Regional Health Equity Plan FY23-24
Instructions and Narrative

RAE/MCO Name	Northeast Health Partners
RAE/MCO Region #	Region 2
Reporting Period	[SFY23-24 7/31/2023 – 6/30/2024]
Date Submitted	January 2, 2024, February 22, 2024
Contact	Brian Robertson, PhD

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)

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

COLORADO
Department of Health Care Policy & Financing

Health Equity Plan Measures

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

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.

General Strategy

Northeast Health Partners (NHP) employs a four-fold approach at addressing disparities. First, it deploys a data-driven approach utilizing the principles and methodology of Lean Six Sigma's Define, Measure, Analyze, Improve, Control (DMAIC). This methodology includes defining the problem (including target populations of interest), assessing root causes, developing and implementing targeted interventions, assessing the impact of those interventions, and then refining or maintaining the intervention.

Second, NHP believes effective interventions must include the "voice of the customer," or perspectives from the members to surface customer-level views on barriers, beliefs, and behaviors that contribute to the disparity gap. These perspectives then guide community-based interventions geared toward improving regional performance by focusing on the members' needs.

Third, NHP further believes in utilizing and leveraging community stakeholders to improve efficacy. It will leverage a regional "Health Equity Task Force" to discuss data, barriers, opportunities, and next steps with intervention development and deployment to improve performance.

Lastly, NHP will leverage community partners and the health neighborhood to promote health and wellness throughout the region's targeted populations. This may include various avenues including working with local schools, churches, promotoras/promotoros, immigrant and refugee centers, or media outlets to broaden reach with targeted messaging through trusted partners. The goal is to promote a "grassroots initiative" where information is disseminated from within the community, and can be vital to building relationships in rural and frontier areas.

Community Engagement

The rural and frontier communities across the Eastern Plains have unique characteristics for engaging directly with the community. The Health Equity Task Force surfaced strong community connections to the schools and various programs including football games, the Future Farmers of America, and the Future Healthcare Workers programs. NHP will leverage

these community resources to help with messaging and disseminating information to the community.

Additionally, local radio stations and printed newspapers are widely used avenues in the rural and frontier areas of the northeast region. NHP will work with local entities for target outreach and health and wellness promotions. NHP will track member engagement through the number of opportunities for member engagement (such as health fairs, school events, and additional community led events) where member content will be distributed, the outreaches where messages are sent directly to members (such as text campaigns or messages sent), and the avenues of those outreaches. NHP also take attendance at engagement meetings, when appropriate and tracks outreach engagements attended or hosted via an internal tracking sheet.

During community interactions, staff contact information is provided to members and they are encouraged to contact NHP with any questions or concerns. NHP staff ensures that they connect with all community member requests after initial engagement if any follow up is needed. Staff also bring concerns, solutions, questions or comments garnered from community members to the team to discuss best practices and brainstorm creative solutions to issues members are experiencing or how we can further enhance offerings.

Data Tracking

NHP currently has a number of measures related to prenatal and perinatal health. Data will be tracked monthly utilizing the Data Analytics Portal (DAP) and internal calculations. Data will be stratified by demographic groups to determine performance gaps and improvement in performance over time. These reports/dashboards will be reviewed at regional meetings including the bi-monthly Quality Management Meeting, bi-monthly Quality Improvement/Population Health Committee Meeting, quarterly Performance Improvement Advisory Committee meeting, and the Health Equity Task Force Meetings. Data will also be compared to and validated with the data Health Care Policy and Financing (HCPF) sends quarterly.

Key Incentives

NHP will provide incentive funds for measures that align to current performance metrics. These measures include Well Visits for 0-15 Months, Well Visits for 15-30 Months, Child & Adolescent Well Visits, Timeliness of Prenatal and Postpartum Care, Oral Evaluation/Dental Services, 7-Day Follow-Up after an Emergency Department (ED) Visit for Substance Use Disorder (SUD), 7-Day Follow-Up after an ED Visit for Mental Illness, and Depression Screening and Follow-Up Plan.

Addressing Limited English Proficiency

All materials developed, disseminated, or utilized are provided in English and Spanish. The vast majority of regional members (86%) report English as their primary language, and Spanish as the second most common language (12%). NHP can provide document translation in over

200 languages within five business days for documents under 30 pages in length. Larger documents or Braille translations need one to three additional days. NHP currently develops member-facing documents in both English and Spanish but plans to develop key documents in additional primary languages as needed. NHP will provide the documents in other languages, as needed, to ensure all populations and demographic groups receive the same information in their preferred language. Additionally, interpretation services, visual aids and listening loops for hearing and visually impaired members are available to members upon request. Further, NHP has determined it is most beneficial to members to receive services from individuals who are bi-lingual/multi-lingual and stives to connect members with providers across the region who speak a member's native language.

