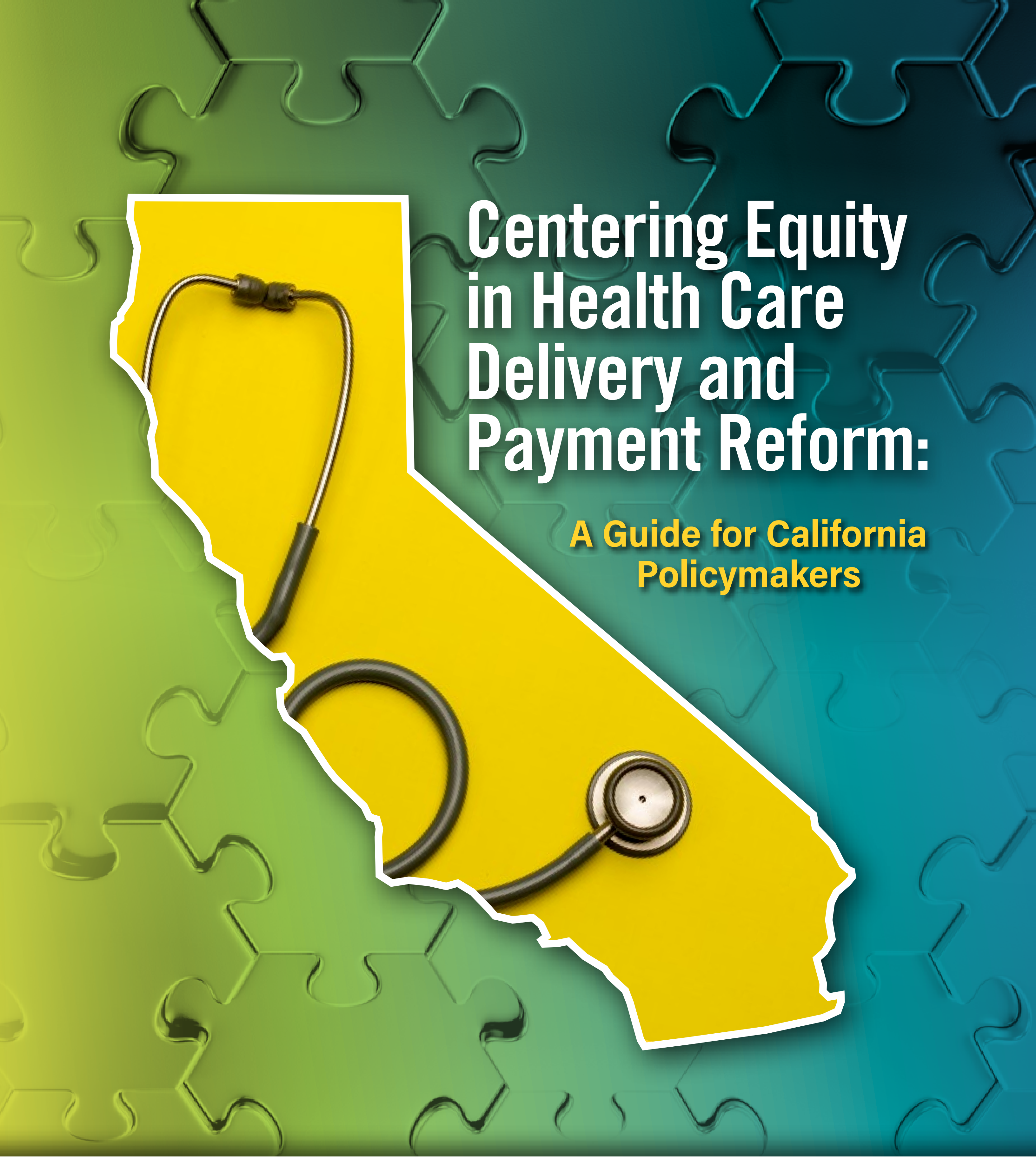


Centering Equity in Health Care Delivery and Payment Reform:

A Guide for California Policymakers

California Pan-Ethnic
HEALTH NETWORK

EXECUTIVE SUMMARY

Although California has a national reputation for advancing progressive health care policies, California's communities of color, including lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals and persons with disabilities, continue to experience discrimination and have poorer outcomes on key health indicators including asthma, diabetes and mental health than other Californians. Despite individual actions and intentions, our health care system as designed often makes health outcomes worse, particularly for communities of color, by perpetuating the very inequities it seeks to address. The imperative to address these systemic inequities is urgent, particularly now against the backdrop of COVID-19 disparities and protests against anti-Black racism and continued violence against Black and Brown communities, sparked by the murder of George Floyd.

