COLORADO
Department of Health Care Policy & Financing

Regional Health Equity Plan FY23-24
Instructions and Narrative

RAE/MCO Name	Rocky Mountain Health Plans
RAE/MCO Region #	RAE 1
Reporting Period	[SFY23-24 7/31/2023 – 6/30/2024]
Date Submitted	01/02/2024
Contact	Meg Taylor

Purpose: Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs) are responsible for comprehensively completing and submitting their Regional Health Equity Plan using this Department-approved template , which aligns with *the Department's Health Equity Plan (eff. 7/1/22).* This plan focuses on how RAEs/MCO's are addressing health equity and decreasing health disparities for members from underserved and marginalized communities. A Health Equity Plan Specification document will be provided to identify the inclusion and exclusion criteria for all measures.

Evaluation and Baseline Period: Baseline calculations FY 2021-22; Measurement Period 2023-2024.

Priority focus areas: The Department has identified vaccination rates (i.e. COVID-19), maternity and perinatal health, behavioral health and prevention as the priority focus areas for this deliverable.

Plan Instructions: Please address the following key points in your Health Equity Plan. For each question please be sure to include strategy, timelines, resources, partnerships, incentives/pass through plans, logistics, goals, and any other relevant information to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations. Please follow the CMS Core Measure which aligns with the NQF Number referenced.

Additional notation: Some of the focus areas and measures for version one of this deliverable do not include CHP+ and MCO plans. Full claims data will be provided on a monthly basis. Member level data specific to measures is provided at least quarterly (see Care Analyzer Data Availability table below). Limited data is available for certain demographic/social groups. The Department is aware of these limitations, and entities can clearly state that strategies to address health disparities for certain groups are not all inclusive of all groups experiencing disparities during the current time period, until more data/information is available. Through data analysis, if RAEs/MCOs identify that significant disparities do not exist, there is flexibility to identify additional areas of disparities not outlined in the Dept. Health Equity Plan (*see* section 5).

As a guideline, 1-2 pages of narrative text per Focus Area is appropriate. This must include strategy, timelines, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

Due Dates: December 31, 2023 (Plan); December 31, 2024 (Annual Report)

Health Equity Plan Measures

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RAE/ACC Health Equity Plan Measures		
Indicator	**Description**	**Steward**
Indicator 1	Improve COVID Immunization rate for bivalent immunization (updated booster or primary) status by June 30, 2025, as described below: Pediatric (0-19): From 4.7% (4/2023) to 12.3%, Adult (20+): From 13% (4/2023) to 21.1%	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

For reference, Care Analyzer Data Availability:

Performance Period	HCPF Availability	CDAP & Quality Dashboard (Dates are approximate)	Health Equity Data Available in MoveIT
Jan 1 – Dec 31	April 30	May 15	May 15
Apr 1 – Mar 31	July 31	Aug 15	Aug 15
Jul 1 – Jun 30	Oct 31	Nov 15	Nov 15
Oct 1 – Sept 30	Jan 31	Feb 15	Feb 15

Revised 3/21/23; Department Approval: 2/2/23

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Strategies to Address Health Disparities in Regional Health Equity Plan

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/MCOs overall approach and strategy to: Addressing COVID-19 related disparity gaps among members. (Reference Long-Term COVID-19 Monitoring Plan).

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

Focus Area	COVID-19 Action Plan & Strategy
COVID-19	• Identify Disparity #1 – COVID vaccination rates among older adults and children ○ Population 1 - Older Adults (defined by HCPF) ○ Population 2 - Children (defined by HCPF) ○ Metric: Improve COVID Immunization rate for bivalent immunization (updated booster or primary) status by June 30, 2025, as described below: Pediatric (0-19): From 4.7% (4/2023) to 12.3%, Adult (20+): From 13% (4/2023) to 21.1% ○ <u>Overall strategy:</u> • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target _____ **RMHP is committed to increasing access to COVID-19 vaccines for Health First Colorado Members throughout the region. Once data is received from the state, RMHP will determine disparity populations and related strategies.**

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
Older Adults - Primary						
Older Adults - Booster						
Children – Primary						
Children - Booster						

2. Using the table below, please explain the RAEs/MCOs overall approach and strategy to: Addressing Maternity and Perinatal Health related disparity gaps among members.

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

Focus Area	Maternity and Perinatal Health Action Plan & Strategy
Maternity and Perinatal Health	• Identify Disparity #1 - Access to Prenatal Care ○ Have you identified a disparity in this focus area? **Yes** ○ Have you identified a population to target for this disparity? **Yes** • **Members living in rural counties** ○ Metric: Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH) ○ Overall strategy: Table and narrative below • Include baseline and target data: • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target _____ **Overall strategy: Rural** The largest prenatal care disparity in RAE 1 is experienced by Members who live in rural counties. Access to comprehensive prenatal care is essential to detect and prevent potential problems and ensure connectivity with appropriate health care and community resources. Early and regular prenatal care provides Members and families with education, confidence and the information needed to promote positive maternal outcomes.[1] [2] RMHP supports access to prenatal care in rural communities through multiple strategies including comprehensive care coordination, community and provider programs and Member engagement activities. The risk level of each pregnant Member is evaluated to determine the most appropriate program or intervention throughout the maternity cycle, some interventions are offered to Members at all risk levels. **Comprehensive Care Coordination:** All Members have access to comprehensive care coordination services and Members identified as high-risk receive outreach from clinical care coordinators to ensure access to

[1] *Till SR, Everetts D, Haas DM. Incentives for increasing prenatal care use by women in order to improve maternal and neonatal outcomes. Cochrane Database Syst Rev. 2015 Dec 15;2015(12):CD009916.*

[2] *American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Antepartum care. Guidelines for Perinatal Care. 8th Edition. American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 2017:149-244.*

comprehensive maternity care. Care coordination teams are embedded in rural communities and promote access to telehealth programs and transportation resources for Members with limited access to care.

Provider and Community Programs: RMHP supports comprehensive maternity programs provided by top-tier Primary Care Medical Providers (PCMP) and community partners in rural communities. Many of these programs offer access to specialized maternity care and resources for individuals with limited access. Programs focused on access to prenatal care include:

- **Local Partnerships and Community Engagement:** Support and develop partnerships to improve rural access to maternity care. For example, RMHP supports the North Colorado Health Alliance (NCHA) Prenatal Plus Program that provides enhanced prenatal care for Members identified as high-risk. Additionally, RMHP has supported - both through community investment funding as well as with bundled rates - an innovative maternity and postpartum program at the Willow Collective who provides high-quality parent, infant and early childhood mental health services. They have created a hub at which families and professionals can access resources.

- **Education:** Offer education to providers and community partners about the importance of prenatal care and available programs (e.g., Perinatal Mental Health Behavioral Health Skills Training, Monthly Provider Newsletter with information on Maternity Care Programs).

- **Provider Incentives:** Offer provider incentive programs to promote prenatal access or telehealth services in rural communities. Participating PCMPs focus on comprehensive assessments and referral processes that include depression and substance use disorder screening.

