Attachment 7 Refresh Workgroup
Health Equity; Reducing Disparities

October 3, 2019

AGENDA

Time	Topic	Presenter
10:00am-10:05	Welcome and Introductions	Thai Lee
10:05-10:35	Presentation: Advancing Health Equity in Health System Transformation	Cary Sanders
10:35-11:45	Health Equity Round Table Discussion • Data Collection & Measurements • Access to Care • Social Determinants of Health	Taylor Priestley Thai Lee
11:45-12pm	Wrap up & Next Steps	Thai Lee

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California Pan-Ethnic Health Network

Advancing Health Equity in Health System Transformation

CARY SANDERS
SENIOR POLICY DIRECTOR
CPEHN

CPEHN ensures health justice and equity are on the agendas of policymakers and that communities are leading policy efforts

We build people power to educate and influence policymakers through lived experience and community expertise for better health equity

We connect data, stories, partners, and regions to build knowledge, relationships, and understanding across cultures

We invest in communities of color to build leadership, sustainability, and advocacy

We pass, change, and implement policies that reflect community needs for better health

To create equitable conditions that promote health equity and allow communities of color and all residents to thrive and prosper

CPEHN's long history of championing **quality of care** for communities of color, limited English proficient, and immigrant communities….

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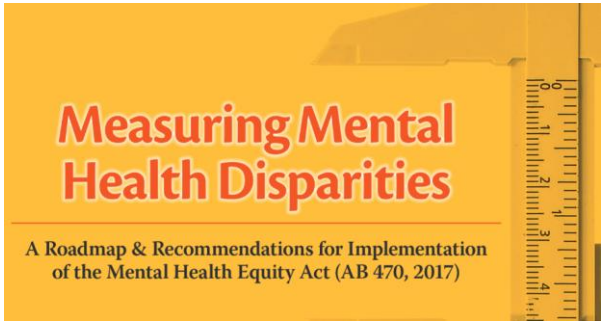

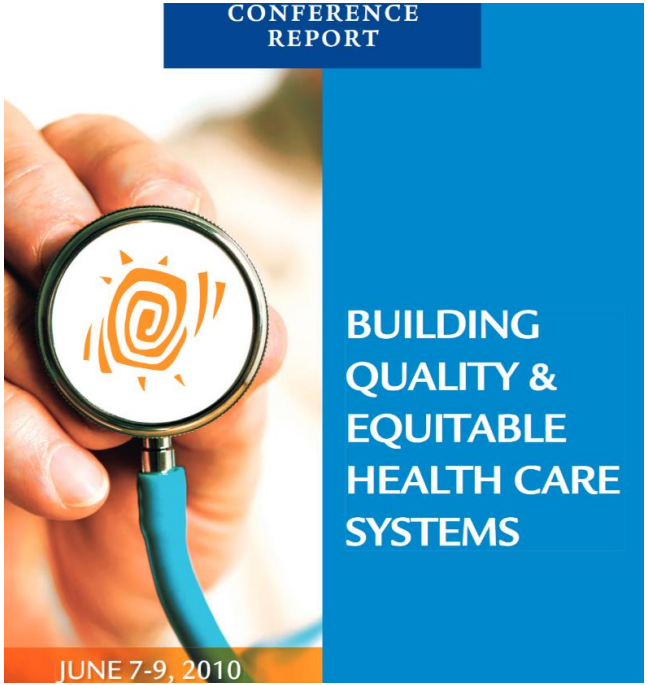

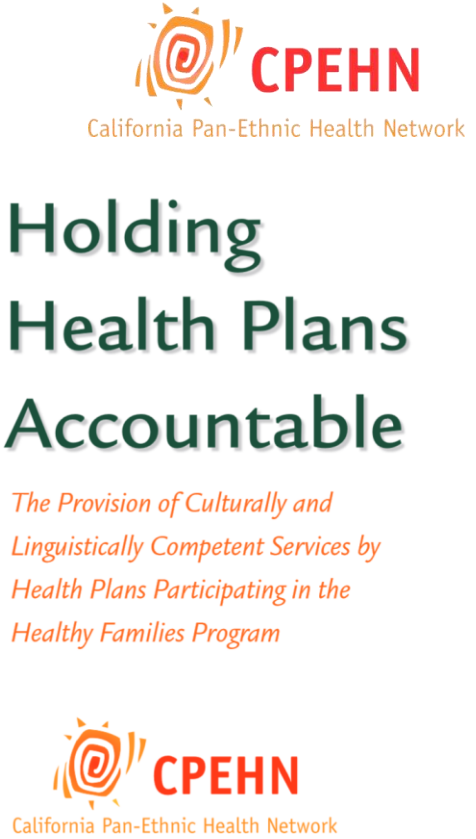

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California Pan-Ethnic Health Network

We **connect and convene** to build knowledge and networks

We **amplify voices and stories** to build leadership and advocacy strength

We **build people power** to influence policy with community expertise

We **advance equity-centered policies** to reflect the needs of communities of color

DIGNITY IN DISCHARGE LAW
WHAT YOU NEED TO KNOW

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Beginning January 1, 2019, all hospitals in California must develop a plan for safely discharging patients without homes. This law prohibits hospitals from engaging in previously reported tactics, such as discharging patients in hospital gowns, leaving patients at unsafe locations, and failing to make necessary mental health referrals.

Specifically, hospitals must do the following:

- Attempt to secure a sheltered discharge location, resource permitting, or discharge a patient to the location of their choice.
- Provide transportation to the discharge location, within 30 miles or 30 minutes of the hospital.
- Offer the patient weather-appropriate clothes.
- Offer the patient a meal.
- Provide referrals to health and mental health resources.

