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Developing A Blueprint for Health Equity Programs and Investigating Interventions and Metrics

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DEVELOPING A BLUEPRINT FOR HEALTH EQUITY PROGRAMS AND INVESTIGATING INTERVENTIONS AND METRICS

BY

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A doctoral project submitted to the faculty of the Medical University of South Carolina
in partial fulfillment of the requirements for the degree
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Abstract

Racial and ethnic minority groups and rural and low-income populations are examples of populations who continue to experience health disparities despite policy mandates to eliminate them. This doctoral project will provide a foundational blueprint to aid health plans in addressing and improving health equity internally and with external stakeholders. The blueprint will be based on research comparing the robust health equity initiatives of four states to the NCQA national guidelines. The barriers to achieving and recommendations for advancing the field of health equity by implementing and analyzing policies and data that target health disparities through improved access to quality care and services will be addressed. This health equity guideline will contain suggestions and templates that may be used to supplement current NCQA Health Equity Standards as a guideline for developing a health equity program for small managed care organizations.

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CHAPTER I INTRODUCTION

1.1 Background and Need

Health Equity means everyone has a fair and just opportunity to attain their highest level of care. Pursuing health equity includes a commitment to reduce and eliminate disparities and its underlying causes, including social determinants of health. In the United States, there are extreme disparities in the health statuses of various population groups. Individuals have a greater risk of poor health if they are in a lower socio-economic position. Health disparities and inequities are systematic and significant in the United States and have great social and economic costs to individuals and societies (World Health Organization, 2018). Health inequality and health disparity are overlapping yet distinct constructs. Yet, they are often used interchangeably when discussing health equity and are used to measure healthcare delivery (accessibility and quality of care and services), healthcare outcomes (individual or population health), or system structure (availability of financial or human resources).

1.2 Problem Statement

In the United States, $93B is estimated to be spent on excess medical costs due to racial and health disparities (HIMSS, 2021). To ensure everyone has a fair opportunity to obtain their highest level of health and wellness, we must address historical and modern-day injustices and overcome social and economic barriers, environmental threats, and educational inequalities. Managing and improving health equity allows for increased opportunities for individuals to live their healthiest lives possible regardless of who they are, where they live, or how much money they make. According to the Centers for Disease Control and Prevention, disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by socially disadvantaged populations (2017). These disparities occur across various races, ethnicities, socioeconomic statuses, ages, languages, gender, geography

(urban and rural), disability or special health care needs status, sexual identification and orientation, and citizenship status (NIH, 2017). NCQA has created a national framework to aid health systems in identifying disparities in care and closing care gaps in populations while supporting the priorities of contracting partners such as state Medicaid plans, which are often administered and managed by MCOs. Earning an NCQA accreditation can be a contract differentiator as some states are mandated to be NCQA accredited to bid for and be awarded state Medicaid contracts.

Factors that Impact Health Equity

According to the Centers for Disease Control and, Prevention, the infant mortality rate for black mothers is 2.3 times higher than that of white mothers in the United States, (2022). The study also listed how segregation impacts health outcomes and contributes to health inequities as follows:

- Poor quality housing, including dampness, inadequate heat, noise, overcrowding, and the presence of environmental hazards and allergens
- Negative social environments, including exposure to violence, crime, and systematic differences in policing and incarceration
- The substandard built environment, including higher exposure to fast food outlets and alcohol retailers, reduced access to supermarkets with fresh fruits and vegetables, and lower access to recreational facilities
- Exposure to pollutants, toxins, and other environmental hazards
- Limited educational and employment opportunities and earning potential
- Limited access to quality healthcare

Social Determinants of Health

Addressing Social Determinants of Health (SDoH) is a primary approach to achieving health equity, According to the Centers for Disease Control and Prevention, Social Determinants of Health are nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, socioeconomic status, education, physical environment, work, and live age, the broader set of forces and systems shaping the conditions of daily life (2023).

Social Determinants of Health can be grouped into five domains, which are as follows: Economic Stability, Education Access, Health care access and Quality, Neighborhood, and Social and Community Context. Examples of SDoH are safe housing and communities, racism, violence, education, employment opportunities, and water and air pollution.

Social Determinants of Health contributes to health disparities and inequities, such as the outcomes of food deserts; persons may not have good nutrition, leading to health risk such as obesity (OASH, 2023).

Health Equity Programs

Health Equity programs are essential for improving access to quality care and services for all people, by systematically evaluating the causes for health inequity and implementing policies, interventions, and data-driven activities to overcome the barriers.

Health Equity Programs should allow organizations, government agencies and consumers to understand the root cause of health inequities and use data, qualitative and quantitative methods or other metrics to decrease and eventually eliminate health disparities and inequalities.

Health equity program activities include: documenting health inequalities, identifying health disparities, advocating for action, and ensuring action is measurable and meaningful. Health equity programs may focus on strengthening the health of minorities, rural communities,

and underemployed and uninsured persons. The United States Department of Health and Human Services has an initiative, Healthy People 2030, in which one objective is to increase access to comprehensive and high-quality healthcare services. One of the goals is to lessen barriers so individuals can get preventive care and treatment for chronic illnesses (USDHHS, 2023). While there are many community and state-level programs and resources to address health equity (CDC, 2023). Little guidance is available for Medicaid health plans to ensure the services and coverage they provide do not contribute to disparities and inequity. Instead, they seek to eliminate inequities in coverage and care.

1.3 Research Objective

To develop a blueprint for Health Equity Programs and evaluate interventions and metrics. Medicaid recipients insured by Managed Care Organizations and uninsured persons would be the focus of building the health equity program.

1.4 Population

Healthcare disparities have been longstanding in the United States healthcare delivery systems, including health insurance plans. Medicaid programs can help mitigate inequities in coverage and care. Health Plan health equity efforts can include the following: reducing health care disparities, organizational readiness, race/ethnicity, gender identity and sexual orientation data, access and availability of language services, and practitioner cultural humility. The paper will focus on health plan Medicaid recipients in rural and urban community settings. Medicaid recipients in the abovementioned communities include infants, children, and older people.

2 CHAPTER II STATE HEALTH EQUITY PROGRAMS

Many states have a health equity program. However, many do not specify plans for reducing health disparities. This chapter outlines the potential role of Medicaid plans in

addressing health equity and provides an overview of four states' efforts to develop health equity programs. The states of Michigan, Minnesota, North Carolina, and Delaware were selected because they have implanted robust health equity programs and provide a broad range of patient needs and population demographics.

2.1 Addressing Health Equity through Medicaid

2.11 Role of Medicaid Plans in Health Equity

Improving Health Equity is listed as a priority by many healthcare organizations and policymakers; however, health inequities are still an issue in the United States. Individuals from some racial and ethnic minority groups, rural areas, and white populations with lower incomes are more likely to face barriers to accessing equitable healthcare, according to the CDC (CDC, 2023). Many of these persons are insured by Medicaid, a public insurance program financed by state and federal governments. As of April 2023, more than 82 million individuals were enrolled in Medicaid (CMS, 2023). Health insurance plays a crucial role in whether, when, and where people obtain medical care, with uninsured people more than likely to forgo medical care than those with medical care. Medicaid involvement in Health Equity could lead to improved healthcare outcomes and increased access to care.

Since being implemented in 1965, Medicaid has been designed to provide health insurance coverage for impoverished people. As the largest health insurance program in the United States, Medicaid is essential in addressing health care disparities. Medicaid reimbursement could make up a significant portion of an organization's revenue, so focusing on healthcare disparities and having the outcomes tied to an organization's revenue would be beneficial. In the past, Medicaid has evolved with delivery systems, managed care enrollment, and expansions; evolving more and implementing additional Medicaid policy reform needed to

reduce health disparities would, in essence, improve access to care, improve quality of care, and better health care outcomes.

Healthcare disparities differ from state to state; for example, maternal health is a crucial indicator in California, and rural health is an indicator in the Commonwealth of Virginia (Academy Health, 2022; VDH, 2023). In addition to incentivizing healthcare organizations, financial investments in the communities served are essential in addressing health equity; in North Carolina, $51 million is invested in primary care providers in historically marginalized communities (AcademyHealth,022).

2.13 Challenge for Medicaid Health Plans in Addressing Health Equity

Under the Biden-Harris administration health equity is a priority. Health equity as a federal focus can mandate all states to strive towards meeting health equity goals. To strengthen the administration of the Medicaid program, The Center for Medicaid and CHIP Services (CMCS) has established three priorities – 1) enhancing coverage and access, 2) ensuring equity, and 3) promoting whole person care and innovation (Academy Health, 2023). The proposed efforts will help improve performance in the abovementioned areas and also improve regulations and requirements around these measures to determine how states are reporting their data how and where funds would be allocated and identify measures to ensure accountability in progress in the right direction. Policies being proposed by CMCs are essential; however, they must address the variability across state Medicaid programs and the different levels and capabilities of innovation there that varies across the states.

Medicaid Health Plans face barriers in addressing health equity for various reasons, one being the enrollment/membership information transmitted via Electronic Data Interchange (EDI)

834 files contains incomplete or unreliable information about the Medicaid beneficiaries such as their race, ethnicity or language receiving unreliable information makes it challenging for Medicaid health plans to quantify healthcare disparities design interventions to address gaps in care and improve care and social determinants of health. Medicaid contracts could include language to report quality measures and stratify the information by race, ethnicity, language, gender identity, and sexual orientation. Stratifying, analyzing, and putting efforts in place will show progress toward reducing health care disparities and establish a baseline so Medicaid health plans can implement meaningful clinical and service improvements and measure their performance in the future.