Member Engagement: RMHP Members in rural counties - as well as all RAE 1 communities - have access to multiple maternity programs that promote access to care, education and engagement. Programs include:

- **Babyscripts:** Maternity wellness and engagement application that offers incentives to Members for completing critical maternity milestones like prenatal and postnatal visits. Babyscripts includes comprehensive educational content, assessments, and checklists to track progress on measures like weight or blood pressure (Available January 2023).
- **EmpowerHealth:** Outreach from a virtual nurse assistant to assess for needs, identify gaps in care, provide ongoing education and connect members with local resources including case management, PCMP or clinical resources (Available January 2023).

	• **Self-Care by AbleTo:** On-demand behavioral health wellness and education application available to all RMHP Members. Offers 24/7 access to evidence-based resources, coping tools, and meditations. Members receive comprehensive assessments that focus on depression, anxiety, and stress management (Available January 2023). • **WellHop:** Virtual group visits in English and Spanish to support prenatal and postpartum engagement through education, peer support and a supportive community for Members at similar gestational age (under 36 weeks).
Maternity and Perinatal Health	• Identify Disparity #2 - Access to Postpartum Care ○ Have you identified a disparity in this focus area? ***Yes*** ○ Have you identified a population to target for this disparity? **Yes** • **Members living in rural counties.** ○ Metric: Core Measure NQF 1517: Post-partum Care (PPC-AD) ○ <u>Overall strategy:</u> Table and narrative below • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target _____ **<u>Overall strategy: Rural</u>** Similar to prenatal access, the largest postpartum care disparity in RAE 1 is experienced by Members who live in rural counties. Access to comprehensive postpartum care is essential for the health and well-being of both the parent and child. All individuals should receive a comprehensive postpartum visit within 6 weeks after birth,[3] and at least one screening for depression and anxiety during the perinatal period.[4] RMHP supports access to postpartum care in rural communities through multiple strategies including comprehensive care coordination, community and provider programs and Member engagement activities. **Comprehensive Care Coordination:** All Members have access to comprehensive care coordination services and Members identified as high-risk receive outreach from clinical care coordinators to ensure access to comprehensive maternity care. Care coordination teams are embedded in rural communities and promote access to telehealth programs and transportation resources for Members with limited access to care.

[3] American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Postpartum Care of the Mother. *Guidelines for Perinatal Care*. 8th Edi on. American Academy of Pediatrics and American College of Obstetricians and Gynecologists, 2017:315.
[4] Ibid, 313.

Provider and Community Programs: RMHP supports comprehensive maternity programs provided by top-tier PCMPs and community partners in rural communities. Many of these programs offer access to specialized maternity care and promote resources for individuals with limited access. Programs focused on access to postpartum care include:

- **Local Partnerships and Community Engagement:** Support and develop partnerships to improve rural access to maternity care. For example, RMHP supports the North Colorado Health Alliance (NCHA) Prenatal Plus Program that provides enhanced prenatal care for Members identified as high-risk. RMHP also supports the Willow Collective, a program that focuses on pregnancy related depression and other behavioral health concerns.

- **Education:** Provider and community partner education on the importance of postpartum care and available programs (e.g., Perinatal Mental Health Behavioral Health Skills Training, Monthly Provider Newsletter with information on Maternity Care Programs).

- **Provider Incentives:** Offer provider incentive programs and value-based contracting to promote postpartum access in rural communities. Participating PCMPs focus on comprehensive assessments and referral processes that include depression and substance use disorder screening.

- **Specialty Care:** RMHP will work to expand current provider relationships and focus on engagement with Obstetrics and Gynecology (OB/GYN) providers throughout the region. A current program is being formalized to incentivize two large OB/GYN practices (St. Mary's OB/GYN, Western Colorado Women's Healthcare) to help close postpartum care gaps for Members in rural communities.

Member Engagement: RMHP Members in rural communities have access to multiple maternity programs to promote access, education, and engagement. Members may enroll in programs during the prenatal period; however programs extend into the postpartum period and include:

- **Babyscripts:** Maternity wellness and engagement app that offers incentives to Members for completing critical maternity milestones like prenatal and postpartum visits. Babyscripts also includes comprehensive educational content, assessments, and checklists to track progress on measures like weight or blood pressure (Available January 2023).

- **EmpowerHealth:** Outreach from virtual nurse assistant to assess for needs, identify gaps in care, provide ongoing education and connect

	members with local resources including case management, PCMP or clinical resources (Available January 2023). • **Self-Care by AbleTo:** On-demand behavioral health wellness and education app available to all RMHP Members. Offers 24/7 access to evidence-based resources, coping tools, and meditations. Members receive comprehensive assessments that focus on depression, anxiety, and stress management (Available January 2023). • **SimpliFed:** Virtual telehealth support with virtual lactation consultants available to Members during pregnancy or the postpartum period. Lactation consultants provide support for breastfeeding, formula feeding, pumping or any combination. This resource is particularly helpful for Members in rural communities who lack access to maternity resources. • **WellHop:** Virtual group visits in English and Spanish to support prenatal and postpartum engagement through education, peer support and a supportive community for Members at similar gestational age (under 36 weeks).

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
(PPC – prenatal) Rural counties	190	400	47.50%	50.87%	0.003	47.84%
(PPC – postpartum) Rural counties	127	400	31.75%	38.65%	0.007	32.44%

3. Using the table below, please explain the RAEs/MCOs overall approach and strategy to: Addressing Behavioral Health related disparity gaps among members.

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.

Focus Area	Behavioral Health Action Plan & Strategy
Behavioral Health	• Identify Disparity #1 - Appointment follow up post-ED for mental health ○ Have you identified a disparity in this focus area? **Yes** ○ Have you identified a population to target for this disparity? **Yes**

- **Follow-up after Emergency Department Visit for Mental Illness (7 days): Hispanic/Latino**
- **Follow-up after Emergency Department Visit for Mental Illness (30 days): Hispanic/Latino**

- Metric: Core Measure NQF 3489: Follow-up after Emergency Department Visit for Mental Illness
- Overall strategy: Table (combined for Behavioral Health) and narrative below
  - Include baseline and target data
  - Include numerators, denominators, and performance rate for each population identified
  - Provide overall strategy to improve towards the identified target

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Overall Strategy

RMHP found that the Hispanic/Latino population had a marked disparity in Emergency Department (ED) follow-up for mental health treatment at seven and 30 days. EDs are key to identifying Members with underlying mental health disorders, especially when the primary complaint appears unrelated. A significant proportion of individuals who die by suicide visited an ED within a year of death. One study showed that seven percent of individuals who died by suicide had visited an ED within seven days of death, greater than 14 percent visited the ED within 30 days and almost 44 percent visited within a year[5]. Identification of a mental health disorder is only useful if there are interventions readily available in the ED, including follow up treatment.

RMHP intends to work with local community mental health centers (CMHCs) and EDs in the form of 2-partner (dyad) groupings, as well as the larger behavioral health network to understand local barriers specific to this population and create targeted interventions to promote access to care upon discharge from the ED.

