COLORADO
Department of Health Care Policy & Financing

Regional Health Equity Plan FY23-24
Instructions and Narrative

RAE/MCO Name	Health Colorado, Inc (HCI)
RAE/MCO Region #	4
Reporting Period	[SFY23-24 7/31/2023 – 6/30/2024]
Date Submitted	3/15/2024
Contact	Lori Roberts

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

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

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

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

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

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

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

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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 (ED) Visit for Mental Illness (NQF 3489)	NCQA
Indicator 8	Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence (NQF 3488)	NCQA
Indicator 9	Follow-up after Hospitalization for Mental Illness (NQF 0576)	NCQA
Indicator 10	Screening for Depression and Follow-up Plan (NQF 0418)	CMS
Indicator 11	Prenatal and Postpartum Care (NQF 1517) *Timeliness of Prenatal Care & Postpartum Care*	NCQA
Indicator 12	Dental and Oral Health: Oral Evaluation, Dental Services (NQF 2517)	DQA

For reference, Care Analyzer Data Availability:

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

Strategies to Address Health Disparities in Regional Health Equity Plan

Include strategy, timelines, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

HCI's Organizational Strategy to Address Health Disparities:

Introduction:
At the heart of HCI's organizational strategy lies a deliberate effort to comprehensively address population health outcomes, with a specific focus on ensuring an equitable distribution of outcomes across our population. Our region is geographically comprised of 19 counties, 34% of the total land in Colorado, yet only 6.35% of the total population of Colorado lives there. HCI serves predominantly rural and frontier regions where approximately 45% of the total population are Medicaid members, with 47% identifying as Hispanic or Black, Indigenous and People of Color (BIPOC), and 17% living with known disabilities. In our commitment to evaluating health equity and identifying disparities, HCI is adopting a multifaceted approach, aligning with the priorities of the Colorado Department of Health Care Policy and Financing (HCPF) and the Center for Medicare and Medicaid Services (CMS) in both their health equity plans. Central to this is our population health strategy of creating a continuous improvement infrastructure across all elements of the healthcare delivery system in our region. As recognized in both HCPF and CMS's health equity plans, the identification and transformation of health disparities will take years and require a collaborative effort in which HCI serves an important role. In the following narrative, we will discuss HCI's plan for addressing health disparities within our region over the next year including discussing HCI's overarching strategy and applied strategy in specific focus areas.

Strategic Initiatives and Context:
In outlining our strategic initiatives to address health disparities, HCI believes it is crucial to provide context for the rationale behind our chosen strategies. Recognizing the complexity of achieving improvement, transformation, and equitable care, especially in regions that have limited resources and are independently run, we acknowledge that health equity progress will follow a unique timeline compared to areas with more robust resources and structures.

Disparity and Target Population Dataset Barriers:
The dataset used to review health disparities for this deliverable incorporated claims data and core demographics provided from the member's original Medicaid application which included age, gender, race/ethnicity, language, and disability status. With that we compared performance in predetermined process and outcome measures that required claims data to meet the expected outcome. Our approach was to compare each measure and look at subpopulations through those demographic filters to identify any obvious outliers.

Upon the evaluation of calendar year 2022 health equity datasets, we were able to identify multiple health disparities that helped HCI to evaluate and determine a target population to focus on in four specific focus areas for calendar year 2024. We provide examples of the dashboards we developed to help our team evaluate the differences between demographic sub-populations in the appendix (**Figures 1** and **2**). We discuss in detail the target populations determined and overall strategy related to specific focus areas in later sections of this document.

Throughout our data analysis, we saw distinct differences between counties, race, age, and gender across measure performances. Because rural counties often share health care resources, understanding utilization patterns and upstream contributing factors was challenging to evaluate in the data. HCI had to work with local organizations to inform us of what we could rely on the dataset to tell us and what might be missing. For example, in the San Luis Valley (SLV), discussions surrounding the claims based dataset revealed that there was a significant gap in data regarding member immunization performance because of organizational billing barriers. This has since been rectified with future datasets to include non-claim based data from the CIIS platform. Additionally, HCI held stakeholder regional/local feedback sessions with provider organizations, public health departments, and other health neighborhood related organizations throughout the region where we collectively reviewed the data analysis local to their region. We were able to have fruitful discussions related to ways we can incorporate health equity data into practice level and health neighborhood related quality improvement efforts.

Another finding uncovered through HCI's discovery process was that the dataset had a low volume of members identifying as races, ethnicities, and languages other than White/Caucasion, Hispanic, and English speaking. Because of this, HCI explored the data collection methodology to better understand how ethnicity, race, and language demographic data could be responsibly applied to our health equity action plan. We learned that the demographics are being reported from the information on the member's Medicaid application. HCI discovered that there could be potential underreporting of certain populations in demographic reporting, which could contribute to the lack of diversity in data demographics. A common issue identified regarding accurate data collection was that members were not disclosing accurate demographic information. Some of the reasons uncovered through discussions with enrollment centers were that members feel fearful and/or hesitant to identify accurately on the application because they felt it might threaten the safety or confidentiality of their family or themselves. This local behavior correlated with Colorado's Health Equity Commission (HEC) findings, where their data workgroup resulted in recommending revisions related to demographic questions on the Medicaid application to provide more transparency related to the the importance of identifying accurately. As improvements are made related to the future collection of the raw dataset demographics, we are hoping that future datasets will reflect more complete and accurate identification of populations so that decisions made from these datasets can drive more efficient and effective action and reveal additional health population insights on which can be applied to health equity work.

We provide these insights and share our journey in identifying our region's health disparities and target populations in this deliverable because we believe that data-driven decisions are valuable and want to impart on the intentionality of HCI's efforts to improve health equity within our region. Before decisions can be driven by data, it is essential to confidently understand what the data means by understanding where and how the data is collected, what it includes, and what it might be missing. Making efforts to use data to uncover health disparities and health inequities that are tangible and actionable requires a reliable dataset. We will discuss in our strategies our plan to address the data inaccuracies, develop a methodology for efficient and actionable health equity

data analysis intended to help over the next year to analyze, pilot, and measure performance and intervention efforts related to health disparities and health inequities.

HCI's Regional Health Equity Plan

Three Overarching Strategies to Address Health Disparities

Strategy 1: Improve Data to Identify Health Inequities

With the mentioned issues associated with the completeness, accuracy, and transparency regarding indicators that are used to sub-divide populations in HCPF's health equity dataset, we intend to expand our contextual dataset with a refined population analytics methodology to dive deeper into the root causes of the disparities found in the original dataset. This will help to direct our decisions related to the modification of interventions in our health equity plan for our target populations.

HCI intends to follow the CMS five priority framework to addressing health care disparities and improving health equity. HCI's first strategy aligns with CMS priority one, which delves into optimizing and validating data. Priority one is a crucial step in uncovering root causes for disparities and tailoring interventions.

