COLORADO
Department of Health Care Policy & Financing

Regional Health Equity Plan FY23-24
Instructions and Narrative

RAE/MCO Name	Colorado Community Health Alliance (CCHA)
RAE/MCO Region #	7
Reporting Period	SFY23-24 7/31/2023 – 6/30/2024
Date Submitted	December 29, 2023, Resubmission February 13, 2024
Contact	Amy Yutzy

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, Timeframes, 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 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, Timeframes, 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 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) *Timeframes 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, Timeframes, resources, partnerships, incentive/pass through plans, logistics, goals, and any other relevant information to identify and address health disparities.

Overall CCHA Strategy:

CCHA's health equity framework is based on driving all operations using a health equity lens while working with members, medical and behavioral health providers, community organizations, and staff to elevate, cultivate, and allocate resources. For us, bringing members, providers, and community organizations together to align interventions is critical to success in this effort. Furthermore, CCHA uses data to identify populations to drive strategy development and resource deployment. We are continuously seeking interventions that could have an immediate impact and long-term sustainable interventions to increase the adoption of a more equity-driven mindset and promote changes in the system to accelerate results.

CCHA is committed to promoting health equity, reducing identified health disparities and improving the health outcomes of our members. As of July 2023, we serve more than 214,300 members in El Paso, Teller, and Park counties (Region 7), representing many different demographic groups,[1] [2] including:

[1] As identified through HCPF Roster data.
[2] 11.3% of CCHA members self-identified their race/ethnicity as Other/Unknown, Not Provided, or Unknown.

More than 214,300 Members in Region 7	**GENDER** 52.4% Female 47.6% Male	**AGE** 11.1% 0-5 years 8.3% 6-9 years 20.9% 10-20 years 56.2% 21-64 years 3.6% 65+ years
RACE/ETHNICITY 46.8% White 22.5% Hispanic/Latino 8.7% Multiple Races/Ethnicities 7.8% Black/African American 1.6% Asian 0.7% American Indian/Alaska Native 0.6% Native Hawaiian/Other	**GEOGRAPHY** 91.45% El Paso County 2.8% Teller County 0.75% Park County 5% Other Counties	**LANGUAGE** 94.1% English 5.2% Spanish 0.7% Other Languages

We acknowledge that our understanding of our member populations is limited by the types of data self-reported by members and collected through the Medicaid enrollment process. We strive to serve our members and support the Accountable Care Collaborative and Health Equity Plan goals with the data available. In addition, CCHA reviewed literature to supplement our understanding of health inequities, support the selection of populations of focus, and help identify evidence-based interventions to inform our plans to drive positive change.

Our Health Equity Plan supports our region's marginalized, underrepresented, and underserved communities. CCHA is invested in identifying causes of disparities and interventions to promote health equity. To that end, CCHA is implementing an overall strategy designed to address health disparities and social determinants of health (SDOH), which are closely tied.[3] In fact, studies have found that up to 80% of a person's health is related to social factors.[4]

To develop this plan, in addition to the literature review mentioned above, CCHA analyzed the data provided by the Department of Health Care Policy and Financing (HCPF or the Department). CCHA identified populations based on the performance of specific metrics, using dimensions such as race/ethnicity, gender, language, member disability, and city and county of residence. CCHA looked at the performance of each measure by population and compared each population group to a sum of all other groups for each dimension using an odds ratio. We completed a chi-square test of statistical significance to determine if the population group had a significantly lower measure rate than the rest of the total population. We also calculated the volume of compliant events needed for the disparate

[3] "Health Equity in Healthy People 2030," U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, accessed November 1, 2023, https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030.
[4] Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B., "County Health Rankings: Relationships Between Determinant Factors and Health Outcomes," *American Journal of Preventive Medicine*, no. *50*(2), 129–135. https://doi.org/10.1016/j.amepre.2015.08.024. https://pubmed.ncbi.nlm.nih.gov/26526164.

population to reach equity. We considered this threshold of statistical significance the criteria for identifying a disparity. This rigor for identifying disparities controls for the substantial differences in the population size of sub-population groups and prevents furthering population stereotypes or magnifying the burden to sub-populations by assuming all differences are inequities. After the analyses were completed, CCHA considered a combination of three factors - literature review, performance of each population and statistical significance - to determine the populations of focus and interventions to reduce health disparities. Since the CCHA strategy centralizes a health equity lens on all plan initiatives, strategies supporting equity in measures where no statistically significant differences were identified are still discussed where applicable.

CCHA set performance target goals, defined in each section below, using the 10% gap closure method to match other HCPF performance target-setting standards. Performance will be monitored using data provided by HCPF for each performance metric to measure progress. In addition, CCHA developed a Key Performance Indicator (KPI) dashboard that allows performance visualization of different populations for each metric that aligns with the Health Equity metrics defined by the Department. CCHA uses this tool to measure and monitor monthly progress and align operational efforts to support improvement.

CCHA's overall strategy to impact health equity applies to multiple disparity focus areas. It includes interventions that could have an immediate impact and long-term sustainable interventions, using resources at member, provider, community organization, and staff levels. Through the development and implementation of this plan, CCHA will also use CCHA's Program Improvement Advisory Committee (PIAC) and Member Advisory Committee (MAC) feedback to tailor interventions as best as possible.

CCHA hopes to reduce health disparities by applying the following strategies:

Member Level:

- Continuously enhancing member data dashboards with information that can help identify, monitor, and track health disparities among our different populations.
- Revising our health needs assessments (HNAs) to include evidence-based questions to expand and standardize SDOH data collection so we can help identify and address members' needs, including those that contribute to health disparities.
- Enhancing member communication through more inclusive and culturally sensitive outreach campaigns and responses when members call us. For this, CCHA will review current processes and scripts from our call center and pilot a texting campaign in the most prevalent non-English language spoken by our members (Spanish). We aim to improve member engagement with CCHA and access to healthcare services in our regions.
- Offering incentives to members by implementing a new program that gives gift cards to members who complete certain health visits.

Provider Level:

- Collecting primary care medical provider (PCMP) data in our annual Office System Review (OSR) to help us improve available information that could help enhance our provider directory. The voluntary and self-identified data collected includes practitioner races/ethnicities and special populations of focus they serve (for example, transgender, people with disabilities, minorities, shared race or

ethnicity, human immunodeficiency virus (HIV) positive, obesity, substance use disorder (SUD), high-risk pregnancy, non-English speakers, etc.).

- Collaborating with all Accountable Care Network (ACN) and other PCMP providers to learn about current initiatives, diversity, equity, and inclusion (DEI) best practices, cultural awareness and responsiveness, gaps in care, and community resources to gather ideas and explore opportunities that could reduce health disparities.
- Expanding access to services and supporting capacity-building among our network, including within our more rural communities, by providing additional funding to support the expansion of services for Health First Colorado members.
- Supporting and continuing to expand the integration of behavioral health (BH) and physical health (PH) services within practices through additional funding and practice transformation support.
- Promoting provider-facing trainings related to cultural competence and health equity for our network providers. Examples of topics include My Diverse Patients curriculum, identifying disparities, advancing equity, building trust, reducing stereotypes, and more.
- Encouraging our ACN providers to incorporate recruitment best practices to incentivize hiring bicultural and bilingual member-facing staff to help communicate and build trust with members.
- Gathering SDOH data using standardized tools and workflows. CCHA's ACNs are working to leverage this data.
- Continuing to require our ACNs to train their staff on cultural awareness as part of the onboarding process and encouraging annual refresher training.

