# Health Equity Plan

## Status Update

## May 2023

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# Ultimate Goal: Embed Equity Into The Walls of HCPF Operations

## Accelerating Health Equity, Diversity, Inclusion & Accessibility

- Equity Lens across all department pillars
- Proactive steps to improve outcomes
- Address unconscious bias through standardizing practices
- Address social determinants of health, bolster prevention and wellness services
- Increase and support diverse workforce

| Member Health | Care Access | Operational Excellence & Customer Service | Health First Colorado Value | Affordability Leadership | Employee Satisfaction |

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# Health Equity Plan Phase I

## SFY 2022-2025 (and beyond)

**2022** — **2022** — **2022** — **2022** — **23-24** — **2025**

**Implement Health Equity Plan**

Effective June 30, 2022

HCPF formally launched strategic plan (SB 21-181) to address health disparities.

**Vendor Contracts**

Effective July 1, 2022

RAEs/MCE's required to submit health equity plans by December 31, 2023

**Statewide Task Force**

Beginning July - September 2022

Convening of 60+ stakeholders focusing on addressing health disparities and provide actionable recommendations to HCPF

**Dashboard & Spec Document**

October - December

Creation of health equity plan dashboard to track and monitor performance measures; Specification document to establish expectations

**Explore Disparities & Policy Opportunities**

Monitor performance measures and identify additional gaps and develop targeted interventions

Identify additional health equity concepts (via Senate Bill 21-181)

**We Are Here**

**ACC 3.0**

Health equity will be embedded in ACC 3.0 through member centricity

# Health Equity Plan Priority Updates

| Goal | Project | Status |
|------|---------|--------|
| Implement Health Equity Plan | Senate Bill 21-181 Strategic Plan Address Health Disparities | On Track |
| Objectives | Health Equity Plan Dashboard | Complete |
| | CDPHE SB-21-181 Concept Document Draft | Complete |
| | Recommended changes to Medicaid Application | In coordination phase |
| | Health Equity Specification Document | Complete |
| | RAE Health Equity Contract Requirement (Instructions and Narrative) - eClearance approved | Complete |
| | Internal/External Health Equity/EDIA Program Request Form | On Track |
| | Community Engagement - Statewide Health Equity Task Force | On Track |

# Health Equity Task Force Membership, Rev. 1/6/23

Regional Accountable Entities & Managed Care Organizations
- ReNae Anderson, Rocky Mountain Health Plans `RAE 1`
- Alexandra LaCalamito, Northeast Health Partners `RAE 2`
- Phuong Dinh, Colorado Access `RAE 3` `RAE 5*`
- Lori Roberts, Health Colorado, Inc. `RAE 4`
- Saphia Elfituri, Colorado Community Health Alliance `RAE 6` `RAE 7`

Health First Colorado Members
- HFC Member #1
- HFC Member #2
- HFC Member #3*
- HFC Member #4

Community Members
- Jose D Torres-Vega, Colorado Cross-Disability Coalition*
- Dr. Sheila Davis, NAACP
- Katie Blickenderfer, Diversus Health
- Abasi Baruti, Solutions FBIA
- Sarah Staron, Young Invincibles
- Essey Yirdaw, Colorado Hospital Association*
- Brenda Figueroa, Servicios de la Raza
- Mirella Chavez, Delta Dental of Colorado

HCPF
- Dana Batey, Senior Health Equity Specialist*
- Lauren Phillips, Cost Control & Quality Improvement