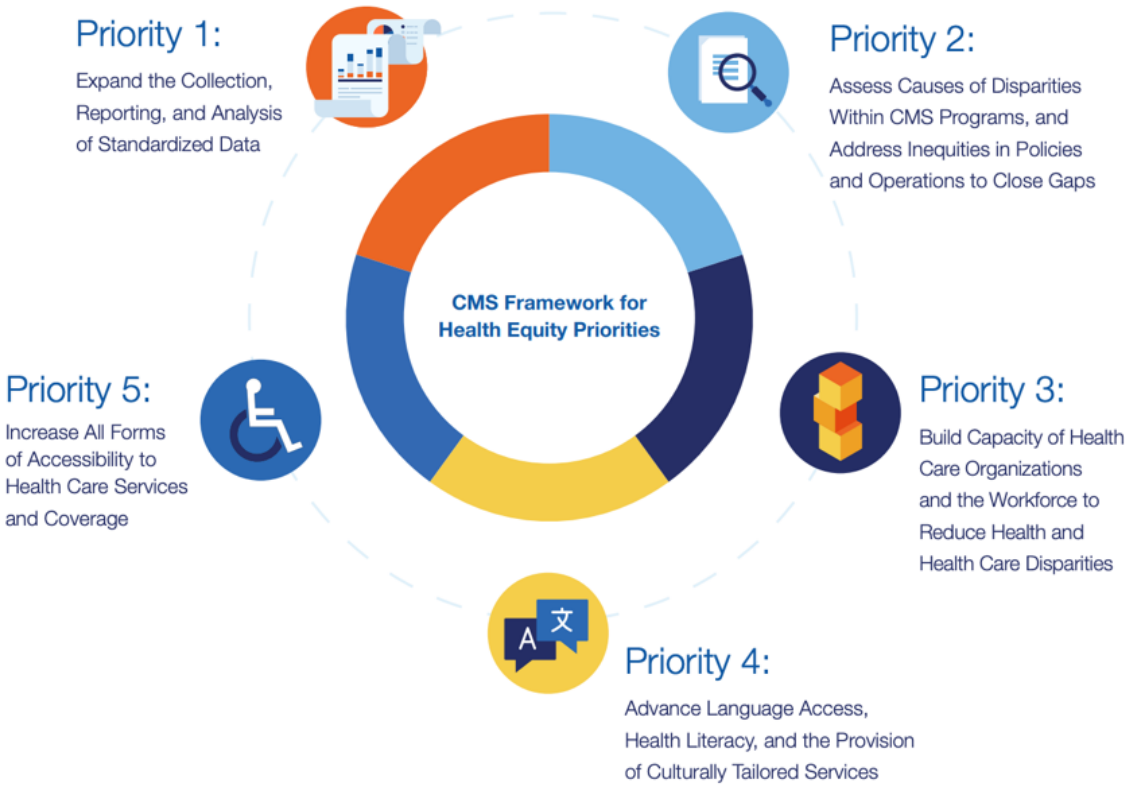

Figure 1: CMS Framework for Health Equity 2022–2032

HCI will be leveraging multiple datasets including larger member claims data, CIIS data, and other programmatic/departmental data to build a framework of health information through which to

analyze our population's performance. This will help to ensure that HCI is evaluating datasets through the inclusive distribution of impact among multiple different subpopulations as well as help to visualize our health equity disparities in a contextual way to incorporate insights into population health interventions.

In tandem, we will be identifying and correlating priority secondary data to help to validate our dataset, using county health rankings, Colorado Department of Public Health and Environment (CDPHE), and census data. HCI is also working within health equity coalitions and practice transformation efforts to understand and evaluate influences surrounding county culture, industry capacity, and upstream social factors to enrich our understanding of social determinants influencing health outcomes. By identifying ways to correlate differentiators in our member population demographics and performance with total population health and social contexts, we hope to identify unique disparities as well as identify more impactful high value intervention methods to close disparity gaps. An example of how we intend to visualize some of the population differences in our counties related to Medicaid membership is provided in the Appendix (**Figure 4**).

Strategy 2: Evaluating For Equitable Intervention Engagement and Performance
HCI will focus on integrating health equity analysis and programmatic improvement into our population health strategies and interventions across multiple departments.

HCI's Strategy 2 incorporates the following CMS priorities:

- Assess causes of disparities within programs and address inequities in policies and operations
- Improve language, literacy, and cultural relevance for members
- Accessibility for all members

HCI's second strategy involves evaluating our organization's business practices, fostering an environment that is more equitable and inclusive internally. Our departments have individually spent time with our health equity consultant over the course of 2023, identifying and reflecting on personal lived experiences, the exposure they have to different parts of the health system, and listening to priority population stakeholders and perspectives, and how it may impact the inclusivity of HCI's managed care programs. Our health equity plan will be incorporated into our population health interventions, which include "big interventions" and "little interventions." Big interventions are identified as member engagement, care coordination, practice transformation, and health neighborhood. Little interventions are identified by specific improvement activities designed to improve care delivered to members. An example of this would be a specific text message sent to members with the intent of getting the member to engage in a dental visit or a wellness visit.

Our region's health network is eager to integrate health equity into their quality and performance improvement efforts with HCI. Practice transformation, hospital transformation, and quality improvement coaching activities will incorporate tailored health equity data visuals and address partner operational practice policies that are potentially exacerbating health disparities related to health care access. Already in FY23-24, our practice transformation coaches broadly assess health equity in their practice assessments and practice transformation will be adding an incentive for FY24-25 with more details to be provided in their network deliverable later this year. HCI will also be working to leverage Hospital Transformation Program (HTP) RAE reporting and

Community and Health Neighborhood Engagement (CHNE) meetings to improve successful engagement and collaboration related to care coordination and the care continuum.

Collaborating with health care partners through these programmatic interventions will help to accurately determine where healthcare access, treatment, and engagement gaps exist for our members across all health care access points, possibly improve claims level data, and help HCI identify and engage target populations and evaluate the impact of population health interventions more effectively.

Strategy 3: Leveraging Community Alliances, Stewardships, and Partnerships
In the pursuit of health equity, HCI's commitment extends to the third strategy, also CMS's priority 3, which is to help to build capacity of clinical and healthcare adjacent organizations through interconnected initiatives of community, partners, and alliances within our region. This strategy encompasses a broad spectrum of actions, each geared towards fostering a holistic environment of inclusivity, equity, and an aligned collective effort to improve health equity for our communities and members.

Our region's county culture, capacity, and upstream factors play a pivotal role in shaping health outcomes; thus, understanding and addressing them are crucial steps toward achieving health equity. To ensure transparency, trust, and common goals regarding the health of our region's population and develop an aligned strategy to support common health equity goals in a collaborative manner, HCI continually and consistently engages in ongoing dialogue with internal and community health equity taskforces. This is to also ensure that our initiatives and interventions are responsive to the evolving needs of the community. For example, our member engagement team developed a subcommittee of members to regularly review language and literacy of the patient education content HCI shares with members. HCI is also collaborating on equitable immunization outreach and promotion with the health neighborhoods that have trust built with our region's members. The intention of collaborating is so that the organizations can align messaging, avoid duplicative efforts, and leverage the strengths of each entity's sphere of influence to close access and engagement gaps. This commitment to community engagement and continuous improvement is embedded in HCI's approach, reflecting a dedication to refining strategies based on real-time insights.

HCI teams will routinely share insights from our journey in addressing health disparities in the region with community partners during learning collaboratives, provider roundtables, and external regional meetings. We will continue to hold external cultural competency roundtables twice a year, inviting partners and stakeholders, to discuss best practices of how to meet patients where they are. Our practice transformation team will continue to hold learning collaboratives where community practices can share their operational protocols and processes best practices through a language, literacy, inclusive, and trauma-informed lens. By uncovering and sharing successes and challenges, we aim to reshape the narrative surrounding health outcomes at the practice level, emphasizing the positive aspects that can drive impactful change, and to use stories to encourage more inclusive care delivery.

HCI also will continue to actively participate in regional health equity task forces, serving as dynamic forums for comprehensive dialogues on equity and disparity issues. HCI looks to continue to foster transparency, advocacy, and support with members. HCI acknowledges the importance of trust that is required to have open dialogue regarding health equity and that trusted community forums that engage our members will initially be the best way to engage with community.

HCI will leverage trainings related to health literacy, health equity, and cultural competency with engagement in current events including Colorado Health Literacy Conference and Telligen's health equity events such as the "Implementing CLAS to Improve Health Equity" series to improve leadership and staff awareness of health equity issues. One example of the continuous improvement effort in member engagement has been to improve the health literacy and language equity of our external facing content by reviewing existing materials in member engagement advisory council (MEAC) subcommittee meetings to gather feedback on how to make it more accessible.

Currently internal health equity taskforce members are participating in the following health equity centered coalitions and committees:

- Colorado Maternal Health Taskforce
- Colorado Digital Equity Committee
- Pueblo Partners in Healthcare Coalition
- Pueblo Vaccine Equity Taskforce
- SLV Equity Coalition
- SLV Vaccine Equity Coalition
- CDPHE HEC
- Rio Grande Health and Wellness Committee
- Regional IOG-CMP Committees

These dialogues delve into the intricate nuances of equity and disparity issues within each region, paving the way for targeted and impactful solutions.