Community Organization Level:

- Recruiting, cultivating, and supporting more diverse community organizations' partnerships by leveraging their voice to understand community needs and aligning efforts with CCHA interventions.
- Identifying cultural responsiveness training and resources offered by community partners and sharing information with the entire health neighborhood.
- Utilizing data to drive strategy around specific populations that community partnerships serve.
- Identifying experts and best practices within community organizations to leverage and replicate the work being done within the CCHA region.
- Incorporating DEI goals and objectives within all CCHA community partnership agreements. For example, CCHA incorporated DEI objectives within our Community Incentive Program (CIP) design. The CIP leverages 25% of CCHA's earned KPI incentive dollars to reinvest funds through our regional PIAC to selected providers and community entities for innovative projects focused on member health that are not covered by Medicaid services. The key priorities of the CIP now include DEI focus areas such as maternity, preventive care, and behavioral health.

Staff Level:

- Establishing internal workgroups to review data, share knowledge on specific topics, and develop interventions and plans to address the identified health disparities.
- Creating an internal, staff-driven Diversity, Equity, Inclusion, and Belonging (DEIB) committee. The committee's goal is to promote and celebrate diversity, equity, inclusion, and multiculturalism among staff through various mechanisms, including but not limited to workshops, discussions, social gatherings, and cultural events. This committee also wants to create spaces that foster and facilitate communication between all staff in the organization.

- Continuing CCHA staff training on cultural competency to improve care for different populations to enhance member trust, engagement, and how members from different populations are being served.
- Revising, standardizing, and monitoring procedures and scripting for member-facing staff, to ensure they know what to do when they encounter a member who speaks a different language or has a different cultural background.

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

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

Focus Area	COVID-19 Action Plan & Strategy

COVID-19	• Identify Disparity #1 – COVID vaccination rates among older adults and children
	  • Population 1 - Older Adults (defined by HCPF)
	  • Population 2 - Children (defined by HCPF)
	  • Metric: Improve COVID Immunization rate for bivalent immunization (updated booster or primary) status by June 30, 2025, as described below: Pediatric (0-19): From 4.7% (4/2023) to 12.3%, Adult (20+): From 13% (4/2023) to 21.1%
	  • <u>Overall strategy:</u>
	  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.

Since the beginning of the COVID-19 vaccine release, CCHA has been committed to promoting equal access to all our members. However, it is well known that many social, geographic, political, economic, and environmental factors can challenge vaccination access and acceptance.[5]

[5] "COVID-19 Vaccine Equity," Centers for Disease Control and Prevention, last updated March 29, 2022, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/vaccine-equity.html#:~:text=CDC%20is%20committed%20to%20COVID,racial%20and%20ethnic%20minority%20groups.

In May 2023, the Public Health Emergency (PHE) ended, but vaccines are still available, and they are still being distributed to keep communities safe. Therefore, CCHA continues supporting COVID-19 vaccinations as they are an effective mechanism to protect people from getting seriously ill, being hospitalized, and dying. While we do not expect COVID-19 vaccine data for this deliverable until February 2024, CCHA has been working to increase vaccination and booster rates for our members. CCHA's strategies to increase COVID-19 vaccination rates include:

Member Level:

- Create and maintain a specific member website landing page to provide member-centered resources around overall immunizations and ensure members have access to information on where they can obtain vaccines. These are the direct links to the website mentioned:
    - https://www.CCHAcares.com/covid
    - https://www.cchacares.com/wellvisit

  Timeframe: Started in 2023, and it is a continuous effort.
- Continue texting campaigns to remind members of the importance of vaccination and include a direct link to the CCHA website described above. *Timeframe:* The latest texting campaign launched in Fall 2023.
- Continue supporting and educating members who contact the CCHA Member Support call center or are engaged in CCHA care coordination programs to help them get vaccinated and reduce vaccine hesitancy. *Timeframe:* CCHA started supporting members when COVID-19 vaccines were approved and will continue working on this.

Provider Level:

- Continue supporting practices to achieve Vaccines For Children (VFC) program certification, allowing them to administer vaccines to Health First Colorado members on-site, as well as promoting existing VFC practices. Offering vaccinations on-site will help reduce barriers for our members, including the time and transportation needed to schedule and attend another appointment at a different location to receive recommended vaccines and offer greater convenience. *Timeframe:* CCHA started supporting practices at the beginning of the RAE contract and when COVID-19 vaccines were approved and will continue working on this.
- Supporting practices with developing workflows to administer vaccines or refer members to other health care providers or community organizations when appropriate. *Timeframe:* CCHA started supporting practices at the beginning of the RAE contract and when COVID-19 vaccines were approved and will continue working on this.
- Analyze data to identify practices with attributed members showing low vaccination rates and share data with those practices while discussing how CCHA can support vaccination efforts. *Timeframe:* Starting in Winter 2023-24.
- Maintaining bi-directional communication with practices to ensure CCHA understands barriers to getting the COVID-19 vaccine and develop resource tips sheets to support providers with these barriers. *Timeframe:* CCHA started supporting practices at the beginning of the RAE contract and when COVID-19 vaccines were approved and will continue working on this.

Community Organizations Level:

- Partnering with community champions (for example, regional health connectors) that have experience promoting and educating marginalized communities about vaccinations. CCHA partnered

with a Latino health equity consultant to help review and trans-create several Spanish-language member materials, going beyond simple translation and making them culturally sensitive for the Latino population CCHA serves. *Timeframe:* Started in the Fall of 2023 and will continue during calendar year 2024 (CY24).

- Promote vaccine information to CCHA's community partners to ensure they are up-to-date on information such as where to locate vaccines and guidelines for receiving the vaccine, including the dissemination of trans-created materials. *Timeframe:* Winter 2023-24.
- Promote Colorado Department of Public Health and Environment (CDPHE) mobile vaccine events and offer data to encourage these events to occur in areas serving higher disparate populations due for vaccines. In addition, develop a bi-directional communication process to relay any barriers or additional resources needed. *Timeframe:* Winter 2023-24.
- Offering training or resources around vaccine hesitancy and information to community partners to increase members' willingness to get vaccinated. *Timeframe:* CCHA started supporting practices when the COVID-19 vaccines were approved and will continue working on this.
- Continuing collaboration with HCPF to identify pharmacies that are interested in becoming VFC sites in areas with limited vaccine access. *Timeframe:* Started when COVID-19 vaccines were approved and is ongoing.
- Incentivizing Single Entry Points (SEPs)/Community Centered Boards (CCBs) to support members who have waivers with education on COVID-19 vaccines and boosters. CCHA created a resource for SEPs/CCBs to use while outreaching members on the Admit, Discharge, Transfer (ADT) list to offer additional support for the SEP/CCB Incentive Program. This resource included information on updated vaccines and boosters, where to get the vaccines, motivational interviewing information to help address hesitancy, and who to contact with additional questions or concerns. *Timeframe:* Started in January 2023 and continued through CY23.

Staff Level:

- Revise procedures and scripts for member-facing staff to improve engagement with diverse populations, e.g., non-English speakers contacting the CCHA call center. *Timeframe:* Spring 2024.
- Provide training to staff who support members. Member-facing staff received vaccine training, and CCHA plans to continue training on vaccine hesitancy. *Timeframe:* Spring 2024.

Table 1. COVID-19 Vaccination Rates

Target Population	Denominator (DEN)	Numerator (NUM)	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
Older Adults	TBD	TBD	TBD	TBD	TBD	TBD
Children	TBD	TBD	TBD	TBD	TBD	TBD

*Data will be populated once it is received from the Department.

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 Timeframes of access to prenatal and postpartum care

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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, through both the data HCPF provided and a literature review.
	  • Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations)
	  Yes, pregnant members who identify as Asian, Black/African American, Native Hawaiian/Other Pacific Islander, Other People of Color.
	  • Metric: Core Measure NQF 1517: Timeframes of Prenatal Care (PPC-CH)
	  • 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.