CMHCs and local EDs (dyads): The ED is an environment with multiple competing priorities. Effective follow-up referrals require a quick and efficient process for providers and Members and close collaboration between behavioral health providers and the ED. RMHP will promote collaborative processes between behavioral health providers and individual EDs to improve continuity of care for this population, current examples include:

- Continue to work with Eagle Valley Behavioral Health (EVBH), Vail Hospital, and Common Spirit (St. Anthony Summit Hospital) to

[5] Ahmedani BK, Westphal J, Autio K, Elsiss F, et al., Variation in patterns of health care before suicide: a population case control study. *Prev Med.* 2019;127:105796.

	understand barriers to care and establish a custom discharge process for Hispanic/Latino Members discharging from the ED. • SummitStone Health Partners (SSHP) has established a model for ED follow up efforts; this model has been presented to the RMHP Provider Cross Collaboration Committee (PCCC). RMHP will work with SSHP to identify best practices that ensure Hispanic/Latino Members receive timely follow-up upon discharge from the ED. **Integrated Care Providers:** RMHP will leverage Community Integration Agreements (CIA) with PCMPs to understand possible barriers to access. Participating practices have integrated physical and behavioral health providers and must submit an annual program evaluation that will include specific questions related to barriers to ED follow up and access to behavioral health services. This detailed, qualitative, information will help RMHP identify solutions to increase access for the Hispanic/Latino population. **Behavioral Health Network:** The results of the CIA annual program evaluations will be presented to the PCCC, a large committee made up of behavioral health providers to include community mental health centers, independent provider network, and integrated care providers. Small groups of mixed provider types will discuss barriers and consider interventions. PCCC best practices may be presented to the larger behavioral health provider community.

Behavioral Health	• Identify Disparity #2 - Appointment follow up post-ED for SUD
	  ○ Have you identified a disparity in this focus area? **Yes**
	  ○ Have you identified a population to target for this disparity? **Yes**
	  • **Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days): Black, Indigenous, People of Color (BIPOC)**
	  • **Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 days): BIPOC**
	  ○ Metric: Core Measure NQF 3488: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
	  ○ <u>Overall strategy:</u> Table (combined for Behavioral Health) and narrative below
	  • Include baseline and target data
	  • Include numerators, denominators, and performance rate for each population identified
	  • Provide overall strategy to improve towards the identified target

Overall Strategy: Black, Indigenous, People of Color (BIPOC)

RMHP found that the BIPOC population had a marked disparity in ED follow-up for substance use disorders (SUD) treatment at seven and 30 days.
In 2019, the population rate of ED visits for substance use disorders (SUD) in the United States was 28.5 ED visits per 1000 people. The rate was highest among Black non-Hispanic individuals (48.3 visits per 1000 people)[6]. The same study showed this population to have the highest rates of ED visits related to specific substances including cannabis, stimulant, and opioid use disorders[6]. No study was found regarding ethnic differences in follow-up rates from the ED specific to substance use disorders, though general studies showed low rates.

EDs have increasingly become a primary location for induction of buprenorphine, a medication assisted treatment (MAT) for opioid use disorder. Many EDs in RAE 1 have this capability and there has been a progressive increase in the willingness to induce in this setting. Induction on buprenorphine is only marginally helpful unless there is a solid follow up plan in place to continue the treatment. Best practice would also include psychosocial treatments, such as group and individual therapy.

RMHP intends to partner with various provider types to create dyads across the region to understand local barriers and create targeted interventions specific to this population. These providers will include CMHCs, the independent provider network (IPN), integrated care providers and local EDs. Initial meetings have occurred, with the plan for quarterly meetings, at minimum. RMHP will also utilize the larger behavioral health network to inform expanded efforts.

CMHCs and local EDs (dyads): Similar to ED follow-up for mental health concerns, coordination of care must be local and occur through strong relationships between health care partners. RMHP will promote collaborative processes between behavioral health providers and the ED to improve continuity of care for Members who require follow up from the ED, current examples include:

- Continue to work with Eagle Valley Behavioral Health (EVBH), Vail Hospital, and Common Spirit (St. Anthony Summit Hospital) to understand barriers to care and establish a custom discharge process for Members who identify as BIPOC that are discharging from the ED for concerns related to SUD.

[6] Owens PL and Moore BJ. *Racial and Ethnic Differences in Emergency Department Visits Related to Substance Use Disorders*, 2019. Healthcare Cost and Utilization Project (HCUP); Agency for Healthcare Research and Quality. Statistical Brief #301, December 2022. https://hcup-us.ahrq.gov/reports/statbriefs/sb301-ED-Substance-Use-Disorders-Race-2019.jsp#1. Accessed December 26, 2023.

	• SummitStone Health Partners (SSHP) has established a model for ED follow-up efforts; this model has been presented to the RMHP PCCC. RMHP will partner with SSHP to identify best practices to ensure Members who identify as BIPOC receive timely follow-up upon discharge from the ED. **Integrated Care and local EDs (dyads):** River Valley Family Health Center (RVFHC) is a Federally Qualified Health Center that provides comprehensive MAT and behavioral health services and works closely with Montrose Regional Hospital and Delta Health Hospital. RMHP is meeting regularly with RVFHC and other partners to ensure the unique needs of the BIPOC population are considered throughout the referral and follow-up process. **Independent Provider Network and local ED (dyad):** Front Range Clinic (FRC) is an innovative provider group that expanded MAT services throughout RAE 1. This provider is also expanding types of services offered, to include psychiatry support and therapy services. FRC is now offering robust SUD treatment services in Southwest Colorado, including Cortez. RMHP is meeting regularly with Mercy Hospital (La Plata County) and FRC to promote strategies to improve engagement with Members identifying as BIPOC and improve the referral system between FRC and the hospital. **Integrated Care Providers:** RMHP will leverage PCMP CIAs to understand possible barriers to access. Participating practices have integrated physical and behavioral health providers and must submit an annual program evaluation that will include specific questions related to barriers to ED follow-up and access to behavioral health services. This detailed information will help RMHP identify solutions to increase access for the BIPOC population. **Behavioral Health Network:** The results of the CIA annual program evaluations will be presented to the PCCC. Small groups, consisting of all provider types, will discuss barriers and consider interventions. PCCC best practices may be presented to the larger behavioral health provider community.
Behavioral Health	• Identify Disparity #3 - Hospitalizations for mental health emergencies ○ Have you identified a disparity in this focus area? **Yes** ○ Have you identified a population to target for this disparity? **Yes** • **Follow-up after Hospitalization for Mental Illness: Male Gender** ○ Metric: Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness ○ <u>Overall strategy:</u> Table (combined for Behavioral Health) and narrative below

- Include baseline and target data
- Include numerators, denominators, and performance rate for each population identified
- Provide overall strategy to improve towards the identified target

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Overall Strategy

Studies indicate that the period immediately following discharge from a psychiatric hospitalization corresponds to a significantly elevated risk for suicide.[7] [8] Other studies support the idea that gender is a unique risk factor, with male deaths being more prominent across the globe.[9] Colorado Department of Public Health and Environment (CDPHE) data shows that of the 1287 deaths by suicide in 2022, 997 were men.[10] RMHP reviewed data related to populations discharged from inpatient psychiatric facilities and the largest disparity was seen with men. As it is also known that men, for varying reasons, may be more difficult to engage in mental health treatment[11], RMHP has determined that closure of this gap is paramount.