Strategy 3 represents a holistic, data-driven, and dynamic approach to health equity, where collaborative efforts, stakeholder engagement, and continuous improvement converge to shape a more inclusive and equitable healthcare landscape.

In summary, HCI's organizational health equity strategy is a meticulous and collaborative effort, grounded in data-driven insights, aligned population health strategies, and meaningful community partnerships, with a focus on health equity at its core. Incorporating similar strategic initiatives taken by HCPF and CMS will not only help to reinforce state and federal initiatives, but also help the region's stakeholders participate, collaborate, and grow within their own communities at a similar pace through facilitation and leadership by HCI. We hope that the impact that HCI has through this plan will have lasting effects in the communities it serves.

1. Using the table below, please explain the RAEs/MCOs overall approach and strategy to:
   Addressing COVID-19 related disparity gaps among members. (Reference Long-Term COVID-19 Monitoring Plan).

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

Focus Area	COVID-19 Action Plan & Strategy
COVID-19	• Identify Disparity #1 – COVID vaccination rates among older adults and children • Population 1 - Older Adults (defined by HCPF)

EXEMPT FROM 1/2/2024 DELIVERABLE	• Population 2 - Children (defined by HCPF) • Metric: Improve COVID Immunization rate for bivalent immunization (updated booster or primary) status by June 30, 2025, as described below: Pediatric (0-19): From 4.7% (4/2023) to 12.3%, Adult (20+): From 13% (4/2023) to 21.1% • <u>Overall strategy:</u> i. Include baseline and target data ii. Include numerators, denominators, and performance rate for each population identified iii. Provide overall strategy to improve towards the identified target: **exempt from 1/2/24 deliverable**

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

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

Focus Area	Maternity and Perinatal Health Action Plan & Strategy
Maternity and Perinatal Health	• Identify Disparity #1 - Access to Prenatal Care • Have you identified a disparity in this focus area? **Yes** • Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations) i. **Target population: 31-40 year old female members** • Metric: Core Measure NQF 1517: Timeliness of Prenatal Care (PPC-CH) • <u>Overall strategy:</u> **see below** i. Include baseline and target data ii. Include numerators, denominators, and performance rate for each population identified iii. Provide overall strategy to improve towards the identified target

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** (If yes, please identify 1 to 2 target populations)
	  i. **31-40 year old females**
	  • Metric: Core Measure NQF 1517: Postpartum Care (PPC-AD)
	  • <u>Overall strategy:</u> **see below**
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified
	  iii. Provide overall strategy to improve towards the identified target

Overall Strategy for the Maternal and Perinatal Health Focus Area:

Metric	Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
Timeliness of Prenatal Care (PPC-CH)	31-40 year old females	308	550	56.0%	60.83%	0.48%	56.48%
Postpartum Care (PPC-AD)	31-40 year old females	279	550	50.73%	53.58%	0.28%	51.01%

In Phase 1, to be completed by July 2024, HCI will conduct a retrospective analysis of population health intervention outreach and outcomes to evaluate the equitable distribution of impacts among health equity focused demographic groups, in particular focusing on the target population for the specific measures related to prenatal and postpartum care access. HCI will also deepen our understanding of performance datasets by conducting a thorough analysis of additional data related to population predictors and journey predictors. This analysis aims to inform Phase 2 of our strategy.

The following HCI interventions will be evaluated related to the prenatal and postpartum performance.

1. Member Engagement (Virgin Pulse IVR Outreach)
    a. Text4Baby campaign
    b. Ad Hoc Targeted Text Messaging Campaign

2. Care Coordination (Elevance Maternity Program)
    a. Care Management (High, Moderate, and Low Risk Tier related programs)
    b. My Advocate education program

Phase 2 of HCI's overall strategy for maternal health, to be completed by October 2024, involves using the retrospective analysis of previous interventions and outreach campaigns to inform HCI's upcoming intervention programmatic design. This in particular will be focused on achieving target population performance goals.

If HCI's initial data analysis reveals an inequitable distribution of successful outreach or outcomes/performance in response to the intervention campaigns, HCI intends to evaluate for ways to tailor big interventions and/or little interventions to intentionally achieve more equitable performance across a diverse set of populations focusing on HCI's 2024 target population. An example of Phase 2 action would be modifying existing outreach interventions (text messaging campaigns) and piloting modified/tailored messaging to subpopulation (language, modality, frequency). If the current intervention shows equitable outcome distribution across the target population and other health equity aggregated populations, HCI will determine whether cadence, messaging, and/or modality require modification. The goal is to test and measure the success of the intervention through an analysis of equitable distribution of outcomes across populations with unique health equity indicators. An example of the intervention assessment and Phase 1 and 2 reporting is in the Appendix (**Figure 5**).

HCI will continue to share findings and insights from Phase 1 and 2 with stakeholders and engage trusted messengers and community-based organizations to review results and gather feedback for future campaigns. HCI also will continue to evaluate the continuum of care for families affected by pregnancy and childbirth, with a focus on engaging the entire family in performance improvement efforts, participating in targeted listening sessions, collaborating with the health neighborhood, and working on identifying ways to support and grow awareness of family planning benefits within our member community.

In summary, HCI plans to complete a retrospective analysis by July 2024, examining the distribution of healthcare impacts across demographics, with a focus on prenatal and postpartum care. Findings will inform Phase 2, aimed at refining intervention designs, by October 2024 to achieve better health outcomes for their target populations. HCI will also collaborate with community stakeholders to review this analysis and continuously improve care for families impacted by pregnancy and childbirth. HCI's approach involves education, early identification, inclusive outreach, family engagement, and provider empowerment. By addressing structural barriers and tailoring interventions, HCI aims to improve maternity and perinatal health outcomes for the target population and the broader region.

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

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

Focus Area	Behavioral Health Action Plan & Strategy

Behavioral Health	• Identify Disparity #1 - Appointment follow up post-ED for mental health
	  • Have you identified a disparity in this focus area? **Yes**
	  • Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations)
	  i. **31-40 year old members**
	  • Metric: Core Measure NQF 3489: Follow-up after ED Visit for Mental Illness
	  • <u>Overall strategy:</u>
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified
	  iii. Provide overall strategy to improve towards the identified target: **See below**

Behavioral Health	• Identify Disparity #2 - Appointment follow up post-ED for SUD
	  • Have you identified a disparity in this focus area? **Yes**
	  • Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations)
	  i. **Frontier county members**
	  • Metric: Core Measure NQF 3488: Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence
	  • <u>Overall strategy:</u>
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified
	  iii. Provide overall strategy to improve towards the identified target: **See below**

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** (If yes, please identify 1 to 2 target populations) i. **Frontier county members** • Metric: Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness • Overall strategy: i. Include baseline and target data ii. Include numerators, denominators, and performance rate for each population identified iii. Provide overall strategy to improve towards the identified target: **see below**
Behavioral Health **EXEMPT FROM 1/2/2024 DELIVERABLE**	• Identify Disparity #4 - Depression screenings • Have you identified a disparity in this focus area? Yes • Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations) • Metric: Core Measure NQF 0418: Depression Screening and Follow-Up Plan • Overall strategy: **exempt from 1/2/24 deliverable** i. Include baseline and target data ii. Include numerators, denominators, and performance rate for each population identified iii. Provide overall strategy to improve towards the identified target:

Overall Strategy for Behavioral Health Focus Area:

Metric	Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
Follow-up after ED Visit for Mental Illness	31-40 year old members	71	116	61.2%	68.4%	7.2%	61.93%

Follow-up after ED Visit for Alcohol and Other Drug Abuse or Dependence	Frontier county members	65	218	29.8%	40.21%	1.04%	30.9%
Follow-up after Hospitalization for Mental Illness	Frontier county members	[redacted]	[redacted]	42.9%	50%	0.7%	43.6%

In Phase 1, to be completed by July 2024, HCI will conduct a retrospective analysis of population health intervention outreach and outcomes to evaluate the equitable distribution of impacts among health equity focused demographic groups, in particular focusing on the target population for the specific measures related to follow-up after ED visit for mental illness, alcohol and other drug abuse or dependence, hospitalizations for mental illness. HCI will also deepen our understanding of performance datasets by conducting a thorough analysis of additional data related to population predictors and journey predictors. This analysis aims to inform Phase 2 of our strategy.