Maternity and Perinatal Health	• Identify Disparity #2 - Access to Postpartum Care
	  • Have you identified a disparity in this focus area?
	  Yes, through both the data HCPF provided and a literature review.
	  • Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations)
	  Yes, pregnant members who identify American Indian/Alaska Native, Black/African American, Other People of Color.
	  • Metric: Core Measure NQF 1517: Post-partum Care (PPC-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 **See below.**

According to data from the Centers for Disease Control and Prevention (CDC), hundreds of people die each year in the United States during or within one year of pregnancy. Additionally, research shows that the rate of maternal mortality may have increased as much as 33.3% in the early part of the COVID-19 pandemic.[5] Thousands more have unexpected outcomes of labor and delivery with ongoing consequences. It is well-known that racial disparities exist in maternal health care. Nationwide, Black women have three times the risk of dying from a pregnancy-related cause than White/Caucasian women, and multiple factors contribute to this disparity, including accessing timely care. In addition, in Colorado, the State Maternal Health Task Force September 2023 Maternal Health Strategic Plan reiterated these known issues and recommended the following strategies:

1. Create Systems Changes to Reduce Racial and Geographic Inequalities, including collaboration with community-based partners to address racism and reduce racial and geographic inequities to promote alignment of initiatives.
2. Address Root Causes Impacting Maternal Health and Equitable Access to Services, such as collaboration with community-level efforts that address housing, income, legal status, the physical environment and structures, transportation, mental health, and substance use supports, etc. to promote alignment of initiatives and leveraging of funds.[6]

CCHA will strive to incorporate these strategies into our Plan, particularly leveraging doula programs, which are addressed below.

Utilizing the health equity data provided by HCPF, CCHA learned that pregnant women who identify as part of the BIPOC population are not accessing timely prenatal or postpartum care as much as other populations. To supplement the data, CCHA conducted a literature review and found that women who identify as Black/African American have lower rates of accessing prenatal care within the first trimester across the state.[7] CCHA's strategies to address this health disparity include the following:

Member Level:

- Incentivize members to earn rewards for completing prenatal and postpartum care visits by launching our Healthy Rewards Program. Members can self-report their visits and earn up to $35

[6] "Colorado Maternal health Strategic Plan," Colorado Department of Public Health & Environment, published September 2023, https://drive.google.com/file/d/1_cXfBqHVN6SxipD01DWxXYznjCpfK-nm/view.
[7] "Maternal Health Equity Report: An Analysis of 2020 Health First Colorado Births,' Colorado Department of Health Care Policy & Financing, published April 2023, https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20Maternal%20Health%20Equity%20Report_April%202023.pdf.

per visit through a gift card of their choice to best serve their current SDOH needs, including gas, groceries, and more. *Timeframe:* Initiate the program by January 2024.

- Expand the Food As Medicine program to maternity members. Based on previous success with Project Angel Heart (PAH) partnership using food as medicine,[8] CCHA will offer eight weeks of meals to high-risk pregnant members, including members who identify as Black/African American, American Indian/Alaskan Native, are non-English speaking, less than 21 or greater than 35 years of age, members with comorbidities of hypertension, diabetes, or HIV, and pregnant members who have one or more hospital admissions or ED visits related to pregnancy. *Timeframe:* Starting in early 2024.
- Collaborate with an equity consultant to trans-create member-facing materials, including our Spanish maternity brochure and women's care materials. The consultant's expertise and insights are pivotal in ensuring our materials are translated accurately and culturally appropriately. This collaborative effort ensures that our resources resonate with the diverse cultural backgrounds of our members, reflecting our commitment to providing inclusive and effective healthcare support. *Timeframe:* January 2024.
- Continue offering care coordination services to pregnant members through our maternity program, including prenatal and postpartum care. CCHA outreaches all identified pregnant women equally to offer care coordination services. However, as part of CCHA's risk stratification, women who self-identified as Black/African American are considered high-risk; therefore, this population of pregnant women is being outreached directly by our care coordination nursing team, among others. In addition, CCHA revamped its health needs assessment to include questions for follow-up if depression or anxiety are identified. *Timeframe:* Started in Spring 2023 and will continue.
- Continue to offer members in care coordination access to the Injoy app, to support access to evidence-based maternal and newborn education. The app represents culturally diverse populations and includes various topics, such as the importance of timely care and available support.[9] *Timeframe:* Started in 2022 and will continue offering this access in 2024.
- Pilot a new onboarding process for newly identified pregnant members to educate them about the benefits and resources available to them free of cost and engage them in timely prenatal and postpartum care. The pilot will include multiple modes of communication, and materials will be available in English and Spanish. *Timeframe:* Early 2024

Provider Level:

- Share prenatal and postpartum KPI performance and demographic data with PCMPs to identify opportunities to positively impact health inequities. Our practice transformation coaches (PTCs) will utilize a new KPI dashboard that shows demographic data related to KPIs for the overall population and member-level reports that already include demographic data. *Timeframe:* Starting in January 2024.

[8] CCHA conducted a pilot program with PAH, providing members with diabetes post-discharge with up to eight weeks of medically tailored meals designed to reduce avoidable hospital and ED utilization and overall costs by ensuring members have access to nutritious meals tailored to their condition. The program evaluation found that eligible members who received seven meals per week for eight weeks decreased costs related to inpatient stays by an average of $1,142 per member, demonstrating great success in achieving the intended outcomes.
[9] https://injoyhealtheducation.com.

- Educate providers about the Health First Colorado doula benefit, including promotion of the benefit, referral pathways, and billing processes. *Timeframe:* Starting in January 2024 once the doula benefit is approved.

Community Organizations Level:

- Expand team-based maternity management by offering funding to include and expand doula services within our region. Multiple studies have demonstrated promising results on better birth outcomes, such as lowering birth complications or the odds of postpartum depression and anxiety.[10] Community-based doulas can provide culturally and linguistically appropriate care to improve communication between mothers and their health care team. Based on these findings, CCHA has partnered with Elephant Circle to expand its training of community-based doulas within our region. CCHA provided $50,000 to Elephant Circle to expand its work into Region 7. Their work will include the following:
    - Fund an associate to lead service expansion efforts and cohort training over six months.
    - Train and certify a cohort of approximately ten doulas to work with Health First Colorado members located in the Region 7 service area.
    - Provide approximately 15 families with doula services at no charge to the families.
    - Provide harm reduction care to the families receiving services.

  Timeframe: The partnership started in May 2023 and will expand through 2024.
- Provide organizations that support pregnant and postpartum members with financial support through CCHA's Community Incentive Program (CIP). This program aims to fund services that are not billable Health First Colorado benefits, intending to equip members with the tools and skills to be self-sufficient and successfully manage their health. *Timeframe:* January 2023 for CY23 projects, January 2024 for CY24 projects.
    - CY23 awardees impacting this population include:
        - WeeCycle received $163,000 to expand their mobile distribution of diapers, wipes, baby food and formula to Health First Colorado members in Region 6, and expand their services to El Paso County in Region 7.
        - Women Partnering received $40,000 to increase reach, visibility and credibility to respond to unmet needs of vulnerable women and children in the Colorado Springs area.
    - CY24 awardees include:
        - WeeCycle will receive $135,400 to expand the availability of baby supplies (diapers, wipes, formula, baby food) to El Paso members.
- Increase partnerships and bi-directional communication with community organizations that provide community resources, including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Nurse-Family Partnership (NFP) services to Medicaid members in marginalized and BIPOC communities to understand barriers and opportunities where CCHA can support. *Timeframe:* January 2024.

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[10] Sobczak, A., Taylor, L., Solomon, S., Ho, J., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J., "The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review," *Cureus*, no. *15*(5) (May 2023), e39451. https://doi.org/10.7759/cureus.39451. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292163/#:~:text=The%20studies%20in%20this%20review,to%20reduce%20anxiety%20and%20stress.