Health Equity Task Force

NHP launched its Health Equity Task Force with a kickoff meeting on October 13, 2023. Outreach to the task force focused on the region's unique populations and included representatives supporting people with intellectual disabilities, Special Olympics, the Eastern Plains Healthcare Consortium (EPHC), the Colorado Department of Public Health and Environment (CDPHE), behavioral health, physical health, and care coordinators. The task force will meet monthly to guide and inform the health equity strategy and will determine a meeting frequency to support program implementation. NHP has been communicating the Health Equity Strategy and the Task Force across multiple avenues and will include member voices to better inform and shape regional strategies.

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: 10% increase in COVID booster vaccination rates • Overall strategy: NHP serves a region with a high degree of vaccine hesitancy and skepticism around the COVID vaccine. Reducing stigma, providing clear information, and connecting members to resources should improve vaccination rates. NHP utilizes a strategy of education, outreach, and increasing access to available resources to increase COVID vaccination rates. This will be accomplished by developing and disseminating tip sheets on vaccine facts and the benefits of

	vaccinations to members, and increasing access to vaccines through mobile vaccine units by partnering with CDPHE, and connecting CDPHE to contracted Vaccine for Children (VFC) clinics. <u>Target Population:</u> NHP will utilize two key populations for this measure. Older adults will be defined as those aged 65 years and above, and children will be defined as those aged under 21 years in alignment with Early Periodic Screening Diagnostics and Treatment (EPSDT) and Key Performance Indicator (KPI) age parameters. <u>Regional Goals:</u> • Increase COVID vaccination rates by 10% <u>Targeted Interventions:</u> • Reduce Stigma around COVID vaccines and boosters through member-facing education • Identify members for targeted outreach and communications • Develop partnerships to link communities to resources <u>Action Items:</u> • Distribute educational materials and tip sheets around COVID vaccines and boosters • Send Colorado Immunization Information System (CIIS) data to care coordinators for member outreach • Utilize CDPHE to launch mobile vaccine delivery in the region • Promote regional community events • Continue discussing vaccine hesitancy with care management programming

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

Children	TBD	TBD	TBD	TBD	TBD	TBD

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** (If yes, please identify 1 to 2 target populations)
	  Target Population 1: Rural/Frontier Counties, specifically Logan, Phillips, and Yuma Counties.
	  • Metric: Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH)
	<u>Overall strategy:</u>
	The overarching strategy is to connect to local members and practices to support pregnant and preterm members to receive prenatal care, and to support practices to accurately code in alignment to specification documents to capture clinical procedures.
	<u>Target Population:</u>
	NHP identified several areas of opportunity for this measure, but landed on rural/frontier counties as the target populations. Logan County (rural), Phillips County (frontier), and Yuma County (frontier) all had the lowest rates of any variable for this measure at 29%, 14%, and 40%, respectively.
	<u>Regional Goals:</u>
	• Improve billing code use in alignment to the performance measure coding requirements
	• Expand member knowledge on the importance of prenatal care and prenatal visits

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Expand member knowledge about care coordination resources
Increase referrals to regional prenatal care programs

<u>Targeted Interventions:</u>

Connect members to care coordinators for appointment scheduling support
Distribute member-facing tip sheets on the importance of prenatal care
Work with practices to educate and inform about billing codes per metric specifications
Connect members to regional prenatal care programs such as the Prenatal Plus Program

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<tr><td>Maternity and Perinatal Health</td><td>

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 (If yes, please identify 1 to 2 target populations)
Target Population 1: Frontier Counties (with emphasis on Yuma, Kit Carson, Lincoln, Washington, Sedgwick, Cheyenne)
Target Population 1: Rural Counties (Morgan, Logan and Phillips)
Metric: Core Measure NQF 1517: Post-partum Care (PPC-AD)