RMHP will promote access to care upon discharge from inpatient facilities both within and outside the region and the initial approach to addressing this disparity will be focused on understanding barriers to access from outpatient providers, hospitals, community organizations, and State partners.

Outpatient providers: The RMHP PCCC is a forum that includes multiple provider types involved in coordination of care post discharge. RMHP will leverage this committee to create a greater understanding of barriers to care and identify interventions to improve engagement and follow-up with men after psychiatric hospitalizations.

Hospital providers: RMHP has strong case management relationships with inpatient psychiatric hospitals and will use these connections to explore barriers and solutions unique to this population.

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[7] Olfson M, Wall M, Wang S, Crystal S, et al. Short-term Suicide Risk After Psychiatric Hospital Discharge. *JAMA Psychiatry*. 2016 Nov 1;73(11):1119-1126.

[8] Forte A, Buscajoni B, Fiorillo A, Pompili M, Baldessarini RJ. Suicidal Risk Following Hospital Discharge: A Review. *Harv Rev Psychiatry*. 2019 July/Aug; 27(4):209-216.

[9] Bennett S, Robb KA, Zortea TC, Dickson A, et al. Male suicide risk and recovery factors: A systematic review and qualitative metasynthesis of two decades of research. *Psychological Bulletin* 2023;*149*(7-8), 371–417.

[10] Colorado Suicide Sta s cs. Suicide Deaths 2020-2022 Races alone and two-or more races with Hispanic origin. Workbook: COVDRS Suicide Dashboard Single Race and Mul ple Race (state.co.us). Accessed December 26, 2023.

[11] Seidler ZE, Rice SM, Ogrodniczuk JS, Oliffe JL, Dhillon HM. Engaging Men in Psychological Treatment: A Scoping Review. *Am J Mens Health*. 2018 Nov; 12(6): 1882–1900.

	Community partnerships: RMHP will explore partnerships with community organizations to learn about targeted interventions for the target population. For example, much of RAE 1 includes rural and agricultural communities, RMHP will partner with the Colorado Agricultural Addiction and Mental Health Program (CAAMHP) to explore opportunities specific to farmers and ranchers in the region. **State partners:** RMHP will contact state partners to create deeper connections and cross-system collaborations. For example, the CDPHE Suicide Commission or Behavioral Health Administration may have specific programs designed to promote access to care after hospitalization for behavioral health concerns. As more information is discovered about this topic, RMHP will educate providers about best practices and interventions. In April 2024, RMHP will hold its annual Behavioral Health Skills Training event for clinicians and care coordination teams. A session during this event will focus specifically on engaging men in treatment across behavioral health settings. ***Note:*** *A disparity was also seen in Members who primarily speak a language other than English, but the denominator did not meet the 30-person cut off necessary for this deliverable. RMHP will continue to focus on this and other subpopulations to ensure follow-up care after hospitalization.*

Behavioral Health	• Identify Disparity #4 - Depression screenings
	  ○ Have you identified a disparity in this focus area? ***N/A***
	  ○ Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations)
	  ○ Metric: Core Measure NQF 0418: Depression Screening and Follow-Up Plan
	  ○ <u>Overall strategy:</u>
	  • Include baseline and target data
	  • Include numerators, denominators, and performance rate for each population identified
	  • Provide overall strategy to improve towards the identified target
	_____
	RMHP is committed to identification of depression and treatment for those suffering from its effects. Once data is received from the state, RMHP will determine disparity populations and related strategies.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
(ED FU – 7 days) Hispanic and Latino	68	171	39.77%	42.39%	0.003	40.03%
(ED FU – 30 days) Hispanic and Latino	84	171	49.12%	54.89%	0.006	49.70%
(ED FU SUD – 7 days) BIPOC	40	152	26.32%	27.71%	0.001	26.46%
(ED FU SUD – 30 days) BIPOC	56	152	36.84%	39.81%	0.003	37.14%
(Hosp FU – 7 days) Languages other than English	■	■	27.59%	27.11%	0.0005	27.54%
(Hosp FU – 30 days) Languages other than English	■	■	44.83%	46.73%	0.002	45.02%
(Hosp FU – 7 days) Males	137	564	24.29%	27.11%	0.003	24.57%
(Hosp FU – 30 days) Males	242	564	42.91%	46.73%	0.004	43.29%

4. Using the table below, please explain the RAEs/MCOs overall approach and strategy to: Addressing Prevention and Population Health related disparity gaps among members.

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

Focus Area	Prevention/Population Health Plan & Strategy
Prevention/ Population Health	• Identify Disparity #1 - Childhood immunization status ○ *Have you identified a disparity in this focus area?* ***Yes*** ○ *Have you identified a population to target for this disparity?* ***Yes*** • ***Members living in rural counties*** ○ Metric: Core Measure NQF 0038: Childhood Immunization Status Combo 10 ○ Overall strategy: Table (combined for Prevention) and narrative below • Include baseline and target data

- Include numerators, denominators, and performance rate for each population identified
- Provide overall strategy to improve towards the identified target

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Overall Strategy

Children living in rural communities make up the largest to childhood immunization disparity in RAE 1. RMHP is committed to increasing access to vaccines for all Health First Colorado Members and will continue to use Colorado Immunization Information System (CIIS) data to monitor progress, identify disparities and create outreach opportunities.

RMHP will work to increase vaccine access for children in rural counties through six areas of focus: 1) access to care, 2) community integration and engagement 3) data collection and monitoring 4) education, 5) outreach, and 6) provider, community, and Member incentives.

- **Access to Care:** Work with local pediatricians, public health agencies and community partners to increase access to vaccines for children including promotion of mobile vaccine clinics, new access points and enhanced availability at existing locations (e.g., pediatrician extended hours). **Timeframe:** ongoing

- **Community integration and engagement:** Collaborate with Local Public Health Agencies (LPHA), Colorado Department of Public Health and Environment (CDPHE) Regional Health Connectors, schools/districts, and other community partners to support vaccine access for children, events, and education throughout the region.

- **Data Collection and Monitoring:** Monitor Colorado Immunization Information System (CIIS) and other data sources to identify opportunities to improve vaccine access. PCMPs and Integrated Community Care Teams (ICCT) will continue to receive quarterly vaccine status reports for attributed Members.

- **Education:** Support educational campaigns that promote comprehensive understanding of vaccine benefits, risks of not getting vaccinated and how to communicate with trusted health care providers.

- **Outreach:** Use CIIS data to identify Members with vaccination gaps and send reminder messages and/or educational material. Care coordination teams work with members to provide additional reminders and resources to assist with vaccine access (e.g., school-based health center, transportation).

