COLORADO
Department of Health Care Policy & Financing

Regional Health Equity Plan FY23-24
Instructions and Narrative

RAE/MCO Name	Colorado Access (COA)
RAE/MCO Region #	RAE REGION 3
Reporting Period	SFY23-24 07/31/2023 – 06/30/2024
Date Submitted	01/02/2024
Contact	Lisa Hug

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/MCOs address health equity and decrease 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 focus areas and measures for version one of this deliverable do not include CHP+ and MCO plans. Entire claims data will be provided every month. Member-level data specific to actions 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 specific groups are only all-inclusive of all groups experiencing differences during the current period once more data/information is available. Through data analysis, if RAEs/MCOs identify that significant inequality does not exist, there is flexibility to identify additional areas of differences 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 other relevant information to identify and address health disparities.

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

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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

Colorado Access Regional Health Equity Plan - Strategies to Address Health and Health Care Disparities

Colorado Access (COA) is deeply committed to the principle that everyone deserves to achieve their full health potential, regardless of their background or circumstances. Driven by this belief, COA is unwaveringly committed to partnering with communities and empowering people through access to quality, equitable, and affordable care. Diversity, Equity, and Inclusion sit at the center of the COA Health Equity strategy, ensuring that its diverse members experience a respectful, inclusive and individualized healthcare journey. This commitment extends beyond visible differences, encompassing the invisible, cognitive, and experiential aspects that shape each person's unique needs and perspectives.

The Department of Health Care Policy and Financing's (the Department's) FY 2022-23 Health Equity Plan, in alignment with the Centers for Medicare and Medicaid Services (CMS), underscores that health disparities have long-standing historical roots in structural discrimination and systemic inequities. Health care disparities lead to delays in diagnosis and treatment, impacting more significant morbidity and potential mortality in the lives of people. Complex downstream, midstream, and upstream factors prevent communities that are under-resourced from receiving the care they need, inspiring the commitment of COA to a multi-dimensional and multi-sectorial approach to advance health equity, particularly in the focus areas of COVID-19 vaccinations, maternity care, behavioral health, and prevention, in the 2023-2024 Health Equity Plan.

Driven by data and the lived experiences of its members, community, and provider network, COA prioritizes social justice in its strategy to not only address disparities, but also empower individuals and communities to break down barriers into health care access, achieve optimal health outcomes, and create a landscape where everyone has the opportunity to thrive. The COA Office of Diversity, Equity, and Inclusion (DE&I) implemented a seven-pillar functionally integrated coaching/consulting model to help realize this vision, applying DE&I principles across policies and operational areas facing members, community, providers, health care systems, workplace, regulatory, and procurement partners, and engaged DE&I champions across horizontal and vertical lines. In the 2023 to 2024 plan year, the DE&I strategy implemented by the COA DE&I team and champions, will continue to create an evidence-based learning culture and continuous improvement toward equitable policies and programming. The COA Health Equity Plan for 2023 to 2024 will first describe the comprehensive strategy and goals for all focus areas, using the CMS Health Equity Framework, then will discuss design and goals specific to addressing health and health care disparities among metrics for COVID-19, Maternal Care, Behavioral Health, and Prevention for RAE Region 3's around 300,000 members attributed to care in Adams, Arapahoe, Douglas, and Elbert counties.

1. Expansion of the collection, reporting, and analysis of standardized data on COVID-19, Maternity, Behavioral Health, and Prevention

COA is committed to a data-driven decision-making strategy. It employs advanced teams of evaluation and business intelligence analysts, as well as partners with the Department and collaborators, to expand on the collection and analyses of health equity data. COA dashboards display health metrics, including COVID-19, maternity, behavioral health, and prevention metrics, and are disaggregated by standard race/ethnicity (RE) and other demographic data. Clinical registries exist for physical and behavioral health, disaggregated by RE, to proactively identify and manage member subpopulations, and measure impact over time. The COA behavioral health registry, as alluded to in the Condition Management report, encompasses physical and behavioral health indicators and will be used in the future to develop interventions that address concurrent challenges.

According to the U.S. Department of Health and Human Services (USDHHS), clinical care impacts only 20 percent of county-level variation in health outcomes, while social determinants of health (SDOH) affect as much as 50 percent (2022). Relative to downstream clinical data, more challenges exist with collecting member-level upstream SDOH and demographic data due to the sensitive nature of the information, which has traditionally been used to perpetuate stigma and discriminate against individuals in under-resourced communities, creating mistrust in sharing personal information with institutions. On the provider end, expanding the collection of data illuminating provider diversity gives rise to privacy concerns. COA has a dedicated SDOH Committee, Data Evaluation Subcommittee, committed to prioritizing member and provider privacy and ensuring they are comfortable with how the data will be used to advance health equity priorities in the journey of COA to expand on upstream health equity data collection and analysis.

Beyond identifying disparities in COVID-19, maternity, behavioral health, and prevention, COA is exploring ways to collect more comprehensive demographic and social risk data to advance population-level stratification that will result in more tailored programming. This includes capturing demographics from multiple sources not included in the Department's Cost Control and Quality Improvement (CCQI) and 834 files. Current files reveal the following for COA's Region 3's around 300,000 members, as of December 2023:

- Assigned sex at birth: 53.32% Female, 46.68% Male
- Age group: 18-64 (55.34%), 0-12 (29.20%), 13-17 (11.55%), 65+ (3.91%)
- RE self-identification: Multiple RE (36.09%), White/Caucasian (31.66%), Black/African American (10.66%), Unknown (10.64%), Hispanic/Latinx (5.32%)**, Asian (4.55%), American Indian Alaska Native (0.55%), Hawaiian/Other Pacific Islander (0.54%)
    - **Proportions of members identifying with specific RE, such as Hispanic/Latinx, might appear low, due to members that have 2+ RE flags in the data will show up as having "multiple RE"
- Language preference: English is the most preferred (20.80%), followed by Spanish (16.34%), Russian (0.60%), Arabic (0.41%), Vietnamese (0.33%), Amharic (0.28%) and other languages
- Top 5 counties by membership address: Arapahoe (35.79%), Adams (35.37%), Denver (9.92%), Douglas (9.38%), Jefferson (3.94%). Around 99% of members live in urban areas; 1% live in rural and frontier areas

In addition, further SDOH information will be collected through care management social risk screens and by encouraging and incentivizing providers to improve the number of SDOH

diagnostic codes for which they bill. These diagnostic outcomes are mapped in COA's DE&I Dashboard. COA analysts also supplement health equity evaluation with publicly available SDOH data from the American Community Survey (jobs, educational attainment, veterans, housing, and demographics at the census tract), Food Access Research Atlas (overview of food access indicators at census tract), and CDC Social Vulnerability Index, which uses 15 U.S. census variables to help identify communities that may need support in the event of disasters. Analyses reveal that members with chronic conditions and SDOH needs tend to incur more significant costs. The combination of health and social data has helped identify if members with different races, ethnicities, ages, sexes, and disability statuses experience relatively more SDOH, live in high SDOH areas, and inform dedicated support in addressing health-related social needs.

Collection and analysis of provider diversity data additionally support the journey of COA toward a more culturally responsive network by giving opportunities for members to be cared for by providers with similar lived experiences, backgrounds, and values. COA collects provider race, ethnicity, and language data into the Apogee database in several ways, including Council of Affordable Healthcare's (CAQH's) credentialing data, through the internal provider credentialing progress, and through a data agreement from the Colorado Department of Public Health and Environment (CDPHE). The advancing efforts of COA to collect provider demographics led to integrating the information into heat maps, which combines member demographics and health equity needs. The heat maps will inform workforce capacity and alignment and will be used by the COA provider recruitment department to inform strategies to diversify its provider network.

The strategy of COA with CMS Priority 1 is to continue existing efforts and additionally prioritize the following goals for 2023 to 2024, to be completed by June 2024:

- **Goal 1: Expand the collection, reporting, and analysis of standardized data to understand health disparities for member populations better.**
    - Tactic 1: Evaluate standardized data by demographics (i.e., race, ethnicity, age, geographic location, languages spoken), especially for members living with specific conditions and who are at increased risk.
    - Tactic 2: Continuously improve DE&I dashboard tracking performance on the seven pillars (members, community, providers, health care systems, regulatory, procurement, and workplace) and health equity metrics.
- **Goal 2: Direct a data-driven strategy to recruit and maintain a provider network of culturally responsive providers based on the needs of Colorado Access members in their communities.**
    - Tactic 1: Utilize heat maps to look at the geographic overlay of members to providers.
    - Tactic 2: Utilize claims data to understand the provider network better and determine provider gaps (determine active vs. inactive PAR providers).
    - Tactic 3: Continue to support new initiative to enhance reimbursement to providers for providing services in another language.
- **Goal 3: Utilize DE&I data collected in the credentialing process to enhance and increase the accessibility of the provider directory.**
    - Tactic 1: Ensure that all credentialed providers are listed in the internal directory with information on cultural competency, RE, gender, Americans with Disabilities Act (ADA), and languages spoken.
    - Tactic 2: Ensure that the provider directory shows overall providers accepting patients at the practitioner level rather than at the practice level.

2. Assess causes of disparities with programs and address inequities in policies and operations to close gaps in COVID-19, Maternity, Behavioral Health, and Prevention

Diversity, Equity, and Inclusion are not simply what COA does, but who it is. Starting in 2021, after the peak of the COVID-19 pandemic, COA hired the first VP of Diversity, Equity, and Inclusion (DE&I) to perform a company-broad analysis, subsequently deploying the DE&I seven-pillar functionally aligned strategy to implement DE&I principles across operations affecting ***members***, ***community***, ***providers***, ***health care system***, ***workplace***, ***regulatory***, ***and procurement*** to achieve equitable care – this includes programming in COVID-19, maternity, behavioral health and prevention. Since implementation, notable shifts in company culture and collaboration across traditionally disparate parts of operations are supporting health equity transformations to close gaps in care for under-resourced member populations. The strategy:

- Employed **DE&I internal consultants** with experience and expertise in their respective pillars to serve as (1) extended departmental teammates and (2) advisors to executives. DE&I consultants, who are full-time members of the COA staff, have advised on maternity efforts, the COA behavioral health strategic plan, behavioral telehealth services, COVID-19 programming, and population health management regarding vaccinations, well-child visits, diabetes, and more. The same consultants serve as thought partners in health equity in provider forums like the Governing Council and community health equity boards/committees.
- Deployed an employee engagement strategy – more than 80 **DE&I champions** across vertical and horizontal organizational lines contributed to DE&I initiatives and explored operational intersections with their teams. COA DE&I champions include the director of AccessCare, director of provider services, chief operating officer, chief communications and member experience officer, population health experts, community cultural navigators, information technology experts, vice president of health plan operations, and many more.
- Implemented **DE&I as a sixth company value**, with curiosity, learning, and courage as core competencies, and incorporated the value into performance management systems for annual employee reviews.
- Executed a long-term **voluntary learning and education strategy** utilizing internal resources, including a Speaker Series and Connecting Circles, as well as *required* completion across the enterprise, including executive leadership on DE&I core curriculum – supporting learning and growth in topics that include but are not limited to cultural humility, intersectionality, biases, and microaggressions.
- Collaborated with executive leadership to identify strategic guidance and operational tracking metrics across the seven pillars and created a **DE&I dashboard to measure progress,** including building the diversity of employee, provider, and procurement networks to reflect the diversity of members.