Medicaid health plans may lack the programs to advance health equity, and some of the barriers include the following:

- Improving the collection and reporting of race, ethnicity, gender identity, and sexual orientation information
- Prioritize health equity at the state Medicaid level
- Reduce systematic barriers that impact people of color from gaining and keeping coverage by examining the enrollment, redetermination, and renewal process
- Embed health equity requirements in the contracts
- Develop a culturally competent and diverse workforce (macpac, 2023)

2.2 Health Equity Frameworks

Achieving health equity requires ongoing efforts to address historical and contemporary injustices. Adopting a health equity framework is how Medicaid health plans can

work towards systematically improving and advancing health equity by assisting communities, healthcare providers, and practitioners to understand better how social, political, economic, and environmental factors impact one's health.

In 2022, the Center for Medicaid and Medicare Services (CMS) updated and released a framework to advance health equity, expand coverage, and improve health outcomes for more than 170 million people. The framework establishes a new baseline and set of priorities or CMS to strengthen its infrastructure to improve the health care system, drive structural change, and work towards eliminating barriers to services, benefits, and coverage. The newly implemented health equity framework will be in place until 2032. The priorities put in place will help CMS achieve health equity, decrease health disparities, and put programs in place to improve the lives of underserved and disadvantaged people. CMS plans on doing this with five priority areas, which are as follows: 1) expand the collection, reporting, and analysis of standardized data to assess causes of disparities within CMS programs; 2) address inequities in policies and operations to close gaps 3) build the capacity of health care organizations and the workforce to reduce health and health care disparities, 4) advanced language access health literacy and the provision of culturally tailored services and lastly 5) increase all forms of accessibility to healthcare services and coverage (CMS, 2023).

CMS's priority is to increase the understanding of the needs of those served, including social risk factors. CMS has committed to improving the collection and use of comprehensive standardized individual-level demographic and social determinants of health data. This information will include data on race, ethnicity, language, gender identity, sex assigned at birth, sexual orientation, disability status, and social determinants of health (CMS,2022).

CMS has committed to incorporating measures to assess programs and policies And making actionable decisions about policy investments and resource allocations. Evaluating the causes of disparities within CMS programs will allow CMS to measure the impact of its policies on health equity and develop sustainable solutions to close gaps in health healthcare access, quality, and outcomes (CMS, 2023)

CMS recognizes that healthcare professionals serving minority and underserved communities have a direct link to individuals and families, and they are in a position to address disparities at the point of care. To support this effort, CMS has committed to assisting healthcare providers so they can provide the highest quality of care and services to the members. CMS must ensure policies, programs, and resource allocations are in place to allow providers and practitioners to meet the needs of the communities they serve. In addition to building a workforce to reduce healthcare disparities, CMS is committed to advanced language access, health literacy, and culturally tailored services. Patients need to relate to the staff providing them with health care. This plays a critical role in healthcare quality and enhances the patient experience, which could then improve health outcomes. There are opportunities for direct communication and outreach to guide Medicaid plan providers and community partners to improve healthcare quality, patient safety, and the patient experience within the healthcare delivery system. Lastly, all stakeholders are responsible for ensuring that persons and their families can access health care services when and where they need them. Two, they ensure that the resources are available to meet their needs and preferences. It is beneficial for CMS to receive individual-level feedback, especially from persons with disabilities, to understand their experiences navigating Medicaid-supported benefits and services to ensure programs and policies are in place to provide equitable access to medical services (CMS, 2022).

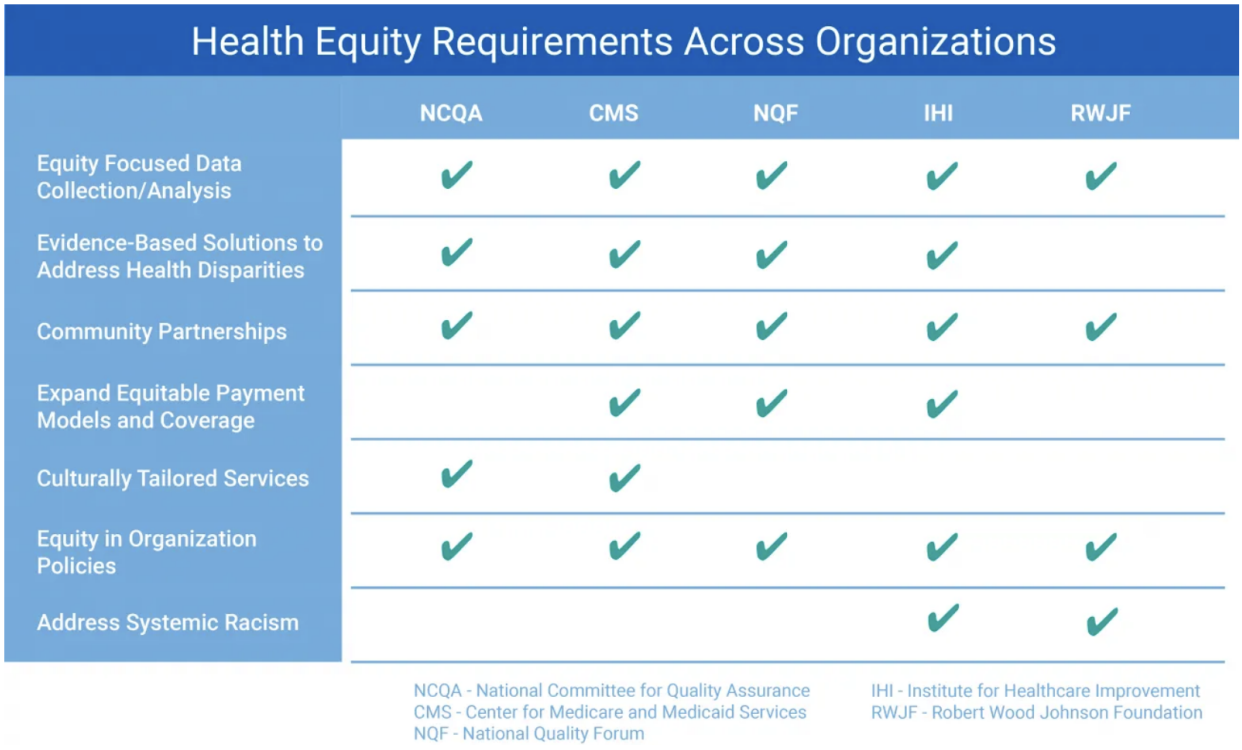
The National Committee for Quality Assurance (NCQA) is an independent organization headquartered in Washington, DC, that works to improve healthcare quality outcomes through evidence-based standards, measures programs, and accreditations. The National Committee for Quality Assurance is committed to measuring, analyzing, and improving the healthcare industry by working with policymakers, employers, healthcare practitioners, and health plans.

NCQA's health equity accreditation gives healthcare organizations an actionable framework for improving health equity. The health equity accreditation focuses on enhancing the foundation of health equity work in a manner that supports an organization's external health equity work by building and enhancing an internal culture by collecting data that will assist an organization in creating and offering language services and ensure there is a robust provider network that can meet the individuals cultural and linguistic needs as well as identifying opportunities to reduce health inequities and improve care. NCQA provides the framework for organizations to improve health equity by ensuring operational readiness; they have the technology and infrastructure to collect data regarding race, ethnicity, language, gender identity, and sexual orientation data. NCQA also understands the importance of having a practitioner network that is culturally responsive to the population it is not sure it is serving. This will help reduce healthcare disparities, which NCQA requires organizations to stratify. There are measures to identify all populations and subpopulations that are being served (NCQA, 2022).

Other health equity frameworks have been developed by Joint Commission, the Institute for Healthcare Improvement, the National Quality Forum, and the Robert Wood Johnson Foundation. The Research Triangle Institute compared the various frameworks and found the primary requirements to be 1) Equity Focused data collection and analysis; 2) Adopting evidence- based solutions to address health disparities, 3) Maintaining community partnerships;

Expanding equitable payment models and coverage; 4) Providing culturally tailored services; 5) Ensuring Equity in organizational policies; and 6) Addressing systematic racism (RTI, 2023). In their assessment, no established framework addressed all six areas (Figure 1).

Figure 1:



Source: RTI, 2023

State-level Initiatives

Several states have established state-wide initiatives to improve health equity in Medicaid programs. I choose four state level initiatives that have developed and implemented robust health equity guidelines as a foundation to compare against NCQA national health equity standards.

2.3 Michigan

Michigan has made a significant commitment to improving health equity in Medicaid. Michigan has invested in a 10-year plan, which incorporates health equity efforts across the continuum in its Department of Health and Human Services, including Medicaid. Michigan is one of few states that stratifies race and ethnicity information and requires Managed Care Organizations (MCO) to report specific Medicaid Core Set measures by race and ethnicity. This information is published in a health equity report updated annually, and the measures are analyzed to set goals, including health equity priorities to improve the health status of racial and ethnic populations in Michigan.