	• **Provider, community, and Member incentives:** Continue incentive programs designed to motivate local Tier 1 pediatric practices and community organizations to develop the infrastructure needed to increase vaccine access. All aspects of the RMHP immunization strategy are currently ongoing however, the following are key milestones in the 2024 overall strategy: • **January – March:** Review immunization data to identify opportunities with subpopulations and regions in rural counties. Refine strategy to meet specific needs of the population and communicate opportunities with providers/community partners. • **April – June:** Implement all aspects of immunization strategy with focus on member and provider education and provider interventions (e.g., extended hours, school-based clinics etc.) • **July – September:** Continue focus on provider interventions to increase access and data evaluation to identify recurring gaps in access. • **October – December:** Evaluate impact of immunization strategy on target population and refine overall strategy as needed.
Prevention/ Population Health	• Identify Disparity #2 - Immunization for adolescents ○ Have you identified a disparity in this focus area? **Yes** ○ Have you identified a population to target for this disparity? Y**es** • ***American Indian/Alaskan Native*** ○ Metric: Core Measure NQF 1407: Immunizations for Adolescents Combo 2 ○ Overall strategy: Table (combined for Prevention) and narrative below • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target _____ **Overall Strategy** American Indian/Alaskan Native Members in Region 1 make up the largest adolescent immunization disparity. RMHP is committed to increasing access to vaccines for all Health First Colorado Members and will continue to use Colorado Immunization Information System (CIIS) data to monitor progress and create outreach opportunities. RMHP will ensure interventions to increase access to immunizations are aligned with the unique needs of American Indian/Alaskan Native adolescent Members. RMHP will work to increase vaccine access through six areas of focus: 1) access to care, 2) community integration and engagement 3) data collection and monitoring

4) education, 5) outreach, and 6) provider, community, and Member incentives.

- **Access to Care:** Work with local providers, public health agencies and community partners to increase access to vaccines including promotion of mobile vaccine clinics, new access points and enhanced availability at existing locations (e.g., extended hours).

- **Community integration and engagement:** Collaborate with community leaders and other community partners to support vaccine access, events, and education.

- **Data Collection and Monitoring:** Monitor Colorado Immunization Information System (CIIS) and other data sources to identify opportunities to improve vaccine access. PCMPs and Integrated Community Care Teams (ICCT) will continue to receive quarterly vaccine status reports for attributed Members.

- **Culturally Relevant Education:** Support educational campaigns that promote comprehensive understanding of vaccine benefits, risks of not getting vaccinated and how to communicate with trusted health care providers.

- **Outreach:** Use CIIS data to identify Members with vaccination gaps and send reminder messages or educational material. Care coordination teams work with members to provide additional reminders and resources to assist with vaccine access (e.g., transportation).

- **Provider, community, and Member incentives:** Continue incentive programs designed to motivate local providers and community organizations to develop the infrastructure needed to increase vaccine access.

All aspects of the RMHP immunization strategy are currently ongoing however, the following are key milestones in the 2024 overall strategy:

- **January – March:** Review immunization data to identify opportunities within the American Indian/Alaskan Native Member populations. Refine strategy to meet specific needs of the population and communicate opportunities with providers/community partners.
- **April – June:** Implement all aspects of immunization strategy with focus on member and provider education and provider interventions (e.g., extended hours, school-based clinics etc.)
- **July – September:** Continue focus on provider interventions to increase access and data evaluation to identify recurring gaps in access.
- **October – December:** Evaluate impact of immunization strategy on target population and refine overall strategy as needed.

Prevention/ Population Health	• Identify Disparity #3 - Decrease diabetes poor A1C control in populations at risk ○ Have you identified a disparity in this focus area? **N/A** ○ Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations) ○ Metric: Core Measure NQF 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) ○ Overall strategy: • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target _____ **RMHP is committed to engaging Members and providers in order to support comprehensive diabetes care throughout the region. Once data is received from the state, RMHP will determine disparity populations and related strategies.**
Prevention/ Population Health	• Identify Disparity #4 - Increase well child visits while reducing disparities in visits among priority populations ○ Have you identified a disparity in this focus area? ***Yes*** ○ Have you identified a population to target for this disparity? **Yes, the below populations have been targeted for this disparity:** • **W30: Black/African American, American Indian/Alaskan Native** • **W30: Rural Counties** • **WCV: Native Hawaiian/Other Pacific Islander and American Indian/Alaskan Native** ○ 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) ○ Overall strategy: Table (combined for Prevention) and narrative below • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified

- Provide overall strategy to improve towards the identified target

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Overall Strategy

RMHP will deploy multiple interventions that focus on providers, Members and community organizations to promote equity and improve overall access to care for target populations.

1) Well child visit within first 30 months (W30): Black/African American & American Indian/Alaskan Native

RMHP recognizes that Members of color may experience discrimination, access barriers, and other challenges that impact access to well-visits in the first 30 months of life; and parents or caregivers may be less likely to take their child to a well-visit due to mistrust or fear in the health care system.

Provider Interventions:

- **Education:** RMHP will continue to promote PCMP educational opportunities that address cultural considerations to fill gaps in care. RMHP's annual Care Management training in October 2024 will include education on racial/cultural considerations for pediatric well-visits. Best practices will be shared throughout the PCMP network.

- **Provider Directory (Race/Ethnicity):** In December 2023, network providers were prompted to update race/ethnicity information in the UnitedHealthcare (UHC) Provider Portal. This information populates the provider directory. Member-facing teams use this directory to schedule appointments based on Member preference. Additionally, Members can filter the online provider directory by race/ethnicity to help Members find an ideal provider partner.

- **Gaps in Care Reports:** When RMHP sends PCMPs gaps in care information, Member race/ethnicity is included. RMHP will include education about racial/cultural considerations and encourage PCMPs to adopt culturally informed quality improvement processes.

- **Value Based Contracts**: RMHP completes an annual assessment of RAE PCMPs and asks them to report about diversity within membership of Patient and Family Advisory Councils (PFAC) and whether consideration of patient demographics is applied to quality improvement activities. RMHP will leverage PCMP value-based contracts to promote health equity for pediatric well-visits. In 2024, RMHP will offer additional "credit" to practices that attest-to and demonstrate that they implemented activities to support pediatric well-visits for these priority populations.

Member Interventions:

- **Care Coordination Screeners:** RMHP's care coordination screeners include questions related to Member cultural preferences and needs. RMHP will use this data to evaluate current population health programs to meet the needs of Members who identify as non-white.

Community Interventions:

- **Western Slope Native American Resource Center (WSNARC):** In collaboration with WSNARC, RMHP currently funds health navigators and, together, we are developing a focused ICCT team for the Native American population. The dedicated ICCT Care Coordinators within WSNARC will help promote community trust, improve health outcomes and enhance the Member experience.

- **Member Advisory Council (MAC):** RMHP will continue to promote diverse MAC membership to ensure the council includes Members with similar lived experiences and perspectives of target populations.

- **Beyond MAC, Listening Tour:** During Fall 2023, RMHP partnered with the Colorado Cross Disability Coalition (CCDC), to facilitate a listening tour including nine meetings across the RAE 1 geography, hosted in four different languages, including English, Spanish, Ute and ASL (American Sign Language). The listening session report will help RMHP understand the unique needs of the target population and inform actions we can take immediately and in the future.

2) Well child visit within first 30 months (W30): Rural

RMHP's region consists of many rural counties that lack access to PCMPs, health care services, and community resources to support pediatric well visit compliance. In many rural areas, Members are more likely to have social determinants of health (SDOH) barriers including lack of transportation or time off work. Providers and community organizations have a shared role in improving overall access to well visits in rural communities.