The COA strategy with CMS Priority 2 is to take inventory of existing programming, apply evaluative methods to assess program effectiveness, and benchmark current operations to national standards. In addition to continuing the current strategy, COA will prioritize the following goals for 2023 to 2024, to be completed by June 2024:

- **Goal 4: Evaluate population health data to understand gaps in programming and continually identify opportunities to address health inequities.**
    - Tactic 1: Enhance collaborative evaluation framework to integrate process and quantitative data, including digital engagement data, claims, performance metrics, and KPIs within various systems at each level of program development.
    - Tactic 2: (also in Maternal Health and Prevention sections) Implement program improvements based on learnings from recent diabetes and maternal health program evaluations.
- **Goal 5: Assess the current state of operations according to national/industry standards and collaborate on areas of gaps for continuous improvement.**
    - Tactic 1: Regularly conduct Culturally Linguistic Appropriate Services (CLAS) assessments and collaborate on areas of continuous improvement.
    - Tactic 2: Regularly conduct health equity assessments and collaborate on areas of continuous improvement.
    - Tactic 3: Regularly assess compliance with ADA and collaborate on areas of continuous improvement.

3. Build capacity of COA workforce and provider network to reduce health and health care disparities in COVID-19, maternity, behavioral health and prevention

COA believes in achieving health equity through the support of its network in comprehensive ways, including camaraderie, thought-partnership, culturally responsive care training, enhanced reimbursements, value-based programming, data-sharing, and sponsorships in efforts to provide culturally responsive care and address health and health care disparities in COVID-19, maternity, behavioral health, and prevention. A large part of building capacity is to create a provider talent pipeline in behavioral health, physical health, and health care leadership. COA commits to investing in building the health care talent pipeline in the short and long term. Enterprise and network-wide collaboration have led to strategic, systemic, and sustainable capacity building across several fronts, impacting the delivery of whole-person care. In this overview, COA will go beyond what is already mentioned in the Network Adequacy Report to highlight existing efforts to build capacity within COA with its provider network and community partners to build an inclusive, diverse culture well-resourced to address health and health care disparities.

Capacity building within COA to address health and health care disparities

COA is committed to continually building capacity to meet its growing member population's increasing needs in COVID-19, maternity care, behavioral health and prevention, and chronic disease management. Innovation to advance health equity necessitates diverse thought-partnership. Thus, COA is on a journey to have the organization led by leaders and teams that reflect the diversity of the people it serves. COA includes diverse community voices in multiple levels of governance, from member-facing committees to the executive board of directors. **Over the past three years, the COA executive leadership team transformed representation from 0% to 60% Black, Indigenous, and People of Color (BIPOC)**, with diverse capabilities, skills, lived experience, and perspectives. The people services team is committed to recruiting, hiring, promoting, and managing to build a diverse, equitable, and

inclusive culture, leading to being named by the Denver Post as a Top Workplace in 2023. Positions created and filled within the past couple of years in response to growing health and health care disparities include, beyond experts within the office of DE&I, (1) Community cultural navigators – whose primary role are to develop and maintain ongoing grassroots community collaboration within diverse communities and support health equity priorities (2) Provider recruitment program manager – whose primary role is to manage the provider network adequacy including access to services capacity, diversity of contracted providers, and inclusiveness of cultures and identities to promote health equity (3) Evaluation and health information analyst dedicated to analyzing health equity data (4) Member experience team, including a new chief communications and member experience officer and director, whose roles includes understanding diverse perspectives of members to inform equitable programming and partnerships.

The COA internal diverse workforce talent pipeline strategy supports its colleagues within BIPOC communities with opportunities to join the next generation of BIPOC health care leaders. Beyond traditional educational and conference support available at many organizations, the COA office of DE&I sponsors colleagues within BIPOC diasporas annual memberships to the National Association of Health Services Executive (NAHSE), the National Association of Latino Healthcare Executives (NALHE), and the American College of Healthcare Executives (ACHE). Resources and gatherings related to the membership help the BIPOC colleagues of COA expand their networks and connect to industry best practices, and ultimately gain confidence to grow professionally within the industry.

Beyond the strategies mentioned earlier to embed DE&I into operations, COA creates ways to support the growth of its DE&I core values amongst leaders and staff by building the core competencies of **curiosity, learning, and courage**. Leaders and staff are encouraged to develop an interest in the lived-experiences of their colleagues through forums like Connecting Circles – the next evolution of employee resource groups that brings people together from diverse backgrounds, and Speaker Series, where renowned industry leaders educate on the lived experiences and effects on health inequities of different communities. Speakers, such as Carlotta Wells LaNier, the youngest member of Little Rock Nine, have inspired and educated COA colleagues with rich history and lived experience. DE&I champions with perspectives and expertise across horizontal and vertical organization lines created the COA:

- **DE&I core curriculum** – internally created DE&I training that includes a growing list of topics, including cultural humility, intersectionality, biases, and microaggressions. COA executive leadership has made this training mandatory for all employees, and participation is tracked through the enterprise learning management system.
- **DE&I toolkit** - a leadership resource to recruit and retain talent and develop a diverse workforce through various strategies, including coaching a diverse team.
- **DE&I language dictionary** - a guide on creating a workplace culture where all people are included and treated with respect by using non-stigmatizing, bias-free language. The guide uses the industry's top resources on inclusive language to employ among COA colleagues, community and provider network, and, ultimately, members, and help COA advance on the journey towards becoming an anti-racist organization.
- **Healing Series** - External consultants provided a five-part series of interactive sessions for COA employees to address generational trauma and white guilt, based on the *5R's of Restorative Practices, a proven framework grounded in trauma informed care and anchored in cultural humility.*

Continuous curiosity and learning across the enterprise often lead to the courage to explore new ways to address health care needs. The COA health equity team, with cross-functional representation across the enterprise, created shared goals and exercised courage by continuously evaluating and improving programming. Brave leaders also wanted to strategically tackle the SDOH challenges, forming an expert SDOH committee and respective subcommittees. New policies were created, such as the paid employee volunteer policy, allowing employees to build camaraderie with community members during events like LGBTQ+ PrideFest – gaining a more profound understanding of the experiences of COA members. Key personnel for health equity regularly engage and provide thought partnership with the COA Health Equity Task Force, the SDOH Committee, the Statewide Health Equity Task Force as co-chair, the DE&I Community of Practice consisting of health system and community partners, Metro Denver Partnership for Health (MDPH) Social Health Information Exchange and Health Equity Efforts – to identify opportunities for collaboration, create and align goals, and regularly track progress.

Capacity-building within the COA Provider Network to address health and health care disparities

The COA provider network is committed to serving Health First Colorado and CHP+ members, and COA adopts a comprehensive approach to building its capacity to address health and health care disparities, particularly in COVID-19, behavioral health, maternity, and prevention. The diverse perspectives of the COA provider network are gathered through long-established forums like the COA Provider Forum, Governing Council and the Program Improvement Advisory Committee (PIAC), and newer forums like the DE&I Community of Practice, where the DE&I leaders from the COA network receive support and share best practices to address DE&I challenges towards building an inclusive culture in their organizations. COA took a step further by gathering provider voices through innovations like the Sobre Mesa, where COA joins in camaraderie with providers from the Hispanic/Latinx community to understand their challenges and resource needs. We have taken action on provider recommendations, including creating a pilot to increase reimbursement by 10% to providers that deliver care in a language other than English using a coding modifier.

Specific focus sections of the COA health equity plan will detail its Alternative Payment Models – a summary is in this overview. COA value-based programs support physical health providers, incentivizing quality care, including management of complex conditions to prevent further disease exacerbation and acute/emergent needs. In addition to the language modifier previously mentioned, the Encounter Rate program increases reimbursements for 23 Fee-for-Service (FFS) behavioral health codes, higher than the standard FFS reimbursement rates to cover costs for primary care-based behavioral health providers. The four largest Community Mental Health Centers (CMHCs) in the COA network, along with Jefferson Center for Mental Health, are in a value-based program, and the CMHC Structural Quality Assessment determines incentive dollars. Since the fall of last year, the Enhanced Care Provider Investment Payment was created to build capacity among Primary Care Medical Providers (PCMPs) seeking to reduce health disparities, improve clinical outcomes, enhance member experience, and reduce inappropriate utilization of avoidable services.

Building provider capacity to deliver culturally responsive care involves DE&I training, embedding DE&I values into their practices, and diversifying the workforce to include providers with shared backgrounds and lived experiences as the communities they serve. Regarding culturally responsive training, COA physical health providers must undergo training

as part of their value-based contracts, and COA behavioral health providers are encouraged and incentivized to utilize culturally responsive training through the COA Learning Management System. COA is also building a health care talent pipeline. COA and the Colorado Access Foundation expanded partnerships with the Health Institute and Social Work Departments at the Metropolitan State College of Denver to invest $1.2 million in undergrad and graduate-level students in physical and behavioral health fields to obtain their degrees, licensure, mentorships, and internships to be successful. Additionally, expansion projects funded start-up and training costs of established BIPOC behavioral health providers, with FY 2023 support totaling $1.3 million, and FY 2024 planning for around $700,000. The funds support BIPOC behavioral health providers to be better resourced to address health and health care disparities in behavioral health.

The comprehensive support of downstream and upstream care areas is essential to achieving health equity for COVID-19, maternity, behavioral health, and prevention. Thus, COA strives to bring health care services to where members work, learn, pray, play, and recreate. COA supports providers through co-integrating tele-behavioral health in primary care practices across the network, including School Based Health Centers (SHBCs) like Kids First Health Care. Through Community Giving Projects, COA partners to address upstream social needs around provider practices with a high deprivation index. An example has been using data to examine food bank deserts to support food partnerships and mobile clinics. The data and analyses are shared with provider partners within impacted census tracts to support their health equity initiatives. COA will continue to provide this type of relevant data to its provider network.

The COA strategy with CMS Priority 3 specifically for capacity building within the provider network is to take inventory of existing provider partnerships and identify areas of opportunity for additional connections to address health and health care disparities for diverse member populations. In addition to continuing this current strategy, COA will prioritize the following goals for 2023 to 2024, to be completed by June 2024:

- **Goal 6: Ensure providers have the training and the resources to provide culturally competent care.**
    - Tactic 1: Provide culturally responsive training for member-facing staff (including care management and customer service) and providers to serve members with diverse backgrounds better.
    - Tactic 2: Reduce disparities by consistently evaluating encounter rates by race and ethnicity. Look at access and quality of care by RE to understand areas of cost savings and gaps in care.
- **Goal 7: Evaluate the telehealth landscape to adapt better and meet the changing needs of providers and members.**
    - Tactic 1: Using findings from provider needs assessment, identify opportunities for change/growth within the VCCI model.
    - Tactic 2: Increase DE&I representation of providers and accessibility of language services of the VCCI program.
    - Tactic 3: Work with Colorado Health Institute to conduct an environmental scan of e-health options in Colorado.
- **Goal 9: Expand provider partnerships to include increased accountability for improving health outcomes for members with complex physical, behavioral, and social health needs.**
    - Continue implementation of a three-phased VBP model with five CMHC organizations that focus on improved health outcomes for members with severe mental illness.

  - Strategically invest funds in provider programming that will support Colorado Access members at increased risk for adverse health outcomes including, but not limited to, refugee, unhoused, medically fragile, people living with disabilities and non-English speaking populations.
- **Goal 10: Enhance and align the COA provider communication strategy across the organization.**
  - Tactic 1: Assess non-English language services through provider focus groups to bolster available linguistic interventions.
  - Tactic 2: Engage with provider workgroups to collect feedback and develop an effective provider communication strategy.

