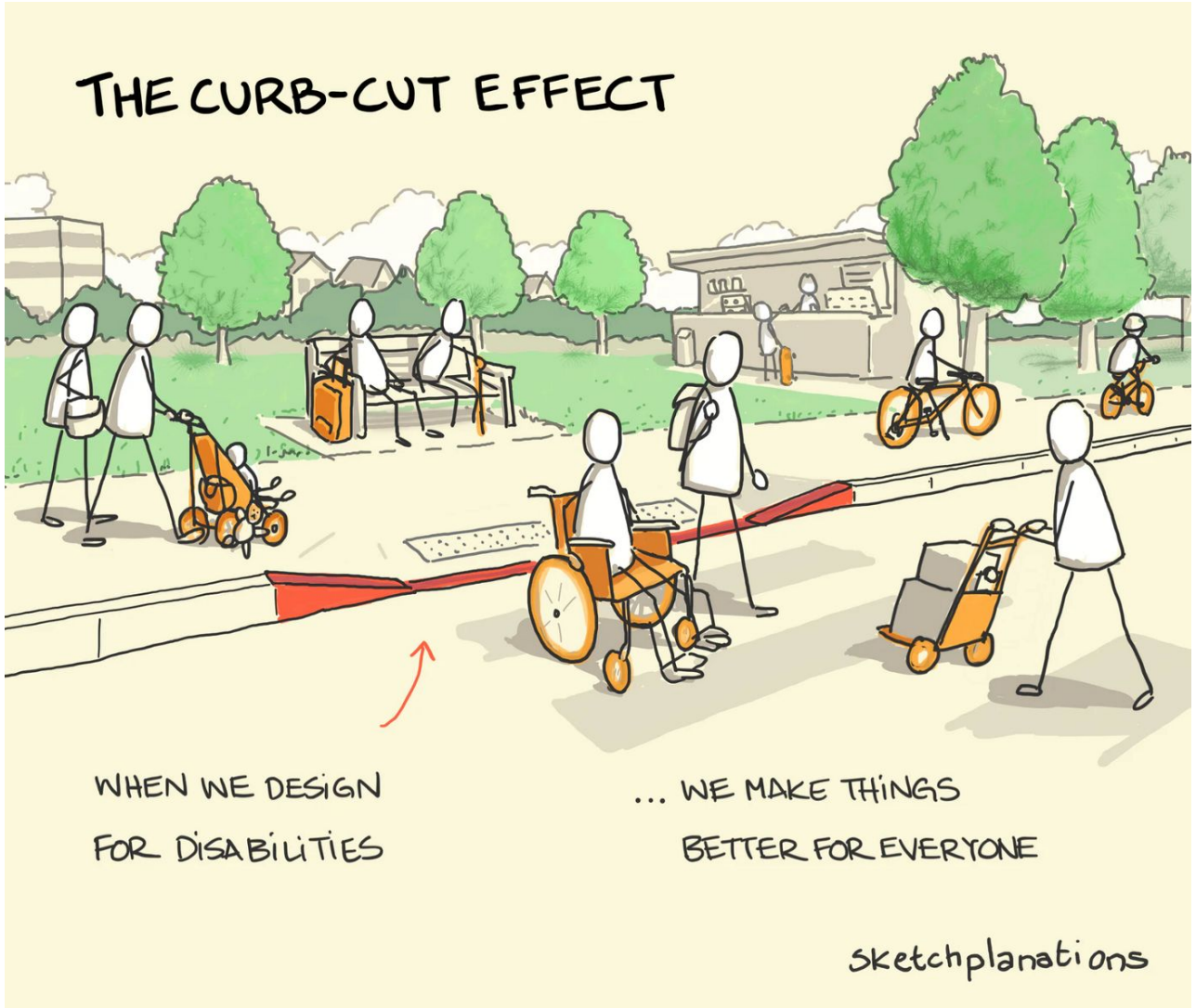
Vaccination Rates (COVID-19)	Maternity and Perinatal Health	Behavioral Health	Prevention and Population Health
Short term projects: Activities or projects to accomplish in the near future (i.e. 12 months or less)			
• **Collaborate with Health First Colorado Primary Care Providers to eliminate barriers to COVID-19 vaccination rates** • **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 target populations** • **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.** • **Continue to collaborate with CDPHE on outreach activities.**	• **Evolve the Department's Health First Colorado Maternity Alternative Payment Model (APM).** • **Document the experience of Black, Indigenous, People of Color (BIPOC) birthing people to increase maternity health disparity drivers and insights** • **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. • **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.	• **Increased the Health First Colorado behavioral health network to more than 11,000 active behavioral health providers.** • **Create a report that identifies those providers who are enrolled but not seeing patients, and create outreach to identify why.** • **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. • **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.	**Improve Diabetes A1C control** in populations at risk by: ▪ 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 **Create the initiatives to increase well child visits.**