The Office of Minority Health was established in 1988 by executive order and serves as the coordinating body for minority health, which includes the following five racial and ethnic groups: African Americans, American Indians, and Alaska Natives, Arab and Chaldean Americans, Asian Americans and Pacific Islanders and Hispanics (State of Michigan, 2010). The State of Michigan has shown it is dedicated to implementing practices that promote workforce diversity, retention, and advancement, as 88.9% of organizational respondents stated that they had such as program. Health Equity survey data was collected through various sources such as state databases, disease registries, health system databases, and population assessments such as vital statistics, Violent Death Reporting System, and the Disease Surveillance System; 65.1% of

organizations reported having practices in place to collect, analyze, and report race and ethnicity data.

Some limitations in Michigan's data have been noted, such as the lack of standardized classifications for race and ethnicity. Racial and ethnic grouping and definitions differ across the various systems and tools used by the Michigan Department of Health and Human Services and its partners. Although Michigan is making great strides in improving health equity, closing health disparity gaps is noticeably absent. A limited number of staff is available, and a void of dedicated teams for health disparities efforts (Michigan DHHS, 2021).

2.4 Minnesota

On average, Minnesotans rank among the healthiest states in the nation; however, data shows the following communities are experiencing the highest inequities in the states: minority communities, American Indian, differently abled communities, lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, and rural and low-income communities. In addition, the inequalities in education, income, and home ownership increase health disparities in some Minnesota communities. According to the Advancing Health Equity Report, it has been determined that structural racism has played a part in the differences mentioned above (State of Minnesota, 2023).

In February 2023, the Minnesota Department of Health released its Eliminating Health Disparities Initiative Report to the state legislature for fiscal years 2021 and 2022. In 1990 people of color comprised nearly 6% of the population; in 2020, people of color made up 23.7% of the total population. The growing community of people of color is one of the reasons the State of Minnesota has prioritized improving health and wellness and closing health equity gaps for communities of color within the state. Minnesota has committed to addressing eight priority

health areas that impact racial and ethnic minorities, and they are as follows: Breast and Cervical Cancer Screening, Diabetes, Heart Disease and Stroke, HIV/AIDS and Sexually Transmitted Infections, Immunizations for Adults and Children, Teen Pregnancy Prevention, Unintentional Injury and Violence, and Infant Mortality. Based on evaluation results, the health equity program has proven to be a valuable investment, with community collaborators reporting that addressing health and wellness holistically and adapting community-driven solutions has been beneficial by increasing social support, improving behavioral health, ensuring basic needs are met, decreasing barriers to care, reducing stigmas while increasing awareness, and improving health behaviors (State of Minnesota, 2021).

2.5 North Carolina

For the last 31 years, the State of North Carolina has promoted and advocated for eliminating health disparities among all underserved racial and ethnic minorities within the state through the Department of Health and Human Services, Office of Minority Health and Health Disparities. Currently, North Carolina has five initiatives to improve the health of underserved North Carolinians, which as follows: NC Minority Diabetes Prevention Program (NC MDPP), Cultural and Community Health Initiatives, NC Culturally and Linguistically Appropriate Services Program (NC CLAS), Health Equity Lunch and Learn Series, and the Community Health Ambassadors Program (CHAP).

The multi-county collaborative between health departments, community health centers, and community-based organizations engages, screen, and deliver lifestyle classes to pre-diabetic minority and at-risk communities to prevent them from developing type 2 diabetes; The NC MDPP oversees this program. Much like the NC MDPP, the NC CLAS program also works collaboratively with health departments, community health centers, and faith-based

organizations; however, the focus is on providing free training to those interested in learning about cultural competence to equip organizations with information and resources necessary to address the changing needs and demographics of the state. Although the target market of the health equity programs in NC is geared towards minorities and at-risk populations, the literature is void on how the members of the patients, organizations, and community members are selected as participants (NCDHHS, 2022).

2.6 Delaware

Since 2019 the total population of the state of Delaware has increased by 2.9% to 1.018 million residents in 2022, according to the United States Census Bureau. Black Americans comprise 23.8% of the population, while Hispanics comprise 10.3%. Minorities with chronic illnesses remain a concern in the state of Delaware. To lessen the issues that lead to health disparities, the state launched an online dashboard that allows improved tracking of racial disparities in health and income. The National Institutes of Health awarded Delaware State University a five-year, $18 million grant to fund the study of health disparities in Delaware (WHYY/NPR, 2022). Social factors significantly impact health disparities, including economic stability, access and availability to quality education, healthcare, and environmental barriers. Delaware uses zip code-specific data to identify equity gaps on a granular level. To combat health disparities Delaware has committed to prioritizing (DHSS DE, 2023):

- Promoting and providing training on cultural competency to improve access to health services for Delaware's under-served populations;
- Provide relevant statistical data to assess and identify the health status of such populations;
- Increasing awareness of significant health problems and factors that influence health;

- Identify needs and expand community-based health promotion and disease prevention outreach efforts;
- Establish and strengthen networks, coalitions, and partnerships to identify and address health problems; and
- Collaborate with public health partners to develop and promote programs and best practices to achieve health equity.

The State of Delaware has excellent priorities, and while the vision is to ensure everyone in the state achieves their full health potential, the priorities focus is not on the total population. Delaware acknowledges there are systematic inequities that impact socially disadvantaged sub-populations.

The University of Delaware conducted a study that described how racism creates and perpetuates health inequities among Black Americans. Racism is defined as a belief that race is a fundamental determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race, according to Merriam-Webster (Merriam-Webster, 2023). The study highlights social determinants of health connected with work and social conditions and poor living that jeopardize good health. The study noted that infant mortality rates have fallen among all racial and ethnic groups since 2000; however, for black women infant mortality rate has increased by 6% since 2014.

2.7 Summary

This framework combined the primary elements of the four health equity frameworks into the following categories, which are relevant to Medicaid organizations. First, MCOs must employ strategies at the organizational level that prioritize health equity. Second, they must hire and train employees to be able to overcome disparities. Third, the services offered must address the

systematic barriers to equity. Fourth, there must be ongoing systematic data and reporting. We have categorized the four state-level programs to see if they fully or partially met these elements.

Table 1: Comparison of Equity Program Elements and State-level Implementation

Program Element	**Delaware**	**Michigan**	**Minnesota**	**North Carolina**
Prioritize Health Equity	Yes	Yes	Yes	Yes
-Leadership Support[3] -Assess Needs and Root Causes of Disparities[1,2,4] -Understand social risk factors & SDOH[1,5] -Performance improvement & evidence-based interventions [1-5] -Collaboration with community partners [1-6] -Health equity plan and strategy [1,5] -Eliminate institutional racism [5-6] -Building Culture[2,5] -Equitable policies and structures[1-6]	Yes	Yes	Yes	Yes
Hire & Train Employees -Train workforce to address disparities[1,2] -Train culturally competent workforce[1,2]	Yes	Yes	Yes	Yes
Patient Services Offered[3] -Increase Access[1] -Equitable payment models and coverage[1,2,5] -Language Accessible[1,2] -Culturally Tailored[1,2] -Consider Health Literacy [1]	Yes	Partially	Partially	Yes
Measurement & Reporting[1-6] -Standardize data collection[1-3] -Data inclusive of race, ethnicity, language, gender, sex, sexual orientation, disability, SDH[1,2.4]	No	Yes	Yes	Yes

Sources: 1. CMS; 2. NCQA; 3. Joint Commission; 4. NQF, 5. IHI, 6. RW

3 CHAPTER III METHODOLOGY

3.1 Research Design or Method

We reviewed 1) peer-reviewed literature, 2) health organizations' websites, and state and federal agencies' plans and data to understand how others are approaching the issue of health equity and what elements are often recommended for health equity programs. Our results found that no framework covered all essential elements of a health equity program. We will use this information to develop an implementation guide for state Medicaid programs to establish a health equity program.

3.2 Equity Program Frameworks

Multiple Equity Program Frameworks will be compared and contrasted to find the essential elements of a Medicaid Health Equity Program. These elements will then be adapted utilizing the population demographics and needs of rural and urban populations. The foundation will be the NCQA Health Equity Standards. See Table 2 for the list of the Health Equity Standards and underlying Elements.

Table 2 NCQA Health Equity Standards

1: Organizational Readiness
A: Building a Diverse Staff
B: Promoting Diversity, Equity and Inclusion Among Staff
2: Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data
A: Systems for Individual-Level Data
B: Collection of Data on Race/Ethnicity
C: Collection of Data on Language
D: Collection of Data on Gender Identity
E: Collection of Data on Sexual Orientation
F: Privacy Protections for Data
G: Notification of Privacy Protections
3: Access and Availability of Language Services
A: Written Documents
B: Spoken Language Services
C: Support for Language Services
D: Notification of Language Services
4: Practitioner Network Cultural Responsiveness
A: Assessment and Availability of Information
B: Enhancing Network Responsiveness
5: Culturally and Linguistically Appropriate Services Programs
A: Program Description
B: Annual Evaluation
6: Reducing Health Care Disparities
A: Reporting Stratified Measures
B: Use of Data to Assess Disparities
C: Use of Data to Monitor and Assess Services
D: Use of Data to Measure CLAS and Inequities
NCQA Standards, 2022

3.3 Program Development and Evaluation

To ensure the program is systematically developed and appropriate guidance is provided for implementation and evaluation. Next, based on our literature review, elements that are missing, incomplete or irrelevant to Medicaid agencies will be addressed. The final product will be a blueprint for implementing a health equity program within a Medicaid program. The Blueprint will explain each element, evidence-based initiatives, and policies to achieve the element, step-by-step workflows and guidance on tools, data sources, and measurement.