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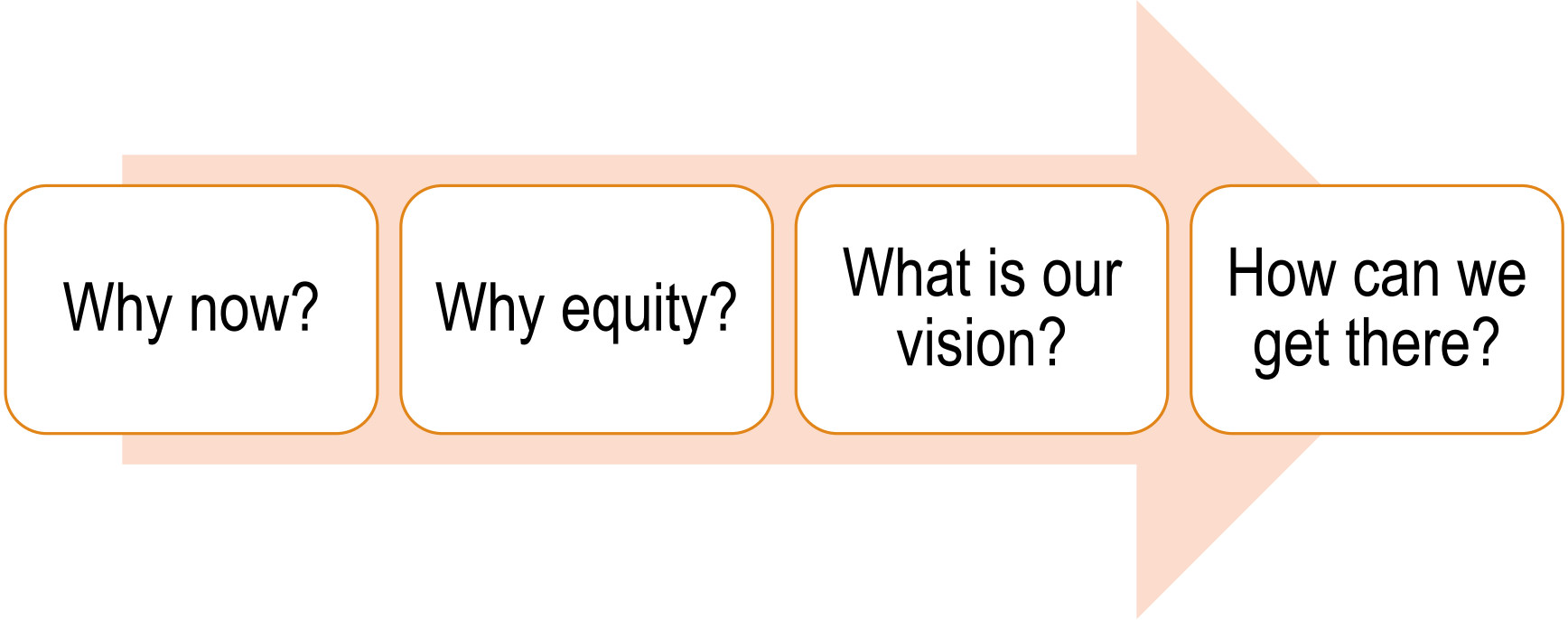
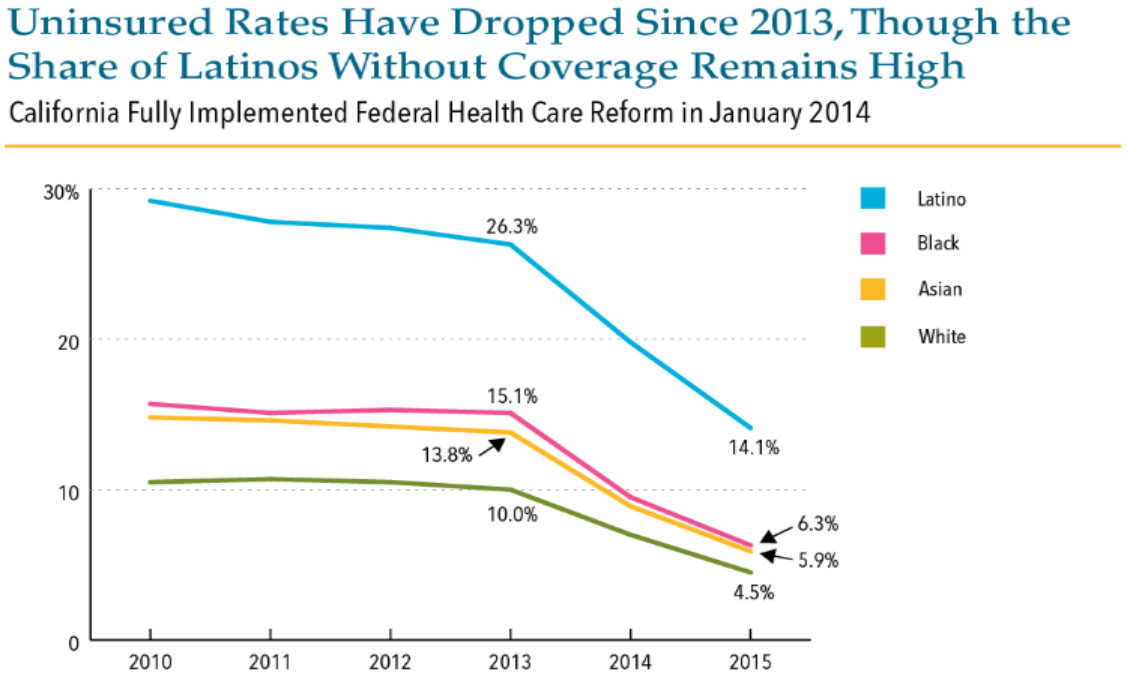
Overview



California has reduced disparities in health insurance coverage



Source: California Budget & Policy Center, November 2016

But Disparities in Health Outcomes Remain

- Latinos and African Americans have twice the prevalence of **type 2 diabetes** and are twice as likely to die from the disease.

- American Indians and Alaska Natives are three times as likely to have **asthma** than the state average.

- African Americans have exceptionally higher rates of **asthma** prevalence (40%), four times higher asthma ED visit and hospitalization rates, and two times higher asthma death rates.