Capacity-building with community partners to address health and health care disparities

Building capacity to address more whole-person needs is crucial to addressing health and health care disparities in COVID-19, maternity, behavioral health, and prevention. COA and the COA Foundation develop intentional community partnerships to address health-related social needs and SDOH. Assessment of member and community needs through quantitative and qualitative data, surveying, and engaging with diverse communities revealed immediate upstream needs for sustainable housing, transportation, and food solutions. COA community engagement operations and the COA Foundation built capacity through the following ways to address these health-related social needs and broader SDOH needs:

- **Community cultural navigators** engage with diverse communities, hear their voices, and address their needs. Existing cultural navigation includes the Black/African American and Hispanic/Latinx communities that partnered to bring vaccination clinics, including COVID-19, into community spaces, including churches, community based organizations (CBOs), and schools.
- **Community engagement department** – through strategic partnership efforts and network development, the COA community engagement team is committed to strengthening community support and collaboration with community-based organizations, public health agencies, and cultural brokers to address social health-related needs for diverse member populations.
- **Office of DE&I** – COA DE&I partnerships focus on collaborations and investments in education access, provider diversity, health equity, and advising in DE&I/health equity forums, especially for communities that are traditionally underrepresented and under-resourced.
- **The COA Foundation** funds upstream, systems-level efforts that address the root causes of health-related challenges. This is done through grants, contracts, and other funding mechanisms.
- **Community investment programs** provide opportunities for special projects in the community to receive financial support and thought partnership from COA. The COA Community Giving Program provides investments and community-wide collaboration to strategically and sustainably address SDOH needs for members and their communities.
- **The COA SDOH Committee** developed an organization wide SDOH strategy and standardized processes/tools for tracking, evaluating, and systematically aligning SDOH work. Community partners will be invited to join the committee to increase community voice in identifying needs and setting priorities.

Building capacity to address community health and health-related social needs is a complex process that requires commitment and partnership to provide a streamlined approach when

addressing the whole person's needs. Beyond building partnerships and investing in community efforts, COA has been a proud sponsor and thought partner in the Metro Denver Partnership for Health's Social Health Information Exchange (SHIE) planning processes, including collaboration on a SHIE Implementation Plan, Sustainability Plan, and Accountability Plan. This work has evolved and recently been rebranded as the Connected Communities of Care initiative, which aims to build the capacity of critical CBO networks and ensure closed loop referrals, ensuring the successful implementation of forthcoming SHIE technology solutions. The COA health equity lead has served on the Care Coordination Workgroup at the Office of eHealth Innovation (OeHI) to discuss strategies to strengthen care coordination by building a more robust network that enables people to receive the equitable services they need. The COA chief medical officer will join the SHIE Data Governance Advisory Board created by the OeHI to collaborate directly with the state's SHIE vendor.

The COA strategy with CMS Priority 3, specifically for capacity-building within the community, is to take inventory of existing community partnerships and identify areas of opportunity for additional connections to address health and health care disparities for diverse member populations. In addition to continuing this current strategy, COA will prioritize the following goals for 2023 to 2024, to be completed by June 2024:

- **Goal 11: Utilize an organization-wide strategic data-driven approach to understand SDOH priorities better and inform funding priorities, community partnerships, and health programming.**
    - Tactic 1: Continue to explore innovative sources of SDOH data, as well as analyze overall currently available SDOH data to understand trends and priorities within member sub-populations to drive equity.
    - Tactic 2: Prioritize community funding partnerships that are focused on addressing priority SDOH.
    - Tactic 3: Review processes for screening SDOH and identify opportunities to continuously improve via streamlining processes, capturing new information, and developing standards to enhance interoperability.
    - Tactic 4: Explore how Hospital Transformation Program (HTP) data can be used to address SDOH at the admission, discharge, and transfer points.
    - Tactic 5: Continue to support and provide thought-partnership on statewide Social Health Information Exchange Efforts.
- **Goal 12: Leverage community partnerships to extend the reach of member-facing programming and identify further opportunities for collaboration toward enhancing member engagement and reducing disparities.**
    - Tactic 1: Establish two new community partnerships and develop collaborative strategies for engaging members in health programming (Related examples: Mobile units, community centers, recovery groups, informal locations).
    - Tactic 2: Establish relationships with additional community partners to reach member populations that are medically underserved through telehealth.
    - Tactic 3: Build a framework for deeper community engagement and care management (CM) collaboration and develop additional community-based interventions to enhance CM's presence in the community.

4. Advance language access, health literacy, and the provision of culturally tailored services to address health and health care

disparities in COVID-19, maternity, behavioral health, and prevention

COA strives to ensure members have access to high-quality, culturally and linguistically appropriate health care services, regardless of their background, circumstance, and language proficiency. Under the leadership of a new chief communications and member experience officer and the new director of member experience, COA will create many more opportunities to capture quantitative and qualitative data from members about their experiences with COA, with their health care providers, with the health care system, and provide COA with more significant opportunities to address their whole health journey equitably and inclusively.

Cultural responsiveness is essential in addressing health and health care disparities because it helps to ensure that all patients understand and have equitable access to high-quality care. This can lead to improved connections and trust with members, ensure that members understand their care options, and help the COA network develop treatment plans tailored to members' individual needs and values.

Regarding language access, particularly for members who speak languages other than English, COA strives to adhere to appropriate CLAS standards. All members with a preferred language other than English may request professional interpretation support (at no additional cost to members) during encounters with COA customer service and care management, as well as their providers, when requested 24 to 72 hours in advance. Services may be available sooner for special cases. In addition, any printed materials are available in both English and Spanish translations and may be requested to be translated into other languages. Details regarding language accessibility may be viewed through the Language Accessibility Deliverable previously submitted.

The provision of culturally tailored services is core to standard practices. Many COA care managers and customer service representatives speak languages other than English and assist in the respective languages. Many care managers, as part of their licensure training as RN, LCSW, DC, or LPC, complete cultural responsiveness training. As mentioned in the building capacity section, COA requires DE&I training for all staff and is providing DE&I consultation and resources to support culturally responsive care delivery. Additionally, COA member-facing teams organically created an Inclusive Language Initiative, and a Culture and Inclusion Workgroup, to elevate delivery of culturally responsive care to members.

In planning for the intermediate and long-term advancement of culturally tailored services, cross-collaboration across sectors in the health care ecosystem is critical. Collaborations with technology partners are being utilized to support the delivery of culturally responsive care – for example, in digital engagement programs. These programs identify members needing preventive services, including wellness visits, dental visits, immunizations, and pre/postpartum care, and send reminders in English and Spanish depending on the member's preference. Collaborations with members are also essential - COA programs are continuously improved by gathering member voices via the long-established Member Advisory Committee (MAC), PIAC, and Member Engagement Advisory Committee (MEAC). It is standard practice at COA to gain members' perspectives on new programming before implementation.

Communities traditionally under-resourced disproportionally experience health and health care disparities, including BIPOC, refugee/immigrant, and LGBTQ+, communities, among many others. Thus, COA carefully considers expanding capacity within the community to provide connections that value and understand cultural uniqueness. COA recognizes that in addition to stigma and lack of access to culturally responsive care, BIPOC members also face

historical trauma due to a history of enslavement, segregation, discrimination, SDOH, and mass incarceration that leads to a myriad of behavioral and physical health disparities. COA recognizes the trauma and challenges faced by its respected members and honors the diversity of cultures, values, identities, and hopes of the people COA serves by continuously exploring ways to serve their whole personal needs in a culturally responsive manner. COA creates partnerships with trusted cultural brokers to deliver whole person needs, summarized in Table 14 near the end of the Health Equity Plan.

The COA strategy with CMS Priority 4 is to continue existing processes and additionally prioritize the following goals for 2023 to 2024, to be completed by June 2024:

- **Goal 13: Advance accessibility of communication modalities and messaging to increase member engagement and health literacy and identify opportunities for culturally tailored approaches to communications.**
    - Tactic 1: Continue to create equitable, and inclusive ways to gather information from members. Align and streamline member surveys across COA. Expand the current model of the biannual COA member survey, including data collection and employment of post-survey process improvement activities with enhanced cross-departmental organization alignment.
    - Tactic 2: The community engagement team will pilot processes for sharing member feedback collected by community cultural navigator(s) and will utilize this feedback in program improvement strategies.
    - Tactic 3: Improve workflow and connectedness between customer service and care management to streamline member communication and access to health-related information.
    - Tactic 4: Implement inclusive language practices within the member-facing workflow and develop training for member-facing teams, including customer service and care management.
    - Tactic 5: Evaluate the current state of Guiding Care functionalities to identify opportunities for continuous improvement, including standardization of data, streamlining efforts among member-facing operations, and member experience improvements.
    - Tactic 6: Regularly conduct full CLAS standards assessment and collaborate on areas of gap for continuous improvement.

5. Increase all forms of accessibility to health care services and coverage

COVID-19 vaccinations, maternity, behavioral health, and preventive services are essential health needs that Coloradans deserve access to, regardless of their ability status. In compliance with the ADA, COA ensures that members, including members living with disabilities, have equal access to its benefits, programs, and services. COA continuously strives to ensure that facilities are physically accessible, alternative communication methods and interpreter services are available, and requests for assistive devices and reasonable modifications are addressed. To understand its members' experience regarding access to care, COA surveys members each quarter – this helps to understand the specific challenges that members face in accessing health care and to develop programs and services to address those challenges. COA also recruits diverse voices and lived experiences into committees like the MAC to ensure that the perspectives of all members are considered when making decisions about health care access.

COA member-facing teams provide extra care to ensure that members with disabilities and their families have their needs met. This may include providing transportation to and from appointments, helping members to communicate with their providers, and providing support with self-management of chronic conditions. COA partners with the Colorado Cross Disability Coalition (CCDC) and Family Voices as cultural brokers and navigators for members living with disabilities to reduce barriers to care and services, improve health care systems navigation, promote shared decision-making, develop policy strategies, and cultivate critical relationships.

As mentioned in other deliverables, including the Population Health Management Report, COA partners with physical and behavioral providers to create varied modality options to access care coordination and services, including phone telehealth through AccessCare services and in-person. This gives members more flexibility in choosing how they want to receive care, regardless of their physical abilities. EConsults are available in crucial provider networks: the University of Colorado Medicine, University of Colorado Hospitals, Children's Hospital Colorado, and Kaiser Permanente Colorado (KPCO). This allows members to get specialty care guidance, including behavioral health, without traveling to a specialty clinic.

During the Public Health Emergency (PHE) unwind, a dedicated care coordination team contacted members living with disabilities to remind them to renew services and offer support essential to continued coverage for members needing COVID-19 vaccination, maternity care, behavioral health services, and preventive services. In partnership with Denver and Arapahoe counties and the Department, the COA Access Medical Enrollment Services (AMES) team engages in the Long-Term Care Project in partnership with state agencies, and is staffed to ensure that members who qualify for long-term care benefits continue to maintain coverage.

The COA strategy with CMS Priority 5 is to continue existing processes and explore ways to increase accessibility to health care services and coverage for members living with disabilities, and have greater connections with communities needing coverage like the Region's Eligible But Not Enrolled (EBNE) member population, particularly within communities that are under-resourced to sign on to Health First Colorado and CHP+. COA will prioritize the following goals for 2023 to 2024, to be completed by June 2024:

- **Goal 14: Increase all forms of accessibility to health care services and coverage, including for members living with disabilities.**
    - Tactic 1: Partner with community organizations that serve members living with disabilities to create a strategic plan that will help reduce barriers to care and services, improve health care systems navigation, promote shared decision-making, develop policy strategies, and cultivate a critical relationship.
    - Tactic 2: Regularly assess current state of operations in compliance with ADA standards and identify critical areas for continuous improvement.
    - Tactic 3: Seek feedback from partners and members living with disabilities on their experience with COA/health care and identify areas for continuous improvement.
- **Goal 15: Increase knowledge and awareness with eligible but - not enrolled members in Health First Colorado, CHP+, and dual eligibility plans at annual DE&I flagship events within the community.**
    - Tactic 1: Engage members from diverse communities at DE&I flagship events throughout the year – such as LGBTQ+ community (Denver Pride), Asian/Americans (Dragon Boat Festival), Black/African American (Colorado Black Arts Festival),

Native American Alaska Native (March Denver POW WOW), Hispanic/Latino Community.
- Tactic 2: Collaborate with AMES to be present at the events to answer questions about eligibility enrollment and support prospective new members with applications as needed.
- Tactic 3: Develop evaluation methods/data with the COA/AMES team regarding membership growth for the eligible - but not enrolled member population during DE&I flagship community events.