3.4 Outline of Health Equity Blueprint

Introduction and explanation of health equity

1. Making the case for a Health Equity Program
2. Assessment of NCQA Health Equity Standards, including explanations and rationale for new standards or exclusion of standards.
3. Guidance for each Standard
4. Assessment of Organizational Readiness (Diversity, Equity, and Inclusion)
    a. Common barriers and failure
    b. Recommended Changes
    c. Tools, resources, and examples
5. Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data
    a. Common barriers and failure
    b. Recommended Changes
    c. Step-by-step sequence of activities
    d. Tools, resources, and examples
6. Access and Availability of Language Services
    a. Common barriers and failure
    b. Recommended Changes
    c. Step-by-step sequence of activities
    d. Tools, resources, and examples
7. Practitioner Network Cultural Responsiveness
    a. Common barriers and failure
    b. Recommended Changes
    c. Step-by-step sequence of activities
    d. Tools, resources, and examples
8. Culturally and Linguistically Appropriate Services Program
    a. Common barriers and failure
    b. Recommended Changes
    c. Step-by-step sequence of activities
    d. Tools, resources, and examples
9. Reducing Health Care Disparities
    a. Common barriers and failure

b. Recommended Changes
c. Step-by-step sequence of activities
d. Tools, resources, and examples

4 CHAPTER IV HEALTH EQUITY PROGRAM BLUEPRINT

4.1 Organizational Readiness

Many Managed Care Organizations are committed to advancing health equity and ensuring all members have access to the resources needed to live their healthiest and most fulfilling lives by improving access to high-quality healthcare and addressing social determinants of health. The Health Equity Framework is a starting point for establishing and implementing interventions to acknowledge, address, and decrease disparities in healthcare. MCOs that use it at least annually should improve and modify this Framework. It can be tailored to the individual MCO to address disparities while providing quality services and care to its members. Health Plan executives and governing bodies, such as Diversity Councils, may use this Framework to identify and prioritize expected outcomes, goals, performance measures, and strategies for addressing and improving health equities and disparities and sustaining them over time.

Achieving health equity is a daunting challenge for any MCO due to constrained budgets, staff shortages, lack of organizational buy-in and support, technology gaps, and an absence of stratified member information, such as sexual orientation and gender identity. The Framework should be a part of an organization's should be implemented in but not limited to the following areas:

- Strategic Planning
- Clinical Services
- Member Operations

- Administrative Support
- Infrastructure and Technology Support
- Human Resources Management
- Community Relations

Managed Care Organizations could use this Framework to organize and prioritize the goals, strategies, expected outcomes, and improvement opportunities for addressing and decreasing healthcare inequities by creating community partnerships, having a Board of Directors or Diversity Council for Executive Level oversight and providing Culturally and Linguistically Appropriate Services as a few suggestions.

Pursuing Health Equity is imperative so clinicians, practitioners, and other MCO staff members can understand the lives, social and cultural norms and address the population-specific needs of the community they serve. A supportive environment in which data can be collected in a non-judgmental way while building trust that has been caused because of discrimination, historic and ongoing poverty, and systematic and structural racism. Possessing a diverse workforce and promoting Diversity, Equity, and Inclusion among staff is foundational in ensuring organizational readiness. Building a diverse and inclusive workforce and taking action to reduce biases and improve Diversity, Equity, and Inclusion allows for an organization to be better positioned to respond to the cultural beliefs and practices of the immediate community, as well as provide equitable, respectful, and linguistically appropriate care to members (Workhuman, 2023). Employing a diverse staff could aid members from underrepresented and excluded communities and backgrounds to feel more comfortable and willing to communicate with health professionals and health plan staff, directly impacting their health outcomes and

quality of life. Workplace equity allows for accountability, internal alignment, and cultural awareness and competence that permeates throughout the organization.

4.11 Common barriers and failure

There is not a lack of talent or qualified people to work in an MCO; however, there is a pipeline issue. Health plan workers who are part of gender, racial, religious, and sexual minority groups may face more significant obstacles in the workforce, such as discrimination, lack of promotion opportunities, fewer job offers, and a lack of sponsorship for higher-level positions. Organizations must create a safe and welcoming environment for people of all backgrounds, especially underrepresented populations (Chief health, 2023).

The Harvard Business Review says, "When women are at the table, the discussion is richer, the decision-making process is better, and the organization is stronger." Healthcare CEOs have released statements in recent years, and the statements all have the same themes in common: they all share the desire to hire more women or people of color; all demonstrate good intentions; and none of the claims are supported by robust research findings (2023).

There must be more diversity within the C-Suite and governing bodies at many managed care organizations. A study by the University of Michigan and McGuireWoods law firm looked at healthcare board representation from 2016-2018 at 41 of the largest healthcare organizations in the United States. The results showed that healthcare boards comprised 87% white members and 13% people of color, 72% were males, and only 3% were black women. To ensure health equity, the boards should reflect the community it serves. Change starts at the top, and it is vital that boards and executive leadership mirror and relate to the community it is serving (2021).

Barriers to establishing health equity within a small managed care organization (MCO)

could require more buy-in and understanding from leadership and staff. The need for more resources also factors in barriers and failures in establishing health equity.

Lacking diversity in the managed care workforce may decrease the public's trust in the MCO because the benefits may need to be more suitable for the member's or potential consumer's needs. Diversity challenges could cause failure as prejudice, racism, stereotyping, and discrimination may occur amongst staff.

4.12 Recommended Changes

When recruiting staff members, ensure the workforce reflects the membership being served. Workforce diversity comprises multiple ages, ethnicities, genders, orientations, races, and religions. Unfortunately, the same characteristics needed to diversify a workforce could be used to discriminate -often, organizations know what needs to be done; however, there are people in positions to make decisions who lead with personal beliefs than that of the mission of the organization, while that is unfortunate change can start at recruitment practices and strategies. Recruitment practices should consider identifying and closing workforce gaps, including leadership roles, as recommended by NCQA. Conducting a needs assessment would benefit the organization in learning where there are gaps in the current and desired state of the MCO. Further guidance from NCQA includes blind review resumes and diverse interview panels that include underrepresented groups. Interviewing panelists and managers should be trained in cultural competence and implicit biases; this would be beneficial as it could demonstrate fair and inclusionary practices, enhance positive corporate culture, and create a supportive work environment. Recruiting students from Historically Black Colleges and Universities (HBCUs) will increase the candidate pool and provide career opportunities to more

minorities and women. Engaging staff to share feedback regarding what diversity looks like and means to them will help identify areas for improvement; internal resources can be allocated to educate staff, close gaps, and solicit increased buy-in. Revising job descriptions to focus on skills and implementing standardized interview questions and processes for all candidates. Executing practices that support a diverse workforce is essential; however, areas for opportunities must also be addressed to engage staff to share feedback regarding what diversity looks and means to them. Organizations should integrate diversity into the company's structure, mission, and vision – this will allow employees to contribute insights, skills, and experiences as members of cultural-identifying groups. Organizations should have clearly defined goals. This will allow the organization to track progress and refine as time goes by. Creating a safe space to discuss DEI issues as needed is essential and will allow organizational cultural shifts and keep DEI issues in the forefront; this can be done in huddles, team meetings, and in senior-level leadership state of the company messages (Compass Healthcare, 2023). Leadership should champion Health Equity efforts – do not decide for a group of people one does not belong to; invite them to the table so their voices can be heard, and input can be provided.

4.13 Tools, resources, and examples

Employers can partner with multicultural professional organizations to recruit and hire diverse candidates and host recruiting events geared towards underrepresented groups such as women, minorities, and veterans. Attainable pathways to C-Suite opportunities must include women and people of color; this will increase buy-in from employees to remain at the organization if they can see themselves in higher-level roles. Employees must feel valued and supported as they consider opportunities for advancement. Taking time to celebrate differences is

important – recognizing and celebrating cultural norms and religious practices leads to an inclusive and innovative work environment (Forbes, 2022).

4.2 Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data (REaL SOGI)

Technical specifications should allow an organization's electronic data system to receive, store, and retrieve individual-level information and data on race/ethnicity, language, gender identity, and sexual orientation (REaL SOGI). REaL SOGI data should have granular categories, allowing detailed and defined data to be captured and reported. Not collecting and examining REaL SOGI data could hide differences and disparities in healthcare. Understanding and addressing disparities hold health plans accountable for considering the unique health and healthcare experiences of people who exist at the intersection of multiple axes of inequality (AHRQ, 2022). Collecting REaL SOGI data allows health plans to develop and promote infrastructure and resources and provide benefits that are conducive to the health and wellness of all members.

4.21 Common barriers and failure

Evidence on healthcare system-level strategies to reduce health and healthcare disparities is expanding, however, clarity about which strategies work remains lacking, indicating the need to determine the most effective and long-term strategies and interventions (AHRQ, 2022). Efforts to reduce healthcare disparities are dependent on the collection of high-quality data. REaL SOGI data is not often collected or needs to be collected in formats that meet federal standards. Gaps in data make it challenging to address disparities in healthcare.

Emotional reluctance may pose a challenge in data collection; members may not feel comfortable sharing such personal information, and valid mistrust of the healthcare system is an issue for some members; practitioners may not feel comfortable asking for sensitive information.