The ACA = Focus on the Triple Aim But Disparities Overlooked

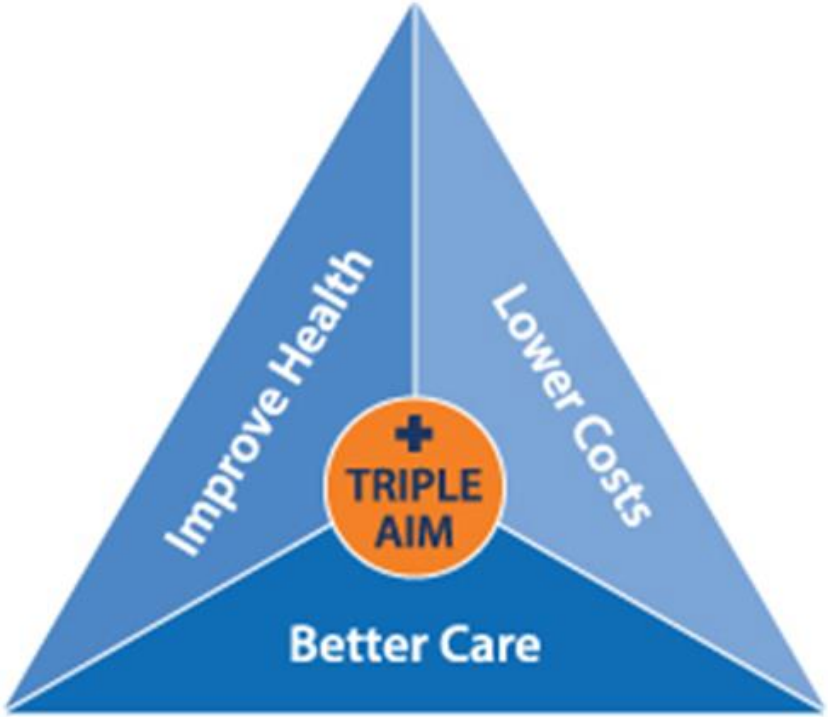


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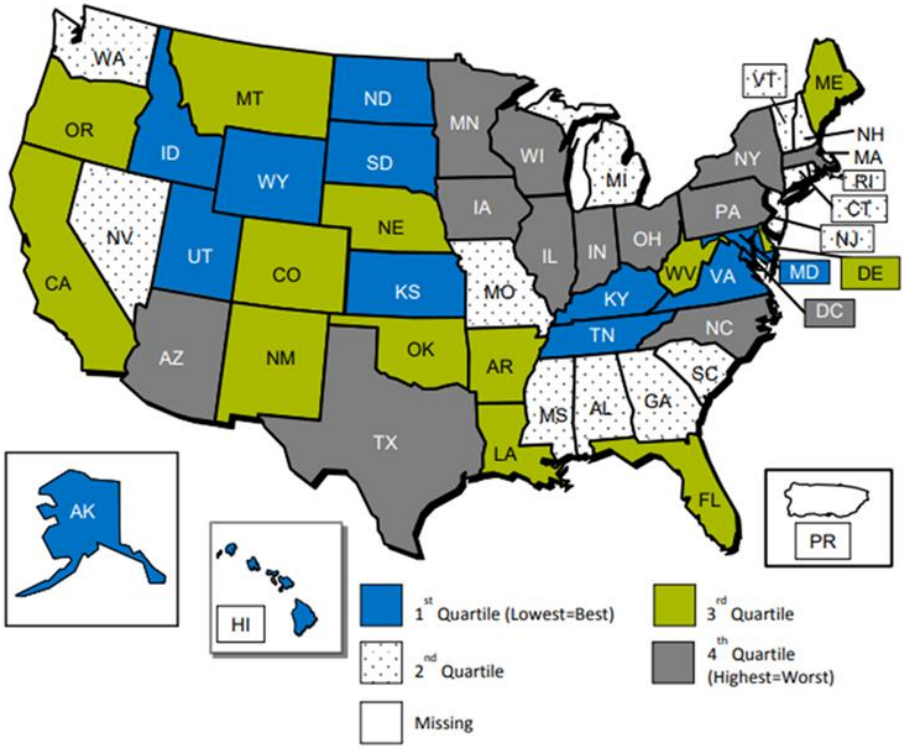
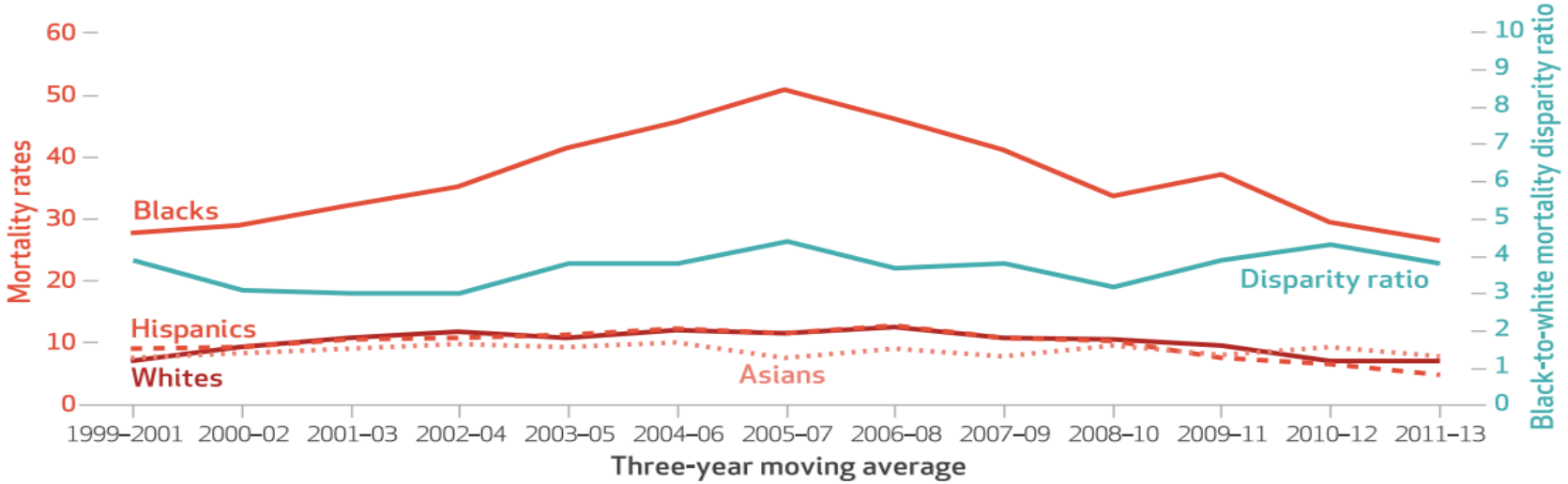
Figure 8. Average differences in quality of care for Blacks, Hispanics, and Asians compared with Whites, by state, 2014-2015