Staff Level:

- Continue training member-facing staff to help them become more culturally competent. During the first semester of CY2023, staff received the following training:
    - March of Dimes: Dismantling Bias in Maternal and Infant Healthcare
    - SimplyFed: Breastfeeding presentation
    - String of Pearls: Grief and Loss
    - Colorado Hospital Substance Exposed Newborns (CHoSEN) Forum
    - Colorado Prenatal Care Quality Collaborative Conference
    - WIC training

  Timeframe: CCHA will continue offering new training in 2024.

Table 2. Timely Prenatal Care

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
Asian, Black/African American, Native Hawaiian/Other Pacific Islander, Other People of Color	591	354	59.90%	60.16%	0.26%	59.92%

Table 3. Timely Postpartum Care

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
American Indian/ Alaska Native, Asian, Black/African American, Other People of Color	587	155	26.41%	37.86%	1.15%	27.55%

*CCHA did not identify statistically significant disparities for the Prenatal and Postpartum care measures. However, based on the literature review and the data provided by the State, the BIPOC populations show as the lower performers for these metrics. Therefore, we are not including numbers to close the gap to equity.

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.

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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? **No.**
	  • Have you identified a population to target for this disparity? **No.**
	  • Metric: Core Measure NQF 3489: Follow-up after Emergency Department Visit for Mental Illness (FUM)
	  • 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
	  No statistically significant disparities were identified in rates of follow-up within 7 days or 30 days after emergency department (ED) visit for mental illness.

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:
	  o **Population 1: Male members**
	  • Metric: Core Measure NQF 3488: Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
	  • 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	• 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:** o **Population 1: Male members** o **Population 2: Black/African American members.** • Metric: Core Measure NQF 0576: Follow-up after Hospitalization for Mental Illness (FUH) • <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 #4 - Depression screenings • Have you identified a disparity in this focus area? **Not applicable.** • Have you identified a population to target for this disparity? **Not applicable.** • Metric: Core Measure NQF 0418: Depression Screening and Follow-Up Plan • <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 **CCHA did not receive data for this metric, and per HCPF direction, will not build a plan to address this disparity at this time.**

Poor transition between high levels of care and the community may harm members' health outcomes and functional status. The risk of psychiatric readmission is higher in the periods immediately after discharge.[11] It may be indicative of a lack of access to adequate community-based aftercare, challenges with psychiatric medication adherence, and effective condition management in lower-intensity settings. Timely treatment is associated with a reduction in substance use, alcohol, or other drug (AOD) associated morbidity and mortality, future emergency department (ED) use, hospital admissions, and bed days,[12] as well as improved health, productivity, and social outcomes.[13]

In 2022, 18.9% of males in Colorado reported using prescription drugs non-medically,[14] and 24.3% of adult males reported either binge drinking (having five or more drinks on one occasion in the past 30 days) or heavy drinking (having 15 or more drinks per week), [15] compared to females' rates of 14.1% and 16.8% on the same measures, respectively. In addition to higher reports of substance use, notable disparities are observed by gender on rates of follow-up within 30 days after emergency department visit for AOD (FUA 30) in Region 7.

A similar pattern is observed in rates of follow-up within 30 days after hospitalization for mental illness for males in Region 7, with meaningfully lower rates for males compared to females. In addition, follow-up care performance is demonstrably disparate for Black/African American members in comparison to other racial/ethnic subgroups.

[11] Osborn D.P., Favarato G., Lamb D., Harper T., Johnson S., Lloyd-Evans B., Marston L., Pinfold V., Smith D., Kirkbride J.B., et al. "Readmission After Discharge from Acute Mental Healthcare among 231,988 People in England: Cohort Study Exploring Predictors of Readmission Including Availability of Acute Day Units in Local Areas." *BJPsych Open* 7, no. 4 (2021):e136, https://doi.org/10.1192%2Fbjo.2021.961.

[12] "Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)," NCQA, accessed October 4, 2023, www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-alcohol-and-other-drug-abuse-or-dependence.

[13] "Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)," NCQA, accessed November 1, 2023, https://www.ncqa.org/hedis/measures/initiation-and-engagement-of-alcohol-and-other-drug-abuse-or-dependence-treatment.

These findings are demonstrated in the data tables below. For the purposes of this plan, a health inequity is identified when there is a statistically significant difference between outcomes for a specific group compared to rates observed for all other populations combined. The gap to equity value shows the number of compliant events needed to achieve equity for the target population compared to other populations, not to achieve the overall target of closing the gap by 10%. This absolute value notes the practical magnitude of the disparity which is meaningful in intervention development. The 10% gap closure is calculated using the top performer population rate.

Table 4. Appointment follow-up within 30 days post-ED for SUD

Target Population	DEN	NUM	Target Population Rate	Gap to Equity	Other Populations Rate	10% Gap Closure	Target
Male	1198	518	43.24%	72	49.17%	0.59%	43.83%

Table 5.1 Follow-up within 7 days from hospitalizations for mental health emergencies

Target Population	DEN	NUM	Target Population Rate	Gap to Equity	Other Populations Rate	10% Gap Closure	Target
Black/ African American	140	[redacted]	[redacted]%	18	28.07%	1.24%	16.95%

Table 5.2 Follow-up within 30 days from hospitalizations for mental health emergencies

Target Population	DEN	NUM	Target Population Rate	Gap to Equity	Other Populations Rate	10% Gap Closure	Target
Male	795	302	37.99%	42	43.26%	0.53%	38.52%
Black/ African American	140	43	30.71%	17	42.24%	1.15%	31.86%

CCHA recognizes that addressing disparities in health outcomes is essential for whole-person care, to promote health equity and establish conditions in which no one is disadvantaged from achieving their full health potential independently of social position. Although no statistically significant disparities were identified in rates of follow-up after emergency department visit for mental illness (FUM), CCHA's quality strategy includes initiatives designed for continuous performance improvement on this measure across all populations while routinely analyzing outcomes for inequities. CCHA’s approach to addressing barriers to securing health for patients and individuals and promoting equitable outcomes is listed below.

Member Level:

- Launch the Healthy Rewards member incentive program designed to financially reward members for participating in healthy activities, including attending a follow-up service with a behavioral health

provider within 7 days of discharge from an ED visit for treatment of substance use disorder or mental illness (MI), and attending a follow-up service with a behavioral health provider within 7 days of discharge from hospitalization for mental illness. *Timeline:* CY2024.
    - Applicable Measures: FUM, FUA, FUH
- Offer peer support services to members when outreaching them after an emergency department visit for AOD or MI. CCHA's Peer Support specialists are a diverse group of individuals with lived experience, who are trained in motivational interviewing to promote and facilitate access to aftercare. Staff work to identify and help resolve barriers to access and engagement in services, and referrals offered prioritize members' needs and preferences, including cultural and language needs as well as through convenient and accessible modes of delivery. Staff fluent in the member's primary language are prioritized, and language interpretation services are offered and available at no cost to members. *Timeline:* January 2024.
    - Applicable Measures: FUM, FUA.
- Continue implementing a Performance Improvement Project (PIP) to increase the percentage of SDOH screenings for unmet food, housing, utility, and transportation needs administered to CCHA members transitioning out of a Psychiatric Inpatient facility or Acute Treatment Unit (ATU) for a behavioral health condition. Identifying and addressing our members' social needs helps us address and remove barriers to effective health management, help engage members in their care, reduce ED utilization and inpatient stays, and promote equitable outcomes. *Timeline:* SFY23-24.
    - Applicable Measures: FUM, FUA, FUH.