In connection with programming, partnerships, and internal policies, COA can make a state and nationwide impact by working well upstream by advocating for policies to advance health equity. COA acknowledges the deeply entrenched health care disparities that people of color and other populations living in communities that are under-resourced experience, often as a result of systemic racism and other structural inequities. COA supports policies that advance a more equitable health care environment for all Coloradoans, including approaches to improve black maternal and infant health, offering fair treatment in health care settings, supporting a culturally responsive health care workforce, and collaborating with partner providers to support the recently proposed rules to enhance community health integration services, SDOH risk assessment, and principal illness navigation services. Through organizational, community, and policy level priorities, COA is committed to creating strategic, systemic, and sustainable impact to advance health equity.

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-19 vaccination rates among older adults and children**
	  • Population 1 - Older Adults (defined by the Department)
	  • Population 2 - Children (defined by the Department)
	  • Metric: Improve COVID-19 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%
	  • Strategy: Please see Table 1 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for COVID-19 booster vaccination rates.

Table 1: Baseline (FY 2022-2023) and target data for RAE Region 3 populations experiencing health and health care disparities with COVID Immunization Rate. [P*er the Department, COVID, Diabetes, and Depression data will be available in 2024, and RAE HEPs will be updated with an addendum*]	

Target Population	Numerator	Denominator	Target Population Performance (TPP)	Regional Performance (All Members)	10% Gap Closure[1]	Target
To be Determined (TBD)						
TBD						
TBD						

[1] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest COVID booster vaccination rate

Overall Strategy to Improve Performance Targets for COVID-19:

The root causes of disparity in COVID-19 vaccination rates among older adults and children, through speaking and engaging in the community, are barriers that the traditional health care system often overlooks for members living in communities that are under-served and under-resourced. Some of these barriers include transportation to vaccination sites, getting time off of work, language barriers, and lack of culturally competent vaccination services that contribute to misinformation, mistrust, and vaccination rate disparities. At the start of the pandemic, COA identified through COVID-19 data that members within BIPOC communities experience the most significant disparities and thus created innovative strategies to impact COVID-19 rates, as detailed in previous COVID-19 Deliverables. [CURRENT DATA SHOWS] In addition to the comprehensive health equity strategy in alignment with the CMS Health Equity Framework detailed in the overview section to address disparities in COVID-19 vaccination rates for all members, COA is committed to its health equity strategy to close disparity gaps for members.

(1) Focus on prevention and early intervention

COA is committed to protecting its members from COVID-19 by promoting vaccinations and making them accessible. The population health team's COVID-19 digital engagement initiative educates members about the importance of vaccinations, links them to vaccination clinics, and sends regular reminders about boosters – services are delivered in English and Spanish, and COA is exploring ways to add more languages with the vendor. Marketing materials emphasizing the importance of vaccination are regularly disseminated in member newsletters in English and Spanish. Additionally, the care management team is available to answer questions, address concerns, and assist with scheduling vaccination appointments. These efforts demonstrate the dedication of COA to protecting members from COVID-19 through proactive education and support.

(2) Provide access to culturally responsive care

COA is proud to provide culturally responsive care when addressing disparities with COVID-19. COA community cultural navigators, specifically for the Hispanic/Latinx and Black/African American communities, built trusting relationships with cultural brokers in their respective

communities to deliver COVID-19 vaccination education, outreach, and services. Cultural brokers understand the cultural nuances, deeply care about their communities, and connect with their communities in a profound way that builds trust in the health care system. Within the Hispanic/Latinx community, COA partners with Adelante and Julissa Soto to work with local public health agencies and community spaces like schools and churches to bring mobile vaccination clinics during hours most convenient for the community, like evenings and weekends. Within the Black/African American community, COA has partnered with the Ktone Cares Foundation, Center for African American Health, and African Youth Advocates to bring education and outreach about COVID-19 vaccinations.

(3) Ensure that data and member/community/provider perspective guide decision-making

Regarding quantitative data, COA strives to understand the member COVID-19 story through numbers. COA evaluation and health informatics analysts utilized Colorado Immunization Information System (CIIS) data, enhanced demographic data, and integrated member-level data with publicly available upstream SDOH information to identify which member groups are less likely to be vaccinated, and identified that BIPOC members, particularly members within the Hispanic/Latino and Black/African American communities, live in areas with more SDOH present – this informs expansion of partnerships in such areas to set up COVID-19 clinics. The COA business intelligence team utilized available Department data on member demographics and CIIS and claims data to create dashboards to monitor vaccination rates and identify disparities in COVID-19 to inform programming.

Qualitative information from community engagement activities, particularly from COA community cultural navigators, reveal specific goals and challenges that members face, and thus, COA strongly considers valuable perspectives from the communities it serves to design programming and partnerships.

(4) Build capacity with the health care and community networks to address the disparities

COA has been expanding partnerships with CBOs using the community ambassador model to organize and provide COVID-19, adult, and childhood vaccines, focusing on the Hispanic/Latinx and Black/African American communities. Specifically for children, COA partners with schools and youth-serving CBOs to improve childhood vaccine rates and increase education and outreach to parents using culturally responsive messaging. Key partners include local public health agencies, CDPHE, and Aurora Public Schools (APS).

Colorado Access has a growing relationship with key partners in the Asian American community, including the Asian American Chamber of Commerce and the “Asian Avenue” magazine, as mechanisms for information-sharing, such as COVID-19 information.

(5) Integrate a culture of continuous improvement and innovation towards addressing whole person, upstream care needs

COA is eliminating access to care challenges of traditional structures by bringing vaccinations to where its diverse members live, play, pray, learn, and work – even during nights and weekends when families can attend the vaccine clinics. This also eliminates social barriers to vaccines, including transportation and the inability to leave work due to not having sick leave or paid time off. While engaging in its communities to deliver COVID-19 vaccination outreach

and services, COA recognizes that this touchpoint is a rare opportunity to make an additional impact on preventive and upstream areas of need, like promoting wellness visits and other vaccinations and supporting food security. Through partnering with cultural brokers, COA has expanded education and outreach to preventive care and connection to social resources for its diverse communities during the COVID-19 vaccination clinics, addressing whole-person needs.

The COA strategy to close disparities in COVID-19 vaccinations is to continue the existing plan detailed in the overview section to more broadly build a more inclusive and equitable health care system, and additionally build out best practices and lessons learned to increase efforts into communities experiencing disparities.

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 the timeliness of access to prenatal /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 identifying with the following RE: Native Hawaiian, Black/African American
	  • Metric: Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH)
	  • Overall Strategy: Please see Table 2 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for timeliness to prenatal care.

Table 2: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities with Access to Prenatal Care.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[2]	Target
Members identifying with Native Hawaiian/Other Pacific Islander RE*#	[redacted]	57	[redacted]%	64.03%	2.19%	47.80%
Members identifying with Black/African American RE	430	695	61.87%	64.03%	0.56%	62.43%

[2] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of timeliness to prenatal care (Members identifying with American Indian/Alaska Native RE, 67.50%)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[2] is statistically significant (p-value <0.05)

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 identifying with the following RE: other People of Color, White/Caucasian
	  • Metric: Core Measure NQF 1517: Post-partum Care (PPC-AD)
	  • Overall Strategy: Please see Table 3 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for timeliness to postnatal care.

Table 3: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities with Access to Postpartum Care.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[3]	Target
Members identifying with Other People of Color RE*#	137	321	42.68%	51.15%	1.97%	44.65%
Members identifying with White/Caucasian RE#	57	122	46.72%	51.15%	1.57%	48.29%

[3] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of timeliness to postpartum care (Members identifying with Asian RE, 62.41%)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[3] is statistically significant (p-value <0.05)

Overall Strategy to Improve Performance Targets for Access to Prenatal and Postpartum Care:

The root causes of disparities in access to prenatal and postpartum care for BIPOC communities are complex and multifaceted. Still, they can be traced back to structural racism and discrimination, particularly for mothers within Black/African American communities who are statistically more likely to experience complications during pregnancy, die from pregnancy-related complications, give birth prematurely or have low-birth-weight babies, experience postpartum depression and anxiety, and less likely to have access to high-quality prenatal and postpartum care (Njoku et al., 2023). Region 3 data shows that members identifying with the Native Hawaiian/Pacific Islander and Black/African American communities are experiencing a disparity getting timeliness to prenatal care (Table 2). When

it comes to timeliness to postpartum care, members identifying with the following races/ethnicities are experiencing disparities: other People of Color, and White/Caucasian (Table 3). The differences in timeliness of prenatal and postpartum care are statistically significant when compared with highest performing groups, i.e., American Indian/Alaskan Native, and Asian, respectively. COA is committed to improving pregnant mothers' outcomes and transforming these statistics. In addition to the comprehensive health equity strategy in alignment with the CMS Health Equity Framework detailed in the overview section to address disparities in Maternal Prenatal and Postpartum visit rates for all members, COA is dedicated to its health equity strategy to close the gap for members within members living in the diverse communities mentioned in tables 2 and 3.

(1) Focus on prevention and early intervention

Early intervention to achieve the best outcomes for pregnant members is a priority, and COA provides different modalities to reach out to all pregnant mothers at different stages. The COA population health team manages a digital engagement program called “Healthy Mom, Healthy Baby” that outreaches to all pregnant mothers with the education and critical steps to be up to date with guideline-based care during the prenatal and postpartum phases. The outreach messages are conducted in both English and Spanish. The COA care management team supports pregnant mothers with complex health and social needs with warm referrals to community resources and health services. As a health plan, COA also provides comprehensive reproductive health care, particularly in the postpartum phase, including access to contraception and contraception services so mothers may plan their pregnancies according to their family’s timeline.

(2) Provide access to culturally responsive care

COA is committed to adhering to the CLAS standards when delivering care services, as mentioned in the overview section. COA is working with a nonprofit organization, Mama Bird Doula Services (MBDS) – which offers doula support as well as perinatal care and education to families in Denver and Aurora – on efforts aimed to ultimately reduce health disparities among Black birthers. When the partnership began in December 2021, the two groups sought to identify and support 40 Black birthers covered by Health First Colorado. Supporting this initial group remains a priority, and the partners are seeking to expand their support to encompass both the doula workforce and members served by doulas.

(3) Ensure that data and member/community/provider perspective guide decision-making

The COA in-house health programs evaluation team conducted analyses of maternal health data, disaggregated by RE, and identified significant disparities among Black/African American pregnant mothers. This led to system-wide conversations on strategies, leading to the creation of the Black Birthing Design Challenge back in 2021, capturing the voices of more than 30 organizations and [redacted] community members, with 80% identifying as Black/African American with lived experience, to provide culturally tailored services to Black/African American pregnant women. The collaboration culminated in community-led strategies, including the Mental Health Community Investment Project and Doula Workforce Pilot that COA is implementing in this reporting period.

Tables 2 and 3 reveal that COA has continuously improvement opportunity with expanding programming and partnerships to meet the perinatal needs of members in additional communities, especially Native Hawaiian/Pacific Islander and White/Caucasian.

(4) Build capacity with health care and community networks to address the disparities

The COA Black Birthing Mental Health Community Investment initiative funded nine projects, totaling $350,000, to improve Black Birthing mental health support. COA-led initiatives funded an additional four projects, totaling $200,000, to advance health equity for Black Birthing mental health. The goal with the investments, thus far totaling $550,000, is to reduce stigma within the Black community regarding mental health services and increase accessibility to these services in a culturally responsive way. COA plans to evaluate programming and investments, and implement improvements to address disparity gaps for members identified in Tables 2 and 3.

(5) Integrate a culture of continuous improvement and innovation towards addressing whole-person, upstream care needs

COA invests in strategies and partnerships to address health-related social needs and SDOH, especially for pregnant persons. Recently, COA secured a contract with Dr. Sheila Davis, a community leader with lived experience as a Black/African American physician, to partner with COA to identify continuous improvement opportunities to address disparities in maternal health.

The COA policy team, within 2022 to 2023, has supported several bills that expand coverage and culturally responsive care for pregnant people. Within the reporting period, COA plans to support members and providers in leveraging the benefits of these new policies.