The following HCI interventions will be evaluated related to follow-up after ED visit for mental illness, alcohol and other drug abuse or dependence, hospitalizations for mental illness performance.

1. Care Coordination (Transitional Care)
    a. Care Management (delegated coordination in High, Moderate, and Low Risk Tier related programs)
2. Health Neighborhood (Hospital Transformation)
    a. Followup after ED for Alcohol/Drug and Mental Illness (embedded care coordinator i.e. Health Solutions in Parkview Hospital)
    b. Utilization management for inpatient mental health transitions (Utilization management team)

Phase 2 of HCI's overall strategy for mental health transitional care, to be completed by October 2024, involves using the retrospective analysis of previous interventions and outreach campaigns to inform HCI's upcoming intervention programmatic design. This in particular will be focused on achieving target population performance goals.

If HCI's initial data analysis reveals an inequitable distribution of successful outreach or outcomes/performance in response to the intervention campaigns, HCI intends to evaluate for ways to tailor big interventions and/or little interventions to intentionally achieve more equitable performance across a diverse set of populations focusing on HCI's 2024 target population. An example of Phase 2 action would be modifying existing outreach interventions (text messaging campaigns) and piloting modified/tailored messaging to subpopulation (language, modality, frequency). If the current intervention shows equitable outcome distribution across the target population and other health equity aggregated populations, HCI will determine whether cadence, messaging, and/or modality require modification. The goal is to test and measure the success of the intervention through an analysis of equitable distribution of outcomes across populations with unique health equity indicators. An example of the intervention assessment and Phase 1 and 2 reporting can be found in the Appendix (**Figure 5**).

HCI will continue to share findings and insights from Phase 1 and 2 with stakeholders and engage trusted messengers and community-based organizations to review results and gather feedback for future campaigns. HCI also will continue to evaluate the continuum of care, participating in targeted listening sessions, collaborating with the health neighborhood, and working on identifying ways to support and grow awareness of mental health transitional care support within our member community.

Particularly in this focus area, HCI recognizes frontier regions may have ongoing nuanced social dynamics related to mental health stigma, high acuity outpatient resources, and unique support system dynamics and lifestyles. We hope that targeting our health equity efforts on this population will not only reveal important insights that can help to close the gap in health outcomes, but also inform our health neighborhood on ways HCI can support their populations.

In summary, HCI plans to complete a retrospective analysis by July 2024, examining the distribution of healthcare impacts across demographics, with a focus on Frontier county and 31-40 year old member populations. Findings will inform Phase 2, aimed at refining intervention designs by October 2024, to achieve better health outcomes for their target populations. By addressing structural barriers and tailoring interventions, HCI aims to improve mental health transitional care performance for the target populations and the broader region.

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

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

Focus Area	Prevention/Population Health Plan & Strategy

Prevention/ Population Health	• Identify Disparity #1 - Childhood immunization status
	  • Have you identified a disparity in this focus area? **Yes**
	  • Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations)
	  i. **Black/African American members**
	  • Metric: Core Measure NQF 0038: Childhood Immunization Status Combo 10
	  • Overall strategy: **see below**
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified:

	iii. Provide overall strategy to improve towards the identified target:
Prevention/ Population Health	• Identify Disparity #2 - Immunization for adolescents • Have you identified a disparity in this focus area? **Yes**/No • Have you identified a population to target for this disparity? **Yes**/No (If yes, please identify 1 to 2 target populations) i. **Black/African American members** • Metric: Core Measure NQF 1407: Immunizations for Adolescents Combo 2 • Overall strategy: **see below** i. Include baseline and target data ii. Include numerators, denominators, and performance rate for each population identified iii. Provide overall strategy to improve towards the identified target:
PREVENTION/ POPULATION HEALTH ***EXEMPT FROM 1/2/24 DELIVERABLE***	• Identify Disparity #3 - Decrease diabetes poor A1C control in populations at risk • Have you identified a disparity in this focus area? Yes/No • Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations) • Metric: Core Measure NQF 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) • Overall strategy: i. Include baseline and target data ii. Include numerators, denominators, and performance rate for each population identified iii. Provide overall strategy to improve towards the identified target: **exempt from 1/2/24 deliverable**

Prevention/ Population Health	• Identify Disparity #4 - Increase well-child visits while reducing disparities in visits among priority populations
	  • Have you identified a disparity in this focus area? **Yes**
	  • Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations)
	  i. **For 0-30 months well child visits: Black/African American population**
	  ii. **For child and adolescent well-care visits: 11-20 year old members**
	  • Metric: Percentage of children/youth receiving preventive visits through EPSDT; Core Measure NQF 1392 Well-Child Visits in the First 30 Months of Life (W30-CH); NQF 1516 Child and Adolescent Well-Care Visits (WCV-CH)
	  • Overall strategy: **see below**
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified
	  iii. Provide overall strategy to improve towards the identified target:

Prevention/ Population Health	• Identify Disparity #5 - Dental and Oral Health for Children
	  • Have you identified a disparity in this focus area? **Yes**
	  • Have you identified a population to target for this disparity? **Yes** (If yes, please identify 1 to 2 target populations)
	  i. **11-20 year old members**
	  • Metric: Core Measure NQF 2517: Oral Evaluation, Dental Services (OEV-CH)
	  • Overall strategy: **see below**
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified

	iii. Provide overall strategy to improve towards the identified target:

Overall Strategy for Prevention/Population Health Focus Area:

Metric	Target Population	Numerator	Denominator	Target Population Performance	Regional Performance (All Members)	10% Gap Closure	Target
Childhood Immunization Status Combo 10	Black/ African American members	[redacted]	[redacted]	19.2%	28.9%	0.96%	20.2%
Immunizations for Adolescents Combo 2	Black/ African American members	[redacted]	[redacted]	21.05%	24.7%	0.36%	21.4%
Well-Child Visits in the First 30 Months of Life	Black/ African American members	[redacted]	50	[redacted]	59.1%	1.31%	47.3%
Child and Adolescent Well-Care Visits	11-20 year old members	8,673	27,186	31.9%	36.3%	0.44%	32.3%
Oral Evaluation, Dental Services	11-20 year old members	12,288	27,593	44.5%	48.2%	0.37%	44.9%

In Phase 1, to be completed by July 2024, HCI will conduct a retrospective analysis of population health intervention outreach and outcomes to evaluate the equitable distribution of impacts among health equity focused demographic groups, in particular focusing on the target populations for the specific measures related to well visits, immunizations, and other preventive care. HCI will also deepen our understanding of performance datasets by conducting a thorough analysis of additional data related to population predictors and journey predictors. This analysis aims to inform Phase 2 of our strategy.

The following HCI interventions will be evaluated related to the prenatal and postpartum performance.

1. Member Engagement
    a. Ad hoc messaging for well visits
    b. Ad hoc messaging for dental visits
    c. Ad hoc messaging for immunizations
    d. Text4Kids Campaign
2. Practice Transformation
    a. Incentives for well visits/immunizations

   b. Practice level Plan, Do, Study, Act (PDSAs) for well visits/immunizations improvement
3. Health Neighborhood
   a. Expanding Pueblo Community Health Center dental access and collaborative promotion to members

Phase 2 of HCI's overall strategy for the prevention and population health focus area, to be completed by October 2024, involves using the retrospective analysis of previous interventions and outreach campaigns to inform HCI's upcoming intervention programmatic design. This in particular will be focused on achieving target population performance goals.