Provider Level:

- Fund projects through CCHA's High Intensity Outpatient Services Program (HIOP). CCHA's HIOP transformation efforts strive to address inequities by enhancing network capacity that can expedite access for a higher volume of members discharging from emergent and inpatient levels of care, as well as to offer specialized programming. All awardee projects include efforts to address gaps while advancing health equity. The following providers will launch expansion projects through 2024. *Timeline:* SFY23-24.
    - Applicable Measures: FUM, FUA, FUH.
    - Approved projects:

Region 7 Providers	Gap Filled
Crisalida, Inc.	Spanish-speaking family care
Consultants for Children	Youth, high fidelity wraparound
Kids Crossing	BH respite
ED Care	Eating disorders
Sunrise Counseling	Medication assisted treatment (MAT), intensive outpatient treatment (IOP), peer support
The Patterson Center	Youth, trauma systems therapy (TST), intensive outpatient treatment (IOP)
Bloom Wellness	Rural
Collective Health Partners	Youth IOP (telehealth option)
The Dale House Project	Psychosocial rehabilitation and supportive housing
Palome	BH respite, skills training and crisis response
Diversus	Medication assisted treatment (MAT), intensive outpatient treatment (IOP), peer support

- Partnering with a high-volume Community Mental Health Center (CMHC) on a PIP to increase the percentage of CCHA members 6 years of age and older who have a follow-up visit with a mental health provider within 7 days after discharge from hospitalization for treatment of selected mental illness or intentional self-harm diagnoses, in accordance with NQF 0576 Follow-up after Hospitalization for Mental Illness (FUH) Core Measure standards. *Timeline:* SFY23-24.
    - Applicable Measures: FUH.

Community Organization Level:

- In 2023, CCHA provided funding to sponsor initiatives intended to enhance accessibility and availability of behavioral health services as well as address high-priority community and member needs, including the following. *Timeline:* Starting in 2023.
    - Savio: Secure transportation resources to expand Multisystemic Therapy (MST) access in El Paso and Teller counties.

- Mental Health Colorado: Support mental health stigma and patient rights campaigns.
- Ute Pass: Support to build BH mobile crisis response and hospital diversion in Park and Teller counties.
- Recovery Cafe: Increase access to BH/SUD supports for Spanish-speaking community members.

Staff Level:

- 80% of CCHA's Peer Support Specialists have completed all required Peer Academy trainings, including Cultural Awareness & Humility. *Timeline*: Ongoing.
- BH staff are required to complete Cultural Competency training. *Timeline*: Onboarding and annually thereafter.

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

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

Focus Area	Prevention/Population Health Plan & Strategy
Prevention/ Population Health	• Identify Disparity #1 - Childhood immunization status • Have you identified a disparity in this focus area? **Yes.** • Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations) **R7: Yes, Black/African American, Native Hawaiian/Other Pacific Islander, and Other People of Color members and members residing in Park and Teller counties.** • Metric: Core Measure NQF 0038: Childhood Immunization Status Combo 10 • 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.
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/No (If yes, please identify 1 to 2 target populations) **R7: Yes, American Indian/Alaskan Native, Asian, Black/African American. Native Hawaiian/Other Pacific Islander members and members residing in Park and Teller counties.** • Metric: Core Measure NQF 1407: Immunizations for Adolescents Combo 2 • 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.**
Prevention/ Population Health	• Identify Disparity #3 - Decrease diabetes poor A1C control in populations at risk • Have you identified a disparity in this focus area? **Not applicable.** • Have you identified a population to target for this disparity? Yes/No (If yes, please identify 1 to 2 target populations) **Not applicable.** • 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 **CCHA did not receive data for this metric, and per HCPF direction, will not build a plan to address this disparity at this time.**
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/No (If yes, please identify 1 to 2 target populations) **R7: Yes, American Indian/Alaskan Native, Black/African American, Native Hawaiian/Other Pacific Islander members and members residing in Park and Teller counties.** • Metric: Percentage of children/youth receiving preventive visits through EPSDT; Core Measure NQF 1392 Well-Child Visits in the First 30 Months of Life (W30-CH); NQF 1516 Child and Adolescent Well-Care Visits (WCV-CH) • 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.**
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/No (If yes, please identify 1 to 2 target populations) **R7: Yes, White/Caucasian members and members residing in Park and Teller counties.** ● Metric: Core Measure NQF 2517: Oral Evaluation, Dental Services (OEV-CH) ● 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.**

Accessing preventive health care services is important to children's health and development. Children need regular well-child and dental visits to track their development and find and address health problems early. But for various reasons, many people do not get preventive care. Some barriers include not knowing who their primary care provider is, living too far from providers, and lack of awareness about recommended preventive services.[14]

Populations adversely affected by disparities as defined by the National Institute on Minority Health and Health Disparities include racial and ethnic minority populations (Blacks/African Americans, Hispanics/Latinos, American Indians/Alaska Natives, Asians, Native Hawaiians, and Other Pacific Islanders), socioeconomically disadvantaged populations, underserved rural populations, sexual and gender minority populations, and/or others subject to discrimination, and varied slightly for each metric. These populations have poorer health outcomes attributed to being socially disadvantaged, which results in being underserved in the full spectrum of health care.[15]

We also recognize that the COVID-19 pandemic impacted preventative healthcare services. Many families delayed or missed recommended well visits and immunizations for their children. According to

[14] "Preventive Care," U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, accessed November 1, 2023, https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care.
[15] "Minority Health and Health Disparities: Definitions, Parameters," National Institute on Minority Health and Health Disparities, updated October 4, 2023, https://www.nimhd.nih.gov/about/strategic-plan/nih-strategic-plan-definitions-and-parameters.html.

the Journal of the American Medical Association, Asian or Pacific Islander, Hispanic, multiracial groups and older children were notably more likely to have delayed or missed preventive care.[16]

CCHA's data, provided by HCPF, reiterated what the National Institute on Minority Health and Health Disparities defined. The data showed that the CCHA BIPOC population and members who live in less urban counties have a disparity in preventive care, including immunizations and well visits, compared to our overall population. Therefore, we have defined the above populations to target for planned interventions to reduce this disparity gap. Our strategies include:

Immunizations and Well Visits (Disparities #1, 2 and 4)

Member Level:

- Continue developing the CCHA website to make it more member friendly. The updates will ensure that all members can easily navigate the content to access vaccination services conveniently. CCHA employs website accessibility software to ensure that websites adhere to inclusive design principles, verifying that colors and fonts are chosen with consideration for accessibility standards. This proactive approach helps create webpages that are user-friendly and accommodating for individuals with diverse needs and preferences. *Timeframe:* Updates started in Fall 2023 and will continue into 2024.
- Ensure all member-facing webpages are written so members can easily understand content. To do this, we will ensure content is at a 6th-grade reading level, increasing accessibility and comprehension. Furthermore, we will continue trans-creating member-facing webpages into Spanish, reaffirming our commitment to linguistic inclusivity and making vital healthcare information accessible to a broader audience. As part of our commitment to enhancing member experience, CCHA involves our member advisory committee in the development of new member-facing webpages. For instance, in the creation of a new maternity onboarding webpage, we will prioritize feedback from our members by conducting thorough testing before the page is launched, ensuring it aligns with their needs and expectations. *Timeframe:* Continuous effort.
- Continue population-based texting campaigns to remind members and their families about the importance of well visits and immunizations. Texts include a link to CCHA's website for more information and resources. This the direct link to the website mentioned: https://www.cchacares.com/wellvisit
  Timeframe: First campaign launched in the Fall 2023 and will continue into 2024.
- Continue supporting and educating members who contact the CCHA Member Support call center or are engaged in CCHA care coordination programs to help them and their children complete well visits and receive recommended vaccines. *Timeframe:* Continuous effort.
- Incentivize members to earn rewards for completing well visits by launching our Healthy Rewards Program. Members can self-report their visits and earn $15 - $20 per visit for a gift card of their choice to serve their current SDOH needs best, including gas, groceries, and more. *Timeframe:* Initiate the program by January 2024.