- HB22-1289, "Cover All Coloradans," extends Medicaid coverage to all eligible children and pregnant persons in Colorado, regardless of immigration status.
- HB22 -1289 provides grant funding for programs to create culturally responsive training for health care providers, ensuring culturally responsive care at all health care system levels serving all patients, including pregnant mothers.

The COA strategy to close disparities in Maternal Prenatal and Postpartum Care is to continue the existing plan detailed in the overview section to more broadly build a more inclusive and equitable health care system where pregnant persons, particularly within under-resourced BIPOC communities, feel heard and that their whole person needs are met; and additionally prioritize the following new goal for 2023 to 2024, to be completed by June 2024:

Goal 4 (revisited from Overview Section): Evaluate population health data to understand gaps in programming and continually identify opportunities to improve health inequities.

- Tactic: Implement program improvements based on learnings from recent maternal health program evaluations.

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, and measure follow-up after ED visits 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 – Members identifying with the Hispanic/Latinx RE, and members with unknown RE
	  • Metric: Core Measure NQF 3489: Follow-up after Emergency Department Visit for Mental Illness
	  • Strategy: Please see Table 4 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for following up after ED visits for mental illness.

Table 4: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities with Follow-up after ED Visit for Mental Illness.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[4]	Target
Members with unknown RE*#	7-day: 32 30-day: 41	80	7-day: 40.00% 30-day: 51.25%	7-day: 48.11% 30-day: 61.90%	7-day: 1.09% 30-day: 1.51%	7-day: 41.09% 30-day: 52.76%
Members identifying with Hispanic/Latinx RE*#	7-day: 174 30-day: 223	389	7-day: 44.73% 30-day: 57.33%	7-day: 48.11% 30-day: 61.90%	7-day: 0.62% 30-day: 0.90%	7-day: 45.35% 30-day: 58.23%

[4] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of 7-day and 30-day follow-up (Members identifying with the White/Caucasian RE, 50.90% and 66.34%, respectively)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[4] is statistically significant (p-value <0.05)

Behavioral Health	• Identify Disparity #2 - Appointment follow-up post-ED for substance use disorder (SUD)
	  • Have you identified a disparity in this focus area? Yes
	  • Have you identified a population to target for this disparity? Yes – Members ages 65+, 13-17, and members identifying with American Indian/Alaskan Native RE
	  • Metric: Core Measure NQF 3488: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

	• Strategy: Please see Table 5 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for following up after ED visits for SUD.

Table 5: Baseline (FY 2022-2023) and target data for RAE Region 3 members experiencing health and health care disparities with Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[5]	Target
Members ages 65+ *#	7-day: [redacted] 30-day: [redacted]	70	7-day: [redacted] % 30-day: [redacted] %	7-day: 23.01% 30-day: 34.10%	7-day: 1.34% 30-day: 1.17%	7-day: 11.34% 30-day: 24.03%
Members ages 13-17 *#	7-day: 32 30-day: 50	180	7-day: 17.78% 30-day: 27.78%	7-day: 23.01% 30-day: 34.10%	7-day: 0.57% 30-day: 0.68%	7-day: 18.34% 30-day: 28.45%
Members identifying with American Indian/Alaskan Native RE#	7-day: [redacted] 30-day: [redacted]	51	7-day: [redacted] % 30-day: [redacted] %	7-day: 23.01% 30-day: 34.10%	7-day: 1.70% 30-day: 1.08%	7-day: 15.43% 30-day: 28.54%

[5] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of 7-day and 30-day follow-up (members ages 18-64, 23.44% and 34.54%, respectively, and members identifying with the following RE: Asian (7-day: 30.77%), White/Caucasian (30-day: 38.77%))
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[5] is statistically significant (p-value <0.05)

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 – members identifying with Black/African American RE, and members with unknown RE • Metric: Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness • Strategy: Please see Table 6 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for following up after hospital visits for mental illness.

Table 6: Baseline (FY 2022-2023) and target data for RAE Region 3 members experiencing health and health care disparities with Follow-up after Hospitalization for Mental Illness.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[6]	Target
Members with unknown RE*#	7-day: [redacted] 30-day: [redacted]	61	7-day: [redacted] % 30-day: [redacted] %	7-day: 31.74% 30-day: 48.70%	7-day: 1.34% 30-day: 2.49%	7-day: 24.29% 30-day: 33.64%

Members identifying with Black/African American RE[#]	7-day: 47 30-day: 69	161	7-day: 29.19% 30-day: 42.86%	7-day: 31.74% 30-day: 48.70%	7-day: 0.72% 30-day: 1.32%	7-day: 29.91% 30-day: 44.18%

[6] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of 7-day and 30-day follow-up (members identifying with Asian RE, 36.36%, and Hispanic/Latinx RE, 56.08%, respectively)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[6] is statistically significant (p-value <0.05)

Behavioral Health	• Identify Disparity #4 - Depression screenings
	  • Have you identified a disparity in this focus area? TBD
	  • Have you identified a population to target for this disparity? TBD
	  • Metric: Core Measure NQF 0418: Depression Screening and Follow-Up Plan
	  • Strategy: Please see Table 7 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for depression screening and follow-up plan.

Table 7: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities with Depression and Follow-up Plan. [*Per the Department, COVID, Diabetes, and Depression data will be available in 2024, and RAE HEPs will be updated with an addendum*]

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[7]	Target
TBD						
TBD						
TBD						

[7] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of depression screening and follow-up (Data)

Overall Strategy to Improve Performance Targets for Depression Screening and Follow-up, and Follow-up After Visits to the ED for SUD, ED for Mental Illness, and Hospitalization for Mental Illness:

According to the National Committee for Quality Assurance (NCQA), follow-up care for people with mental illness is linked to fewer readmissions and improved health outcomes (2023). COA is steadfastly committed to supporting members living with mental illness through a comprehensive approach grounded on early identification and intervention to prevent emergency department and hospital admissions, with systems in place to address acute needs including discharge follow-up care coordination. Region 3 has several groups experiencing disparities with following up after behavioral health events, and often the disparities are statistically significant. Members identifying

with the Hispanic/Latinx community, and members that have not reported their race/ethnicity, experience disparity with following up after the ED for mental illness (Table 4). Regarding follow-up after ED discharge for SUD, members over 65 years of age, adolescents ages 13-17, and members identifying with the American Indian/Alaskan Native experience disparities (Table 5). Members without known races/ethnicities and members identifying with the Black/African American community experience disparities with following-up after hospitalization for mental illness (Table 6). In addition to the comprehensive health equity strategy in alignment with the CMS Health Equity Framework detailed in the overview section to address disparities in Behavioral Health, including Depression Screening and Follow-up, Follow-up After the ED for Mental Illness, Follow-up After the ED for SUD, and Follow-up After a Hospitalization for Mental Illness, COA is committed to its health equity strategy to close the gap for all members, especially members identified in tables 4,5,6 that are experiencing the greatest disparities.

(1) Focus on prevention and early intervention

Along the lines of prevention and early intervention, we continuously assess ways to make programs more equitable and accessible. COA incentivizes providers to screen and follow up when necessary, as well as provide Virtual Care Collaboration and Integration (VCCI) AccessCare services for timely follow-up. All care management staff have been trained in the Ask Suicide-Screening Questions (ASQ) tool to screen for suicidal thoughts and behaviors; when needed, care managers provide crisis services, resources and referrals for additional support. The COA care management team provides proactive outreach to support members experiencing multi-system involvement, housing insecurity and behavioral health challenges. These challenges include but are not limited to justice-involved/Department of Corrections, foster care, and housing insecurity, among other complex conditions. Proactive outreach enables COA care teams to identify and address potential issues early on, preventing them from escalating into more serious problems requiring ED admissions and hospitalization. The COA Access to Promotions, Screenings, Information, Reward and Events (ASPIRE) digital engagement program informs new members who are 18 and older how to access their behavioral health benefits and manage conditions like depression and anxiety that, when left untreated, can lead to mental illness emergencies. More about the ASPIRE program will be provided in the prevention focus section. Members also have access to the latest behavioral health education through the COA partners' resource page, which has education from both national and local organizations, including the Centers for Disease Control (CDC) and Let's Talk Colorado. The site has a chatbot focused on suicide prevention and helps members find a provider and connect to county human services offices for additional care coordination support.

AccessCare psychiatrists and therapists provide virtual integrated tele-behavioral health care through the VCCI Program. A significant benefit of the integrated model is that primary care providers, after screening for depression and identifying a high score, can refer members to the AccessCare team for follow-up. Behavioral health services like assessments, screening, treatment, and care coordination are conducted in collaboration with the member's primary care team and significantly decrease time-to-behavioral health treatment for members in need, as well as costs related to requiring more acute behavioral health needs. For BIPOC members with Health First Colorado who often do not have access to timely behavioral services, VCCI lifts a barrier and advances equitable care.

For members that have been admitted and discharged from the hospital or ED for mental illness or substance use disorders, support mechanisms are established to support transitions and prevent readmissions.

- The COA Transitions of Care (TOC) program utilizes a modified version of the Coleman Model of care transitions to provide members with services during admissions and after discharge, particularly for members at high risk for readmissions and poor outcomes identified through risk-stratification methodologies. To assure best practices are used to close disparity gaps for youth and adult behavioral health members, care coordinators follow clinical guidelines from the American Society of Addiction Medicine (ASAM) and Substance Abuse and Mental Health Services Administration (SAMHSA) to work with hospital staff to understand the discharge plan, medications, the cadence of the member's follow-up appointments, and connection to social support like transportation, food, and housing. Another program, the Hospital Transformation Program, is intended to improve the integration of behavioral health care into primary care, and we continuously improve ways to leverage program design for complex behavioral health.
- AccessCare VCCI Behavioral Health TOC, a pilot started in the third quarter of 2023, is available to COA members who have been discharged from bed-based behavioral health levels of care. The program is designed for members that may need time-limited medication management until they can be established with their long-term outpatient psychiatrist, not to exceed six sessions of gap care. This program will be accessible especially to members with transportation challenges, such as members ages 65+ and adolescents that can't drive, shown in Table 5

COA care managers support specific facilities to build relationships with providers that lead to high levels of care coordination across systems. For continuity of care, care managers continue to serve the same member across facilities if they do not have multiple admissions. Members receive services that align with their unique needs across the behavioral health and SUD care continuum, including withdrawal management (WM) services, opioid/narcotic replacement therapy, outpatient education and counseling, medication-assisted treatment (MAT), intensive outpatient services, or residential treatment services. COA has care managers serving as virtual liaisons, directly serving the Denver Health PES, Children's Hospital ED, and Jefferson Hills CSU. COA care managers provide rapid and personalized service through intentional relationships, direct consultation and referral services, care management interventions, and electronic health record access. The speed of the virtual liaisons' responses supports the fast-paced environment of these emergency settings and urgent member needs, providing a point person members know and trust. This intervention could also include follow-up contact with members to eliminate barriers to community resources, mitigate any barriers to discharge, and prevent readmissions. COA also has close relationships with many EDs in its Regions, and has provided education about how to refer members to COA care management for support.

(2) Provide access to culturally responsive care

COA is committed to adhering to the CLAS standards when delivering care services, as mentioned in the overview section. When member-facing teams do not speak a language that behavioral health members prefer, they partner with the language services vendor to provide the right interpretation resource. All member marketing and resource materials and digital engagement programming are available in both English and Spanish, with options to request availability in additional languages. COA member-facing teams serving behavioral health members are supported with a suite of DE&I cultural responsive training: the DE&I Learning Collection, Speaker Series, Connecting Circles, the Inclusive Language Initiative led by customer service, and the Culture and Inclusion Workgroup led by care management, and will soon have the DE&I toolkit and DE&I

dictionary. These efforts enhance the cultural awareness, knowledge and humility of teams supporting COA members.