If HCI's initial data analysis reveals an inequitable distribution of successful outreach or outcomes/performance in response to the intervention campaigns, HCI intends to evaluate for ways to tailor big interventions and/or little interventions to intentionally achieve more equitable performance across a diverse set of populations focusing on HCI's 2024 target population. An example of Phase 2 action would be modifying existing outreach interventions (text messaging campaigns) and piloting modified/tailored messaging to subpopulation (language, modality, frequency). If the current intervention shows equitable outcome distribution across the target population and other health equity aggregated populations, HCI will determine whether cadence, messaging, and/or modality require modification. The goal is to test and measure the success of the intervention through an analysis of equitable distribution of outcomes across populations with unique health equity indicators. An example of the intervention assessment and Phase 1 and 2 reporting is in the Appendix (**Figure 5**).

HCI will continue to share findings and insights from Phase 1 and 2 with stakeholders and engage trusted messengers and community-based organizations to review results and gather feedback for future campaigns. HCI also will continue to evaluate the continuum of care for families in their preventive care journey, with a focus on engaging the entire family in performance improvement efforts, participating in targeted listening sessions, collaborating with the health neighborhood, and working on identifying ways to support and grow awareness of prevention and population health support within our member community.

Particularly in this focus area, HCI is looking to learn through data driven insights how best to support families in preventive care engagement and to help to identify and close the disparity gaps in multiple performance measures within the prevention focus area. An example of a patient/family journey during their preventive care journey is provided in the Appendix (**Figure 6**). **Figure 6** illustrates the overlap in preventive health engagement for a female caregiver with children. HCI will use this to take a more holistic approach with interventions and be more comprehensive, addressing the interconnected needs of families during this critical period.

In summary, HCI plans to complete a retrospective analysis of focus area population health interventions by July 2024, examining the distribution of healthcare impacts across demographics, with a focus on Black/African American and 11-20 year old member populations. Findings will inform Phase 2, aimed at refining intervention designs by October 2024 to achieve better health outcomes for their target populations. By addressing structural barriers and tailoring interventions, HCI aims to improve prevention and population health related disparity gaps for the target populations identified and the broader region.

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.

Focus Area	Additional Organization Action Plan & Strategy

	• Identify Disparity #1 -
	  • Have you identified a disparity in this focus area? Have you identified a population to target for this disparity? Yes/**No**
	  • Metric:
	  • <u>Overall strategy:</u>
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified
	  iii. Provide overall strategy to improve towards the identified target

	• Identify Disparity #2 -
	  • Have you identified a disparity in this focus area? Have you identified a population to target for this disparity? Yes/**No**
	  • Metric:
	  • <u>Overall strategy:</u>
	  i. Include baseline and target data
	  ii. Include numerators, denominators, and performance rate for each population identified
	  iii. Provide overall strategy to improve towards the identified target

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

As detailed in our three overarching strategies to address health disparities, Strategy 1 is to identify many of the focus area disparities and focus populations. We intend to share with HCPF if other disparities were identified in the next deliverable.

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

Cultural Responsiveness	Overall Strategy

	Description: Cultural Responsiveness involves understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued (Hopf et al., 2021).
	
	● <u>If not already addressed in the above section(s), what steps will be taken to embed culturally responsive practices across the RAE/MCO? Examples include, but not limited to the following[1]:</u>
	  ● **Tribal/American Indian Alaska Native**
	  i. Traditional healing practices (e.g., smudging/purification, healing circles, talking circles, songs and drumming)
	  ● **Non-English Speakers:** Culturally responsive care to non-English speakers (includes, but not limited to:)
	  i. The use of interpreters, using plain language, and communicating care that is linguistically and culturally appropriate
	  ● **African American/Black:**
	  i. Acknowledging historical trauma that has negatively impacted the Black community
	  ● **Refugees and Immigrants**
	  i. Trauma-informed approaches and practices
	  ii. The use of interpreters
	  ● *Entities should have a plan that includes holding **listening sessions** with members to identify culturally responsive practices that bring meaning to each population and report out to the Department annually.*

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

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HCI's Culturally Responsive Practice Efforts
Strategy 1: Improve Data to Identify Health Inequities
• Inclusive data transformation to understand upstream and environmental inequities, challenges, and barriers • Integrating contextual culturally responsive data collection and datasets from programs like CO-CEAL community work, health neighborhood and equity coalition surveying, regional needs assessments, CHAS research, CHF Pulse survey insights, etc. • Analyze through subdividing of population based on health equity indicators the equitable outreach and performance of past interventions • Share data insights with health neighborhood population advocates to gain insights on performance nuances related to language, modality, trusted messengers, member perspectives
Strategy 2: Evaluating For Equitable Intervention Engagement and Performance
• Community facilitated validation of subpopulation diversity outreach and performance • Inclusive data driven member identification and outreach • Member-centric programmatic review using health neighborhood population advocates • Understand and blend programmatic approaches tailoring to the unique diversity of our region • Share intevention outcome data interpretation,visualization, and validation best practices with partners and stakeholders highlighting the importance of evaluating population health through a lens of equitable reach, performance, and outcomes • Focusing intervention outreach with communications respectful of health literacy level and language preference and cultural/lifestyle context referenced in overall strategy section
Strategy 3: Leveraging Community Alliances, Stewardships, and Partnerships
• Stratify outreach and feedback requests from priority population subpopulation stakeholders and continue to evaluate for equitable collaboration across priority populations • Focus on meeting patients where they are by leveraging partners and spheres of influence to share member engagement educational materials, promote events, and encourage preventive action in their communities related to the health care deliveray system • Twice yearly focused cultural competency roundtables held by HCI for external partners and providers • Promotion of local healthcare awareness and engagement activities and encouragement of cross collaboration/partnering between the health neighborhood and priority population focused community based organizations

The graphic above shows the ways HCI intends to incorporate cultural responsiveness into our health equity plan goals. As described in the executive summary of the organization's strategy to address health disparities in the region, HCI encourages local care providers to care for their communities locally and participates in many community-oriented patient advocacy circles.

Part of HCI's third strategy is storytelling and amplifying the voices of individuals and communities. Our team throughout the year shares anecdotal stories, patient journeys, and system barrier scenarios to continually keep the organization connected to the frontline experience. HCI shares with our community what the diversity, representation, and perspectives through lived experience our teams bring to their roles at HCI. In stakeholder forums, when discussing health equity, HCI intentionally promotes the best practice of acknowledging that implicit bias and diversity gaps exist even among the health care delivery system and that we are continuously working to close inequities to priority populations. We intentionally inclusively invite engagement from the community to connect with our health equity team and have focused on increasing our engagement with community advocacy groups that can close perspective and bias gaps that our team may have.

HCI believes in a trauma-informed and inclusive approach, engaging as a stakeholder and asking for the opportunity to hold listening sessions within member advocacy groups that are trusted entities to facilitate conversations around health equity. To be effective in learning what populations need regarding cultural competency and cultural responsiveness in health care, HCI will continue to engage in consistent, collaborative, open, safe, and honest collaboration with the community advocates around indigenous/native, Limited English Proficiency (LEP), Black, and migrant population health needs and cultural expectations.

HCI consults regularly with trusted professional community builders such as Civic Canopy on the best way the RAE can participate in health neighborhood cultural competency and health equity discussions. They requested that HCI participate on SLV's Equity Coalition steering committee and engage with curiosity and the intent to learn so as to to avoid appearing as fixers or leading conversation because historical involvement of healthcare organizations has been inconsistent, unreliable, and contributors of inequities within their community. Over time, by attending these equity coalitions, showing commitment, building trust, and aligning on community defined health equity plans as a stakeholder in the community, HCI believes there will be more opportunity as the managed care entity to lead more proactive efforts in this group such as listening sessions, but not without the proper foundational engagement.