**Task Force Ambassadors**

Chair - HCPF Designee

Co-Chair - Community Designee x 4

**\*Denotes Co-Chair**
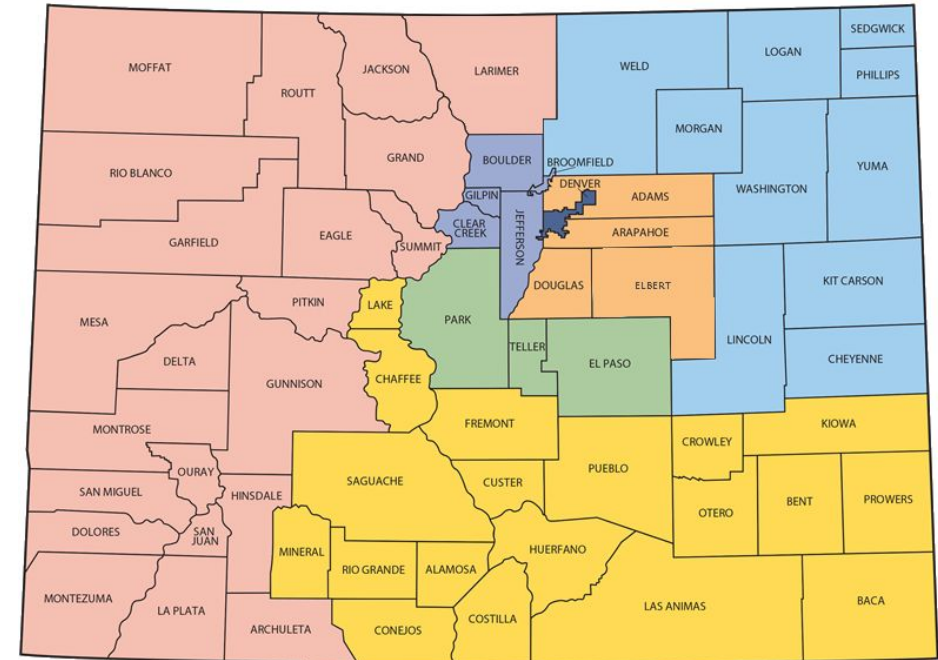


| | | | |
|---|---|---|---|
| Region 1 | Rocky Mountain Health Plans | Region 5 | Colorado Access |
| Region 2 | Northeast Health Partners | Region 6 | Colorado Community Health Alliance |
| Region 3 | Colorado Access | Region 7 | Colorado Community Health Alliance |
| Region 4 | Health Colorado, Inc. | | |

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# Health Equity Dashboard (*Reporting period start date of 10/1/21 )
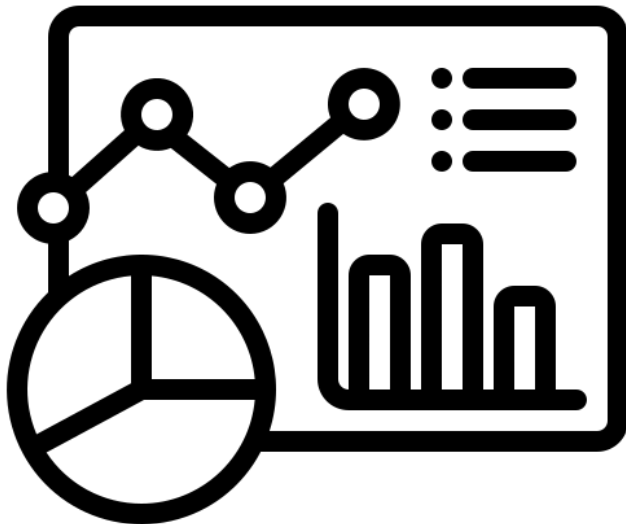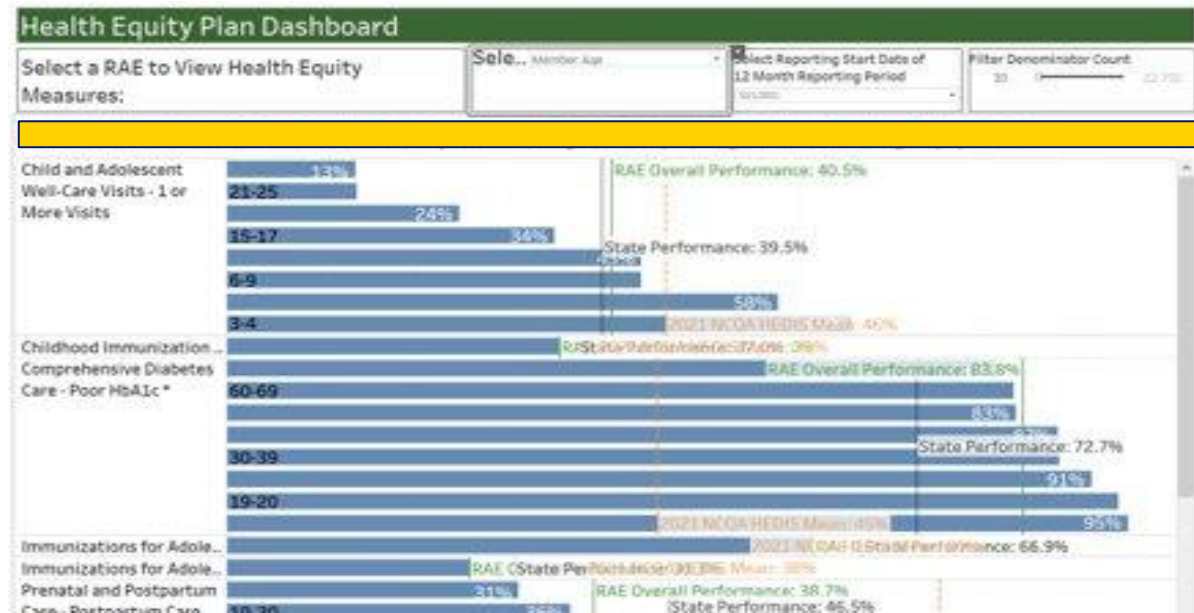
# Health Equity Lens & Decision Making Framework