4.22 Recommended Changes

Recognizing and eradicating the root cause of racial and ethnic disparities, which is systematic racism, so actionable strategies may be implemented to engage these vulnerable populations and exercise transparency regarding collecting and using the requested data. Protecting privacy, confidentiality, and securing all the data will aid in building trust for members and practitioners. Continuous data collection and stratifying the data collection by subgroups will assist in monitoring disparities and adapting strategies to address them. Governing bodies should ensure sustainable measures are in place and inclusive of the needs of underserved and historically excluded populations.

Frontline staff is vital in collecting data. Training staff to collect sensitive data, and leadership support for this work is essential.

4.23 Tools, resources, and examples

According to AHRQ, health plans must have adequate IT infrastructure as they will have to protect the integrity and confidentiality of the information by being able to store, maintain, and use the information collected (AHRQ, 2023). An important feature is a member portal so members can self-report data via the website. Also, having a phone prompt that members can enter the information telephonically by pressing buttons or speaking their answers to be captured will ensure that the information being captured at the member level is accurate. Capturing this information on enrollment forms and health assessments by care managers will make sure this information is captured, reported, and incorporated into an existing workflow. Also, it will be conducive to soliciting state Medicaid agencies to update their enrollment data and include REaL SOGI information on 834 files sent to health plans (Fenway, 2019). PhenX suggests open-ended

response options to ensure the persons are stating how they wish to be identified and may be more prone to share this information if the members feel they can control how they are being presented and categorized (PhenX, 2019).

4.3 Access and Availability of Language Services

Creating an equitable member experience includes implementing language services in the care, benefits, and practitioner experience. Interpretation and translation services can offer equal access to a provider, practitioner, health plan services, and staff communications independent of the person's native language (AMN, 2023). In 1980, approximately 23.1 million people spoke a language other than English in their homes, which tripled. In 2019, nearly 68 million people spoke a language other than English in their homes, according to the US Census Bureau (2022). Providing multilingual services and support can help reduce negative language barriers and improve health outcomes for those with limited English proficiency. Language barriers are a common cause of miscommunication between members, staff, and medical providers and can have a negative impact on care and services received. Studies have shown that 49% of patients who do not speak a local language had trouble understanding a medical situation, 34.7% were confused about how to use prescribed medication, 41.8% had trouble understanding a medication label, and 15.8% had a bad reaction to medication due to not understanding the instructions provided by the healthcare provider (NIH, 2020).

In 2022, The Department of Health and Human Services (HHS) awarded over $4 million for a new language access initiative to aid in overcoming barriers to equity in health and human services. This is a three-year initiative tasked with developing and testing methods of informing individuals with limited English Proficiency about language access services in healthcare-related settings. Table 3 shows the awardees.

Table 3: Language Access Initiative Awardees

Award Recipients	City	State	Amount
Asian Resources, Inc.	Sacramento	CA	$375,000
Georgia State University Research Foundation, Inc.	Atlanta	GA	$310,076
Asian Health Coalition	Chicago	IL	$370,000
Wichita State University	Wichita	KS	$375,000
Centro de los Derechos del Migrante, Inc.	Baltimore	MD	$375,000
Tufts University	Boston	MA	$374,929
Family Voices Inc.	Lexington	MA	$375,000
New York University Grossman School of Medicine	New York	NY	$374,998
Western Carolina Medical Society Foundation	Asheville	NC	$375,000
Thomas Jefferson University	Philadelphia	PA	$375,000
Bexar County Hospital District DBA University Health	San Antonio	TX	$375,000
Total:			$4,055,003

4.31 Common barriers and failure

Language barriers can lead to miscommunication between patients, staff, and medical providers, reduce member satisfaction, and compromise members' safety and the quality of care they may receive. A study on 93 licensed hospitals in Washington showed that only 20%, or nearly 18 hospitals, listed language services on their homepage (WSU, 2023). The use of interpreter services can increase the cost of services and duration of treatment due to the cost of using interpreter services and prolonged conversations or assessments. Having in-house medical interpreters is a benefit to members; however, the cost and lack of medical interpreters must be considered, as some members may speak less common languages, and those interpreters will not be available internally, and the need for telephonic or video interpretation would be needed. The time it would take to locate a medical interpreter could be critical to the members in some instances and significantly prolong interactions, which is a strain on resources. Google Translate and MediBabble are cost-effective options for providing quality medical interpretation services.

If an organization fails to ensure the interpreter services or persons used are not competent, that could pose a significant healthcare barrier in which the quality and integrity of the translation could jeopardize the member's health.

4.32 Recommended Changes

Increased rigor and guidance should be mandated for interpreters. It is not enough to require a person to be fluent in a language; ensuring and testing a person's medical terminology should be mandatory. The National Board of Certification for Medical Interpreters recommends that medical interpreters possess cultural awareness and know legislation and regulations (2023). Continuing Education requirements should focus on medical knowledge and interpreting. Qualified interpreters should, at a minimum, meet the definition of a qualified interpreter as outlined in the Affordable Care Act (HHS, 2023).

Health Plans should hire culturally competent multilingual staff so members' unique needs can be understood and addressed. Leveraging digital, AI, and technology can assist members in communicating with staff in their preferred language. Implementing and enhancing multilingual online support via mobile applications or translation devices also enables multilingual chat features in the member portal, which could lead to great member satisfaction and those with limited English proficiency to feel empowered and in greater control of their health.

4.33 Tools, resources, and examples

The AHRQ has 21 toolkits that address spoken and written communication, supportive systems, and self-management and empowerment. The North Carolina Health Literacy website is the information hub for health literacy resources and efforts at the University of North Carolina at Chapel Hill and throughout North Carolina. The health literacy library houses vetted guides

and patient education materials that may help improve health outcomes for all members. Incorporating a checklist as implemented by the Migrant Clinical Network is beneficial to ensuring medical interpreters are competent and able to carry out the duties as tasked (Table 4). Having a checklist is a metric that can be used by leadership or quality assurance staff as an internal process to ensure best practices and guidelines are being followed, (Migrant, 2005). MCOs could also consider telehealth options such as Language Line Solutions (LLS) who have certified medical interpreters who can assist in reducing misunderstandings and improve the overall member experience. LLS also offers an app in which health plans can integrate technology in to needed interpretation needs while at a cost, however more cost-effective options are Google Translate and MediBabble, (Language Line, 2023).

Table 4: Interpreter Competency Checklist

COMPETENCY (*For further details on competency requirements, please refer to Manual of Orientation for Medical Interpreters and Guidelines for Establishing Competency*)
A. INTRODUCTION/ROLE OF INTERPRETER: The interpreter… ❑ Introduces self, explains role of interpreter to patient, and establishes rapport with patient. ❑ Ascertains whether the patient has prior experience working with interpreters. ❑ Encourages patient to ask for clarification of any issue as it arises during the visit. ❑ Relays to the patient legal requirements and essential information regarding informed consent, confidentiality, and security of medical communication. ❑ Asks the provider to introduce him/herself to the patient using his/her full title and to state the provider's goal for the visit. ❑ Relays to both the health professional and the patient that if either desires a confidential conversation that they do <u>not</u> want the interpreter to hear, that the interpreter must leave the room given the requirement that interpreters translate <u>everything</u> that is said by either the patient or healthcare professional.
B. MANAGEMENT OF PHYSICAL SPACE: The interpreter… ❑ Effectively arranges the spatial configuration of the interview to encourage direct face-to-face contact by the patient and provider of care.
C. CULTURAL UNDERSTANDING: The interpreter… ❑ Understands the rules of cultural etiquette with respect to status, age, gender, hierarchy, and level of acculturation. ❑ Demonstrates an understanding of potential barriers to communication including cultural differences, ethnic issues, gender issues, lack of education or differences between patient or provider life experience. ❑ Anticipates the need for and reassesses patient and provider comfort levels and addresses any perceived barriers that may impact on the success of the interaction between provider and patient. ❑ Shares any relevant cultural information with both patient and provider to facilitate understanding between all parties.

D. **INTERPRETATION SKILLS:** The interpreter...

- ❑ Understands the vital role of accurate interpretation and understands the risks of inaccurate interpretation in a medical situation.
- ❑ Considers and selects the most effective mode of interpretation prior to the start of the interpretation service (e.g., consecutive, simultaneous, or first/third person) and adjusts mode as needed during clinical interview.
- ❑ Ensures that he/she understands the message prior to transmission.
- ❑ Understands his/her limitations of medical knowledge, refrains from making assumptions, and demonstrates willingness to obtain clarification of medical terms and concepts as necessary.
- ❑ Accurately transmits information between patient and provider, transmitting the message completely, utilizing communication aids (e.g., pictures, drawings, or gestures) to supplement communication.
- ❑ Ensures that the listener (patient/family) understands what is being conveyed after transmission of the information.
- ❑ Manages the flow of communication in order to ensure accuracy of transmission and enhance rapport between patient and provider. Specifically:
    - ❑ Manages the conversation so that only one person talks at a time.
    - ❑ Interrupts the other speaker to allow the other party to speak when necessary.
    - ❑ Indicates clearly when he/she is speaking on his/her own behalf.