<u>Overall strategy:</u>
The overarching strategy is to connect to local members and practices to support postpartum and newborn members to receive timely postpartum care, and to support practices to accurately code in alignment to specification documents to capture clinical procedures.
<u>Target Population:</u>
Looking at regional performance data, NHP identified rural and frontier counties as the disparity populations of interest as 8 of its 9 rural and frontier counties are performing at rates below the
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	regional average. The regional average currently rests at 42% while Logan (a rural county) and Weld (an urban county) are performing at 56% and 43%, respectively. Rural and Frontier rates range from 41% in Phillips to 0% in Cheyenne (both frontier counties). Regional Goals: • Improve billing code use in alignment to the performance measure coding requirements • Expand member knowledge on the importance of postpartum care and postpartum visits • Expand member knowledge about care coordination resources • Increase access to regional postpartum care programs Targeted Interventions: • Connect members to care coordinators for appointment scheduling support • Distribute member-facing tip sheets on the importance of postpartum care • Work with practices to educate and inform about billing codes per metric specifications • Connect members to regional postpartum and maternity care programs such as Healthy Steps Action Items: • Develop postpartum care tip sheets for disseminating to members • Disseminate information about care coordination to members who may need support with scheduling appointments • Develop and disseminate tip sheets to regional practices for improved coding • Identify new regional community groups to support outreach and engagement.

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

Disparity 1 (Prenatal) Rural/Frontier Counties (Logan, Phillips, and Yuma Counties).	53	173	30.6%	53%	4.2%	34.9%
Disparity 2 (Postpartum): a). Frontier Counties b). Rural Counties	a). 47 b). 122	a). 147 b). 303	a). 32% b). 40.3%	42%	a).2.4% b). 1.6%	a).34.4% b).41.8%

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** (If yes, please identify 1 to 2 target populations)
	  Target Population 1: Hispanic Members
	  Target Population 2: Weld County
	  • Metric: Core Measure NQF 3489: Follow-up after Emergency Department Visit for Mental Illness
	
	Overall strategy:
	
	The overarching strategy is to connect members with the highest levels of need to available behavioral health services to include working with members and providers to address gaps and improve processes in care delivery.
	
	Target Population:
	
	NHP identified Hispanic members and members residing in Weld County as the two populations of interest in for this measure. The region's Hispanic and urban members account for the two largest

	underperforming target populations for both the 7-day follow-up and 30-day follow-up measures. Only 29% of Hispanic members had follow-up appointments within 7 days of ED discharge, and 49% had follow-up appointments within 30 days of ED discharge. In contrast, 29% of Weld County members had follow-up visits within 7 days, and 51% had visits within 30 days. The regional average was 30% for 7-day follow-ups and 52% for 30-day follow-ups. Regional Goals: • Improve Behavioral Health Incentive Program (BHIP) performance rates for follow-up appointments after an ED visit for mental health • Expand peer-support services to members Targeted Interventions: • Improve coding practices with providers to ensure proper codes are entered • Improve processes for scheduling appointments Refer and connect members to available resources • Implement WISDO for peer support Action Items: • Develop and disseminate coding tip sheets to regional practices • Develop process maps for care coordination, hospitals, and clinics to assess gaps in service delivery • Develop materials in English and Spanish about behavioral health services and follow-ups • Identify new regional community groups to support outreach and engagement. • Disseminate the WISDO platform to regional members
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** (If yes, please identify 1 to 2 target populations) **Target Population 1: Weld County** **Target Population 2: Hispanic Members** • Metric: Core Measure NQF 3488: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Overall strategy: The overarching strategy is to connect members with the highest levels of need to available behavioral health services to include working with members and providers to address gaps and improve processes in care delivery. Target Population: NHP identified Hispanic members and Weld County members as underperforming demographic groups for both the 7-day and 30-day follow-up appointment measures. The regional average for 7-day follow-up appointments after an ED visit for SUD is 22%. Only 18% of the region's Hispanic members and 22% of the Weld County members are getting appointments within this time frame. Further, NHP averages 33% for 30-day follow-up appointments after an ED Visit for SUD. Similarly, 30% of the region's Hispanic members and 32% of the Weld County members are getting appointments within this period. Regional Goals: • Improve BHIP performance rates for follow-up visits after an ED visit for SUD • Refer and connect members to available resources • Expand member support services Targeted Interventions: • Align health equity activities to the state Performance Improvement Project (PIP) on SUD engagement • Implement WISDO for peer support

	• Work with practices to educate and inform about billing codes per metric specifications • Provide resources in preferred languages Action Items: • Disseminate the WISDO platform to regional members • Develop and disseminate coding tip sheets to regional practices • Develop materials in English and Spanish about behavioral health services and follow-ups • Identify new regional community groups to support outreach and engagement.
Behavioral Health	1) 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** (If yes, please identify 1 to 2 target populations) **Target Population 1: Disabled Members** • Metric: Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness Overall strategy: The overarching strategy is to connect members with the highest levels of need to available behavioral health services to include working with members and providers to address gaps and improve processes in care delivery. Target Population: NHP identified disabled members as the key population of focus for this measure. The regional averages 21% for a 7-day follow-up after a hospital discharge for a mental illness, and the region's disabled members averages only 16%. Similarly, the regional average for a 30-day follow-up appointment is 35% and only 28% of the disabled members are getting appointments within this time frame.