Dept. Short Term Projects/Initiatives

Vaccination Rates (COVID-19)	Maternity and Perinatal Health	Behavioral Health	Prevention and Population Health
Long term projects: More than 12 months, requiring additional time and planning			
• **Determine additional strategies needed to close the COVID-19 vaccination disparity** equal to the overall Colorado population and Health First Colorado/CHP+ vaccination disparity.	• **Maternity Health Equity Plan.** Develop and implement a Maternity Equity Plan that addresses maternal morbidity in Black, Indigenous, People of Color (BIPOC) communities. • **Leverage the Hospital Quality Incentive Payment (HQIP) Program - 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.** • **Leverage HTP. Improve hospital care by tying CHASE fee-funded hospital payments to quality-based initiatives through the Hospital Transformation Program (HTP**	• **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. • **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 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.	• **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 • **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. • **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.**

Dept. Long Term Projects/Initiatives

Accessibility for All - HB21-1110



- State of Colorado Accessibility Statement:
  - The State of Colorado is committed to providing equitable access to our services to all Coloradans.
  - Our ongoing accessibility effort works towards being in line with the Web Content Accessibility Guidelines (WCAG) version 2.1, levels A and AA criteria. These guidelines not only help make web content accessible to users with sensory, cognitive, and mobility disabilities but ultimately to all users, regardless of ability.
- Internal HB21-1110 Project Implementation Workgroup
- **Language Access** - Both translation AND interpretation services are critically important for ensuring that the information and materials HCPF shares are inclusive and accessible by anyone who needs them.
- Guide to Accessible Web Services (OIT)
- Accessibility Glossary A-Z

RAE/MCE Health Equity Plans

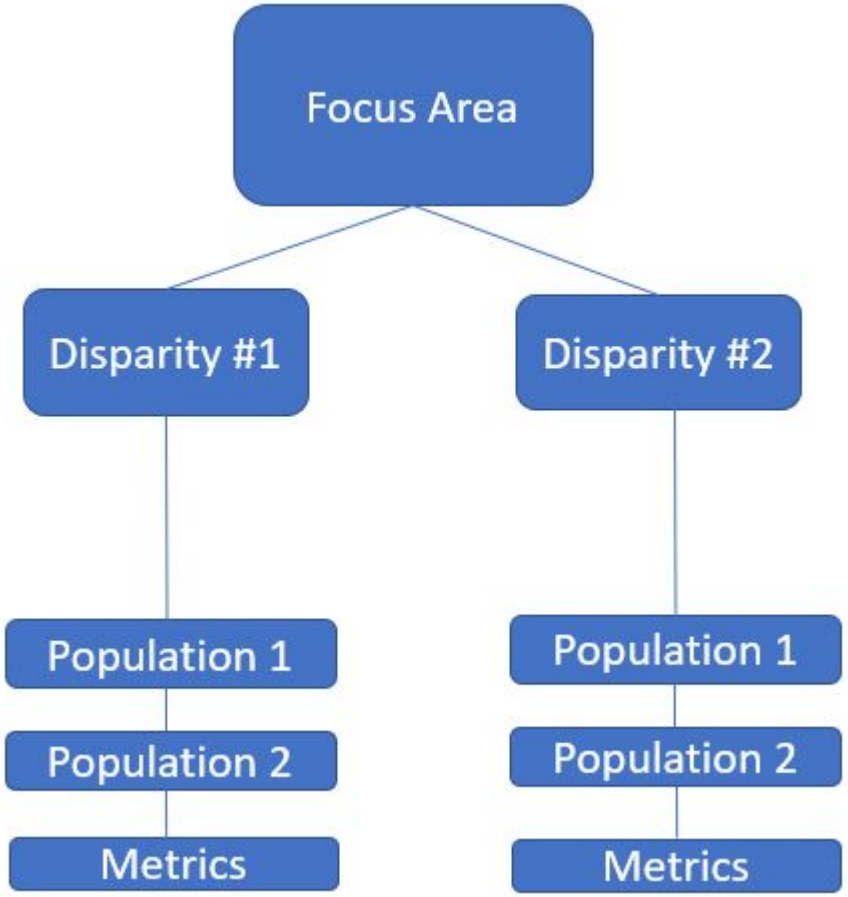
Health Equity Plan added to vendor contracts

- Add health equity plans to Regional Accountable Entities (RAE) and Managed Care Entities (MCE) contracts effective 7/1/22
- Exploration: Identify regional disparities, incentive measures to close gaps
- Vendor plans due 7/31/23

Embed Health Equity Plans into health delivery system vendor contracts, in order to accomplish the following:

- Mutual responsibility and accountability to reduce health disparities for all members
- Establish regionalized metrics and specific population areas to target, outreach, and improve health outcomes

Action Plans and Contract Requirements



- The Department will use the fiscal year 2022-23 to explore gaps in health outcomes for our members.
- We will collaborate with stakeholders (RAEs/MCOs) 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

Instructions and Narrative template can be found here. Due 7/31/2023

Draft Narrative and Instructions - COVID-19

Strategies to Address Health Disparities in Long-Term Health Equity Plans
Include strategy, timelines, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

1. Using the table below, please explain the RAEs/MCEs overall approach and strategy to:

   Overall approach of addressing COVID-19 related disparity gaps among members. *Reference Long-Term COVID-19 Monitoring Plan.*

   a. Identify, monitor, measure and increase vaccination rates among older adults.