Within its network, COA builds cultural awareness, knowledge, and humility in several ways. Behavioral health providers are supported with culturally responsive care DE&I training through the Learning Management System, and training completion is tracked. COA and the COA Foundation committed investments and provided thought partnership towards building a diverse **health professionals talent pipeline**, with the goal that the provider network will have similar backgrounds and lived experiences as the patients they serve. COA expanded partnerships with the health institute and social work departments at the Metropolitan State College of Denver to invest in undergrad and graduate-level students in physical health, behavioral health, and health care administration fields to 1) increase representation in the pool of health care providers available in Colorado; and 2) improve systems to recruit better and retain a more diverse workforce. Strategies are in place for recruitment, matriculation/graduation, employment, licensing/credentialing, retention, and leadership building.

BIPOC communities have disproportionally experienced health and health care disparities, and our Region 3 data agrees (Tables 4,5,6). Thus, we carefully consider expanding capacity within the community to provide connections that value and understand cultural uniqueness. COA recognizes that in addition to stigma and lack of access to culturally competent care, BIPOC members also face historical trauma due to a history of enslavement, segregation, discrimination, SDOH, and mass incarceration that leads to a myriad of behavioral and physical health disparities. According to the USDHHS, SAMHSA division, it is often easier for people who need mental health services to receive information and be encouraged to seek treatment by persons with similar cultural backgrounds (2014). COA partners to build intentional community relationships to address health-related social needs and SDOH. An example partnership is with Ktone Cares Foundation, which aims to promote mental wellness by providing inspiration, community building, mental health support and resources to young people in the Black/African American community, particularly among youth. COA also supports CHIC Denver and the Center for African American Health, which provides mental health services and resources for the African American Community. Community investments, as mentioned in Table 14, improve access to social resources and benefit all members with behavioral health needs in culturally responsive ways. COA plans to continuously strengthen and expand these relationships to support diverse communities experiencing disparities.

(3) Ensure that data and member/community/provider perspective guide decision-making

COA hires dedicated analysts and business intelligence support to collect and analyze data on health and health-related social needs disparities in behavioral health, and evaluate programming. The behavioral health registry encompasses physical and behavioral health (anxiety, depression, severe and persistent mental illness, and SUD) indicators and will be used in the future to develop interventions that address concurrent challenges. The payment reform dashboard tracks performance in behavioral health care including depression screening and complex condition management. Data from utilization management and placement data revealed consistent challenges for youth and adolescents living with eating disorders, prompting collaboration to close disparity gaps for this population.

The diverse perspectives of the behavioral health provider network are gathered through:

- long-established forums like the Joint Governing Council (GC) and the Process Improvement Advisory Committee (PIAC) and newer forums like the DE&I Community of

Practice (COP), where the DE&I leaders from the COA network gather in camaraderie to share best practices to address DE&I challenges within the respective organizations.
- **Sobre Mesa**, which is attended by more than 40 behavioral health providers from the community who self-identify as serving clients/members with limited English proficiency, starting with Spanish-speaking members. The December 2023 Sobre Mesa had over 70 attendees. The agenda is developed by the community partners, and supplemented by COA updates.

COA internal utilization management and placement data revealed increasing numbers of youth/adolescents needing residential treatment in behavioral health. Lack of access may lead to worsening morbidity and acute care needs like emergency visits. COA aims to strengthen the continuum of care for youth and young adults and is working to increase resources in-state for complex members while also working upstream to prevent the need for high acuity, bed-based levels of care. COA is also working to strengthen the Colorado Safety Net, as many inequities seen in the data are rooted in historic policies and discrimination that have limited people's access to health care and resources. COA continuously works to maximize operational processes, procedures, and relationships to serve behavioral health needs of COA youth and adolescents.

(4) Build capacity with health care and community networks to address the disparities

The COA provider network is supported in several key ways to prioritize prevention and early intervention for behavioral health, so that needs are taken care of at early onset.

- **Tele-behavioral health integration: The COA AccessCare VCCI** Program virtually integrates tele-behavioral health in primary care practices across the network. The benefits of telebehavioral health are many, including increased access to care, especially for members with physical and transportation barriers. Telehealth can also reduce the stigma associated with seeking mental health care by allowing members to receive care directly over telehealth in the comfort of their homes or other safe spaces, including within schools for members connected to school-based health centers that participate in the VCCI Program. The VCCI Program has been shown to reduce time to treatment after initial depression diagnoses/positive screens for members at VCCI vs. Non-VCCI clinics and creates continuity of care and coordination for members through the integrated model (Shore et al., 2023).
- **Value-based contracting with behavioral health providers** focuses on improved patient outcomes across behavioral health metrics:
  - Depression Screening and Follow-up is a key metric in COA primary care value-based programs, incentivizing providers to screen, and refer members that have high scores to behavioral health providers to address needs.
  - As a result of a successful value-based care pilot with AllHealth during SFY 2022-2023, five CMHCs started new value-based contracts in July 2023. Payments are tied to performance on Follow Up After Hospitalization for Mental Illness (within seven days), suicide screening and safety planning. This program also includes infrastructure investments for the licensing and implementation cost related to measurement-based care programming. Future value-based care programming will include the addition of the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure and measurement-based care outcome goals for SFY 2024-2025.
- Enhanced reimbursements to behavioral health providers help advance efforts to prevent and intervene early, in culturally responsive ways.
  - The **Encounter Rate program** is an innovative payment model available to the network and increases reimbursements for 23 FFS behavioral health codes, higher than the standard FFS reimbursement rates to cover costs for primary care-based behavioral

health providers. The program has led to the utilization of non-emergent BH care at the clinic level, reduced total billed claims for providers in the program through a recent study, and decreased the need for emergency health care utilization.
    - The **Language Access pilot is a** language services coding modifier that increases the reimbursement rate for behavioral health providers by 10% to providers who are offering a clinical service in a language other than English. The program rolled out to all providers October 2023, and continues to incentivize providers with the additional skill to enhance language access and culturally responsive care to members.
- COA provides **workforce development funding** for CMHCs who deliver walk-ins, crisis stabilization units, and mobile crisis services. Collaborations are in place with AllHealth Network to create an adolescent crisis unit. In addition, Jefferson Center New Vista, along with Children's Hospital of Colorado, developed a fast-track program to deliver COA members from inpatient psychiatry. A partnership also is in place with the Tennyson Center to develop care models for crisis services.
- Denver Health Medical Center partnered with COA to create three new programs: a 3.7 WM program (live January 2023) for adolescents, an intensive outpatient program (IOP) for adolescent SUD treatment, and the "Access Transformative Outreach Program (ATOP)," which is a high-intensity community treatment model for those with severe SUD. Contracts are in place for each program, and the IOP and ATOP programs began operating this year.
- Grant support:
    - The COA payment reform team facilitated the Request for Proposal (RFP) process for the distribution of American Rescue Plan Act (**ARPA) dollars** to support members with behavioral health conditions coming out of the hospital.
    - **Expansion projects with BIPOC behavioral health providers** funded the start-up and training costs, with FY2023 support totaling $1.3 million, and FY2024 planning for around $700,000.
- **Sharing health and health care disparities** of Health First Colorado members living in census tracts surrounding a health care organization – COA will continue to provide this type of relevant data to providers.

(5) Integrate a culture of continuous improvement and innovation towards addressing whole person, upstream care needs

COA has steadfast commitment to continuous evaluation and improvement to achieve operational excellence in BH Program work, by maximizing operational processes, procedures, and relationships to support both downstream and upstream areas of care. The inequities that create barriers to getting needed care are rooted in historical policies and discrimination that have kept people in poverty, thus it is important to strengthen the Colorado Safety Net, including continued funding for existing programs to support health-related social needs, expanding eligibility and ensuring cross-collaboration within the network. COA is doing this through its network as mentioned in the Network Management Report, and making investments to improve access to social resources that benefit all behavioral health members, improving access to food, housing, and transportation and creating educational opportunities for members with behavioral health needs. COA has also worked to strengthen the continuum of care for youth, adolescents, and young adults. As increasing number of youths/adolescents in residential care are forced out-of-state because Colorado does not have the resources to meet the complex, high-acuity behavioral health needs of the youngest members, COA is increasing resources in-state for complex members while also working upstream to prevent the need for high acuity, bed-based levels of care.

The COA policy team, within 2022-2023, has supported several bills that advance health equity in behavioral health. Within the reporting period, COA plans to support members and providers in leveraging the benefits of these new policies.

- SB23-174, which requires select mental health services to be covered for Health First Colorado members under 21, even without a covered diagnosis.
- SB23-002, which requires the Department for a waiver from CMS to reimburse for services provided by community health workers – which in turn further advance whole person and addresses health related health care needs for behavioral health members.

The COA strategy to close disparities in Behavioral Health Follow-up Care after ED and Hospital Discharge is to continue the existing plan detailed in the overview section to more broadly build a more inclusive and equitable health care system where members feel heard and that their whole person needs are met, and additionally prioritize the following new goal for 2023 to 2024, to be completed by June 2024:

Goal 15: Increase access to appropriate levels of care across the behavioral health care continuum for youth and adolescents.

- Tactic 1: Expand intensive in-home services for youth and adolescents through funding opportunities.
- Tactic 2: Support full implementation of Denver Health adolescent inpatient SUD unit.
- Tactic 3: Develop and build upon a long-term strategy to increase residential treatment and other high-intensity services.

Goal 16: Increase access within VCCI Direct Care and Transitions of Care programs through more robust connections with Care Management.

- Tactic 1: Design an internal referral system to take referrals from COA CM for members who need short-term mental health resources.
- Tactic 2: Work with UM to design a medication management referral system for members who are being released from in-patient hospitalization.

Goal 17: Increase access to Eating Disorder services to help keep members affected by ED in the state

- Tactic 1: Fund ED Cares to develop and expand a new residential program for adults with Eating Disorders.
- Tactic 2: Add capacity for PHP (partial hospitalization program) and IOP (intensive outpatient) programming.

Goal 18: Expand and diversify the Behavioral Health Workforce.

- Tactic 1: Focus recruitment efforts on DE&I, respite providers, SUD-ASAM providers, long-term residential mental health and SUD treatment for adolescents, and eating disorder treatment providers. Partner with the COA community cultural navigator to recruit and build relationships with bilingual providers.
- Tactic 2: Work with MSU Denver to fund the School of Social Work scholarship program, enhancing/diversifying the behavioral health career pipeline. Continue supporting the first cohort of scholars that began in Q4 2023.

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, and measure childhood immunization status, adolescent immunizations, 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 identifying with the following RE: Native Hawaiian/Other Pacific Islander, Black/African American
	  • Metric: Core Measure NQF 0038: Childhood Immunization Status Combo 10
	  • Strategy: Please see Table 8 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for childhood immunization status.

Table 8: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities with Childhood Immunization Status (Combo 10).

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[8]	Target
Members identifying with Native Hawaiian/Other Pacific Islander RE*#	[redacted]	45	[redacted] %	41.60%	3.91%	21.69%
Members identifying with Black/African American RE*#	296	837	35.36%	41.60%	2.15%	37.52%

[8] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of childhood immunizations (members identifying with Asian RE, 56.90%)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[8] is statistically significant (p-value <0.05)

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- members identifying with the following RE: Native Hawaiian/Other Pacific Islander, unknown, and White/Caucasian
	  • Metric: Core Measure NQF 1407: Immunizations for Adolescents Combo 2
	  • Strategy: Please see Table 9 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for immunizations for adolescents.

Table 9: Baseline (FY 2022-2023) and target data for RAE Region 3 members experiencing health and health care disparities with Immunizations for Adolescents (Combo 2).