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<td>However, the data currently shows whether the member is or isn’t disabled as a “Yes/No” field. More information is needed to understand the type of disability for better outreach and intervention development.

<u>Regional Goals:</u>
• Understand variations in disability data
• Improve coding practices with providers to ensure proper codes are entered
• Expand peer-support services to members

<u>Targeted Interventions:</u>
• Data analysis on disability status to identify various disabilities experienced by regional members
• Implement WISDO for peer support
• Work with practices to educate and inform about billing codes per metric specifications

<u>Action Items:</u>
• Disaggregate data by disability type
• Disseminate the WISDO platform to regional members
• Develop and disseminate coding tip sheets to regional practices
• Identify new regional community groups to support outreach and engagement.</td>
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<td>Behavioral Health</td>
<td>• Identify Disparity #4 - Depression screenings
  • Have you identified a disparity in this focus area? Yes
  • Have you identified a population to target for this disparity? Yes (If yes, please identify 1 to 2 target populations)
  Target Population 1: Hispanic Members
  Target Population 2: Weld County
  • Metric: Core Measure NQF 0418: Depression Screening and Follow-Up Plan</td>
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Overall strategy:

The overarching strategy is to work with practices to ensure depression screenings are completed and accurately coded in alignment to specification documents.

Target Population:

As the most prominent populations for behavioral health disparities are Hispanic members and Weld County residents, NHP will continue the behavioral health focus on these two populations to create symmetry in messaging.

Regional Goals:

- Increase provider knowledge of the Depression Screening and Follow-Up plan KPI measure
- Improve coding practices to ensure proper codes are being captured

Targeted Interventions:

- Work with practices to educate and inform about billing codes per metric specifications
- Track and disseminate KPI performance to regional practices through DAP chart and action list dissemination and balanced scorecards

Action Items:

- Develop and disseminate tip sheets to regional practices for improved coding
- Incorporate the KPI metric into balanced scorecards
- Send Action Lists and DAP charts when the Data Analytics Portal (DAP) is updated
- Discuss regional performance in regional meetings

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
Disparity #1 a). Hispanic Members	a). 39 (7day) 67 (30day)	a). 136 b). 216	a). 28.7% (7day) 49.3% (30 day)	30% (7day), 52% (30-day)	a). 1.3% (7day) .4% (30day)	a). 30% (7day) 47.9% (30day)

b). Weld County Members	b). 63 (7day) 111 (30day)		b). 29% (7day) 51.4% (30day)		b). 5.7% (7day) 3.4% (30day)	b). 34.7% (7day) 54.8% (30day)
Disparity #2 a). Weld County Members b). Hispanic Members	a). 178 (7day) 261 (30day) b). 88 (7day) 148 (30day)	a). 819 b).486	a). 21.7% (7day), 31.9% (30day) b). 18.1% (7day) 30.5%(30day)	22% (7day) 33% (30day)	a). 2.8% (7day) 1.8% (30day) b). 1.5% (7day) .7% (30day)	a). 24.5% (7day) 33.7% (30day) b). 19.6% (7day) 31.2% (30day)
Disparity #3 Disabled Members	(7day) (30day)	32	% (7day), % (30day)	21% (7 day) 35% (30 day)	.8% (7day) .9% (30day)	16.4% (7day) 29% (30day)
Disparity #4 - (depression screen with F/U) a). Weld County Members b). Hispanic Members	a). N/A b).N/A	a). N/A b).N/A	a). N/A b).N/A	N/A	N/A	N/A

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/No (If yes, please identify 1 to 2 target populations)

  Target Population 1: Rural Counties (Morgan, Logan and Phillips)

  Target Population 2: Frontier Counties (Yuma, Kit Carson, Lincoln, Washington, Sedgwick, Cheyenne)