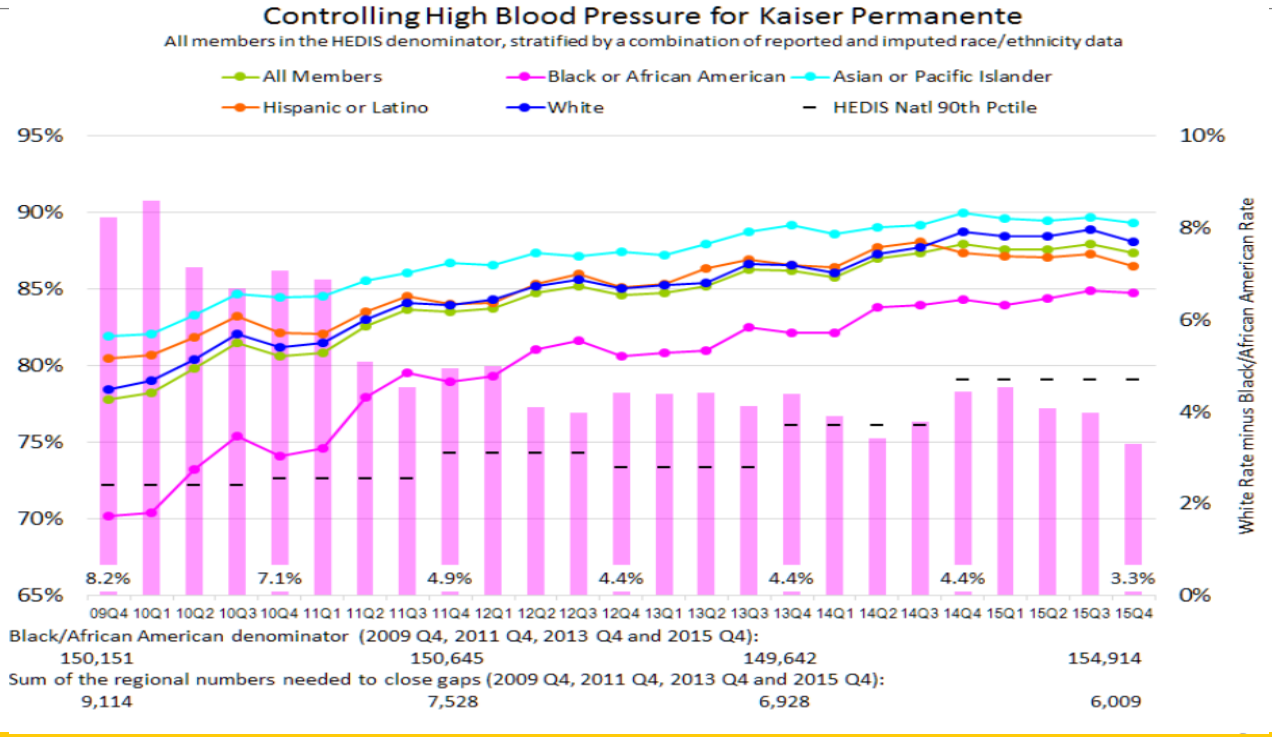
Ignoring disparities risks leaving them in place or worsening them

EXHIBIT 4

Maternal mortality rates per 100,000 live births in California, by race/ethnicity, and mortality disparity ratio for non-Hispanic blacks and whites, 1999–2013



Individualized equitable care improves health outcomes for all



Covered California's Attachment 7 Requirements an Important First Step

Self-Reported Data

- Health plans required to improve their data collection efforts, to move towards collecting 80% self-reported identity data from patients

Year-Over-Year Improvements

- Required to show improvements in health disparities by race, ethnicity and gender in:
  - Diabetes
  - Hypertension
  - Asthma; and
  - Behavioral health
- With ability to expand to other subpopulations including LEP, LGBTQ+

COVERED CALIFORNIA

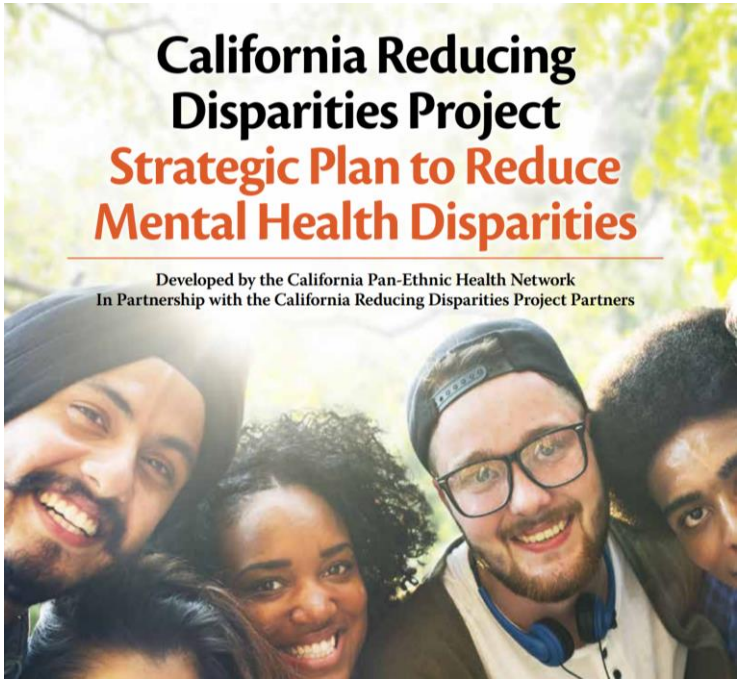
A multi-pronged approach is needed to reduce disparities