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[9]	Target
Members identifying with Native Hawaiian/Other Pacific Islander RE*#	[redacted]	37	[redacted] %	36.66%	2.73%	18.95%
Members with unknown RE*#	73	277	26.35%	36.66%	1.72%	28.07%
Members identifying with White/Caucasian RE*#	577	1951	29.57%	36.66%	1.39%	30.97%

[9] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of immunizations (members identifying with Hispanic/Latinx RE, 43.52%)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[9] is statistically significant (p-value <0.05)

Prevention/ Population Health	• Identify Disparity #3 - Decrease diabetes poor A1C control in populations at risk
	  • Have you identified a disparity in this focus area? TBD
	  • Have you identified a population to target for this disparity? TBD
	  • Metric: Core Measure NQF 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)
	  • Strategy: Please see Table 10 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for comprehensive diabetes care.

Table 10: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities with Comprehensive Diabetes Care. [*Per the Department, COVID, Diabetes, and Depression data will be available in 2024, and RAE HEPs will be updated with an addendum*]

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

[10] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of diabetes care (Data TBD)

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?
	  i. W30: Yes – members identifying with the following RE: Native Hawaiian/Other Pacific Islander, Black/African American
	  ii. WCV: Yes – members with the following RE: Native Hawaiian/Other Pacific Islander, American Indian/Alaskan Native, and members ages 18-21
	  • 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)
	  • Strategy: Please see Tables 11 and 12, as well as the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for well-child visits in the first 30 months of life, and child and adolescent well-care visits.

Table 11: Baseline (FY 2022-2023) and target data for RAE Region 3 members experiencing health and health care disparities with Well Child Visits in the first 30 months of life.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[11]	Target
Members identifying with Native Hawaiian/Other Pacific Islander RE*#	0-15 mos.: [redacted] 15-30mos.: [redacted]	0-15 mos.: 57 15-30 mos.: 58	0-15 mos.: [redacted] % 15-30mos.: [redacted] %	0-15 mos.: 58.81% 15-30mos.: 63.88%	0-15 mos.: 4.23% 15-30mos.: 3.00%	0-15 mos.: 32.30% 15-30mos.: 42.66%
Members identifying with Black/African American RE *#	0-15 mos.: 374 15-30mos.: 547	0-15 mos.: 708 15-30mos.: 876	0-15 mos.: 52.82% 15-30mos.: 62.44%	0-15 mos.: 58.81% 15-30mos.: 63.88%	0-15 mos.: 1.76% 15-30mos.: 0.72%	0-15 mos.: 54.58% 15-30mos.: 63.17%

[11] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of well-child visits in the first 15 months and 30 months of life (members identifying with the Asian RE, 70.40% and 69.67%, respectively)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[11] is statistically significant (p-value <0.05)

Table 12: Baseline (FY 2022-2023) and target data for RAE Region 3 members experiencing health and health care disparities with Adolescent and Well Child Visits.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[12]	Target
Members identifying with Native Hawaiian/Other Pacific Islander RE*#	237	816	29.04%	42.93%	1.69%	30.73%
Members identifying with American Indian/Alaskan Native RE *#	213	644	33.07%	42.93%	1.29%	34.36%
Members ages 18-21 *#	5497	27644	19.88%	42.93%	3.18%	23.07%

[12] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of adolescent and well-child visits (members identifying with the Asian RE, 45.93%; members ages 3-12, 51.73%)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[12] is statistically significant (p-value <0.05)

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 – members identifying with Native Hawaiian/Other Pacific Islander RE, members with preferred language of Armenian
	  • Metric: Core Measure NQF 2517: Oral Evaluation, Dental Services (OEV-CH)
	  • Strategy: Please see Table 13 and the succeeding narrative for COA's disparities data and overall strategy to achieve performance targets for dental and oral health.

Table 13: Baseline (FY 2022-2023) and target data for RAE Region 3 member populations experiencing health and health care disparities for Dental and Oral Health.

Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure[13]	Target
Members identifying with Native Hawaiian RE *#	302	974	31.01%	52.49%	2.77%	33.78%
Members with preferred language: Armenian *#	[redacted]	47	[redacted] %	52.49%	4.04%	29.58%

[13] Gap Closure considers metric baseline performance rates for member groups experiencing the greatest disparities (Target Population) and population experiencing the highest rate of oral evaluations (members identifying with Hispanic/Latinx RE, 58.72%, members with preferred language of Korean, 65.98%)
*Disparity between TPP and Regional Performance is statistically significant (p-value <0.05)
Disparity between TPP and highest performing population[13] is statistically significant (p-value <0.05)

Overall Strategy to Improve Performance Target for Prevention: Childhood and Adolescent Immunization, Well Child Visits, Dental/Oral Health, and Adult Diabetes Care:

Health care prevention is complex for members in communities that are under-resourced. Recommended services including Childhood and Adolescent Immunization, Well Child Visits, Dental/Oral Health, and Adult Diabetes Control have different timelines for different members of the family based on age, clinical recommendations, service locations, etc., making it challenging for households to stay up to date with guideline-based care for disease prevention and chronic disease management. RAE Region 3 data reveals that disparities in prevention exist in many communities, including members identifying as White/Caucasian (Table 9) and BIPOC communities, specifically members identifying as Native Hawaiian/Pacific Islander, Black/African American (Tables 8, 9, 10,12,13), and American Indian/Alaskan Native (Table 12). Also notable are the statistically significant disparities in well care visits among members transitioning into adulthood (ages 18-21), and dental evaluation for members with preferred language of Armenian, when compared to the regional performances and highest performing groups. The efforts of COA to close disparities in preventive care are rooted in delivering streamlined population health strategies that provide comprehensive, culturally responsive assistance at each critical touchpoint, providing education, outreach, and available services when available. In addition to the comprehensive health equity strategy in alignment with the CMS Health Equity Framework detailed in the overview section to address disparities in Maternal Prenatal and Postpartum visit rates for all members, COA is committed to its health equity strategy to close the gap for members, especially in communities mentioned in Tables 8-13.

(1) Focus on prevention and early intervention

COA utilizes a comprehensive approach to educating, outreaching, and providing preventive services, including a combination of digital engagement, member newsletters, and partnering with cultural brokers to bring culturally responsive preventive care outreach into communities. News and digital outreach methodologies are described below, and culturally responsive community outreach will be in strategy point #2.

- General health and wellness information is disseminated through social media channels (including Facebook, X (formerly known as Twitter), and LinkedIn) and a quarterly newsletter, “Regions,” which is sent to all RAE households to educate on topics such as cancer screenings, vaccines, dental visits, and more.
- The COA ASPIRE program was mentioned in the Behavioral Health section as a series of SMS-based interventions related to general wellness and prevention, for both behavioral and physical health for the COA population ages 18 and over. ASPIRE supports wellness by sending members messages that support the following modules: screening reminders, health survey, health education, healthy challenges, and reminders. Members are notified of check-ups and screenings recommended by the US Preventative Task Force. Reminders are sent for physical and dental screenings, among others, and are based on member age, gender, and eligibility.

Health education messages support topics such as obesity, blood pressure, cholesterol, heart disease, sexually transmitted diseases, and smoking – which supports overall health. Healthy challenges include a four-week diet challenge and a four-week exercise challenge. Messages are sent in both English and Spanish translations.

- Similar to ASPIRE, the COA version for children and adolescents is Text4Kids. This is a pediatric-focused program that educates and supports parents and guardians of children ages 0-17. Messages include well-visit reminders (15 months, 18 months, 36 months, and 2-18 years old), vaccination reminders like those needed to start school, information on developmental milestones, parenting tips, and health education tailored to each child's age. Separate programming is adopted for pediatric members identified as needing EPSDT. This includes messaging about benefits (including dental), the importance of scheduling dental visits, and reminders about well checks for members overdue for their annual appointments. Messages include both English and Spanish translations.

For members that have been diagnosed with diabetes due to having an A1c>9.0%, prevention plays a critical role in managing diabetes, improving overall well-being, and delaying or preventing complications associated with the disease. Support to members living with diabetes is multifaceted, including education through newsletters, digital engagement and care management support. The COA Diabetes Management Program takes clinical utilization registries and clinical guidance from the ADA to stratify members into the appropriate intervention channels, including both care coordination and population-based outreach campaigns.

- The COA digital engagement team contacts all members with a diabetes diagnosis. The general program includes members receiving two tips (IVR or SMS) per month for two months after their welcome call, regardless of whether they have a Type 1 or Type 2 diabetes diagnosis. These messages remind members to (1) schedule an appointment for an A1C with their primary care provider, (2) contact the care coordination team for additional needs, and (3) visit the COA diabetes management webpage, which provides comprehensive information about diabetes management.
- A more personalized diabetes management program offers bidirectional support and includes six tracks based on the member's unique situation, and offers diabetes education, nutrition, exercise advice, blood and glucose reminders, weight and exercise goal setting and medication adherence tracking. The program is based on recommendations from the American Diabetes Association and is sent to all members with a diabetes diagnosis over the age of 20. The vendor offers bidirectional support.
- Dario: COA selected Dario Health to help improve the health of members living with diabetes and other conditions through a person-centric and integrated chronic condition management platform. Members can enroll in one or multiple Dario programs to meet their health needs. The addition of Dario's digital app-based and online solutions enhances the existing COA diabetes and condition management interventions by providing members with a comprehensive array of condition management education and tools to help them better manage and engage in their health care. All enrolled members receive access to digital programming, coaching, phone app, educational materials, and other in-app tools, in addition depending on the program the member is enrolled in, they may receive a blood pressure cuff, digital scale and a glucometer.
- Regarding care management support, COA care managers use a diabetes-specific assessment in the GuidingCare clinical documentation system that helps them gauge members' needs for support related to behavioral health and/or SDOH concerns. Members may be identified for intervention based on the diabetes clinical registry, A1C lab value data in conjunction with inpatient visits, and the Transitions of Care Team receives daily Admissions, Discharge and Transfer (ADT) data for the hospital locations

they cover and support members who have had an inpatient visit for diabetes and/or diabetes complications.

(2) **Provide access to culturally responsive care**

COA is committed to adhering to the CLAS standards when delivering care services, as mentioned in the overview section, and COA is continuously exploring ways to deliver more culturally responsive preventive care support especially in digital engagement that is currently in two languages – English and Spanish. Due to the disparities we see in the data, such as for members with preferred language in Armenian (Table 13), COA has continuous improvement opportunities to expand digital engagement programming and language offerings. In addition to the cultural competency strategies outlined in the overall approach section, COA ensures that members with diabetes have access to specialized care that aligns with cultural competency standards. For example, the diabetes digital engagement program addresses aspects of culturally competent care through referring members to diabetes self-management education and support (DSMES) classes, as well as reminding members to contact their doctor to find appropriate DSMES classes for their needs. DSMES courses are self-driven and allow members to make culturally relevant goals relating to lifestyle, dietary choices, and overall diabetes management.

COA community cultural navigators establish connections with community cultural brokers to deliver a comprehensive preventive care outreach approach that includes COVID-19, childhood and adolescent vaccinations, and education on well-child visits. The education and services are brought to schools, community health centers, and community events, and are often open after hours on evenings and weekends. Parents, caregivers, and children receive fact sheets, brochures, and videos with clear information about the benefits and risks of the services, often in the language of their preference. Experience reveals that outreach is impactful when it is delivered by individuals that understand the culture, share lived experiences, and speak the same language as community members – and thus partnerships with cultural brokers effectively connect with members in a powerful way. COA partners with Julissa Soto to bring COVID-19 and other CDC-recommended childhood vaccinations to communities within COA Regions. During outreach events in the community, COA cultural brokers promote preventive services like routine vaccinations and well visits, address any concerns, assist with navigating the complex health system to gain access to the services if they are not available at the event, and connect members with resources. The COA community cultural navigators and partner cultural brokers help communicate with members in their language of preference and cultural context.

(3) Ensure that data and member/community/provider perspective guide decision-making

On the quantitative side, COA manages a suite of registries and dashboards to manage the health of its member population, and is continuously improving on how to deliver programming in culturally responsive ways.