California's public health programs, particularly Medi-Cal, have a stated commitment to addressing health disparities. Yet very few payment and delivery reform efforts are tied directly to measurably reducing them. The next chapter of health care delivery and payment reform in California offers both a significant opportunity to address California's disparities and a risk that our continued failure to do so will only make disparities worse. Centering equity in payment and delivery reform then will require all parts of the health care system to act with urgency and a willingness to create a radically different system of care. Change has to start with diversifying leadership and governance, which must be a top priority. But it will also require a commitment to redesigning our systems of care at all levels and touchpoints, with individuals and families at the center.

In January 2019, the California Health Care Foundation funded the California Pan-Ethnic Health Network (CPEHN) to develop a set of policy recommendations on ways to more directly link health care payment and delivery reform efforts to promising strategies to achieve health equity. We were hopeful that now is the time for bigger and bolder reforms to our public health care system to address persistent inequities in access, quality, and health outcomes in Medi-Cal and health care more broadly.

The guide's recommendations were informed by a series of focus groups held with diverse patients, families, and caregivers throughout the state on their personal experiences accessing physical, oral, and behavioral health care in California. CPEHN shared these experiences with community partners, advisory committee members, and state and national experts composed of consumer advocates, health plans, health systems, health care practitioners, and experts in quality and payment reform. CPEHN also partnered with Families USA, a national, nonpartisan consumer healthcare advocacy organization, to conduct an assessment of best practices across the country that we compared and contrasted with current practices in California today.

From these discussions, CPEHN identified **Six Key Strategies** that will help to radically reform the way care is paid for and delivered in California:

1. Center Equity in Quality & Payment:

In California, health inequities are persistent. However, efforts to reduce disparities have generally not been tied directly to quality improvement requirements or payment reform. For example, although Medi-Cal managed care plans must collect demographic data on their members, financial payments are not contingent on their ability to do so or to reduce disparities more broadly. Despite ample research demonstrating the effectiveness of tying payment strategies to disparities reduction, California has failed to commit time and resources to disparities reduction and has too often shifted responsibility for progress in this area to health care organizations that have been more consumed with business imperatives, or lack the time or resources to address disparities seriously. To make real progress, California state policymakers must center equity in all quality and payment reform as a top priority.

2. Engage Patients, Families & Caregivers:

Many health plans and health systems in California already understand the value and importance of patient perspectives as part of quality improvement efforts and have implemented strategies such as Community Advisory Committees (CACs) to better integrate these perspectives in their health system transformation efforts. Unfortunately, many of these strategies often fall short due to lack of meaningful engagement, resources, and attention. This guide provides recommendations for ways to strengthen patient engagement through the adoption of more equitable structures that facilitate collaboration, communication, consultation, co-ownership, and design.

3. Strengthen Culturally & Linguistically Appropriate Care:

California's population is diverse, yet the racial and ethnic breakdown of California physicians is not representative of the state's population. Evidence demonstrates that patients do better with racially, ethnically, and linguistically concordant providers. Changing this will require a long-term commitment and investment by California in improving the health care pipeline. In the near term, the state must focus on systematic data collection on the language proficiencies, disability status, sexual orientation, or gender identity of health care providers to improve provider-patient concordance with all diverse Californians.

4. Improve & Integrate Physical, Behavioral & Oral Health Care:

California's health care delivery system is fragmented, particularly for Medi-Cal beneficiaries who must navigate across multiple complex managed care and fee-for-service delivery systems in order to access physical, oral, and behavioral health. This complex array of systems is confusing and difficult for patients to navigate, often leading to avoidable gaps in care and treatment. Better care coordination will improve health outcomes, reduce inefficiencies, and address disparities in access to critical services.