Address the social and environmental determinants of obtaining appropriate health care and adhering to provider recommendations;

Implement capacity building at all levels;

Improve data collection standards at all levels; and

Address the social and environmental determinants of health



COVERED CALIFORNIA'S QUALITY CARE AND DELIVERY REFORM FRAMEWORK

Assuring Quality Care Domains

INDIVIDUALIZED EQUITABLE CARE

- Health Promotion and Prevention
- Mental Health and Substance Use Disorder Treatment
- Acute, Chronic and other conditions
- Complex Care

Effective Care Delivery Strategies

Organizing Strategies

- Effective Primary Care
- Promotion of Integrated Delivery Systems and ACOs
- Networks based on Value

→ **Sites and Expanded Approaches to Care Delivery** → **Appropriate Interventions**

Key Drivers of Quality Care and Effective Delivery

Covered California recognizes that promoting change in the delivery system requires aligning with other purchasers and working with all relevant payers to reform health care delivery in a way that reduces the burden on providers.

- Benefit Design
- Measurement for improvement choice and accountability
- Payment
- Patient-Centered Social Needs
- Patient and Consumer Engagement
- Data Sharing and Analytics
- Administrative Simplification
- Quality Improvement and Technical Assistance
- Certification, Accreditation and Regulation

Community Drivers: Workforce, Community-wide Social Determinants, Population & Public Health

DRAFT: Version 08/29/19

Centering Equity in California Health System Transformation

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1) Identify equity opportunities: **Assess** equity in current initiatives

2) Center consumer input: Community **discussions** for views/needs on quality

3) Develop recommendations : **Analyze** findings & discussions to inform pathways.

4) Create a policy roadmap: Develop state and federal **recommendations** to advance equity in system transformation

Project Funded by the California Health Care Foundation

CPEHN & Our Partners Conducted Consumer Focus Groups

Focus Group Facilitator	Location	Demographic Focus
Disability Rights Education and Defense Fund	Bay Area	Individuals with disabilities
Black Women for Wellness	Los Angeles	Black and African American
Latino Coalition for a Healthy California	Central Valley	Latinx
Asian Americans Advancing Justice-Los Angeles	Los Angeles	Asian American
California Consortium for Urban Indian Health	Sacramento	American Indian
Diversity Collective of Ventura County	Central Coast	LGBTQ+

Goal

Engage diverse stakeholders including communities of color, LGBTQ+, and persons with disabilities, in meaningful discussions regarding their experiences accessing health care in order to ensure more equitable health outcomes.

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Participant Criteria

1. Has used or had a family member use health care services in the past year
2. Has health insurance and/or has used safety-net services (e.g. county health care services)
3. Variety of ages and family configurations
4. Variety of lived experiences, including languages spoken, countries of origin, immigration status, residency in the U.S., gender identity, disability types, occupation, etc.

Summary of Demographics

Facilitator	Focus Group Location	# of ppl	Race/Ethnicity	Focus Group Language
DREDF	Berkeley	7	African American, multiracial, white, Chinese American, Black immigrant	English and ASL
BWW	South Los Angeles	6	Black and African American	English
LCHC	Fresno	5	Hispanic, Latino, or Spanish of Mexican descent	Spanish
AAAJ-LA	San Gabriel Valley	10	Cambodian, Chinese, Chinese/Burmese, Chinese/Filipino/Spanish, Guatemalan, Korean, Nicaraguan, Thai, Vietnamese	English
CCUIH	Sacramento	8	American Indian, multiracial	English
DCVC	Ventura	12	White/Hispanic, Latino or Hispanic, Black or African American, White, German/Mexican, Asian Indian	English

Common Themes

- Barriers to accessing care continue
- Difficulty navigating coverage system
- Stigmatizing or disrespectful treatment
- Poor patient engagement
- Desire to engage in feedback mechanisms with proper support

Barriers to Accessing Care

Even though most participants had health care coverage, many still reported challenges accessing care:

- Long wait times (both for appointments and at facilities)
- High out-of-pocket costs, especially dental services
- Lack of access to specialty care and mental/behavioral health
- Transportation barriers, especially in rural areas
- No affirmation of language rights by providers
- Poor quality/ inadequate interpretation services

Difficulty Navigating Coverage System

Participants at every focus group discussed how complicated the current health care system is, and how difficulty navigating particularly insurance systems impeded their ability to get quality care:

- Provider directories are inaccurate/outdated
- Health plan support lines dreadful & not helpful
- Documents (such as handbooks and billing) are hard to read
- Shifting eligibility can lead to unpredictable lapses in coverage

Stigmatizing or Disrespectful Treatment

Participants shared many stories of being mistreated by providers, often in ways that made them reluctant to seek further care:

- Inappropriate treatment based on a person's language, race, sexual orientation, gender identity, disability status, and/or size and weight including:
  - Unwelcome comments
  - Unwarranted assumptions about a person's lifestyle
  - Ignoring a patient's holistic needs based on a single aspect of their identity and/or condition

Poor Patient Engagement

Participants also complained of poor engagement with their provider, which kept them from feeling they were being adequately cared for:

- Excessively short appointments with a doctor
  - Substituted with time spent with nurses and PAs
- Inadequate or lack of explanation about medication, medical procedures, or home care instructions
  - Patients often feel rushed to make decisions or bombarded with paperwork
- Physicians themselves not having language capacity