HCI is looking to establish stronger partnerships with advocacy organizations that are trusted by the Black/African American population, which is one important reason we chose to target this population for these metrics. HCI understands that there are existing distrust and historical trauma associated with past healthcare experiences and will be approaching building relationships and outreach campaigns intentionally under the guidance of advocates within the community. HCI is determined to develop more allies and partnerships that are identified as trusted messengers and advocates for the African American population in our region to better understand the contributing factors regarding immunization completion as well as other preventive care engagement. Our health equity lead is already working on having more intimate discussions with population advocates to build trust and gain insights on how HCI can reach and make a larger impact in their community.

HCI is taking the same relationship building approach within our Tribal/American Indian/Alaska Native populations, especially in the SLV region. Our goal is to understand the community and how they would like to be approached regarding member outreach and disseminating information pertaining to culturally inclusive health benefits through HCI. HCI acknowledges how integral it is to leverage strong relationships and collaboration with trusted messengers in this community in order to have the most effective impact in advocating for culturally responsive/competent care benefits including traditional healing practices.

HCI also recognizes the importance of access to interpreters and member awareness of their right to use interpreters when engaging in health care, and has centered much of the continuous improvement efforts related to member engagement around language accessibility. HCI manages a region in which 40% of Medicaid members are identifying Hispanic and 2% identify Spanish as their primary language. Recognizing that especially language identity may not be accurate due to upstream factors, HCI is making an effort to still provide an inclusive outreach campaign and support populations with LEP. These populations could include refugee and migrant workers as well. In 2023, HCI invested in having physical outreach material solely targeted for Spanish speaking individuals with monolingual Spanish content language. Additionally, as mentioned in earlier sections, our member engagement department is continually reviewing their materials to ensure accessibility for LEP members, which includes review by a targeted MEAC subcommittee

and by a bilingual team member. Monolingual outreach materials were intentionally created to signal the importance of members who speak primarily Spanish to learn about health care in their preferred language. Especially in SLV and Pueblo, healthcare advocacy groups appreciated having HCI health education materials in Spanish to distribute within their communities and have continued to request more materials in Spanish. HCI's most populated refugee, migrant, and immigrant communities receive most of HCI's outreach and health engagement materials by providing materials to close allies that pass along the materials to their community. These communities in particular are protected by advocacy groups and our messages are best delivered indirectly from HCI; HCI does our best to respect how these communities want to communicate.

Along with external and internal facing discussions centered around health equity, HCI participates in multiple health neighborhood meetings, ensuring that our community's voice and local needs are considered.

The following is a non-exhaustive list of meetings routinely attended:

- Children's Disability Advisory Committee
  - Advisory Committee to HCPF to make recommendations regarding issues related to benefits for disabled children and youth age 20 and under
- Health Care Justice Transitions Workgroup
  - Develop, discuss, and implement strategies for Medicaid-eligible members releasing from prisons
- Child Welfare Custody Workgroup
- Home Visiting Investment Task Force
  - To expand equitable access to appropriate and effective evidence-based early childhood home visiting programs in Colorado
- Pueblo Suicide Prevention Coalition
  - Meets at HCI monthly
- Pueblo County Outreach and Equity Task Force
  - Pueblo focused equity coalition working to collaborate between stakeholder for health equity and social need equity
- Pueblo County Provider Roundtable
  - Pueblo providers come together to review all health related topics and data
- SLV Equity Commission
  - SLV equity coalition run through the Health Disparities and Community Grant Program (HDGCP) grant through CDPHE
- SLV Vaccination Taskforce
  - Workgroup for immunization equity in SLV and also stakeholder meeting for public health collaboration
- Pueblo Equity Coalition
  - Pueblo focused equity (vaccination initially) coalition working to collaborate between stakeholders for health equity and social need equity
- Early Childhood Learning Collaborative
  - Workgroup to increase early childhood protective factors
- Colorado Blueprint to End Hunger
  - Meeting to discuss food insecurity
- Maternal Health Task Force
  - Workgroup to evaluate and recommend state initiatives for improved maternal health outcomes

Additionally, HCI's health equity lead routinely participates as a stakeholder in decisions related to grant funding through HCI and on statewide cultural competency training evaluation. This ensures that we can provide as inclusive of a reach as an organization in all aspects of our business including reinvestment and high fidelity wraparound programs. HCI's health equity lead participated in the evaluation of organizations and programs selected for HCI reinvestment funding and in the evaluation of the HEC's cultural competency grant determinations.

HCI continues to encourage within the our spheres of influence including provider engagement, member engagement, health neighborhood, and care coordination about opportunities for cultural competency training. HCI will promote the following organizations selected for the HEC cultural competency training grants where local expert organizations are developing and implementing cultural competency training within our region.

- LGTBQ+ cultural competency training for behavioral health providers through reputable EnvisionYou
- Southwest Area Health Education Center (SWAHEC) indigenous cultural competency training to help providers approach members about overcoming generational trauma and substance use
- Rural member centered cultural competency training being developed by RAE 4 provider Castillo Primary Care

For the 2024 HCI reinvestment/health and wellness grant cycle, 21 organizations completed Part 1 of the application, and 19 moved on to Part 2. Part 2 of the grant application consisted of the development of a five-minute video explaining the program, why HCI should consider them for funding, and how they would focus on health equity. HCI pulled together a diverse health and wellness steering committee consisting of 10 scorers from across Region 4. The steering committee passed their recommendations to the HCI Board in December of 2023 for final approval, and MOUs were developed and signed. 14 organizations were approved for funding, and one is still under review; a list of the projects is available in the Appendix (**Figure 7**).

HCI will continue to advocate and spread awareness regarding the programs available to our healthcare delivery partners, health neighborhood, and individual members in an effort to promote collaboration and referrals to culturally competent and responsive proactive health navigation, supportive services, and generational health building programs.

Since cultural competency and responsiveness goes beyond training providers, HCI's teams continue to promote healthcare organization participation in local community member advocacy forums and local health related events and education that promote cultural competency and cultural responsiveness. HCI promotes the health neighborhood to connect with communities through promotion of events on social media platforms, newsletters to providers, sponsoring events related to priority population health advocacy, and continuing to engage with the health neighborhood community to build trust, agency, and empowerment targeting aid to those serving the priority populations listed in HCPF's health equity action plan.

Lastly, HCI will actively elicit ongoing feedback from community advocates to understand their perception of HCI and where HCI can improve in equitably engaging with the priority populations in our region and improve access to care perceptions. Specifically, HCI has built relationships with CDPHE regional coordinators and Disproportionately Affected Population team. We are looking to help funnel resources to them as trusted messengers related to health engagement and offer support in helping their teams understand the benefits, support, and additional health

prevention services that HCI offers to better serve their populations. We have shared educational material, promoted at events together, recommended for their community members to join our MEAC, and offered to hold ad hoc meetings to hear from their community on how to improve the member experience.

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

HCI is grateful for the opportunity to highlight and discuss the efforts being made within RAE4 that continue to further health equity and address health disparities in our region. This health equity action plan deliverable serves as the first of hopefully many iterations of its kind in which the purpose is to share actionable insights, document a community and health care delivery system's journey, and strategically develop actionable and accountable efforts to address health disparities for targeted populations experiencing health inequities. HCI shared many of our challenges, barriers, and assistance needed from HCPF in the introduction narrative summary and will continue to provide feedback throughout the performance period related to the progress of our health equity action plan for FY23-24.