- COA digital engagement programs as previously mentioned, requires identification of eligible members using clinical data and demographic data, to ensure messaging to members that truly are eligible and have not completed the service as recommended.
- Diabetes: COA comprehensive diabetes clinical utilization registry identifies members who have had a diabetes diagnosis sometime within the prior three years. The registry includes a comprehensive demographic profile and relevant SDOH indicators, as well as variables specific to diabetes management. Additionally, the registry incorporates a profile of pre-existing conditions that impact diabetes management (e.g., depression, poor oral health, hypertension) and places those at higher risk of adverse outcomes at the top of outreach lists.

Finally, the registry flags when members visit the ED or utilize other high-cost services due to uncontrolled diabetes that could have been managed in lower-cost settings.

- Population health metrics, including immunizations, well-child visits, oral care, and diabetes care are included in the DE&I dashboard, disaggregated by demographics including RE, age, gender, disability status, language preference, and geography. SDOH data from claims is also included in the dashboard to provide an overall view on the needs of its member population. COA is continuously improving ways to utilize available data to identify member risk and offer services.

On the qualitative side, COA continues to solicit member feedback via the MAC and collect best practices from the Department's Learning Collaborative to continually improve messaging, as well as obtain community and provider feedback on population health programming as previously described. Member and provider forums meet regularly to discuss COA programs, and feedback from the MAC is included in program continuous improvement.

(4) Build capacity with health care and community networks to address the disparities

Key strategies for building the capacity within COA health care and community networks are to increase the diversity of the health care workforce, strengthen relationships with community-based organizations (CBOs) and cultural brokers, and grow connections. Strengthening of partnerships with cultural brokers (Table 14), build capacity within the community to achieve performance goals for metrics surrounding immunizations, well-child visits, diabetes and dental.

Value-based-programming is essential to building capacity within the COA provider network to achieve performance goals for immunizations, well visits, oral care, and diabetes care, by incentivizing delivery of high-quality care.

- Pay-for-Performance (P4P) programs help improve the quality of health care and promote health equity by shifting the focus from volume to value, promoting preventive care, supporting evidence-based practices, and encouraging collaboration. The COA P4P program rewards providers financially for achieving specific performance metrics, such as childhood and adolescent well visits, and depression screening.
- The COA Ascension Program was created to reward providers who demonstrate excellence in performance across clinical metrics and offers increased PMPM rates for practices that are interested in expanding care management/coordination services and interventions.
- The Enhanced Clinical Partner (ECP) part of the COA Administrative Payment Model is focused on care management and potential outcomes associated with successful care management, including diabetes medications adherence.

(5) Integrate a culture of continuous improvement and innovation towards addressing whole-person, upstream care needs

Health Related Social Needs (HRSN) and SDOH significantly impact population health outcomes like immunization rates, well visits, dental care, and chronic disease management by affecting access to health care, adherence to guideline-based recommendations, and knowledge and attitudes towards the services. Moreover, factors such as transportation challenges, linguistic barriers, lack of childcare options, financial constraints, lack of access to healthy food and exercise facilities, among others, can make it difficult to complete recommended services. Efforts to promote equitable health outcomes need to address the root causes, which include underlying

social, economic, and environmental factors that contribute to health disparities (Public Health Institute, 2014).

Driven by a commitment to achieve equitable outcomes for Health First Colorado members, COA, led by the chief medical officer, embarked on a journey throughout 2023 to establish a SDOH Committee to secure an organization-wide SDOH strategy, develop standardized processes and tools for tracking, and evaluate and systematically align SDOH initiatives. The COA SDOH Committee fosters interdepartmental collaboration, and is seated by leaders with diverse expertise and lived experience across the enterprise including customer service, care management, community engagement, population health, health strategy, the COA Foundation, DE&I, member experience, provider affairs, quality, with advisory seats including evaluation and health informatics, business intelligence, and more. The committee will ensure that community voices and input are at the center of all SDOH strategic and programming elements. SDOH Committee members additionally commit to three subcommittees, focused on community engagement, evaluation, and programming. The COA SDOH Committee, during its initiation, took inventory of programming and partnerships, completed a Strengths, Weakness, Opportunities, Threats (SWOT) Analysis of existing programming, and plan to summarize areas of continuous improvement.

In connection with achieving performance goals for the Department's prevention focus area in the Health Equity Plan, the COA SDOH Committee aims to prioritize multisectoral collaboration to address the complex and interconnected nature of health inequities in prevention and chronic disease management, work with communities to identify, prioritize, and address SDOH issues, and use a data-informed approach to evaluate the effective of interventions. An example area of work has been COA's collaboration with Project Angel Heart to address nutrition needs, where medically tailored meals are delivered to COA members with diabetes or heart problems, with meals altered based on allergies, preferences, and more. COA will continue to explore bridging of existing focus on downstream clinical care to upstream areas of need. By prioritizing HRSNs and SDOH, COA plans to improve health outcomes and create a more equitable environment, giving members the opportunity to achieve their full health potential.

The COA strategy to close disparities in prevention is to continue the existing plan detailed in the overview section and this specific section on prevention, to more broadly build a more inclusive and equitable health care system where members feel heard and that their whole person needs are meet. COA additionally prioritizes the following new goal for 2023 to 2024, to be completed by June 2024:

- **Goal 1 (revisited, with an additional tactic 3): Expand the collection, reporting, and analysis of standardized data to understand health disparities for member populations better.**
    - Tactic 1: Evaluate standardized data by demographics (i.e., race, ethnicity, age, geographic location, languages spoken), especially for members living with specific conditions and who are at increased risk.
    - Tactic 2: Continuously improve DE&I dashboard tracking performance on the seven pillars (members, community, providers, health care systems, regulatory, procurement, and workplace) and health equity metrics.
    - Tactic 3: Evaluate well care and immunization programming and recommend improvements based on findings.

- **Goal 11 (revisited): Utilize an organization-wide strategic data-driven approach to understand SDOH priorities better and inform funding priorities, community partnerships, and health programming.**
    - Tactic 3: Review processes for screening SDOH and identify opportunities to continuously improve via streamlining processes, capturing new information, and developing standards to enhance interoperability.
    - Tactic 5: Continue to support and provide thought-partnership on statewide Social Health Information Exchange Efforts.

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 that address your identified disparity gaps among members.

*** COA utilized the same health equity strategy defined in the overview and focus area sections to address health and health care disparities in focus areas not currently in the state's Health Equity Plan.

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

***Please refer to the COA Overall Strategy Section, discussion on CMS Health Equity Framework 4 - Providing Language Access, Health Literacy, and Culturally Responsive Care, for the overall approach to cultural responsiveness. Table 14 supplements the narrative with COA programming and partnerships serving select diverse communities.

Table 14: COA partnerships elevating culturally responsive care for RAE Region 3 member populations

Member groups	Partnerships to elevate cultural responsiveness
Tribal/American Indian Alaska Native	• COA collaborated with indigenous employees of COA and tribal elders of the local indigenous community to create an official COA Land and People Acknowledgement to be adopted across the enterprise. COA collaborators include the Denver Indian Health and Family Services and the Denver Indian Center. • Denver March PowWow is an annual COA DE&I flagship event; COA commits to bringing visibility of Health First Colorado/CHP+ programs to attendees. COA is working on getting the AMES team to engage with eligible but not enrolled members to learn about Health First Colorado/CHP+ and potentially enroll. • The Colorado Alliance for Health Equity and Practice (CAHEP) and the Denver Indian Health and Family Services (DIHFS) are key clinical partners for COA members. These two clinics are considered cultural "centers" in the community and have developed positive and trusted relationships with members of the community grounded in culturally aligned and responsive care.
African American/Black	• COA is committed to partnering with cultural brokers within the African American/Black community to address health disparities and empower the community. COA has established partnerships with:

	Ktone Cares Foundation, Rise 5280, Kappa Alpha Psi Scholarship Foundation, The Colorado Black Arts Festival, CHIC Denver, MetroDEEP, The Crowley Foundation, African Youth Advocate, and the Center for African American Health. These partnerships aim to address health disparities by focusing on reducing stigma, promoting education, diversifying the health care workforce, and communicating health care coverages and benefits. • Regarding maternal health, COA collaborates with key partners to advance culturally responsive care for pregnant people within the Black/African American community. More details are in the Maternal Health section.
Hispanic/Latinx	• COA has a dedicated community cultural navigator serving the Hispanic/Latinx Community and partners with organizations including Julissa Soto Consulting, Adelante Community Development, LifeSpan Local, CREA Results, Sun Valley Kitchen, and Re:vision. These organizations focus on providing public health education and services including vaccines, redetermination assistance, food insecurity services and help with access to care. • Colorado Access convenes a group of behavioral health providers quarterly who specialize in working with individuals and families whose primary language is Spanish. This group of more than 40 providers, named themselves the Sobre Mesa Group. The group is bilingual and self-identify as being part of the Hispanic/Latinx community both culturally and linguistically. They consider themselves to be cultural brokers on behalf of their beloved community, serving as a bridge to quality behavioral health services and supports. In addition to the behavioral health providers, there are also representatives from higher education and the COA DE&I team.
Refugees and Immigrants	• COA recognizes the unique challenges faced by members within refugees and immigrant communities, including language barriers, cultural differences, and lack of familiarity with the health care system. COA has implemented several initiatives to address these challenges, including: ○ Providing resettlement agencies with funding to support health navigator roles, maternal health classes, mentorship opportunities, and health education programs. These programs allow expanded services provided by the resettlement agencies to increase health literacy and address needs culturally responsively. • COA is committed to supporting physical and behavioral health providers with specific expertise and cultural validation for people who are refugees or identify as part of the immigrant community. The long-standing partnership with Dr. Parmar and the Mango House is one example of a strong culturally responsive clinical partnership that addresses the whole person needs of this community. In addition, COA promotes its partnership with the Refugee Clinic at Denver Health as well as Step By Step Pediatrics and the Colorado Alliance for Health Equity and Practice (CAHEP).

	• COA has a strong partnership with the Asian American Pacific Development Center to provide behavioral health services to members of the immigrant and refugee community broadly
LGBTQIA+ Community	• COA partners with community organizations serving LGBTQIA+ communities to advance equitable care for members, including Envision: YOU, One Colorado, and the Center on Colfax, all seeking to close gaps in health care for individuals within the LGBTQIA+ community through programming, resources, and advocacy. One specific area of the partnerships includes advancing collection of self-identification data for members, and thus in 2022 COA partnered with Envision: You to gather the "Pros, Consequences and Best Practices re: Adding LGBTAIA+ Questions on the Health First Colorado Application to Include Optional LGBTQIA+ Self-Identification Questions." COA remains steadfast to the goal of increasing collection of member self-identification to better care for members. In 2023, COA volunteers participated throughout Denver Pride, joined the parade, and hosted a table to connect with members. • Relating to provider partnerships, COA conducts DE&I training for COA staff and culturally responsive training for providers, to help create a welcoming and inclusive environment for LGBTQIA+ individuals and their families. • The COA director of community and external relations is working with a cross-departmental team to develop an outreach plan to work with members, providers, and CBOs on gender affirming care benefit changes.

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

Colorado Access commends the Department's partnership in advancing equitable care for Health First Colorado and CHP+ members. COA values the opportunity to collaborate on the health equity plan and engage in the Statewide Health Equity Task Force. COA requests continuous improvement efforts from the Department in the following areas:

- Streamlining processes and requirements for members to access Health First Colorado and CHP+ services.
- Partnering with RAEs to expand, collect, and analyze standardized data, including member demographics and gender self-identification.
- Relating to the recommendation above, enhanced efficiency and sharing of data analyses and disparities dashboard creation efforts. This will expand capacity to identify and address health disparities for all partners.
- Collaborating with RAEs on the Social Health Information Exchange implementation, ensuring smooth transitions.
- Continuing statewide Health Equity Task Force collaborations to address health and health care disparities.

COA appreciates the opportunity to play its role as a regional accountable entity in achieving health equity for its diverse members who deserve to achieve their full health potential and feel respected, heard, and included, regardless of their visible or invisible differences, cognitive or physical abilities, and lived experiences.

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