Desire to Engage in Feedback Mechanisms with Proper Support

Participants expressed interest in serving on a committee that met regularly to review complaints and share thoughts about how health care providers could improve patient care and safety. Participation in this type of committee would be contingent on the following:

1. Babysitting/daycare

2. Convenient time/place

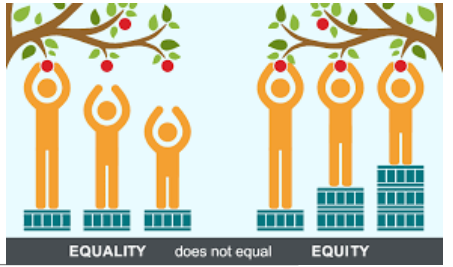
3. Language accessibility

"I believe that health care providers are well intentioned and well meaning...we know that people on the front line often times don't always make decisions.. When you go to a restaurant and something is bad, you know okay give me the manager, you know who to ask for. But in a hospital who do you ask for? Is there a president of the hospital, is there a customer service department? You don't know who to ask for...(important) for layperson to know that they have a right.. to complain to a larger system."

Additional Themes

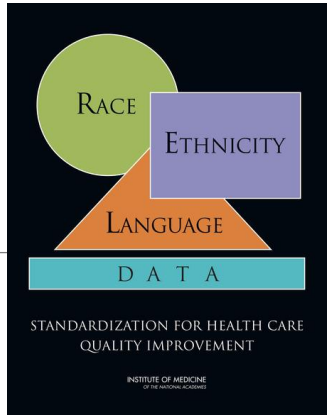
- **Intersectional Experiences:** One can experience multiple forms of discrimination or inappropriate treatment due to their multiple identities
- **Use of technology:** text/email & patient portal can be helpful
- **Alternative Care:** Across racial/ethnic groups many reported using traditional/non-Western/holistic/herbal care and treatments and the desire for their doctors to "supplement not supplant" such care

6 Key Strategies to Achieving Health Equity



- Improve self-reported collection/reporting of quality data by race/ethnicity and other sociodemographic factors
- Strengthen access to culturally and linguistically competent care
- Invest in primary care
- Strengthen care coordination
- Improve patient engagement
- Address the social determinants of health

Improve self-reported collection and reporting of quality data by REL, other factors



Next Steps:

- ✓ Strengthen reporting and accountability of current Attachment 7 Requirements
- ✓ Expand to other subpopulations including Limited English Proficient (LEP), LGBTQ+, persons with disabilities as well as by income and geographic regions (HMA recommendation)
- ✓ Collect better patient data on interpreter need, access and quality
- ✓ Monitor and report on the provision of language services (by language) annually

Strengthen access to culturally and linguistically competent care

Next Steps:

- ✓ Expand access to interpretation for medical care but also specifically for care coordination, case management and patient navigation.
- ✓ Scale the engagement of bilingual/bicultural Community Health Workers (CHWs) and Community-Based Navigators (CBNs) on care teams as recommended by the California Future Health Workforce Commission
- ✓ Incentivize adoption of Patient-Centered Medical Homes (PCMHs)
- ✓ Make implicit bias training and trauma informed screening and referrals which have been shown to improve the quality of care, required activities for providers who contract with QHPs or in the alternative, consider providing a bonus payment for completion.

Invest in Primary Care

Next Steps:

✓ Incentivize adoption of Patient-Centered Medical Homes

- Collect baseline data on the percentage of providers contracting with QHPs in Patient Centered Medi-Cal Homes (PCMHs)
- Set targets for achievement (e.g. Oregon: 90% of Medicaid recipients assigned a PCMH)
- Encourage QHPs to enter into Alternative Payment Models (APMs) including with safety-net providers for enhanced primary care

Improve Care Coordination

Next Steps:

✓ Ensure better care coordination for physical, dental and mental health

- Require PCPs to report on process measures that demonstrate integration of behavioral health and oral health with physical care including screenings and referrals to treatment
- Scale the use of CHWs and care teams

Improve Patient Engagement

Next Steps:

✓ Require QHPs to establish Community Advisory Councils (CACs) that are representative of the populations served as well as providers serving them (e.g. Oregon's new Attachment K) tasked with:

- Reviewing consumer and provider survey results
- Drafting a Community Health Needs Assessment and Equity Plan
- Identifying proposed interventions to strengthen quality/performance outcomes

Address the Social Determinants of Health

Next Steps:

✓ Require QHPs to:

- Screen patients for social needs and make referrals including to housing supportive services, food and rental insecurity and medical respite/recuperative care.
- Conduct local/regional Community Health Assessments and Improvement Plans
- Bring CBOs into contractual relationships to identify opportunities to integrate social determinants of health interventions
- Submit data on the Social Determinants of Health and make significant investments in addressing them (e.g. Oregon's Attachment K).

Additional resources exist at the national and state levels

*Integrating Payment and Delivery System Reforms to Solve Disparities: Recommendations from Finding Answers Grantees. Retrieved from http://www.solvingdisparities.org

*National Quality Forum's Roadmap for Promoting Health Equity and Reducing Disparities
project: http://www.qualityforum.org/Disparities_Project.aspx

*National Health Plan Collaborative working on reducing disparities that developed this
toolkit: https://www.rwjf.org/en/library/research/2008/09/the-national-health-plan-collaborative-toolkit.html

*Oregon Health Authority Model Contract, Newly updated – Oct. 2019!
https://www.oregon.gov/oha/OHPB/CCODocuments/Updated-draft-CCO-contract-terms.pdf

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Contact us at CPEHN

- Cary Sanders
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ROUND TABLE DISCUSSION

Taylor Priestley

CURRENT COVERED CALIFORNIA REQUIREMENTS

- Covered California has worked with issuers to reduce health disparities and promote health equity through:
  - Identifying the race or ethnicity of all enrollees
  - Collecting data on diabetes, hypertension, asthma, and depression by race and ethnicity
  - Conducting population health improvement activities and interventions to narrow observed disparities in care
  - Promoting community health initiatives that foster better health, healthier environments, and promote healthy behaviors

HMA CURRENT BEST EVIDENCE REVIEW FINDINGS

- HMA's research identified strategies that have strong evidence of reducing health care disparities.
  - **Incorporating equity into overall quality strategy will enhance ability to achieve equity gains**
  - **Disparities reduction requires a multi-pronged approach**
  - Using payment to improve quality shows mixed results on disparities
  - Screening can provide an entry to better care
  - Engaging supportive service providers enhances outcomes
  - Patient engagement improves outcomes and patient satisfaction
- These strategies align closely with Covered California's Quality Care and Delivery Reform Framework.