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# Brainstorm The 5 I's of Equity, Diversity, Inclusion & Accessibility

| What is the… | Description/Details |
|---|---|
| Innovation | Introduce new ideas and methods for target populations to close health disparity gaps |
| Intent | Our goals, purpose and aims are clear 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 |
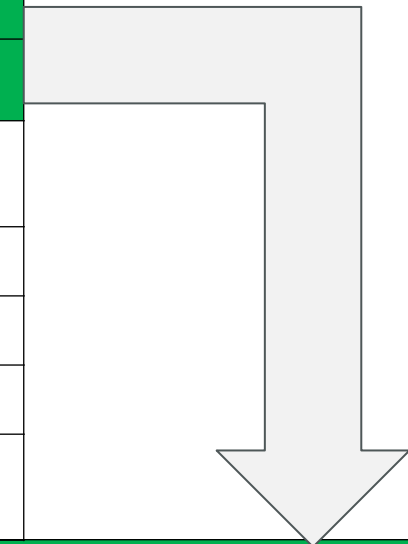
# Apply Equity Lens Questions

| | Questions 1-5 | | | Questions 6-10 |
|---|---|---|---|---|
| 1 | How are people from different underserved groups affected by this issue? | 6 | | How can those most adversely affected by the issue be actively involved in solving it? |
| 2 | What does the data tell us? What is missing from the data? | 7 | | How will the proposed policy, practice or decision be perceived by each group? |
| 3 | If this policy is adopted, who is burdened most and who benefits most? | 8 | | If funding is involved, how do we ensure equitable distribution of resources across geographic areas? |
| 4 | If this policy is adopted, what are the health inequities, barriers or negative outcomes involved in the problem being examined? | 9 | | Historically, how has our use of data impacted disenfranchised communities we seek to serve? How does this decision address this? |
| 5 | How can we ensure that this policy results in inclusive, equitable and accessible solutions? | 10 | | What must we do differently to center equity? |

Questions

# Thank you!

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# Contact Info

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

Dana L. Batey, CPC
Sr. Health Equity Specialist
Dana.Batey@state.co.us

https://hcpf.colorado.gov/health-equity

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# Appendix

| 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) | | | |

**Vaccination Rates (COVID-19)**

- **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.**

**Maternity and Perinatal Health**

- **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.

**Behavioral Health**

- 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.

**Prevention and Population Health**

**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.**

| 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.<br>• **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.<br>• **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.<br>• **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<br>• **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.<br>• **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.** |

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# RAE/ACC Health Equity Plan Measures, Rev2_2023

| Indicator | Description | Steward |
|---|---|---|
| Indicator 1 | 10% increase in booster vaccination rate - Adult and Child (under revision) | HCPF |
| Indicator 2 | Comprehensive Diabetes Care, Hemoglobin A1c Poor Control >9% (NQF 0059) | NCQA |
| Indicator 3 | Well-child Visits in the first 30 months of life (NQF 1392) | NCQA |
| Indicator 4 | Child and Adolescent Well-care Visits (NQF 1516) | NCQA |
| Indicator 5 | Childhood Immunization Status (NQF 0038) | NCQA |
| Indicator 6 | Immunizations for Adolescents (NQF 1407) | NCQA |
| Indicator 7 | Follow-up after Emergency Department Visit for Mental Illness (NQF 3489) | NCQA |
| Indicator 8 | Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (NQF 3488) | NCQA |
| Indicator 9 | Follow-up after Hospitalization for Mental Illness (NQF 0576) | NCQA |
| Indicator 10 | Screening for Depression and Follow-up Plan (NQF 0418) | CMS |
| Indicator 11 | Prenatal and Postpartum Care (NQF 1517) *Timeliness of Prenatal Care & Postpartum Care* | NCQA |
| Indicator 12 | Dental and Oral Health: Oral Evaluation, Dental Services (NQF 2517) | DQA |

## CHP+/MCO Health Equity Plan Measures_Rev2_2023

| Indicator | Description | Steward |
|---|---|---|
| Indicator 1 | Core Measure NQF 1392: Well-child Visits in the first 30 months of life (W30-CH) | NCQA |
| Indicator 2 | Core Measure NQF 1516: Child and Adolescent Well-Care Visits (WCV-CH) | NCQA |
| Indicator 3 | Core Measure NQF 0038: Childhood Immunization Status Combo 10 | NCQA |
| Indicator 4 | Core Measure NQF 1407: Immunizations for Adolescents Combo 2 | NCQA |
| Indicator 5 | 10% increase in COVID booster vaccination rate: Children (ages 0-19) (under revision) | CHP+/MCO |
| Indicator 6 | Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness | NCQA |
| Indicator 7 | Core Measure NQF 0418: Depression Screening and Follow-up | NCQA |
| Indicator 8 | Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH) | NCQA |
| Indicator 9 | Core Measure NQF 1517: Postpartum Care (PPC-AD) | NCQA |