4.4 Practitioner Network Cultural Responsiveness

Maintaining a practitioner network that can serve a diverse membership while being responsive to members' cultural and linguistic needs and preferences is vital to the effectiveness of services received by the membership. By adhering to and attesting to cultural competence of network practitioners are demonstrating the ability to honor and respects the beliefs, languages and behaviors of members who culture, and lifestyle may differ from their own.

When MCOs ensure practitioners have to exhibit cultural competence to its members it reinforces the values of diversity, respect, and responsiveness.

4.41 Common barriers and failure

Organizational cultural competence is an outgoing process that begins with awareness, willingness, and commitment. Some common barriers may include a lack of cultural knowledge, cultural training, and language. Being able to identify and accept cultural differences while being sensitive to the needs of those with diverse backgrounds. When differences of opinion arise, seeing the other point of view may be difficult if values and beliefs do not align. Misunderstandings due to stereotypes, prejudices, and lack of trust can make it difficult for

practitioners to form meaningful connections with members if a practitioner is unfamiliar with the social norms, customs, and practices of a culture, that could lead to members being offended and not wanting to receive further services from that practitioner or practice (social work, 2023).

4.42 Recommended Changes

Establishing and maintaining a practice with robust cultural sensitivity is needed and a must have. It is recommended that practitioners understand their own beliefs, prejudices, and biases to determine how their beliefs may influence their practice and work. Practitioners should be familiar with the demographic and culture they are serving by becoming familiar with and understanding their patients' race, ethnicity, linguistic differences, religion, customs, and cultures. Implementing strategies and resources, including multilingual materials and offering culturally competent services, is essential.

4.43 Step-by-step sequence of activities

This step-by-step guide was developed to assist the health plans practitioner network with developing a cultural competency plan for their organization.

- Identify internal stakeholders and leaders to be a part of the team to develop a cultural competency plan.
- Establish scope by identifying what you wish to accomplish and the limitations and barriers that may prevent the work from being successful. Review and update the mission, vision, and value statements.
- Determine a realistic timeline by scheduling meetings, creating and reviewing materials, discussing findings and making recommendations and decisions. Create goals and objectives. Establish a culturally competent committee that includes internal and external stakeholders.

- Conduct organizational, staff, and self-assessments.
- Identify community resources, including obtaining input from community partners and patients. Increase resources for treating diverse populations: Black, Latino, LGBTQ+, Native American for example.
- Set goals and objectives.
- Evaluate your progress – gather evidence, measure progress, communicate results and modify when needed.

4.44 Tools, resources, and examples

There are numerous resources to assist with CLAS matter and some resources are as follows:

Cultural competency training for members of the LGBTQ+ community and those living with HIV and AIDS – this toolkit will assist with the skills needed to work with populations that have been stigmatized, discriminated against, and harassed (sageUSA, 2023).

Multi-cultural Counseling Self Efficacy Scale – This Racial Diversity Form is a 60-item self-report that assesses the perceived ability to perform various counselor behaviors in individual-level counseling in a racially diverse client population, according to the National Institute of Health (2023).

4.5 Culturally and Linguistically Appropriate Services Programs (CLAS)

Organizations should continually work to improve their services to meet the needs of multicultural populations. Organizations should have a written process stating their overall objective for serving a culturally and linguistically diverse population; it should also solicit input from the community it serves to ensure the population's needs are being met. Being respectful of and responsive to diverse populations' health beliefs, needs, and practices defines CLAS (AHRQ,

2023). To be in a continual state of readiness as organizations gather the information that can guide their decision-making in identifying the target audience – our primary audience would be people on Medicaid plans. The secondary audience would be parents or caretakers of minors covered by Medicaid, adult children of parents on Medicaid, or any person who may assist in making healthcare decisions, including advocates for low-income groups who may be concerned about how information is disseminated and directed to Medicaid recipients.

Health plan organizations sometimes use data and surveys to identify members' needs. NCQA has an interactive, web-based comparison tool where health plans can view HEDIS, CAHPS, and accreditation results to identify and establish benchmarks. Analyzing the available information will allow the health plan to identify improvement opportunities and create plans to serve its population's CLAS needs (NCQA, 2023). Ultimately, CLAS is a way to improve the quality of services provided to all members, which will aid in reducing health disparities and gaining health equity (HHS, 2023).

4.*51 Common barriers and failure*

Language, stereotypes, symbols, behaviors, and beliefs can cause cultural barriers. The inability to communicate effectively can be limiting and stressful – even in the happiest moments, such as childbirth- because language or culture may negatively impact patient safety, health outcomes, and health equity. In its current state, the United States healthcare system is not equipped to operate in a way that a large portion of language assistance needs to be pulled from resources.

It is commendable for MCOs to offer and require staff to take cultural competence training. Many trainings are not challenged, and it is believed the training will aid staff in understanding beliefs and behaviors, thus achieving acceptable CLAS services; however, MCOs

must be open to genuinely listening to members to understand their needs and learn from them. Given organizations advanced understanding of the root causes of CLAS disparities; more studies are needed on member satisfaction with health disparities.

CLAS barriers increase health inequities because members may be unable to obtain the care and testing needed to identify and treat ailments, leading to misdiagnosis and possible malpractice lawsuits. According to a 2015 CRICO Strategies Benchmarking Report of 23,658 malpractice claims filed from 2009 to 2013, 55% resulted from miscommunication due to language barriers. 7,149 of these claims accounted for $1.7 billion of incurred losses from irreparable patient harm due to miscommunication (2013).

4.52 Recommended Changes

In an effort to decrease CLAS barriers I recommend the following:

- Establish stringent guidelines and training for medical interpreters.
- Only use board-certified medical interpreters.
- Require that board certification for medical interpreters be mandatory instead of voluntary.
- Prioritize member understanding of medication, health resources, and benefits.
- Health Plan websites should be available in multiple languages, and the feature should be easily identifiable on the website's landing page.
- Prioritize hiring staff that reflects the membership.
- Ask questions in a manner that helps reveal the patient's understanding of the health issue being discussed.
- Consistently demonstrate respect and concern.
- Penalize practitioners for multiple findings showing biases
- Incorporate interventions that address barriers to access to care.
- Improve specific knowledge of health needs unique to subpopulations such as the LBGT community.
- Acknowledge and respect people's desired pronouns.
- Offer member experience surveys at the conclusion of calls and before a member signs out of the website to capture experiences in real time
- Administer random cultural knowledge assessments to staff members – these assessments should be reflective of the cultures and subpopulations served by the health plan.
- Send medical buses into the community to close care gaps and enhance access to quality care.
- Implement annual cultural trainings that is specific to the population being served, ex. Latinos, Black Americans, etc.

Consider how religion, culture, and ethnic customs can influence interactions with the membership. It is essential to treat and recognize the whole person. Be intentional in getting to know the members by understanding and addressing their desired pronouns. Learn about health beliefs – some people believe that discussing poor health outcomes will cause that outcome to become true. Health customs – In some cultures, family members play a large part in healthcare decision-making; ethnic customs may determine if men or women make healthcare decisions, and religious and spiritual beliefs may impact a person's willingness to accept specific treatments and require changed behavior. Interpersonal customs must be considered, as eye contact is expected in some cultures but offensive in others. In order to treat one's cultural and linguistic needs, healthcare staff must understand and establish a membership knowledge base.

4.53 Step-by-step sequence of activities

For Medicaid plans to advance health equity, help eliminate health care disparities, and improve quality, the following blueprint is suggested:

- Standard of care
    - Ensure the cultural health beliefs and practices, language preferences, health literacy, and other communication needs are provided effectively, equitably, respectfully, and in a manner the member can understand.
- Governance, Leadership, and Workforce
    - Ensure CLAS is promoted through policy, practices, and resource allocations.
    - Recruit, promote, and support a workforce that is culturally responsive to the population insured.
    - At least annually, educate and train the workforce in CLAS policies and practices.
- Communication and Language Assistance

- Offer language assistance to members who have limited English proficiency and other communication needs at no cost to them

- Inform all members of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

- Ensure the competence of individuals providing language assistance.

- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

* Accountability, Continuous Improvement, and Engagement

- Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations.

- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS related measures into measurement and continuous quality improvement activities.

- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes.

- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, members, and the general public (HHS, 2023).

4.54 Tools, resources, and examples

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Ambulatory Care Improvement Guide is a resource for health plans who wish to improve their member

experience performance. The CAHPS Survey identifies, cultivates, and encourages an environment that sustains and improves member-centered care. Analyzing the survey results allows the health plan to identify strengths and weaknesses and develop performance improvement strategies.

The Department of Justice Limited English Proficiency (LEP) agency has tools and resources that any person or agency can use in the hope that the tools and resources will be used to overcome language barriers (LEP, 2023). There are links embedded within their website that direct users to additional resources such as AHRQ, Oral, Linguistic, and Culturally Competent Services guides for MCOs. CLAS diverse groups and individuals with LEP typically experience inadequate access, diminished quality of care, and poor health outcomes, which led AHRQ to develop two guides for MCOs on planning and providing CLAS services (AHRQ, 2023).

4.6 Reducing Health Care Disparities

MCOs can use race/ethnicity, language, gender identity, and sexual orientation data to assess the existence of disparities and to focus on quality improvement services and reducing health care disparities. MCOs can use annual data collected by HEDIS measures and stratify that data by race and ethnicity to determine if medical or behavioral health disparities exist in its population. In addition to race and ethnicity, to assess healthcare disparities, the stratified data must be analyzed by preferred language, gender identity, sexual orientation, and member experience surveys. MCOS must implement and prioritize opportunities to improve once disparities are identified.