DATA COLLECTION & MEASUREMENTS

Taylor Priestley

IDENTIFYING RACE OR ETHNICITY

- Covered California set a goal in the 2017-2019 model contract for all issuers to achieve race and ethnicity self-identification rate of at least 80% of all Covered California membership by year-end 2019 and encouraged use of various data collection methods beyond the enrollment form to identify membership.
- Collection of data
  - The race and ethnicity question in the enrollment application is voluntary and responses are included in the 834 enrollment file sent to issuers.
  - Sources of race and ethnicity identification: enrollment data, data from providers, customer service, health risk assessments, web site registration, and proxy methodology (ie. zip codes, surname analysis).
- For measurement year 2018, 8 of 11 plans were at or above the 80% requirement.

COLLECTING DATA ON DISEASE CONTROL AND MANAGEMENT BY RACE OR ETHNIC GROUP

- Diabetes, Hypertension, Asthma, Depression
  - These conditions chosen based on existence of National Quality Forum (NQF)-endorsed measures and public health research demonstrating persistent racial disparities in care for these conditions.
- In addition, five Healthcare Effectiveness Data and Information Set (HEDIS) measures and nine Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) measures were selected for annual required reporting by issuers, with rates supplied by gender and race/ethnicity.
- Given membership churn and in recognition that narrowing disparities requires intervention regardless of coverage type, issuers are required to report aggregated data for all lines of business excluding Medicare.

COLLECTING DATA ON DISEASE CONTROL AND MANAGEMENT BY RACE OR ETHNIC GROUP

Plan-Reported Measures for Health Disparities			
No.	Measure	Measure Steward	Condition
1	Diabetes Care: HbA1c Control < 8.0% (NQF 0575)	NCQA	Diabetes
2	CBP – Controlling High Blood Pressure (NQF 0018)	NCQA	Hypertension
3	AMR - Asthma Medication Ratio Ages 5-85	NCQA	Asthma
4	Antidepressant Medication Management (Effective Acute Phase Treatment)	NCQA	Depression
5	Antidepressant Medication Management (Effective Continuation Phase Treatment)	NCQA	Depression
6	Admissions for Diabetes Short-term Complications among Members with Diabetes	AHRQ PQI*	Diabetes
7	Admissions for Diabetes Long-Term Complications among Members with Diabetes	AHRQ PQI*	Diabetes
8	Admissions for Uncontrolled Diabetes among Members with Diabetes	AHRQ PQI*	Diabetes
9	Admissions for Lower-Extremity Amputation among Members with Diabetes	AHRQ PQI*	Diabetes
10	Admissions for Hypertension among Members with Hypertension	AHRQ PQI*	Hypertension
11	Admissions for Heart Failure among Members with Hypertension	AHRQ PQI*	Hypertension
12	Admissions for Asthma among Older Adults with Asthma	AHRQ PQI*	Asthma
13	Admissions for Bacterial Pneumonia among Members with Asthma	AHRQ PQI*	Asthma
14	Admissions for Asthma among Children and Younger Adults with Asthma	AHRQ PQI*	Asthma
Measures Reported by Racial/Ethnic Group and Gender			
American Indian/Alaska Native (AIAN), Asian (A), Black/African American (BAA), Hispanic/Latino (HL), Native Hawaiian or Pacific Islander (NH), White (W), Other Race (OR), Two Races (TR), Unknown Race (UR), Declined to Report (DR), Female (F), Male (M)			

CONDUCTING DISPARITIES REDUCTION INTERVENTIONS

- Following issuer collection and submission of three years of baseline data on the 14 health disparities measures, Covered California is working with each plan to select a quality improvement project aimed at narrowing a health care disparity identified in the three years of baseline data.
- Performance on narrowing the disparity is tied to financial penalties or credits included in the QHP Issuer Model Contract performance standards.

CHALLENGES (1 OF 2)

- Identifying data sources
  - As Covered California increasingly relies on IBM Watson to understand the care experience of its membership, plan-reported data may become less relevant, though limitations exist in relying only on claims experience.
  - Measurement of health disparities requires other sources of data such as clinical records, patient experience surveys, community needs assessments.

- Interpretation of data and identifying health care disparities
  - Current data analysis is based on observed rate differences in admissions, disease control, and medication management by race and ethnicity.
  - Observed difference does not confirm a true health care disparity.
  - Aggregated data submitted by issuers places limitations on Covered California's ability to identify its member population by different lines of business or regions.
  - HEDIS is challenging as some are based on sampling of a subset of members with a condition.
  - These factors lead to small denominators making it difficult to assess statistical significance.

CHALLENGES (2 OF 2)

- Scale of intervention
  - Per performance guarantee requirements, issuers are assessed on their progress towards narrowing a disparity, based on performance in one or two measures selected for the intervention.
  - Covered California accepts interventions of varying scale. However, interventions without prior investigation into root causes and pilot testing to assess effectiveness could be ineffective or counter-productive.

- Performance assessment and accountability
  - Because measurable progress can often take years, Covered California has delayed assessment of the narrowing disparities performance standard to allow time for data collection and development of improvement strategies.
  - Covered California needs to determine how contracted issuers should be assessed on their progress in meeting the goals of the health equity agenda, while allowing enough time for issuers to deploy evidence-based strategies for narrowing disparities.