5. Hold Health Plans and Systems Accountable:

Ultimately, designing an equitable health system will require a fundamental shift in existing health care spending, from the current corporate-driven model to a public and transparent system that proactively invests in prevention and community health. However, to improve health outcomes in the short term, we must take immediate and intermediate steps to improve the system we have today through stronger oversight and accountability.

6. Improve Social Determinants of Health:

Social determinants of health are "conditions in which people are born, grow, live, work, play, and age that shape health." (1) In a state as diverse as California, systemic racism; persistent poverty and income inequality; lack of affordable housing; under-investment in education; over-investment in policing, criminalization, and mass incarceration; rural needs; federal immigration policies; and factors like climate change also impact health. Other external factors like climate change also impact health. Issues such as housing instability and food insecurity are health-related social needs that require increased attention.


Center Equity in Quality & Payment
Improve Social Determinants of Health
Engage Patients, Families & Caregivers
ACHIEVING EQUITABLE CARE AND HEALTH OUTCOMES
Hold Health Plans & Systems Accountable
Strengthen Culturally & Linguistically Appropriate Care
Improve & Integrate Physical, Behavioral & Oral Health Care

SUMMARY OF STRATEGIES

This guide includes a set of twenty-one priority recommendations tied to each of the six strategies. While some of these strategies can be implemented in the short-term, others may take longer to implement. Although these recommendations are primarily addressed to state policymakers, health care organizations, health plans, systems, providers, and patients can also proactively implement these recommendations absent state policy action, and we encourage them to do so. Many of our suggested approaches will be easier to implement under a more unified health care financing system with better coordination and integration of care between California's fragmented systems; This will require a strong commitment from our state and federal leaders and policymakers to the type of long-term transformational health care reform we envision.

Strategy 1: Center Equity in Quality and Payment		
1.A.	**Embrace and Invest in Community-Based Care**	**Pg 20**
1.B.	**Prioritize Tracking, Reporting, and Reducing Disparities**	**Pg 21**
1.C.	**Implement Equity as a Strategic Organizational Priority**	**Pg 22**
Strategy 2: Engage Patients, Families and Caregivers		
2.A.	**Remove Barriers to Engagement of Diverse Patients in Quality and Equity Efforts**	**Pg 26**
2.B.	**Give Patients, Family Members and Caregivers Real Decision-Making Power**	**Pg 27**
2.C.	**Tie Feedback to Meaningful and Measurable Quality Improvement and Disparities Reduction Goals**	**Pg 30**
Strategy 3: Strengthen Culturally and Linguistically Appropriate Care		
3.A.	**End Stigmatizing, Disrespectful, and Discriminatory Treatment Across all Provider Types**	**Pg 32**
3.B.	**Strengthen Access to and Quality of Interpreter and Language Services**	**Pg 34**

Strategy 4: Improve and Integrate Physical, Behavioral, and Oral Health Care

Strategy 5: Hold Health Plans and Systems Accountable

Strategy 6: Improve the Social Determinants of Health

TABLE OF CONTENTS

INTRODUCTION

California has led the nation in expanding access to health care for all. Yet communities of color, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals, and persons with disabilities, continue to experience disparities in care and health outcomes. Despite a stated commitment to addressing these disparities and years of effort, state policymakers, health plans, systems, and providers have still not made significant progress. The data on persistent health inequities, including recent data on the disparate impacts of COVID-19 on communities of color, as well as the lived experience of people of color, points to a health care system that, as currently designed, often makes health outcomes worse through discriminatory treatment, high rates of uninsurance, geographic provider shortages, medical errors, lack of patient safety, and uncoordinated and late care, particularly for communities of color. The challenge to address systemic racism presented by this historic moment, only further heightens the imperative for California policymakers and stakeholders to implement specific actions to advance racial equity now.