- Metric: Core Measure NQF 0038: Childhood Immunization Status Combo 10

<u>Overall strategy:</u>

The regional strategy for immunizations is the same as the COVID strategy: To disseminate accurate and reliable information on the value of vaccines to our members, and to increase access to available vaccines in the region. Reducing stigma and increasing access to vaccines through mobile clinics, local health care providers who are trusted, as well as education of the importance through community leaders. For example, doing Public Service Announcement with a local medical provider on immunizations and the current rise of infectious diseases i.e. Tuberculosis (TB)

<u>Target Population:</u>

NHP identified rural and frontier counties as the populations of interest for the Child Immunization Status Combo 10 measure. Regional performance is at 32% and all of its rural and frontier counties are below that threshold with ranges from 30% in Logan County to 0% in Cheyenne County. In contrast, Weld County, the region’s only urban country, is the only county to perform above the regional average.

<u>Regional Goals:</u>

- Increase knowledge of the benefits of vaccines
- Expand vaccine access to rural and frontier areas

<u>Targeted Interventions:</u>

Immunizations have been a challenging topic across the region since COVID-19. To combat vaccine hesitancy while maintaining trust with regional members, targeted interventions will be community-based and educational. NHP will:

	• Community education on the importance of vaccines, specifically around the Combo 10 vaccines • Leverage mobile vaccine units by connecting CDPHE to the VFC clinics across the eastern plains • Increase vaccine rates by promoting well visits <u>Action Items:</u> • Identify VFC clinics in the Eastern Plains and connect CDPHE to these clinics to launch mobile vaccines in the region • Develop tip sheets on the importance of vaccines, specifically around the Combo 10 vaccines • Identify new regional community groups to support outreach and engagement • Continue text campaign reminders and birthday cards to promote members in scheduling well visits (leading to increased rates of vaccines) • Continue discussing vaccine hesitancy with care management programming

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? **Yes** (If yes, please identify 1 to 2 target populations)
	
	Target Population 1: Frontier Counties (Yuma, Kit Carson, Lincoln, Washington, Sedgwick, Cheyenne)
	
	Target Population 2: Rural Counties (with special emphasis on Phillips County).
	
	  • Metric: Core Measure NQF 1407: Immunizations for Adolescents Combo 2
	
	<u>Overall strategy:</u>
	
	The regional strategy for immunizations is the same as the COVID strategy: To disseminate accurate and reliable information on the value of vaccines to our members, and to increase access to

available vaccines in the region. Reducing stigma and increasing access to vaccines through mobile clinics.

Target Population:

NHP also identified rural and frontier counties as the populations of interest for the Child Immunization Status Combo 2 measure. Regional performance is at 29% and almost all of its rural and frontier counties are below that threshold with ranges from 7% & 9% in Sedgwick (frontier) and Phillips Counties (rural) to 22% in Cheyenne County (frontier). Only three counties are above the regional average and include Morgan County (Rural) at 30%, Weld County (urban) at 31%, and Logan County (Rural) at 36%.

Regional Goals:

- Increase knowledge of the benefits of vaccines
- Expand vaccine access to rural and frontier areas

Targeted Interventions:

- Community education on the importance of vaccines, specifically around the Combo 10 vaccines
- Leverage mobile vaccine units by connecting CDPHE to the VFC clinics across the eastern plains.
- Increase vaccine rates by promoting well visits

Action Items:

- Identify VFC clinics in the Eastern Plains and connect CDPHE to these clinics to launch mobile vaccines in the region.
- Develop vaccine tip sheets for Combo 10 vaccines
- Identify new regional community groups to support outreach and engagement
- Continue text campaign reminders and birthday cards to promote members in scheduling well visits (leading to increased rates of vaccines)
- Continue discussing vaccine hesitancy with care management programming

Prevention/ Population Health	● Identify Disparity #3 - Decrease diabetes poor A1C control in populations at risk
	  ● Have you identified a disparity in this focus area? **Yes**
	  ● Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations)
	  Target Population 1: Hispanic Members
	  Target Population 2: Spanish-Speaking Members
	  ● Metric: Core Measure NQF 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)
	<u>Overall strategy:</u>
	The regional strategy for diabetes control is to disseminate accurate and reliable information on the importance of managing diabetes, to provide information and resources to support members in controlling diabetes, and to connect members to regional diabetes management programs.
	<u>Target Population:</u>
	NHP has a regional average of 72.98% for members with controlled diabetes. However, the region's Hispanic members and more specifically, the region's Spanish-speaking members both have performance rates below the regional average. Only 67% of Hispanic members report controlled diabetes and only 51% of the Spanish-speaking members are noted to have controlled diabetes.
	<u>Regional Goals:</u>
	• Educate members about early diabetes symptoms and life-long management
	• Increase utilization of diabetes programs (such as Diabetes Self Management Education and Support (DSMES) and Diabetes Prevention Programs (DPP) programs) and/or local pharmacies or community advocates.
	• Increased access to diabetes technologies through primary care or community advocates.