- Addressing other disparities via data collection
  - Need to address other disparities beyond race and ethnicity data collection such as sexual orientation, gender identity, language, income, geography and disability status.

HMA & PWC RECOMMENDATIONS

HMA	PwC
Align disparities data collection and analysis with other state efforts as part of its requirement of issuers to collect relevant demographic and clinical data needed to assess access, quality and outcomes by race, ethnicity, gender, and other patient characteristics.	Maintain current measures that focus on high volume conditions and consider expanding its scope of areas for measurement beyond race and ethnicity.
Utilize the Mapping Medicare Disparities tool created by the HHS Office of Minority Health; the tool's interactive map identifies areas of disparities between subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending.	Continue to improve demographic and socioeconomic status member data collection.
	Continue to track disease control by race/ethnicity and other demographic factors, such as income.
	To increase QHP disparity measure credibility, consider multiple year averaging or rolling year average reporting. Examples of existing measures that use multiple years of data include: • Quality Rating System • Medicare Shared Savings Program

QUESTIONS

- How does your organization define health equity or health care disparities?
- How does your organization measure and collect health equity or health care disparities data?
- What can Covered California do to improve health disparities measures and collection of data?

ACCESS TO CARE

Thai Lee

CURRENT ACCESS TO CARE REQUIREMENTS

- Covered California QHP Issuers conduct the following activities to facilitate access to care:
  - Continually monitor provider network for unmet cultural and linguistic member needs and actively contract with providers to meet those member needs.
  - Maintain adequate network participation of Essential Community Providers (ECPs).
  - Conduct outreach to members who haven't used health care services since enrollment.
  - Make available to members online tools or other methods to communicate provider quality and costs of services.
  - Report to Covered CA the number and percent of members who have utilized preventive care, tobacco cessation, and obesity management services.

HMA & PWC RECOMMENDATIONS

HMA	PwC
Engage with issuers and their providers to align with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards).	Consider adding tracking measures beyond racial/ethnic disparity: ▪ Stratified outcome analysis by socioeconomic status ▪ Provider access measures by region/geographic sub area ▪ Consideration of rural and urban geographies and market characteristics
Insurers could promote the use of non-clinical providers (eg. Community health workers) where they have been demonstrated to improve access to care, address social determinants of health, health disparities, and support more effective engagement of patients and families.	Recommend Healthcare Effectiveness Data Information Set (HEDIS) measures: • Adult Access to Care and Hospitalization for Potentially Preventable Complications • Integrated Healthcare Association (IHA) Align Measure Perform (AMP) measure: Encounter Rate by Service Type
Retail clinics and urgent care clinics provide an important alternative to the emergency room and enhance access to primary care.	
Use issuer contracts to establish requirements and standards for patient engagement and activation, allowing issuers the flexibility to determine how to operationalize the payment arrangements with providers.	
Require issuers to use their contracting mechanisms to require providers to implement organizational-level efforts to implement a culture of equity and utilize culturally specific models that promote equity in health care outcomes.	

QUESTIONS

- What does access to care mean to your organization?
  - Timing
  - Location
  - In-person/Telehealth
  - Provider type
  - Culturally congruent care
- How does your organization address patient access to care?
- What can Covered California do to improve patient access to care and reduce disparities in care?

SOCIAL DETERMINANTS OF HEALTH

Taylor Priestley

SOCIAL DETERMINANTS OF HEALTH

- Social Determinants of Health
  - The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
  - Examples of these include public safety, access to education, access to health care services, exposure to toxic substances, and socioeconomic conditions.

- Patient-Centered Social Needs
  - Identifying and, as needed, addressing patient-centered support for non-medical services recognizing that many people may face barriers that prevent them from receiving the right care at the right time, such as lack of transportation, food insecurity, physical barriers especially for those with disabilities, and language proficiency.
  - These social needs greatly impact a patient's access to care and health status.

PROMOTING COMMUNITY HEALTH INITIATIVES

- As part of Article 6 on Prevention and Wellness in Attachment 7, issuers are encouraged to partner with community organizations on initiatives that foster better health, healthier environments, and promotion of healthy behaviors across the community.
- Covered California specifically encourages initiatives that have undergone systematic review to determine effectiveness, such as those recommended by the Community Preventive Services Task Force.
- No performance guarantees are tied to these requirements, but issuer involvement in external-facing activities is used by Covered California to identify potential disparity reduction opportunities.

HMA & PWC RECOMMENDATIONS

HMA	PwC
Evaluate issuers' current methods for ensuring patients' issues with environmental and social factors such as food security and housing are identified in the clinical setting or through issuer-based mechanisms such as health risk assessments.	Require the use of Health Risk Assessments to identify enrollees with chronic conditions in order to gain a better understanding of the social determinants of health affecting these enrollees.
Promote the use of non-clinical providers where they have been demonstrated to improve access to care, address social determinants of health, health disparities, and support more effective engagement of patients and families.	

QUESTIONS

- How does your organization address social determinants of health?
- What can Covered California do to address social determinants of health?

WRAP UP & DISCUSSION

- For this session on Health Equity, we took a three prong approach: Data & Measures, Access to Care, and Social Determinants of Health. What are your thoughts on this approach?
- Moving forward, how can we better organize the discussions so that they can lead to the development of contract requirement language?
- Reducing health care disparities crosses multiple domains and care delivery strategies. In the QHP model contract, would you recommend Health Equity measures and requirements be embedded into each domain and strategy, or would you recommend a section focused specifically on Health Equity measures and requirements?

NEXT STEPS

2019 Meetings

- November 6 Mental Health & Substance Use Disorder Treatment
- December 5 Primary Care

2020 Proposed Meeting Topics (January – June)

- Sites and Approaches to Care
- Networks Based on Value
- Integrated Delivery Systems and Accountable Care Organizations
- Data Sharing
- Payment Reform
- Complex Care

THANK YOU

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