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Appendix

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

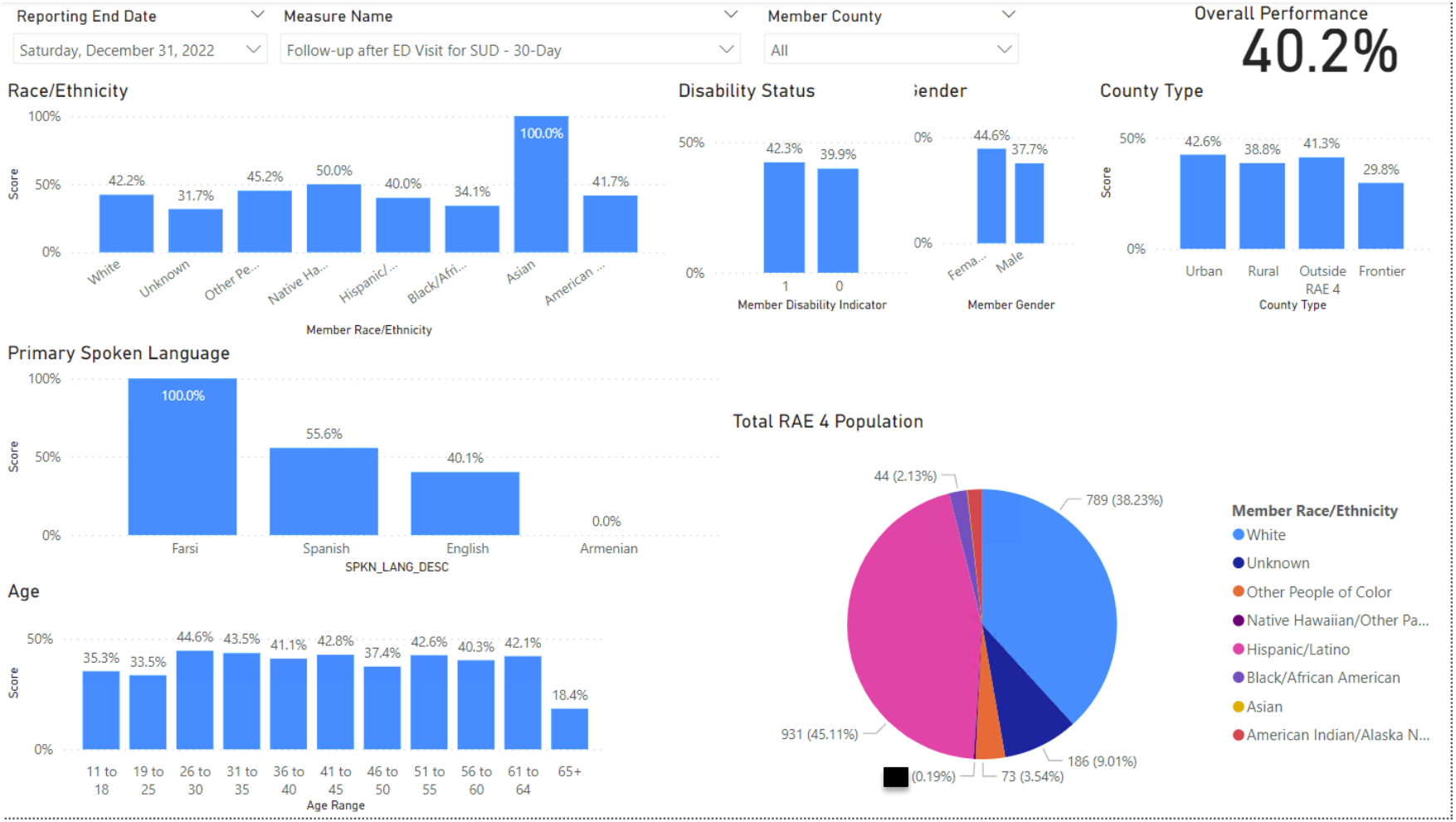

Figure 2: Dashboard Showing Measure Performance by Health Equity Demographic Indicator

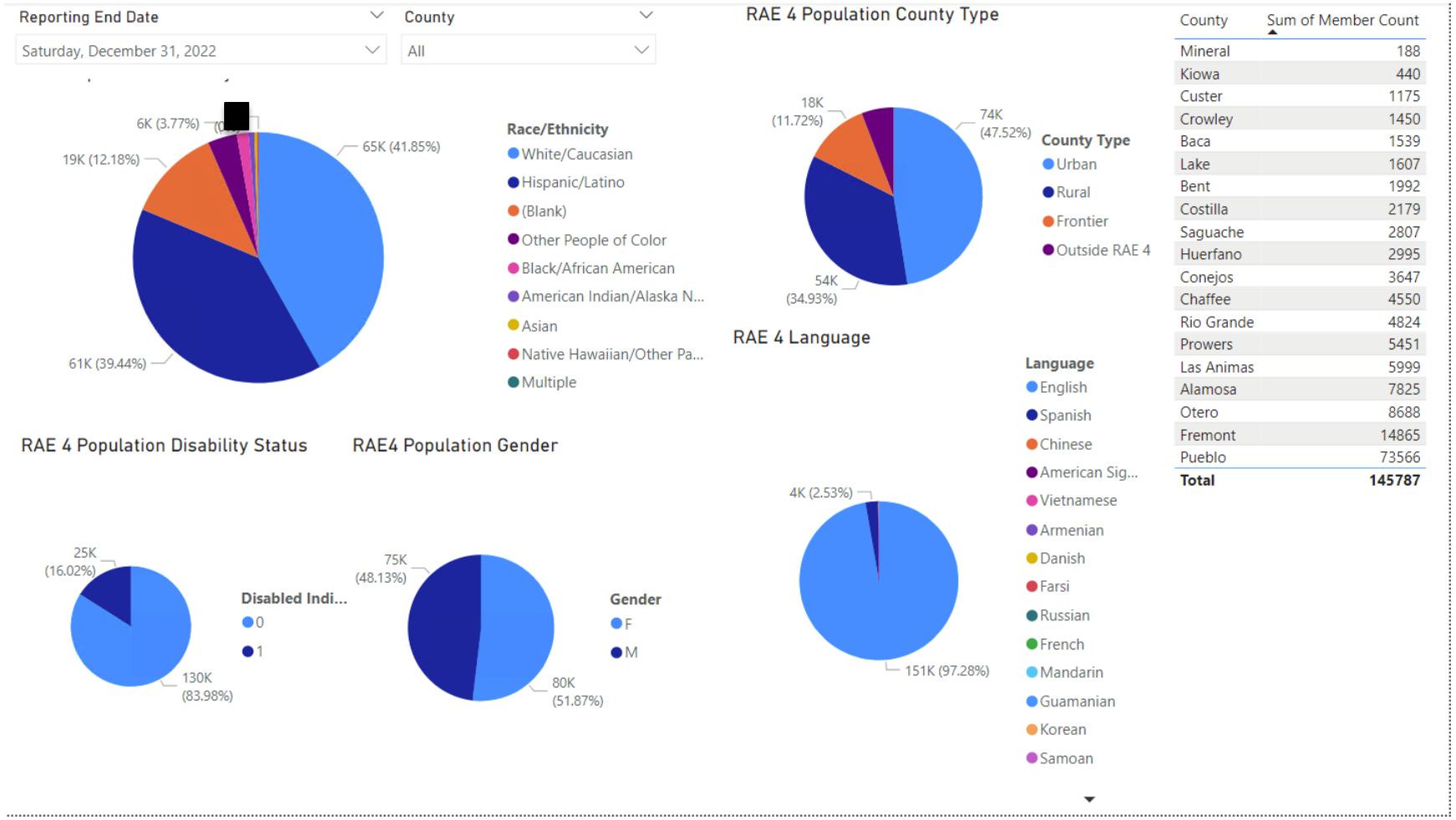

Figure 3: Dashboard Showing RAE Population by Health Equity Demographic Indicator