[16] Tabet M, Kirby RS, Xaverius P. "Racial and Ethnic Differences in Factors Associated With Delayed or Missed Pediatric Preventive Care in the US Due to the COVID-19 Pandemic," *JAMA Netw Open.* 2023;6(7):e2322588. doi:10.1001/jamanetworkopen.2023.22588.

- Continue outreaching newly eligible and non-utilizer members about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. This outreach aims to inform these members and their families about EPSDT benefits and encourage them to schedule a well-visit appointment with their PCMP. *Timeframe:* Continuous effort.

Provider Level:

- Help clinics serving higher numbers of disparate populations to achieve Vaccines for Children (VFC) certification, allowing them to administer vaccines to Health First Colorado members on-site. Offering vaccinations on-site will help reduce barriers for our members, including the time and transportation needed to schedule and attend another appointment at a different location to receive recommended vaccines and offer greater convenience. *Timeframe:* Started at the beginning of the RAE contract and is ongoing.
- Share KPI performance and demographic data with PCMPs to identify opportunities to positively impact health inequities. Our PTCs will utilize a new KPI dashboard that shows this data for the overall population, in addition to member-level reports that already include demographic data. *Timeframe:* Starting in December 2023 and continuing into 2024.
- Work with PCMPs to implement workflows to follow up with members who are referred elsewhere (ex., the health department, another practice, or pharmacy) to receive immunizations. This is considered a best practice that our PTCs have been using for the Alternative Payment Model (APM) program since 2019. *Timeframe:* Started in alignment with APM in 2019 and is ongoing.
- Address billing issues that impact performance metric reporting. CCHA is working with HCPF to provide guidance related to billing issues to ensure rural health clinics receive credit for well visits. Resolving these issues will help ensure data is accurate for all populations and help practices meet the KPI goals. *Timeframe:* Started in Summer 2023 and will continue to seek additional guidance.

Community Organization Level:

- Partner with Rural Health Contractors (RHCs) to encourage members to receive preventative care and help address related barriers. CCHA has partnered with two non-profit community organizations in Park and Teller counties since the beginning of the RAE contract, Rocky Mountain Rural Health (RMRH), and Aspen Mine Center (AMC), respectively, that we refer to as Rural Health Contractors. These partnerships leverage existing, trusted resources within the community and facilitate collaboration with staff who are familiar with local needs. These organizations provide outreach, health education and care coordination services to CCHA members residing in these counties where local providers and resources are scarce. Our RHC partners will then outreach these members to help them schedule well and dental visits, using outreach lists provided by CCHA that prioritize identified disparate populations, including:
    - BIPOC members who are due for both a well visit (WV) and an oral evaluation (OE)
    - Other Park and Teller counties members who are due for both WV and OE
    - BIPOC members who are due for a WV
    - Other Park and Teller counties members who are due for a WV

  Additionally, these partners will add language to existing outreach campaigns to encourage members to receive immunizations.
  Timeframe: Summer 2024.
- Promote CDPHE mobile vaccine events and offer data to encourage these events to occur in areas serving higher BIPOC/disparate populations due for vaccines. In addition, develop a bi-directional

communication process to relay any barriers or additional resources needed. *Timeframe:* Winter 2023-24.

- Continuing collaboration with HCPF to identify pharmacies interested in becoming VFC sites in areas with limited vaccine access. *Timeframe:* Started in Summer 2023 and is ongoing.
- Partner with trusted community organizations that serve vulnerable populations and leverage those relationships to help connect members to care. *Timeframe:* Ongoing efforts since the COVID-19 vaccines were approved and ongoing.
- Utilize these partnerships to distribute educational materials to members to ensure providers and community organizations are up-to-date with immunization protocols and best practices. *Timeframe:* Ongoing efforts since the COVID-19 vaccines were approved and ongoing.

Staff Level:

- Refine member-facing staff scripts and workflows to ensure member screening/assessment questions address and facilitate access to preventive care (well visit and immunizations). *Timeframe:* Spring 2024.
- Ensuring that Member Service Support (MSS) and Care Coordination teams have access to adequate data regarding well visits. This data can help identify members who are due for a well visit, and CCHA can support them with reminders on scheduling their appointments and address any other barriers. *Timeframe:* Started in September 2023, and CCHA will continue refining this process.
- Provide training to staff who support members. Member-facing staff received training on vaccines, and CCHA is planning on continuing training on vaccine hesitancy. *Timeframe:* Spring 2024.

Table 6. Childhood Immunizations – Combo 10

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
Black/African American, Native Hawaiian/Other Pacific Islander, Other People of Color	822	193	23.48%	27.10%	0.36%	23.84%
Park and Teller counties	90	[redacted]	[redacted]%	26.74%	1.45%	13.67%

Table 7. Immunizations for Adolescents – Combo 2

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander	385	69	17.92%	21.54%	0.36%	18.28%
Park and Teller counties	129	[redacted]	[redacted]%	21.71%	0.93%	13.33%

Table 8. Well Child Visits – First 15 Months

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
American Indian/Alaskan Native, Black/African American. Native Hawaiian/Other Pacific Islander	272	121	44.49%	56.91%	1.24%	45.73%
Park and Teller counties	83	44	53.01%	56.09%	0.31%	53.32%

Table 9. Well Child Visits – 15-30 Months

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
American Indian/Alaskan Native, Black/African American. Native Hawaiian/Other Pacific Islander	305	160	52.46%	56.75%	0.43%	52.89%
Park and Teller counties	99	49	49.49%	56.69%	0.72%	50.21%

Table 10. Child and Adolescent Well Visits

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	10% Gap Closure	Target
American Indian/Alaskan Native, Black/African American. Native Hawaiian/Other Pacific Islander	6573	1990	30.28%	33.28%	0.30%	30.58%
Park and Teller counties	2163	545	25.20%	33.31%	0.81%	26.01%

*CCHA identified BIPOC and members in rural counties as populations with lower performance for Immunizations and Well Visits. In addition, CCHA also identified statistically significant differences for the White/Caucasian population; however, the White/Caucasian population is performing very near to the regional performance while the BIPOC and rural counties populations are the lowest performers for these metrics overall. As a result, CCHA decided to concentrate our efforts and resources on the BIPOC and members in rural counties.

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Dental and Oral Health for Children (Disparity #5)

Member Level:

- Continue working with our health equity consultant to trans-create member-facing dental materials available in English and Spanish, prioritizing cultural appropriateness and clarity, ensuring that our dental resources resonate with our members' diverse backgrounds, making them easily understood and culturally sensitive. *Timeframe:* Start in Spring 2024.

Provider Level:

- Offer financial support to provide oral evaluation services to reduce barriers for members in less urban counties where provider availability is limited. For example, in October 2023 CCHA formed an agreement with the only dental provider in Fairplay to leverage their dental visits to also discuss the importance of well visits. *Timeframe:* Started Fall 2023 and ongoing.
- Will continue identifying dental providers serving our more rural communities who are taking new members and facilitate connections between them and local PCMPs to support referral workflows. *Timeframe:* CCHA started this work at the inception of the oral evaluation KPI, and it remains an ongoing effort.
- Support innovative programs for integrated care in the health neighborhood and community that support oral health initiatives. For example, Peak Vista Community Health Center's Logan at Myron Stratton clinic is testing a pilot for refugee members, many of whom are BIPOC and/or speak non-English languages, to help expedite dental evaluations and further treatment. They conduct an oral examination, complete with imaging, and send those images in real-time to a Peak Vista dentist who reviews images that day and sends a care plan to the clinic for follow-up and next steps. If this pilot is successful, they will expand this model to other locations, and CCHA will share best practices with other ACNs. *Timeframe*: Started in Summer 2023 and ongoing.