Provider Interventions:

- **Education:** RMHP's Practice Transformation team conducts regular quality improvement meetings with RAE Tier 1-3 practices, many of these providers are in rural and frontier areas of the region. RMHP will educate practices about clinical and operational workflows to increase access to care (e.g., same day access, scheduling sibling appointments together, reminder/recall etc.).

- **SDOH Screening and Referral Resources:** RMHP will continue to encourage PCMPs to screen and refer patients to appropriate

organizations and/or RMHP care coordination to address SDOH needs. For example, transportation to medical appointments is a common barrier in rural communities.

Member Interventions:

- **Gaps in Care Reminders**: RMHP Care Coordination and Integrated Community Care Teams (ICCT), located throughout the region, will complete outreach to Members in rural regions to schedule appointments within the first few days of birth. In 2024, RMHP will use a new vendor (mPulse) to complete Member outreach based on communication preferences and gaps in care information. These reminders will encourage Members to establish care and receive recommended well-visits.

- **Care Coordination:** RMHP Care coordination and ICCTs help Members living in rural communities identify providers to complete gaps in care visits and address SDOH needs (e.g., transportation).

Community Interventions:

- **MAC:** RMHP will continue to promote diverse MAC membership to ensure the council includes Members with similar lived experiences and perspectives of target populations.

3) Well child visit (WCV): American Indian/Alaskan Native & Native Hawaiian/Pacific Islander

RMHP recognizes that Members of color especially American Indian, Alaskan Native, Native Hawaiian and Pacific Islander populations may experience discrimination, access barriers, and other challenges that impact access to well-visits; and parents or caregivers may be less likely to take their child to a well-visit due to mistrust or fear in the health care system. Providers and community organizations have a shared role in improving overall access to well visits.

Provider Interventions:

- **Education:** RMHP will continue to promote PCMP educational opportunities that address cultural considerations to fill gaps in care. RMHP's annual Care Management training in October 2024 will include education about racial/cultural considerations for pediatric well-visits. Best practices will be shared throughout the PCMP network.

- **Provider Directory (Race/Ethnicity):** In December 2023, network providers were prompted to update race/ethnicity information in the UnitedHealthcare (UHC) Provider Portal. This information populates the provider directory. Member-facing teams use this directory to schedule appointments based on Member preference. Additionally, Members

	can filter the online provider directory by race/ethnicity to help Members find the ideal provider partner. • **Gaps in Care Reports:** When RMHP sends PCMPs gaps in care information Member race/ethnicity is included. RMHP will include education about racial/cultural considerations and encourage PCMPs to adopt culturally informed quality improvement processes. • **Value Based Contracts**: RMHP completes an annual assessment of RAE PCMPs and asks them to report on diversity within membership of Patient and Family Advisory Councils (PFAC). They are also required to report whether consideration of patient demographics is applied to quality improvement activities. RMHP will leverage PCMP value-based contracts to promote health equity for pediatric well-visits; for example, PCMPs must meet W30 key performance indicator (KPI) targets to earn credit towards their contract. In 2024, RMHP will offer additional credit to practices that attest-to and demonstrate that they implemented activities to support pediatric well-visits for these priority populations. **Member Interventions:** • **Care Coordination Screeners:** RMHP's care coordination screeners include questions related to Member cultural preferences and needs. RMHP will use this data to evaluate current population health programs to meet the needs Members who identify as non-white. **Community Interventions:** • **Western Slope Native American Resource Center (WSNARC):** In collaboration with WSNARC, RMHP currently funds health navigators and, together, we are developing a focused ICCT team for the Native American population. The dedicated ICCT Care Coordinators within WSNARC will help promote community trust, improve health outcomes and enhance the Member experience. • **MAC:** RMHP will continue to promote diverse MAC membership to ensure the council includes Members with similar lived experiences and perspectives of target populations. • **Beyond MAC, Listening Tour:** During Fall 2023, RMHP partnered with the Colorado Cross Disability Coalition (CCDC), to facilitate a listening tour including nine meetings across the RAE 1 geography, hosted in four different languages, including English, Spanish, Ute and ASL (American Sign Language). The listening session report will help RMHP understand the unique needs of the target population and inform actions we can take immediately and in the future.

Prevention/ Population Health	● Identify Disparity #5 - Dental and Oral Health for Children ○ Have you identified a disparity in this focus area? **Yes** ○ Have you identified a population to target for this disparity? **Yes** • **Annual dental visit: Rural counties** ○ Metric: Core Measure NQF 2517: Oral Evaluation, Dental Services (OEV-CH) ○ Overall strategy: **Table (combined for Prevention) and narrative below** • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified – • Provide overall strategy to improve towards the identified target _____ **Overall strategy - Annual Dental Visit (ADV): Rural** Region 1 includes rural counties that lack access to in-network dental providers. Although there are in-network dentists that meet network adequacy standards, the closest dentist is often in another county or up to 50 miles away from the Member. Therefore, routine dental visits may not occur due to transportation barriers, Members ability to take time off work/school, or other barriers care. RMHP is committed to increasing dental access in rural regions and will focus initial programs on providers and Members, while better understanding barriers to refine interventions. **Provider Interventions:** • **Education***:* RMHP's Practice Transformation team conducts regular quality improvement meetings with RAE Tier 1-3 rural practices. RMHP will encourage PCMPs to develop relationships and referral patterns with their nearest in-network dental office. Additionally, RMHP will continue to educate PCMPs about the dental benefit, administered by DentaQuest, to increase PCMP confidence and efficiency with dental referrals. • **Value Based Contracts***:* PCMPs receive KPI payments if RAE 1 meets the dental KPI target and KPI performance is integrated within their RAE Tier 1-3 annual attestation requirements. By integrating this into their value-based contract, it creates more awareness and incentive to advocate for access in rural these areas. • **SDOH Screening and Referral Resources:** RMHP will continue to encourage PCMPs to screen and refer patients to appropriate organizations and/or RMHP care coordination teams to address

identified SDOH needs. For example, transportation to medical appointments is a common barrier for rural Members.

- **Provider Agreements**: RMHP will continue to provide PCMPs in rural regions with agreements to promote prioritized quality metrics (e.g., access to dental care). These agreements offer additional support for practices and foster improvement to overcome barriers for rural PCMPs and attributed Members.

- **DentaQuest Collaboration***:* RMHP meets each month with DentaQuest to discuss ideas and strategy to close rural area dental disparities. DentaQuest is exploring ways to contract with additional dental providers in rural areas. Providers may be hesitant to join the network due to the administrative burden of contracting. RMHP is aware of this barrier and will work with DentaQuest to collaborate on strategies to streamline the contracting process.

Member Interventions:

- **Gaps in Care Reminders:** In 2024, RMHP will use a new vendor (mPulse) to complete Member outreach (e.g., inter active voice response, text, email) based on communication preferences and gaps in care information. These reminders will encourage Members to establish care and receive recommended dental visits.

- **RMHP Care Management and ICCTs:** RMHP care coordination teams are equipped to help Members in rural communities identify in-network and open providers and assess for SDOH needs (e.g., transportation). Member education via Member handbooks, website, etc. will be used to create awareness about care coordination services.