   b. Overall strategy

Focus Area	COVID-19 Vaccination Rates Action Plan & Strategy
COVID-19 Vaccination Rates	Identify Disparity #1 - Vaccination rates among older adults and other member populations) • Population 1 - Older Adults • Population 2 - TBD after data disaggregation • Metric: 10% increase in booster vaccination rate Identify Disparity #2 - TBD by RAE/MCO • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric: TBD

Draft Narrative and Instructions - Maternity

Strategies to Address Health Disparities in Long-Term Health Equity Plans
Include strategy, timelines, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

1. Using the table below, please explain the RAEs/MCEs overall approach and strategy to:

   Overall approach of addressing Maternity and Perinatal Health related disparity gaps among members.

   a. Identify, monitor, measure timeliness of prenatal and postpartum access to care.

   b. Overall strategy

Focus Area	Maternity and Perinatal Health Action Plan & Strategy
Maternity and Perinatal Health	Identify Disparity #1 - Prenatal Access to Care • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • CMS Core Measure: Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH) Identify Disparity #2 - Postpartum access to care • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric : Core Measure NQF 1517: Postpartum Care (PPC-AD)

Draft Narrative and Instructions - Behavioral Health

Strategies to Address Health Disparities in Long-Term Health Equity Plans
Include strategy, timelines, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

1. Using the table below, please explain the RAEs/MCEs overall approach and strategy to:

   Overall approach of addressing Behavioral Health related disparity gaps among members.

   a. Identify, monitor, measure follow-up after ED visit for mental illness, alcohol and other drug abuse or dependence, hospitalizations for mental illness, and depression screening follow-up.

   b. Overall strategy

Focus Area	Behavioral Health Action Plan & Strategy
Behavioral Health	Identify Disparity #1 - Appointment follow up post-ED for mental health • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • CMS Core Measure: Core Measure NQF 3489: Follow-up after Emergency Department Visit for Mental Illness Identify Disparity #2 - Appointment follow up post-ED for SUD • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric : Core Measure NQF 3488: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Identify Disparity #3 - Hospitalizations for mental health emergencies • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric: Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness Identify Disparity #4 - Depression screenings and follow-up • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric: HEDIS measure DSF: Depression Screening and Follow-up

Draft Narrative and Instructions - Prevention

Strategies to Address Health Disparities in Long-Term Health Equity Plans
Include strategy, timelines, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

1. Using the table below, please explain the RAEs/MCEs overall approach and strategy to:

   Overall approach of addressing Prevention / Population Health related disparity gaps among members.

   a. Identify, monitor, measure childhood immunization status, immunizations for adolescents, diabetes and well-child visits

   b. Overall strategy

Focus Area	Prevention / Population Health Action Plan & Strategy
Prevention / Population Health	Identify Disparity #1 - Childhood immunization status • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric: Core Measure NQF 0038: Childhood Immunization Status Identify Disparity #2 - Immunization for adolescents • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric : Core Measure NQF 1407: Immunizations for Adolescents Identify Disparity #3 - Decrease diabetes poor A1C control in populations at risk • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric: Core Measure NQF 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) Identify Disparity #4 - Increase well child visits while reducing disparities in visits among priority populations • Population 1 - TBD after data disaggregation • Population 2 - TBD after data disaggregation • Metric: Percentage of children/youth receiving preventive visits through EPSDT; Core Measure NQF 1392 Well-Child Visits in the First 30 Months of Life (W30-CH); NQF 1516 Child and Adolescent Well-Care Visits (WCV-CH)

FAQ's + Additional Clarification

- How will the department evaluate progress on the four focus areas?
  - Specifically related to how are the focus areas being calculated? Baseline measures
  - Timeline for collection of data and meeting goals
    - Currently working with Quality Performance Unit Supervisor to identify Data Timeframes
    - Starting August 1, 2023, each metric will be tracked and pulled dependent on the timeframe set
    - RAEs/MCOs have the option to provide quarterly or annual reports based on available data and reporting structure
  - Lookback period - starting October 1, 2023
    - Quarterly
- Deliverables/requirement clarification
  - DAS will be working on a **Health Equity Plan Dashboard** to track and measure health equity plan measures (expected 10/1/22)
- Plan template can be found here
  - Shared with the RAE's for feedback

Joint Health Disparities Workgroup

Health Equity Task Force

- Statewide effort to identify and eliminate health disparities
- Develop strategies and recommendations for future-work and priority setting
- HCPF, SME's, RAEs/MCOs, Members

Improve health equity outcomes with cross-sector partners

- Intentional focus on underserved and marginalized groups and populations in CO
- Develop systems for real time data collection and information sharing among partners
- Joint efforts to reduce poor health outcomes for all members

Health Equity Task Force Planning Sessions

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

COLORADO
Department of Health Care Policy & Financing


Questions

Thank you!

Contact Info

Aaron Green, MSM, MSW
Health Disparities and Equity, Diversity & Inclusion Officer
Aaron.green@state.co.us