Community Organization Level:

- Partner with DentaQuest to ensure dental providers are aware of the KPIs and their role in helping meet them. Additionally, we will share data to inform future interventions related to disparate populations' performance. *Timeframe:* Spring 2024.
- Partner with mobile dental providers and community partners to host oral health events for members in areas without easy access to dental care, including more rural communities or communities with a high concentration of BIPOC members who are failing the measure. *Timeframe:* January 2024.
- Distribute $133,700 of Community Incentive Program funding to Deserving Dental in 2024 for their proposed program to engage members in Regions 6 and 7 in oral care and provide oral evaluations for children. Their program seeks to establish care for children by incentivizing parents to establish oral care for their children.
- Partner with community organizations to distribute oral health educational materials to members. Leveraging local leaders to share this important information helps ensure members receive the message from trusted sources in settings where they are already involved in the community. *Timeframe:* Starting January 2024.

Staff Level:

- Continue ensuring that member-facing teams have access to up-to-date information regarding oral evaluations to educate and connect members to dental services. *Timeframe:* Started in September 2023 and CCHA will continue refining this process.

Table 11. Oral Evaluations for members under age 21

Target Population*	DEN	NUM	Target Population Performance	Other Populations Rate	Gap to Equity **	10% Gap Closure	Target
White/ Caucasian	32500	14805	45.55%	51.59%	2628	0.60%	46.16%
Park and Teller counties	2385	899	37.69%	49.92%	290	1.22%	38.92%

*CCHA identified White/Caucasian members in rural counties as populations with statistically significant disparities for Oral Evaluation.
**This column shows the number of members needed to close the gap to achieve equity for the target population compared to the other populations, not to achieve the overall target of closing the gap by 10%.

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

Focus Area	Additional Organization Action Plan & Strategy

Access to Care	• Identify Disparity #1 -
	  • Have you identified a disparity in this focus area? Have you identified a population to target for this disparity?
	
	  Yes, BIPOC (Black/African American, American Indian/Alaskan Native, Black/African American, Native Hawaiian/Other Pacific Islander, other people of color members.
	
	  • Metric: **Increase access to care, as defined as the metrics for the maternity and prevention focus areas, for the BIPOC (Black/African American, American Indian/Alaskan Native, Black/African American, Native Hawaiian/Other Pacific Islander, other people of color) member population by 10%**

	(using the above metrics of the focus areas where this population was identified). ● 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.**
Access to Care	● Identify Disparity #2 - ● Have you identified a disparity in this focus area? Have you identified a population to target for this disparity? **Yes, lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) members.** ● Metric: **Find trusted community organizations to develop partnerships that could increase access to healthcare services for the LGBTQIA+ population.** ● 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.**

Different studies have shown that the quality of patient-provider relationships for Black/African Americans and the lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) population is driven by perceived discrimination, medical mistrust, race discordance, poor communication,[17] and

[17] Cuevas, Adolfo Gabriel, "Exploring Four Barriers Experienced by African Americans in Healthcare: Perceived Discrimination, Medical Mistrust, Race Discordance, and Poor Communication," (M.S. diss., Portland State University, 2013). https://doi.org/10.15760/etd.615.

prejudice, which can directly contribute to poorer health status.[18] According to data from the University of California at Los Angeles (UCLA) and the Movement Advancement Project, the total LGBTQIA+ population in Colorado in 2020 was 234,000[19] and the proportion of the LGBTQIA+ population is 4.6% (which is considered high). Of those, 21% have an income below $24,000 and 25% are children.[20] In addition, in Colorado, members of the LGBTQIA+ community are more likely to underutilize services if they don't feel they have safe, inclusive options of care. They also might have less trust in health providers due to past negative experiences, according to the Equity on Home and Community-Based Services (HCBS) literature review report.[21] Medical and behavioral health conditions might be further complicated because of the poor access to health care and the discriminatory practices of involved professionals. In addition, systematic racism is a public health crisis in the United States, leading to health disparities and worse health outcomes.[22] In addition, people who are both LGBTQIA+ and part of a racial or ethnic minority will often face the highest level of health disparities.[23] CCHA also joined HCPF's Health Equity Town Hall meeting in May to gain further perspective from the LGBTQIA+ community. Many participants echoed these concerns about the unique disparities these individuals experience and the need to improve access to culturally competent, inclusive care in Colorado.

At CCHA, we can only estimate the full extent of LGBTQIA+ disparities among our members due to a lack of regional data. Data collection on sexual orientation and gender identity is not currently available. We appreciate HCPF, the Department of Human Services, and other agencies' efforts to improve data collection opportunities to include these elements in the future. Nevertheless, we are committed to striving for positive change for our members now. After reviewing the literature and learning about data disparities presented at the Health Equity Town Hall meeting, we learned that this population is likelier to experience certain health-related challenges and disparities. CCHA decided to include efforts in this Plan that could reduce such disparities among our LGBTQIA+ members.

Studies also show that racial and ethnic differentials in the quantity and quality of care are likely contributors to racial disparities in health status. The Black/African American population and other minorities have lower levels of access to medical care in the United States due to their higher rates of unemployment and under-representation in good-paying jobs that include health insurance as part of

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[18] Alencar Albuquerque, Grayce et al., "Access to health services by lesbian, gay, bisexual, and transgender persons: systematic literature review." BMC International Health and Human Rights, vol. 16 2 (Jan. 2016), https://doi.org/10.1186/s12914-015-0072-9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4714514 .

[19] "Colorado's Equality Profile," Movement Advancement Project, accessed December 1, 2023, https://www.lgbtmap.org/equality_maps/profile_state/CO.

[20] "LGBT Data and Demographics: Colorado," The Williams Institute, University of California Los Angeles School of Law, last updated January 2019, https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=8#density.

[21] "Equity in Home and Community-Based Services (HCBS): A Review of the Literature," Colorado Department of Health Care Policy and Financing, published September 2023, https://hcpf.colorado.gov/sites/hcpf/files/LTSS%20Equity%20Report_Literature%20Review_September%202023.pdf.

[22] "Black/African American Health Disparities," American Journal of Preventive Medicine, accessed November 15, 2023, https://www.ajpmonline.org/content/black-african-american-health-disparities.

[23] "How to Close the LGBT Health Disparities Gap," American Progress, accessed November 15, 2023, https://www.americanprogress.org/article/how-to-close-the-lgbt-health-disparities-gap.

the benefit package when compared to the White/Caucasian population.[24] In addition, the BIPOC population is more likely to face social and economic challenges that impact health, including higher rates of poverty and food insecurity compared to the White/Caucasian population.[25]

The following strategies apply to both populations, aiming to improve access to healthcare:

Member Level:

- Continue capturing self-reported member gender identification and race/ethnicity data for members engaged in care coordination services to tailor care plans and improve trust and outcomes. *Timeframe:* CCHA updated its Health Needs Assessment (HNA) in Fall 2022 and will continue revising as needed.