4.61 Common barriers and failure

To adequately identify, prioritize, and address health care disparities, an MCO must use REaL SOGI data to assess the current disparities and create and implement quality improvement efforts to decrease disparities. The Centers for Disease Control and Prevention (CDC) defines health disparities as

"preventable differences in the burden, disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities, (CDC, 2017)."

By 2050, it is projected that people of color will account for over half of the United States population, with the most significant growth occurring among people who identify as Asian or Hispanic. In 2003, HHS identified systematic racism as a significant cause of health disparities in the United States (HHS, 2003).

Inadequate health insurance coverage is also a significant factor in health disparities. Despite implementing the Affordable Care Act (ACA) in 2014, marginalized and underserved populations remain more likely to be uninsured. As of 2021, there were higher uninsured rates for nonelderly American Indian or Alaska Native (AIAN), Hispanic, Black, and Native Hawaiian or Pacific Islander (NHOPI) people than their White counterparts. Other groups, including immigrants and people in lower socioeconomic families, also remained at increased risk of being uninsured. Many uninsured people are eligible for coverage through Medicaid, CHIP, or the ACA Marketplaces but face barriers to enrollment, including confusion about eligibility guidelines, difficulty navigating enrollment processes, and language and health literacy problems. Some immigrant families also have immigration-related fears about enrolling themselves or their children in Medicaid or CHIP, even if they are eligible for fear of deportation

or being separated from their families. Citizens of rural areas face barriers to accessing care due to the low density of practitioners and longer travel times to care (KFF, 2023).

4.62 Recommended Changes

- The HHS Disparities Action Plan focuses on five areas to reduce healthcare disparities, and they are as follows: 1) transforming healthcare; 2) strengthening the workforce; 3) advancing the health, safety, and well-being of people living in America; 4) advancing scientific knowledge and innovation; and 5) increasing the efficiency, transparency, and accountability of HHS programs, (2015).
- Prioritizing the cultural competence of MCO staff to serve members better and having executive support and sponsors supporting initiatives to increase diversity within the workforce may benefit the workforce and will mirror the population being served.
- MCOs can work with local food banks to deliver fresh fruit and produce to members with specific comorbidities such as diabetes.
- Support expecting families so children can obtain health, starts early in life.
- Create dashboards to enhance community access to community-level data to determine where to focus on closing specific care gaps.
- For example, open community health clinics lacking primary care in rural and urban areas include WIC, health screenings, and dental exams.

Reviewing data to aid in advancing health equity and who it affects the most is paramount, and the following are examples of disparities that can be addressed with available data: mortality, life expectancy, burden of disease, mental health, and lack of access to care.

4.63 Tools, resources, and examples

Five-step Framework for Stratifying REAL Data is a guide that provides a framework that allows MCOs to stratify patient data for the purpose of identifying health care disparities. Each MCO may approach stratifying data differently; however, the general framework for the stratification effort is similar. Assemble a working group that is focused on health care disparities data 2. Validate the REAL data 3. Identify the highest priority metrics for stratification 4. Determine if stratification is possible on the selected metrics 5. Stratify the data, (AHA, 2014). Figure 2 illustrates comprehensive resources and guides within the health equity framework while highlighting interventions designed to reduce disparities implanted by MCOs.

Figure 2 Resources for Improving Equity and Responding to Disparities

Source: CMS, 2023

Chapter 5 Discussion and Conclusion

Improving health equity is a collaborative effort between government agencies, internal and external stakeholders and community members. An MCO can establish the foundation towards improving health equity by ensuring the organization is in a continuous state of readiness to undertake such a task. Equipping member level staff to collect sensitive information, ensuring members have access to language services and a culturally aware provider network are things that will aid in reducing health care disparities. In addition to identifying what is needed we must be honest in addressing the barriers and challenges and implementing actionable measures to improve so the membership can be better served.

5.1 Missing Frameworks

The National Committee for Quality Assurance has a robust framework for addressing and possibly reducing health inequities; however, there is still work to do. Reforming how we pay for care is one tool MCOs must use to improve health equity. Healthcare practitioners are reimbursed for each service they provide; that payment model is designed to treat symptoms instead of the root cause of a person's health while promoting long-term health and overall well-being. The fee-for-service payment model reimburses less for preventive and primary care services, which disincentives the practitioner and leaves the most vulnerable populations subjected to blighted health outcomes. Value-based payment (VBP) options may be a viable solution as providers are reimbursed by results and quality of care and services. VBP options are beneficial because practitioners can address underlying causes of health disparities.

Systematic racism is not addressed in the NCQA framework; however, it can influence change in this area. NCQA can encourage health insurance purchasers to embrace their ability to influence the marketplace by ensuring health benefits result in equitable care.

5.*2 Future Research*

There is an urgent need to advance health equity. To do so, the:

The historical past cannot be ignored. Root causes have been identified; now, measurable improvements need to be implemented to reduce inequities.

- Track key performance metrics and tie them to reimbursements
- Optimize business practices to ensure real progress toward health equity
- States must deny Medicaid contracts to MCOs that do not meet health equity benchmarks and make measurable health equity improvements
- Practitioners must collect and report member race and ethnicity information, which is critical in identifying and measuring inequities

5.3 Templates

In this section, I will share templates that will aid in having a successful NCQA survey. The data is fictitious and for demonstration purposes only.

Job Aid:	Diversity Recruiting Hiring and Training		
Manual:	Talent Acquisition Standard Operating Procedures	**Original Date:**	7/1/2023
Section:	Sourcing & Screening	**Revision Date:**	n/a
LOB:	all Business Units	**Approved By:**	Talent Acquisition
		Process Owner:	Talent Acquisition
Revision Description (Most Recent):	n/a		

Purpose:
Carolina Health Plan prides itself on the diversity and inclusiveness of its close to 10,000-member workforce. Diversity, inclusion, and belonging is a guiding principle of the organization to ensure its workforce reflects the community it serves.

Carolina Health Plan, through its recruitment activities, seeks to employ qualified applicants without regard to race, color, religion, age, sex, marital status, gender identity and expression, sexual orientation, pregnancy, childbirth or related medical conditions including lactation, military status, genetic information, national origin, disability, or any other legally protected status, providing the applicant is qualified to perform the essential functions of the job with or without reasonable accommodation.

Guidelines:

1. Recruiting: Identify and attract qualified candidates (inclusive of those who may be marginalized, disenfranchised, or disempowered) using various tools and resources to ensure diverse and inclusive candidate pipelines for open career opportunities.

2. Hiring: Support diversity efforts throughout the hiring process by ensuring a diverse and inclusive slate of candidates selected for interviews and offers.

3. Training: Offer required and optional training for new and existing employees aligned with the organizational commitment to diversity, inclusion, and belonging.

Procedure/Practices:

1. **Recruiting:**

   - Diversity statement on all job postings on career site (www.chpfictious.com) Carolina Health Plan *prides itself on the diversity and inclusiveness of its close to an almost 10,000-member workforce. Diversity, inclusion, and belonging is a guiding principle of the organization to ensure its workforce reflects the communities it serves.*
   - Stories highlighting Carolina Health Plan's diverse workforce on websites and social media platforms.
   - Options to request accommodations under the ADA to complete an application.

- Images on job advertisements reflective of inclusive and diverse workforce
- Sourcing tools to identify diverse (including marginalized, disenfranchised, and/or disempowered groups) and inclusive talent pipelines. Examples include, but not limited to:
    i. Contact database curated from over 1,500 diverse social organizations reaching nearly 2 million active and passive candidates and more than 5 million veterans.
    ii. Platform to source, engage, and build brand awareness with 13 million validated early talent job seekers- college and university students and alumni- inclusive of Historically Black Colleges and Universities (HBCUs), Hispanic-serving institutions (HSIs), women's colleges, plus 150+ student diversity groups.
    iii. Automated solution to provide instant and unbiased candidate matching based on job requirements as well as diversity insights (race and gender) to provide instant feedback on the availability of candidates across the talent funnel while respecting data minimum and anonymization.

- Collaboration with Diversity Recruitment Taskforce, Diversity, and Inclusion Councils, and Employee Resource Groups to identify channels to promote Carolina Health Plan career opportunities through community, social and professional networking.
- Diversity-related partnerships, local and national events, and outreach
    i. Schools, Colleges, and Universities
    ii. Professional Associations
    iii. Community Organizations
- Job Application:
    i. Consistent/standard process for internal and external candidates to express interest in career opportunity via online application (www.chpfictious.com)
    ii. Required fields asks only for relevant information such applicant source ("How did you hear about us"), previous Carolina Health Plan employment, work experience, education, license/certification, and eligibility/availability to work.
    iii. Candidates may voluntarily self-identify race, gender, disability, and veteran status.
- Strategic plan *Forging Ahead*, was unanimously approved by the Board of Directors in December 2023 and is an interactive guide and directional roadmap for Carolina Health Plan's continued success with five strategic imperatives:
    i. Engaged Colleagues and Inclusive Culture
    ii. Exceptional Consumer Experience
    iii. Community Impact
    iv. Transformative Growh
    v. Seamless Connected Systems

2. **Hiring:**
    - Diverse and inclusive interview panel: Talent Acquisition provides guidance to hiring leaders to identify a diverse and inclusive panel of interviewers (peers and/or other key stakeholders) when such panel is included in the selection process.