	• Increased educational opportunities to learn about new medications and technologies for members and providers <u>Targeted Interventions:</u> • Community education on diabetes management • Link diabetic members to diabetes management programs in the region • Leverage the bi-regional Diabetes Workgroup for educational opportunities for providers. <u>Action Items:</u> • Develop & Disseminate diabetes management tip sheets in both English and Spanish • Distribute regional support services to members • Connect with local Community Health Workers / promotoras/promotoros • Identify new regional community groups to support outreach and engagement. • Partner with local experts to present at the bi-regional Diabetes Workgroup

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** (If yes, please identify 1 to 2 target populations)
	
	  Target Population 1: Frontier Counties
	
	  Target Population 2: Rural Counties
	
	  • 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)
	
	<u>Overall strategy:</u>

The regional strategy for well visits is to disseminate accurate and reliable information on the value of well child visits screenings, which includes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) as well as vaccines to our members, and to increase access to available services in the region.

Target Population:

NHP identified rural and frontier counties as the target populations of interest for well visits. Regional performance on well visits in the first 15 months is high across most demographic groups, and the largest populations of lower-performing groups are often non-descriptive (such as “other” for race/ethnicity). Additionally, four rural and frontier counties are under the regional average of 57% and include Yuma (54%), Phillips (48%), Cheyenne (43%), and Kit Carson (20%) counties.

In contrast to well visits within the first 15 months, well visits from 15-30 months has only two counties performing above the regional average of 57%. These are Weld County (60%) and Logan County (60%). Other rural and frontier counties have rates ranging from 53% in Morgan County to 0% in Cheyenne County.

Rates of well visits for those aged 3-21 years are also lower in rural and frontier areas. Only four counties have rates higher than the regional average of 35% and include Washington (38%), Weld (37%), Phillips (37%) and Logan (37%) counties. The remaining rural and frontier counties have ranges from 30% in Lincoln County to 19% in Yuma County.

The focus on rural and frontier areas for all well visit measures creates consistency in messaging and promotes well visits across age groups.

Regional Goals:

- Increase knowledge of the importance of well visits for regional members
- Expand well visits as a better alternative to a sports physical assessment
- Improve billing code use in alignment to the performance measure coding requirements

Targeted Interventions:

	• Outreach members about requesting well visits vs. sports physicals at the beginning of the school year • Outreach physicians on the impact of regional interventions to increase well visits • Educate members on the importance of well visits for all ages • Work with practices to educate and inform about billing codes per metric specifications Action Items: • Distribute well visit tip sheets to members • Promote well visits vs. sports physical tip sheets with members and providers • Representatives from Melissa Memorial will present results of well visit promotions to the region • Develop and disseminate tip sheets to regional practices for improved coding • Utilize text messaging campaigns for well visit reminders • Identify new regional community groups to support outreach and engagement.

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** (If yes, please identify 1 to 2 target populations)
	    Target Population 1: Rural Counties
	    Target Population 2: Frontier Counties
	  ◦ Metric: Core Measure NQF 2517: Oral Evaluation, Dental Services (OEV-CH)
	
	Overall strategy:
	
	The regional strategy for Dental and Oral Health is to increase access to dental care for members, especially across the eastern plains where dental access is often limited or nonexistent. While

	RAEs do not have control over the dental network, NHP is looking to increase access by leveraging tele-dentistry and mobile units. <u>Target Population:</u> NHP is predominantly a rural and frontier region. As such, a dental desert (or a lack of dental practitioners) exists in a significant part of the region, particularly among the Eastern Plains. Looking at regional performance data, NHP identified rural and frontier counties as the disparity populations of interest as all 9 of its rural and frontier counties are performing at rates below the regional average of 48%. Weld County, the region's only urban county, has an oral evaluation rate of 54%, and is the only county performing above the regional average. Rural and frontier county rates range from 40% in Washington to 22% in Morgan (both rural counties) NHP has a long-standing interest in improving dental rates and has been actively seeking alternative strategies to improve across the region. Recently, it engaged in a pilot project with a start-up company, DenTriage, to expand dental access to regional members. DenTriage is an organization that was born out of a need to provide immediate dental consultation and temporary relief to dental pain through a telemedicine modality that could alleviate a potential unnecessary and costly visit to the ED. DenTriage is developing a novel tool that would, at a minimum, allow for a telemedicine consultation, identifying a local dental provider, and a recommended course of action for the member. DenTriage is further building an electronic interface that will allow for direct scheduling with that provider. <u>Regional Goals:</u> ● Expand access to dental services across the eastern plains <u>Targeted Interventions:</u> ● Utilize DenTriage to increase dental access ● Utilize mobile dentistry units for increased dental access <u>Action Items:</u> ● Introduce DenTriage to the Eastern Plains Healthcare Consortium ● Introduce DenTriage to the Eastern Plains Practices