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County	% of CO Land	Total Population	% of CO Population	Total Medicaid Population	% Total Population Enrolled In Medicaid	% RAE4 Members Identfying English Primary Language	% Total Population Limited English Proficiency (LEP)	% RAE4 Members Identifying Spanish Primary Language	% Total Population Non Hispanic White	% RAE4 Members Identifying As Non-Hispanic White	% Total Population Hispanic	% RAE4 Members Identifying As Hispanic	% Total Population Female	% of RAE4 Population Female	% RAE4 Population With Known Disability
Colorado		5,773,714		1,578,595	27%	88%	3%		67%	39%	22%	22%	49%	49%	4%
All RAE4 counties	34.3%	366,456	6.35%	163,938	45%	97%	2%	3%	58%	41%	36%	40%	52%	52%	16%
Alamosa	0.7%	16,180	0.28%	8,557	53%	94%	4%	6%	46%	31%	49%	53%	50%	51%	14%
Baca	2.5%	3,555	0.06%	1,654	47%	98%	1%	2%	82%	74%	12%	11%	50%	52%	18%
Bent	1.5%	5,356	0.09%	2,178	41%	98%		2%	56%	45%	36%	31%	35%	52%	24%
Chaffee	1.0%	20,661	0.36%	5,215	25%	99%	1%	1%	85%	65%	10%	8%	47%	52%	14%
Conejos	1.2%	8,143	0.14%	3,918	48%	99%	1%	1%	46%	31%	48%	55%	49%	51%	17%
Costilla	1.2%	3,921	0.07%	2,503	64%	98%	4%	2%	35%	29%	54%	46%	48%	48%	23%
Crowley	0.8%	5,696	0.10%	1,688	30%	99%	1%	1%	52%	47%	35%	22%	26%	51%	22%
Custer	0.7%	5,183	0.09%	1,403	27%	100%	0%	0%	89%	62%	6%	3%	48%	51%	14%
Fremont	1.5%	47,876	0.83%	17,121	36%	100%	0%	0%	79%	73%	14%	9%	42%	52%	17%
Huerfano	1.5%	6,883	0.12%	3,462	50%	99%	1%	0%	63%	45%	33%	33%	49%	51%	20%
Kiowa	1.7%	1,458	0.03%	557	38%	99%	0%	1%	87%	74%	10%	6%	50%	56%	15%
Lake	0.4%	7,987	0.14%	2,206	28%	83%	4%	17%	61%	39%	33%	35%	46%	50%	8%
Las Animas	4.6%	14,420	0.25%	7,050	49%	99%	2%	1%	53%	41%	41%	40%	47%	51%	19%
Mineral	0.8%	773	0.01%	232	30%	99%	0%	1%	90%	76%	8%	2%	50%	53%	11%
Otero	6.4%	18,201	0.32%	9,518	52%	98%	2%	2%	53%	36%	44%	46%	50%	53%	18%
Prowers	1.6%	12,106	0.21%	6,024	50%	92%	4%	8%	56%	36%	40%	38%	50%	53%	15%
Pueblo	2.3%	169,823	2.94%	82,196	48%	98%	1%	2%	51%	36%	44%	47%	50%	52%	16%
Rio Grande	0.9%	11,296	0.20%	5,306	47%	96%	2%	4%	52%	31%	45%	52%	50%	52%	18%
Saguache	3.1%	6938	0.12%	3,150	45%	91%	2%	9%	59%	40%	33%	39%	50%	51%	15%

Figure 4: Table of County Comparing Population Breakdown by Social Determinants of Health and Demographic Indicators

Focus Area	**Prevention & Population Health**
Measure/Metric	Oral Evaluation, Dental Services (OEV-CH)
Big Intervention	Member Engagement
Little Intervention	Ad Hoc message
Intervention Description	Ad Hoc message about dental services sent to members who have not completed yet
Engagement Criteria	Outreached via SMS
2024 Target Population Description	11-20 Year Old Members
Target Population Baseline Measure Performance (%)	
Target Population Performance Goal (%)	
RAE Population Baseline Measure Performance (%)	
RAE Population Performance Goal (%)	
Phase 1	
Target Population Cohort Size	
Target Population Intervention Performance (%)	
RAE Population Cohort Size	
RAE Intervention Performance (%)	
Target Population Performance Gap	
Equitable Performance (Y/N)	
Phase 2	
2025 Intervention Determination (Keep/Discard/Modify/Expand)	
2025 Intervention Details	

Figure 5: Example of Health Equity Performance Assessment Table for Population Health Interventions by RAE Population and Target Population

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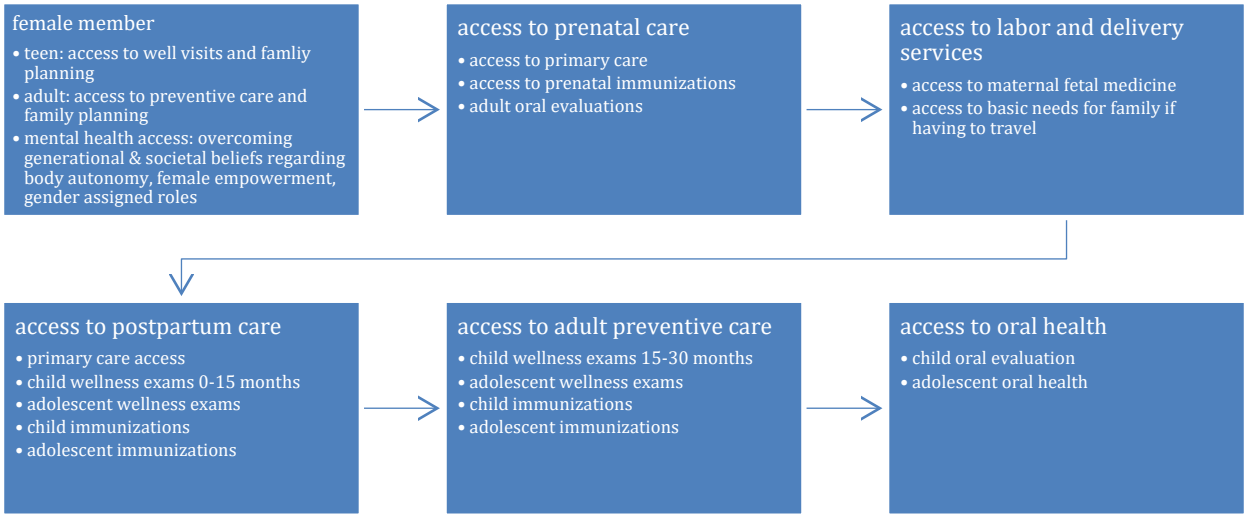

Figure 6: Engagement Journey for a Female Member of Reproductive Age with Additional Family Members Who Rely on Them for Caregiving

Project	Total Awarded	Summary of Proposal
Chaffee County Public Health	$50,000.00	Support free mobile health clinic to provide health navigation, education, prevention, and early intervention services and programming, along with direct services
City of Pueblo, Fire Department	$80,000.00	Expanding personnel to three and number of Pueblo citizens that can be served
Lake County Department of Human Services	$50,000.00	This program intends to establish an emergency transitional housing fund specifically catered to families in distress
CASA of Pueblo	$55,800.00	Hire a case supervisor, Data & Software support, volunteer support
Project Angel Heart	$40,000.00	Offering meals for specific medical diagnoses in RAE 4
Summit Community Care Clinic	Under Review	Covers salary of dental hygienist, part of nurse practitioner, and medical assistant until they can bill for Medicaid.
Pueblo Cooperative Care Center	$75,000.00	Distribute about 50,000 food sacks and host community outreach days to distribute about 5,000 more food sacks
SLV Health	$120,000.00	Support their provider housing project to increase recruitment and retention of providers
Care and Share Food Bank	$50,000.00	Supporting their fleet and refrigeration units to decrease hunger in Pueblo and SLV
SLV Recovery LLC	$85,000.00	Purchase of minivan to increase access, building materials, home furnishings, bike shed, and food storage
Boys and Girls Club of SLV	$75,000.00	Expand number of resource navigators, train five peer navigators
Small Town Project	$65,000.00	Hire a part-time Development Director and Food Pantry Manager to build capacity and expand program services
Southern Colorado Youth Development	$29,200.00	Enroll 70 youth in Pueblo, Crowley, and Otero into the Motovate program
Spark the Change	$60,000.00	Offer pro-bono mental healthcare for individuals in RAE 4 as well as conduct capacity building and provider trainings
Bits of Freedom	$25,000.00	Purchase of a four-horse trailer with office quarters

Figure 7: List of 2025 HCI Health and Wellness Grantees