Provider Level:

- Collected providers' data in our Office System Review to understand practices focusing on special populations or clinical conditions, for example, transgender, people with disabilities, minorities, shared race or ethnicity, HIV positive, obesity, SUD, high-risk pregnancy, non-English speakers, etc. Our call center and care coordination team will soon use the data collected. *Timeframe:* CCHA collected this data for the first time in January 2023 and will continue updating it annually.
- CCHA will work on identifying best practices among providers to train staff on how to better serve the LGBTQIA+ population, for example, trauma-informed care training. *Timeframe:* Summer 2024.
- High Intensity Outpatient funding for Mountain Vista Psychology and Patterson Resiliency Center will support specialized provider training for behavioral health treatment in the LGBTQIA+ community. *Timeframe:* Fall 2023.
- CCHA met with our ACNs in Fall 2023 to discuss our Health Equity Plan. During the conversations, our ACNs shared staff training resources that promote culturally responsive care for the LGBTQIA+ population. CCHA hopes to disseminate the following resources among our provider network. *Timeframe:* Spring 2024.
    - University of California at San Francisco (UCSF) Center of Excellence for Transgender Health – Welcome to Trans 101: Transgender People in Everyday Work and Life
    - UCSF Center of Excellence for Transgender Health – Acknowledging Gender and Sex: Supporting Health Care Providers in Serving Transgender Patients and Clients

Community Organization Level:

- CCHA granted Community Health Partners (CHP) support for opening a Resiliency Center for those affected by the Club Q shooting and the LGBTQIA+ community to receive outreach care and peer support to identify and address behavioral health needs. *Timeframe:* Spring 2024
- Continue seeking trusted community organizations who work with LGBTQIA+ and BIPOC populations to partner with to understand community and system barriers to access care and help decrease those challenges increasing member engagement. *Timeframe:* January 2024.

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[24] Williams, D.R., & Rucker, T.D., "Understanding and addressing racial disparities in health care," *Health Care Financing Review*, no. *21*(4) (Summer 2000), 75–90, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634.
[25] "Health Disparities Were Devastating BIPOC Communities. Then Came COVID-19," Kenan Institute of Private Enterprise, published February 17, 2021, https://kenaninstitute.unc.edu/kenan-insight/health-disparities-were-devastating-bipoc-communities-then-came-covid-19.

- Included DEI goals and objectives in our CIP program. The goals and objectives included the BIPOC and LGBTQIA+ populations as described in the overall strategy section above. *Timeframe:* January 2024.
    - Inside Out Youth Services received $42,362 for their 2023 CIP project in Region 7. Their mission is to build access, equity, and power with LGBTQIA+ young people through leadership, advocacy, community-building, education, and peer support. The CIP project focuses on planning and designing its new Whole Health Hub for LGBTQIA+ Youth. The goal of the health hub is to act as a single source of mental health, social and clinical services, combined with LGBTQIA+-friendly primary care practices. Practitioners will be trained and identified as LGBTQIA+ affirming. In December, Inside Out Youth Services was selected again for the 2024 CIP program to build and expand their current project funded through CIP.
- Partner with Elephant Circle, as described in the maternity section above, to help pregnant members identifying as Black/African American connect with doula services at no cost. *Timeframe:* Starting in Fall 2023 and continuing into 2024.

Staff Level:

- Continue finding ways to diversify CCHA member-facing staff to be better positioned to be responsive to the cultural values, beliefs, and practices of the communities we serve. *Timeframe:* This started at the beginning of the RAE contract and is ongoing.
- Continue training member-facing staff in cultural competence best practices. In 2023, Behavioral Health (BH) teams have already received training on Gender Expression Training and Cultivating LGBTQIA+ Inclusion Practices. In addition, CCHA will continue reviewing literature and the knowledge will be shared during staff meetings. *Timeframe:* Ongoing.

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

Cultural Responsiveness	Overall Strategy
	Description: Cultural Responsiveness involves understanding and appropriately including and responding to the combination of cultural variables and the full range of dimensions of diversity that an individual brings to interactions. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued (Hopf et al., 2021).

	• If not already addressed in the above section(s), what steps will be taken to embed culturally responsive practices across the RAE/MCO? Examples include, but not limited to the following[26]:
	  • **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.*
	  • Overall strategy: **See below.**

We believe human connection is essential in driving conversations and actions to eliminate health inequities. This starts with achieving appropriate cultural responsiveness for the communities we serve. CCHA honors the knowledge, experiences, dignity, and background of individuals and communities. To better understand our members' cultural practices and health needs, it is important that we bring different stakeholders to the table, including providers, community organizations, and members. We want to know what is working well, what is not, and how to expand and leverage best practices into the entire system. As a result, CCHA started to share data, ideas around our Health Equity Plan, and the identified populations showing inequities in meetings with providers and community organizations. Our goal is to co-design a strategy using stakeholders' input and experiences that can address and develop interventions around cultural responsiveness.

During our meetings, we ask if they are aware of existing committees that CCHA could join to align with work already happening. If those committees do not exist, CCHA could start creating a group to discuss

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

current activities, collect and share best practices among different stakeholders. CCHA also used the following questions to guide conversations:

1) What is working well for your organization around cultural responsiveness related to the specific needs of the population you serve?
2) Do you tailor the language or the way the message is delivered to explain things depending on the person's cultural background? (modalities, language used, who delivers the message)
3) Do you have member materials tailored to different populations? (culturally translated for different languages/backgrounds)

Through these meetings, CCHA learned that providers and community organizations are at various stages in their health equity work. Some have hired staff with lived experiences, or their staffing models try to mirror the communities they serve as much as possible, in particular with Spanish-speaking members. They also include cultural responsiveness training as part of their staff onboarding process, but some providers see an opportunity to provide ongoing training. Other providers and community organizations like the idea of ambassador programs to support work in different capacities (for example, Medicaid renewals). The trans-creation of materials is considered important to ensure those materials are more user-friendly and culturally appropriate for community members with different backgrounds. In addition, some organizations and providers continuously ask for feedback from community members to understand what works and what doesn't. Providers and community organizations want to build relationships and facilitate communication to have a greater impact on their work in improving health inequities. This relationship-building is key to truly understanding members' needs and identifying areas where support can be offered to increase trust and reduce gaps in health inequities.

CCHA already participates in several committees that address health equity work, including:

- Teller County Mental Health Alliance
- Park County Mental Health Alliance
- Healthy Community Collaborative in El Paso County
- Nurse-Family Partnership Community Advisory Board

CCHA will continue having conversations on health equity to inform and tailor our programs, pilot interventions, and share successful interventions as best practices among our provider network and health neighborhood and community partners.

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

- Data collection and analysis are critical to identify challenges, allocate resources as best as possible, and develop targeted interventions for those with the greatest needs. A well-known barrier we have with the data received from the Department is the accuracy and completeness of data around race, ethnicity, and language. We appreciate that the Department is already working to improve data collection for these factors. This is particularly true for gender identification data that could help identify disparities and drive interventions for our LGTBQIA+ members.
- Because timely access to data is essential, it would be beneficial if the Department permitted RAEs access to the State's dashboards. This access would allow CCHA to compare it with internal CCHA data to help drive our health equity work.

- RAEs continue to struggle with identifying pregnant members early in their pregnancy to help them connect to services promptly. Even using the pregnancy aid code, CCHA has seen numerous instances where the member is not pregnant or has long since delivered their baby. We have also seen due dates that are more than nine months out, leading to further questions about the data's validity.
- CCHA appreciates the Department's ongoing work on a known issue where CCHA and HCPF have different enrollment dates, likely related to members having a short managed care eligibility span before being enrolled in the RAE. During this managed care span, RAEs would not know about the member and have no way to impact their health outcomes or utilization.
- Access to specialty care continues to be difficult for Health First Colorado members across the state. CCHA is actively learning about the eConsult platform, which is expected to go live in February 2024, and will leverage this tool, particularly in more rural areas where local access to specialists is even more sparse. CCHA will also work with rural PCMPs to identify issues like broadband access and connectivity. CCHA appreciates support from HCPF to find solutions where possible.
- CCHA continues working with HCPF and advocating for providers struggling to stay open to Health First Colorado members due to administratively burdensome billing changes related to obstetrical services. This impacts the number of providers available to accept Medicaid members. Additionally, these billing changes may impact timely prenatal and postpartum performance data, preventing practices from receiving credit for patient visits completed.