- Disseminate information on DenTriage to practices through the Practice Transformation program
- Disseminate information on DenTriage to regional partners in the health neighborhood
- Disseminate information on DenTriage to regional members
- Assess utilization, impact, and satisfaction of DenTriage services
- Identify new regional community groups to support outreach and engagement.
- Connect practices to Dental at Your Door
- Leverage regional Federally Qualified Health Centers (FQHCs) for mobile dentistry

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
Disparity #1 - Childhood immunization status a) Frontier Counties b) Rural Counties	a). █ b). 107	a).155 b). 390	a). █% b). 27.4%	Combo 10: 32%	a). 2.9% b). .8%	a).8.7% b). 28.2%
Disparity #2 – Adolescent immunization status a). Frontier Counties b). Rural Counties	a). █ b). 105	a).208 b). 356	a). █% b). 29%	Combo 2: 29%	a). 2.4% b). .6%	a). 14.4% b). 30.1%
Disparity #4 – WCV a). Frontier Counties b). Rural Counties	a). 0-15: 82 15-30:51 3-21: 921 b). 0-15: 214 15-30:202 3-21: 2203	a). 0-15: 176 15-30:164 3-21: 3858 b). 0-15: 348 15-30: 372 3-21: 6296	a). 0-15: 46.6% 15-30: 31.1% 3-21: 23.9% b). 0-15: 61.5% 15-30: 54.3% 3-21: 35%	0-15: 57% 15-30: 57% 3-21: 35%	a) 0-15: 2.3% 15-30: 2.9% 3-21:1.4% b) 0-15:1% 15-30: .6% 3-21: .3%	a) 0-15: 48.9% 15-30: 34% 3-21: 25.3% b) 0-15: 62.5% 15-30: 54.9% 3-21:35.3%

Disparity #5 – Dental and Oral Health for Children a). Rural Counties a). Frontier Counties	a). 2507 b). 1471	a). 7049 b). 4198	a).35.6% b). 35%	48%	a). 1.8% b).1.9%	a). 37.4% b). 37.5%

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
	1) Identify Disparity #1 - • Have you identified a disparity in this focus area? Have you identified a population to target for this disparity? **N/A. Disparities are listed above.** • Metric: **N/A** <u>Overall strategy:</u> N/A <u>Target Population:</u> N/A <u>Regional Goals:</u> N/A <u>Targeted Interventions:</u> N/A <u>Action Items:</u> N/A •
	2) Identify Disparity #2 - **N/A** • Have you identified a disparity in this focus area? Have you identified a population to target for this disparity? **N/A.** • Metric: **N/A**

	Overall strategy: N/A Target Population: N/A Regional Goals: N/A Targeted Interventions: N/A Action Items: N/A

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[1]:
	    • **Tribal/American Indian Alaska Native**
	        i. Traditional healing practices (e.g., smudging/purification, healing circles, talking circles, songs and drumming)

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

- **Non-English Speakers:** Culturally responsive care to non-English speakers (includes, but not limited to:)
    i. The use of interpreters, using plain language, and communicating care that is linguistically and culturally appropriate
- **African American/Black:**
    i. Acknowledging historical trauma that has negatively impacted the Black community
- **Refugees and Immigrants**
    i. Trauma-informed approaches and practices
    ii. The use of interpreters
- *Entities should have a plan that includes holding **listening sessions** with members to identify culturally responsive practices that bring meaning to each population and report out to the Department annually.*

<u>Overall strategy:</u>

Northeast Health Partners (NHP) is committed to delivering equitable access and culturally competent care for our members. This commitment is evident through its network of culturally and linguistically appropriate providers, its history of developing a diverse workforce of staff by recruiting and retaining staff and community health workers, utilizing local and community organizations that offer interpreter or language services, conducting ongoing analysis of member needs through direct member outreach, and upholding national standards derived by organizations such as the Health Resources and Services Administration (HRSA) and Culturally and Linguistically Appropriate Standards (CLAS).