- Unbiased interview practices: Resource available for hiring leaders for structured/behavioral-based interview questions used consistently for all interviewed candidates to avoid unconscious bias.
- Pay equity for salary offers: Race, gender, or ability does not influence the salary offered to selected individuals. In accordance with state legal requirements, pay ranges must be included on job posting.

3. **Training:**
   - Diversity, Inclusion, and Cultural Competency training (online learning module) required upon hire and annually.
   - Virtual Instructor-led Unbiased Interview training offered annually by Human Resources for hiring leaders and panel interviewers.
   - Over 150 optional diversity training coursing available through electronic learning platform

Related Documents:

Policy	• 102: Employment • 102a: Employment Application • 102e: Reasonable Accommodations • 102i: Diversity Management
Job Aids	Diversity Recruiting Hiring and Training.
Regulatory References	NCQA Standard: Health Equity (HE1) NCQA Standard: Managed Behavioral Healthcare Organization (QI1F) NCQA Standard: Quality Management and Improvement (QI1E)

Exhibit 1, Building a diverse workforce, 2023

Cultural Competency Provider Training

A total of 125 Cultural Competency surveys were completed from September 1, 2022, through August 31, 2023.

Improvement Opportunities

• Educate providers on the new process to complete the Cultural Competency attestation on the Optima Health website

• Regularly update Network Educators of Cultural Competency completion rates throughout the year to drive outreach initiatives to providers

• Inform providers that the revised attestation form allows for the completion of other qualified Cultural Competency courses to receive credit for completion

Control

• Continue to inform providers of the availability of Cultural Competency training through provider orientations and individual provider meetings

• Continue to educate providers of the Cultural Competency resources through written communications such as the provider newsletter and email alerts

Challenges

• The Provider timely completion of the Cultural Competency attestation form due to administrative burden and limited resources. Carolina Health Plan recognizes the challenges providers continue to face which was a driver to revise the Cultural Competency attestation form to ease those administrative challenges.

Exhibit 2, Script to collective SOGI information at the member level, 2023

Agent:

- Thank you for calling Carolina Health Plan.
- My name is (Agent's name and Agent's title).
- May I have your name please?
- (Caller/Member name) How may I assist you today?

After the caller/member states the reason for the call, the agent will respond with one of the following responses and assist as needed

- I would be more than happy to assist you with that.
- I can take a look at your account to resolve your issue.
- Ok! Let me review our list of doctors to see if we can find one in your area.
- Sure! I can review your benefits and explain how they work.
- No problem! I can schedule this trip for you.
- I would be happy to give you the status of your claim.
- I can check the system to find a claim for that date of service for you.

Agent:

Do you have a few moments to answer a few questions?

Caller/Member:

Yes

If the Member states, "No." Ask if there is a more convenient date and time to receive a call back?

Agent:

- Thank you, and I appreciate your time in speaking with me further. At Carolina Health Plan we are interested in learning more about the background and experiences of our

members. Be assured that your answers will not exclude, deny benefits to, or otherwise discriminate against you

- With that being said, do you mind confirming your ethnicity and race?

Proceed to read the options below and inform the Member that more than one answer can be selected. The Member may answer the question directly without the choices being given.

Please ensure if the Member wishes to select more than one answer to document all.

Categories to choose from (Member may select one or more):

Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Declined

Race

- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Asian
- American Indian or Alaska Native
- Other (please specify)
- Declined

Agent:

- Thank you for confirming that information. Next, do you mind confirming your language preference. If the Member is hearing impaired disregard the next question. Document answer provided by the member.

- How would you rate your ability to speak English or How well do you speak English? The choices are (read the selections to the Member):
- Very well
- Well
- Not well
- Not at all
- Less than very well (limited English proficiency)

Agent:

- Thank you for providing that information. Now, I would like to confirm which language you prefer your health care encounters to be spoken in? (Members may answer the same as the above question. You may paraphrase the question as a statement including the Member's spoken language preference, "Do you prefer your healthcare encounters (the times in which you may speak with a provider) in English (or insert Member's preferred language)?"

  If options must be provided to the Member, please utilize the following list (or add and document the Member's preferred healthcare encounter language if the option is not listed under "Other"):

- Spanish
- Arabic
- Bengali
- Chinese
- French
- German
- Hindu
- Japanese
- Korean
- Italian
- Malay
- Marathi
- Panjabi
- Persian
- Portuguese
- Russian
- Spanish
- Tamil
- Telegu
- Turkish
- Ukranian
- Vietnamese
- American Sign Language (ASL)
- Other (please specify)

Agent:

- Thank you again for your time. I have a few more questions to ask.
- For written materials (i.e., Member handbook, brochures, insurance letters), what is your preferred language to receive information?

During this telephonic encounter, the Member may possibly be visually impaired. If so, the option of **BRAILLE** should be used. Please document the answer provided by the Member.

Agent:

- (Caller/Member name) The next two questions that I will be asking are sensitive in nature, and here at Carolina Health Plan, the organization wishes to respect your privacy if you choose to decline. As stated before, your answers or your refusal to answer will not exclude, deny benefits to, or otherwise discriminate against you in any fashion. However, to ensure that each person is identified appropriately and respected, we want to give our members the opportunity to self-identify.

- Do you wish to confirm you sex assigned at birth (The Member may answer directly without giving you a chance to provide the options)?
  The following response options are:

- Male
- Female
- Transgender male/trans man/female-to-male (FTM)
- Transgender female/trans woman/male-to-female (MTF)
- Genderqueer, neither exclusively male nor female
- Additional gender category or other, please specific
- Choose not to disclose.
- The information is unavailable (a response was requested but the Member has not yet provided a response)

Agent:

What are your preferred pronouns or how would you like to be addressed? Document the

answer.

- He/him
- She/her
- They/them
- Other (please specify)

Agent:

Again, I understand that these questions may be new to you or have never been asked before by Carolina Health Plan. This question may feel somewhat uncomfortable in which you may choose not to disclose. My last question is: "What is your sexual orientation?" Document the answer.

The following response options are:

- Straight or heterosexual
- Lesbian or gay or homosexual
- Bisexual
- Something else (please describe)
- Don't know.
- Choose not to disclose (the member declines to share the information)
- The information is unavailable (a response was requested but the Member has not yet provided a response)

Agent:

Thank you so much for your willingness to answer the questions asked. Collecting this data is important in ensuring that we treat each member with compassion and dignity. Thanks again and enjoy the rest of your day

Definitions from Job Aid: LGBTQ+ Patients-Access Guidelines for Quality Care-Transgender

- Cisgender – A person whose sense of personal identity and gender corresponds with their birth sex.

- Gender Identity – One's internal, personal sense of being male or female.

- Gender Expression – The external manifestation of one's gender identity, usually expressed through "masculine", "feminine", or gender-variant behavior, clothing, hair style, voice, or body characteristics.

- Intersex – A physiological sex that does not strictly match medical definitions of male or female.

- Legal Name / Legal Gender – The patient's name and gender as listed on a government issued photo ID.

- LGBTQ+ – Lesbian, Gay, Bisexual, Transgender & Queer or Questioning.

- Preferred Pronoun – He, she, him, her, his, hers, himself, herself.

- Sex Assigned at Birth – Sex labeled at birth, generally by a medical professional.

- Transgender – An umbrella term used to describe people whose gender identity, one's internal sense of being male or female, differs from their assigned or presumed sex at birth. Transgender patients generally are admitted to hospitals for the same types of care as other patients, although transgender patients may also enter hospitals or seek physician treatment for transition-related health services.

- To "Transition" – To undergo a process by which a person changes their physical sex characteristics and/or gender expression to match their inner sense of being male or female. A person may refer to themselves as "in transition" when asked about their gender. The process may include a name change, a change in preferred pronouns, and a change in social gender expression through things such as hair, clothing, and restroom use. It may or may not include hormones and surgery.

5.3 Conclusion

There has never been a time in the United States without health disparities. Injustice based on race, ancestry, gender identity, and sexual orientation is etched in systematic healthcare

disparities, and it arises from the lack of access to financial resources, power, prestige, and community resources. Local municipalities, health centers, health systems, health plans, academia, health organizations, social scientists, and others have defined health equity; these same entities may have also provided solutions for reducing health disparities. However, studies and data have shown that health disparities have increased for racial and ethnic minorities.

Taxes and health care costs will rise if the health of individuals in the most disadvantaged communities is not improved. MCOs must identify, analyze, and implement measurable improvements to reduce disparities. They must hold their provider network accountable for cultural humility and the highest quality of care and services for all persons.

State agencies may require MCOs to be NCQA accredited to be awarded Medicaid contracts; in this paper, four state-level health equity programs were compared to national-level NCQA health equity standards to develop the ideal health equity program. Although NCQA has a robust program, some barriers should be addressed to improve the program. For example, providers can attest that they have taken cultural competency quizzes. However, the examinations could be a part of credentialing and recredentialing requirements and provided by the MCO as a part of the credentialing process. NCQA has taken great strides in addressing health equity matters. However, work must still be done, as evidenced by this project. With the recommendation made, the NCQA health equity accreditation can be improved and enhance the lives and services of Medicaid recipients insured by MCOs.

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