Community Interventions:

- **MAC:** RMHP will continue to promote diverse MAC membership to ensure the council includes Members with similar lived experiences and perspectives of rural communities.

- **RAE 1 Program Improvement Advisory Committee (PIAC):** Similar to the MAC, this group is comprised of a diverse stakeholder group including Members, providers and community organizations. The PIAC is particularly helpful in providing on priority focus areas including access to dental care.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
(CIS – Combo 10)	211	763	27.65%	33.36%	0.006	28.22%

Rural Counties						
(CIS – Combo 10) American Indian/Alaskan Native	60	204	29.41%	33.36%	0.004	29.81%
(IMA – Combo 2) American Indian/Alaskan Native	61	244	25.00%	26.12%	0.001	25.11%
(WCV) Native Hawaiian/Other Pacific Islander	143	394	36.29%	41.39%	0.005	36.80%
(WCV) American Indian/Alaskan Native	1635	4120	39.68%	41.39%	0.002	39.85%
(W30) Black/African American	67	113	59.29%	63.44%	0.004	59.71%
(W30) Black/African American	80	127	62.99%	65.31%	0.002	63.22%
(W30a) American Indian/Alaskan Native	96	167	57.49%	63.44%	0.006	58.09%
(W30b) American Indian/Alaskan Native	134	223	60.09%	65.31%	0.005	60.61%
(W30a) Rural counties	422	713	59.19%	63.44%	0.004	59.62%
(W30b) Rural counties	480	783	61.30%	65.31%	0.004	61.70%
(ADV) Rural counties	7822	17070	45.82%	49.47%	0.004	46.19%

5. Using the table below, please explain your current and planned overall approach and strategy for addressing a Focus Area not identified above. Provide your goals and activities and that address your identified disparity gaps among members.

Focus Area	Additional Organization Action Plan & Strategy

	• Identify Disparity #1 -
	  ○ Have you identified a disparity in this focus area? Have you identified a population to target for this disparity?
	  ○ Metric:
	  ○ Overall strategy:

	• Include baseline and target data • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target **RMHP was able to identify disparities in each of the metrics identified above; therefore, we did not include an additional metric.**
	• Identify Disparity #2 - ○ Have you identified a disparity in this focus area? Have you identified a population to target for this disparity? ○ Metric: ○ Overall strategy: • Include baseline and target data • Include numerators, denominators, and performance rate for each population identified • Provide overall strategy to improve towards the identified target **RMHP was able to identify disparities in each of the metrics identified above; therefore, we did not include an additional metric.**

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target

6. Using the table below, please explain the RAE/MCO's overall approach to cultural responsiveness.

Cultural Responsiveness	Overall Strategy
	Description: Cultural Responsiveness involves understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity,

seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued (Hopf et al., 2021).

- If not already addressed in the above section(s), what steps will be taken to embed culturally responsive practices across the RAE/MCO? Examples include, but not limited to the following[12]:

Overall strategy - Culturally Responsive Services (Non-English Speakers):
In 2022, approximately 7.89% of RAE Members indicated that their primary language was Spanish. This equates to approximately 16,000 RAE 1 Members. In 2022 and 2023, RMHP identified Spanish as a threshold or priority language, and Chinese as an emerging threshold language. This prioritization is a foundational element of RMHP's NCQA Health Equity Accreditation (November 2023) and ensures language accessibility of Member material and communication.

Network adequacy for providers who speak languages other than English is monitored per NCQA standards and RMHP is committed to offering Member programs in as many languages as possible to meet the needs of Members whose primary language is not English.

RMHPs is promoting culturally responsive services through interventions focusing providers, Members, and community organizations.

Provider Interventions:

- **Payment Attribution Reports:** In 2023, RMHP added language fields for each Member to PCMP payment attribution reports so PCMPs can identify patients that speak languages other than English. Many PCMPs utilize this report to supplement risk stratification or identify patients for empanelment. In 2024, RMHP will continue to educate PCMPs on how to utilize the attribution reports to support care management and population health programs for Members whose primary language is not English.

- **Community Integration Agreements (CIA):** RMHP will leverage feedback from practices with CIAs to better understand language barriers. Participating practices agree to submit a program evaluation each year and in 2024, RMHP will add specific questions to the CIA evaluation to include care efforts and barriers for vulnerable populations, such as Spanish-speaking Members.

[12] Adapted from https://www.health.state.mn.us/docs/communities/titlev/cultresponsive.pdf

- **Preferred Behavioral Health Provider Network:** RMHP has a preferred behavioral health provider network with provider incentives specific to cultural background, provider language(s) spoken related to population served and providers who focus on treating underserved populations. RMHP will continue to invest in this program in 2024 to attract and retain a greater number of behavioral health clinicians who are Spanish-speaking (and other preferred languages).

- **Free Interpretation Services for Network Providers:** RMHP offers and promotes the utilization of Language Line Solutions (LLS) with PCMPs and all network providers. Although PCMPs have reported they prefer to hire bilingual staff, interpretation services are widely used to support Members who speak languages other than English. RMHP will continue to promote this service via the website, provider manual, and/or provider webinars.

- **Provider Directory (Language):** RMHP will continue to encourage PCMPs and behavioral health providers to update languages spoken by the practice in their Provider Portal. This information populates the provider directory. Member-facing teams use this directory to schedule appointments based on Member preference. It is vital that providers keep this information updated ensure Members can select a provider who speaks their preferred language (without relying on the use of a language line).

- **Education:** RMHP will continue to promote educational offerings to PCMPs that are culturally informed for Members whose primary language is not English. This will occur in educational materials, webinars, and other means of provider communication. Additionally, RMHP aims to share best practices amongst PCMPs when providing education.

- **Practice Transformation***:* In addition, RMHP is a Practice Transformation Organization for HCPF's House Bill-1302 grant program focusing on behavioral health integration. MidValley Family Practice is working closely with RMHP with a focus on increasing support for older adults in primary care. MidValley Family Practice noted that 22% of their population of behavioral health clients are Hispanic/Latino, some are Spanish speaking. The practice will collaborate with RMHP to understand barriers and create strategies to improve care for Spanish speaking Members.

Member Interventions:

- **Language Line Solutions (LLS):** Telephonic, in-person, and virtual/video interpretation services available to all RMHP staff and contracted providers to assist Members with language needs. In 2022, Spanish was

the most requested language with 2,105 encounters across all RMHP Members. Within the regions, 19 different languages have been requested. Utilization trends appear to be related to increasing refugee populations in the region including Dari, Ukrainian and Georgian languages. RMHP will continue to promote increased utilization of LLS in provider education, new-hire training, and other forums.

- **Member Services:** Member Services offers resources for Members speaking non-English languages. Additionally, Member Services assists by translating any material or communication for Members.

- **Clinical Programs/Vendors:** All RMHP vendors and platforms have at least one language other than English available to Members. For example, Wellhop offers maternity group visits in Spanish and CirrusMD provides telehealth services in any language.