The region’s two largest physical health safety net providers, Sunrise Community Health (Sunrise) and Salud Family Health Centers (Salud), provide integrated behavioral health care on site and employ a diverse workforce representing the communities they serve. A focus of these providers historically and currently continues to focus on delivering member-centric healthcare including mobile health vans serving Migrant workers throughout our agricultural communities. Members can often receive services spoken in their primary language with an added understanding of cultural-specific attitudes and values to address their healthcare needs. Additionally, the Immigrant and Refugee Center of Northern Colorado (IRCNoCo) is embedded within Sunrise. IRCNoCo provides educational services for adult members, specializing in English as a Second Language (ESL), and offers community navigation services, such as written

	language translation services, to its members. Through IRCNoCo, members can have Health First Colorado (Colorado's Medicaid Program) materials, such as mail, translated into their native language which leads to self-sufficiency in taking steps to maintain their coverage and engage in health care. NHP operates as a trauma informed agency. Through this, we also offer opportunities and listening sessions that are connected to our trauma informed providers. Specific to our diverse populations, NHP connects to other agencies as sub-populations are identified and trauma informed education and trainings are curated based on identified needs. Member insights are critically important to surface lived experiences. NHP will engage in various listening sessions including incorporating member involvement in the Health Equity Task Force and conducting local focus group sessions to increase engagement identify opportunities to for community outreach and connections. Information surfaces from members will directly inform approaches for outreach, education, and improved service delivery. Further, NHP provides semi-annual roundtables on cultural diversity. These meetings provide opportunities to discuss key findings and data insights, specific trainings, and providing insights from member feedback sessions.

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

NHP identified several barriers within some of the indicators. Many of these barriers can and will be addressed at the local level, but others will need state assistance to overcome. These barriers are outlined below:

Dental Access:

Much of the northeast region, particularly among the Eastern Plains, is a dental desert. These are sparsely-populated areas where dental practices do not exist without significant travel for the member. Additionally, the Eastern Plains is predominantly an agricultural industry where the demands of work (such as bringing in a harvest or calving season) supersede appointment availability or the need to travel. As a result, the Emergency Department becomes a more convenient point of care along with primary care physicians.

As a Regional Accountable Entity, we do not contract with dental providers and have very limited capacity to impact the dental network. Further, when the KPI on dental visits transitioned to the National Committee for Quality Assurance (NCQA) measure, primary care primary care physicians were removed as a viable and valuable dental provider for rural and frontier regions. As a result, HCPF should place more stringent responsibilities on DentaQuest

to ensure accuracy with network adequacy reporting and reopen the availability of primary care physicians to perform dental evaluations.

COVID-19 and Vaccine Hesitancy:

Much of the northeast region of Colorado is comprised of agricultural workers with specific political leanings and beliefs. Government-mandated vaccines for COVID-19 ran contrary to these beliefs which resulting in eroded trust with government entities and the messaging around COVID-19 vaccines. The vaccine hesitancy that existed in the region with COVID-19 was then projected to hesitancy on general vaccines. Furthermore, many people who are vaccinated are contracting COVID-19, which has impacted public confidence in the vaccine's efficacy.

NHP will continue messaging and outreach to members about the benefits of vaccinations, will work with providers to expand well visits (which will positively impact vaccination rates overall), and will work with CDPHE to expand vaccination availability with mobile units. However, HCPF should recognize the unique personal beliefs of its members and how those beliefs may impact healthcare choices.

Underreported Vaccine Rates:

Several organizations in the region have undergone organizational changes, whether through mergers and acquisitions or by simply changing an Electronic Medical Record (EMR). These changes can take a significant amount of time to fully migrate, and real-time rates may not be accurate due to connection lags. Additionally, pharmacies often promote privacy with COVID vaccines and may not report when a vaccine is received. Both of these elements may play a role in underreported vaccine rates within the region as evidenced by the CIIS data not showing names or Medicaid IDs.

Limited Broadband and Internet Access:

The frontier counties of Northeast Colorado have limited Internet and broadband capacity with inconsistent connectivity which creates challenges with some of the interventions proposed in this plan. As broadband services and internet capabilities are outside the scope of responsibilities of the RAEs, HCPF should work with communications companies and legislators to expand broadband capacity and access in rural and underserved areas.