- **RMHP Bilingual Staff Certification***:* RMHP will provide resources to staff who speak Spanish to become certified through UHC's Talent Acquisition Services. This assessment helps ensure the accuracy and competency of the staff member providing direct Member support in languages other than English.

Community Interventions:

- **MAC in Spanish:** RMHP plans to continue to convene the MAC in Spanish in 2024, and take action on barriers and perspectives provided by this council. An area of concern identified in 2023 during this forum was fear that immigration status could be negatively impacted with healthcare access. RMHP will address this feedback and offer training to PCMPs and community organizations about unique needs of migrant and refugee populations.

Overall Strategy - Culturally Responsive Services and Support (Tribal/American Indian Alaska Native):

Since the inception of the RAE, RMHP has worked to develop trusted partnerships with the Ute Mountain Ute and Southern Ute Tribes in Colorado.

RMHP is committed to serving tribal communities. The first step is engaging and listening. As noted previously, RMHP conducted a listening tour (conducted in four languages, to include Ute) to better understand the needs of the diverse membership. As we distill lessons from the tour, we have also been able to support interventions that came directly from local providers and community.

Provider Interventions:

- **SUD treatment:** Over the past year RMHP has committed supportive funding for the Southern Ute Healing Village, an innovative substance

use disorder treatment and recovery campus for all Tribal members who are in need of residential, outpatient or other supportive recovery services. While the Village project is still in early stages, RMHP has partnered closely with the Southern Ute Tribal Health Department to expand outpatient SUD treatment services, to include methadone treatment. In fact, RMHP has committed 2024 funding specifically for Wi-Fi services and hardware necessary for a planned mobile methadone van. RMHP is committed to continued support of the resource center, behavioral health service development and expansion (including dedicated mobile crisis response) for the Tribal population through ongoing funding and partnerships.

- **Primary Care Support***:* Through RMHP's tiered primary care medical provider network, RMHP supports the Indian Health Service Centers on the Southern Ute and Ute Mountain Ute reservations with enhanced per member per month payments as well as continued availability for practice transformation support.

Community Interventions:

- **Western Slope Native American Resource Center (WSNARC):** In 2022, RMHP provided funding to support the opening of a Native American Resource Center for the Western Slope of Colorado. WSNARC, which is now a 5013(c), is located in Grand Junction and provides services and health care navigation (including Medicaid enrollment) to all Tribal members who seek assistance. Understanding the system of the native nation's elders, knowing the beliefs that dictate living arrangements, and empathizing with the generational trauma of living on sovereign land are part of the fabric of WSNARC. Its mission is to strengthen underserved AI/AN children and their families through collaborative and culturally responsive services. RMHP continues to support WSNARC through an annual contract for peer navigation and a dedicated ICCT care coordination for the Native population.

<u>Overall Strategy – Culturally Responsive Services and Support (Refugees):</u>

In February 2023 organizations in the Grand Valley welcomed refugees from Afghanistan as part of a resettlement program. The primary goal for this population has been to provide support with Medicaid enrollment, connection to providers and community organizations, and direct support to Members.

Provider Interventions:

- **Language supports:** As detailed previously, RMHP ensures providers can meet Member needs, regardless of the language they speak.

- **Education:** RMHP will continue to promote educational offerings to PCMPs that are culturally informed for Members who are refugees. This

will occur through educational materials, webinars, and other methods of provider communication. Additionally, there is a planned session on "Caring for Refugee Populations" during the RMHP annual Behavioral Health Skills Training. This is scheduled for April 5, 2024.

Member Interventions:

- **Care Coordination:** People who are refugees often have complex needs best suited for one-on-one support of care coordination. RMHP Care coordinators assist with multiple supports including Medicaid applications, housing vouchers, and transportation. If necessary, intensive case management and coordination is also available. RMHP has helped 71 people enroll in Medicaid through the supportive resettlement program.

Community Interventions:

- **Support for Community-Based Organizations (CBOs):** During the resettle program and beyond, RMHP has supported CBOs who worked directly with individuals in establishing basic needs (such as utilities and housing). RMHP also created a fund to support individuals who needed personal and home items including computers, as well as the funding of employment opportunities for those seeking work.

Overall Strategy – Culturally Responsive Services and Support (Individuals with an Intellectual and Developmental Disability [IDD]):

As a RAE and Administrative Services Organization that includes behavioral health mobile crisis response, RMHP received ongoing feedback that there is a lack of skilled professionals who serve individuals with co-occurring behavioral health and IDD diagnoses. Specialized provider training is needed to create a network of clinicians who can serve Members with co-occurring diagnoses.

Provider Interventions:

- **Clinician Curriculum and Training:** RMHP partnered with Oliver Behavioral Consultants (OBC) to develop and launch a 5-day live curriculum and training to promote knowledge and practical skills for behavioral health providers serving this population. The first course launched in June 2022. Because many clinicians rely on hourly fee for service reimbursement in their practices, RMHP offered "scholarships" to providers to cover the cost of time away from their practice. Since the first training, OBC has conducted four 5-day trainings with plans to continue. In addition to real-time skills surveys throughout the course, in January 2024 all providers who participated and successfully completed the course will receive a survey regarding the expansion of serving this population.

	<u>Overall Strategy – Culturally Responsive Services and Support (Members who Identify in the LGBTQIA+ Population)</u> **Provider Interventions:** • **Preferred Behavioral Health Provider Network:** RMHP has a preferred behavioral health provider network with provider incentives specific to the cultural background and language(s) spoken related to population served and those with a focus on treating underserved populations, such as the LGBTQIA+ population. RMHP will continue to invest in this program in 2024 to attract and sustain a greater number of behavioral health clinicians who commit to working with the LGBTQIA+ population. **Community Interventions:** • **Funding***:* RMHP focuses on increasing services, resources, and safe spaces for individuals in the LGBTQIA+ population. Since July 2022, RMHP has invested over $900,000 across the Western Slope and Colorado to support inclusivity, safe and affirming health care and community resources for this population. • **Partnerships:** Community funding has supported programs and resources such as The Center, the first safe space community center in Grand Junction for LGBTQIA+ youth and adults. The Center created the first safe community gathering space on the Western Slope. As part of a joint commitment to health equity and access, RMHP is collaborating with Loving Beyond Understanding (LBU) in Grand Junction to promote LGBTQIA+ affirming care. A $320,000 investment will help fund an initiative that offers LGBTQIA+ teen social/support groups and education/support groups for parents and caregivers of LGBTQIA+ youth. In addition, RMHP is funding the hiring of community navigators through LBU and Mountain Pride to focus exclusively on supporting Medicaid Members in this population. Additionally, RMHP is supporting a dedicated LBU Health Navigator whose primary role is providing care coordination and navigation services for RAE 1 Members in this population. The Navigator is supported by RMHP's Care Coordination team but maintains independent decision making as an LBU employee and advocate.

7. Please share any challenges, barriers or assistance needed from The Department.

Data Integrity:

The largest challenge has been data that is not actionable, such as the use of an "other" category. It is understood that some of this is related to Member preference but otherwise it appears to be related to forms not allowing for the complexity that each individual may bring. In the case of race, being able to "check all that apply" versus having to choose, might be more informative.