OUR VISION

The right to have health care is perhaps the most fundamental right of all people. Health care should not only be equitable in its delivery, but it should be a tool for ameliorating broader societal inequities and injustices. Ultimately, ***we envision a world in which all communities have the opportunity to live with optimal physical, behavioral, oral, and overall health and well-being, and to thrive.***

However, we must grapple with the history of health care as a system of oppression, and the impact of that history on care and outcomes today. The evolution of medicine and health care in the United States includes a shameful history of discrimination, experimentation, and exploitation of Black and Indigenous bodies. This

Systemic racism: *the systemic distribution of resources, power, and opportunity in society to the benefit of people who are white and to the exclusion of people of color. Systemic racism is not the result of individual animus, or lack thereof, but is a result of how institutions and structures are designed.*

Health equity: *Everyone has a fair and just opportunity to be healthy. Equity is not the same as equality. Equity often requires additional efforts and investments for those who currently experience worse health and fewer opportunities.*

history impacts the quality of care that people of color receive today and creates well-founded mistrust of the medical system. The disparities in maternal health for Black women, for example, can be traced to a long history of racism and violence against Black birthing people, including forced sterilization, medical experimentation, and sidelining Black midwives in favor of White medical professionals through the medicalization of birth. Native American communities also have been subject to medical experimentation without consent, forced sterilization, and the misuse of medical and genetic data to pursue racist public policies. Psychiatry has historically been utilized to justify mistreatment of people of color and LGBTQ+ people. Psychiatry classified homosexuality as a mental disorder until 1973 and continues to pathologize transgender identities today. These atrocities resulted from systemic racism and discrimination, and contributed to embedding inequities in health care that are seen today. Only through the radical reimagining of our health care system and the explicit pursuit of anti-racist policy and systems changes can we achieve health equity.

Health equity means that everyone has a fair and just opportunity to be healthier.(2) "Health inequity," on the other hand, indicates differences in health outcomes that are systematic, avoidable, and unjust. (3) This guide, ***Centering Equity in Health Care Delivery and Payment Reform: A Guide for California Policymakers***, is a tool for California state policymakers, health plans, health systems, and providers to begin to address these persistent health inequities. It also includes recommendations for educating and engaging patients, families, and caregivers more authentically and comprehensively in the design and delivery of health care. The goal of this guide is to move California towards a more equitable, patient-, family- and community-centered health care system where health care is comprehensive and affordable. In such a system, everyone is treated with the same level of dignity and respect, allowing everyone to achieve the best possible health outcomes, regardless of their income, sex, race, ethnicity, primary language, LGBTQ+ status, disability or immigration status.

We envision a health care system that is easy for patients, families, and caregivers to navigate, where patients have the support they need to manage their health conditions, can make well-informed decisions regarding their health or that of a loved one, and can access the full spectrum of high quality health care services including integrated physical, oral, and behavioral health care.

We envision a health care system that prioritizes prevention and community health over profit, rather than one that treats high quality health care as a commodity available only to those who are wealthy enough to pay market-determined prices. This is not a question of spending more money on health care. In 2014, California spent $292 billion on health care, or over $7,500 for every Californian.(4) We challenge California to aspire to a system where health care payment and delivery is coordinated, payment is risk-based and capitated for health plans, particularly in Medi-Cal, and accountable for reducing the total cost of care, the achievement of quality improvements, and measurable reductions in health disparities.

We envision a health care system that is truly patient, family, and community-centered, where well-informed and engaged patients make shared decisions about their health care with their providers at a clinical level, and have access to the information, data, and governance roles to hold health plans, systems, and providers accountable for quality, value, and equity.

Finally, we envision a deepening partnership among state policymakers and regulators, and community advocates to work mutually towards actualizing this vision.

WHY NOW?

The Affordable Care Act (ACA) and California's Medicaid expansions for undocumented children and young adults have substantially increased access to health care coverage for Californians. Prior to the ACA, communities of color made up just over half of all California residents but represented three-quarters (74%) of the uninsured. Since the passage of the ACA, uninsured rates for Asian, Black, American Indian and Alaska Native Californians declined by more than half from 2013 to 2015.(5)(6) The share of Latinx without coverage also dropped, though by smaller margins (26.3% to 14.1%). While these gains in reducing the numbers of uninsured have been under threat due to attacks by the Trump Administration on the ACA and racist, anti-immigrant policies like the public charge regulation, California's success demonstrates that the reduction of racial and ethnic disparities in coverage is achievable.

However, while health insurance coverage is critical, coverage alone will not drive a reduction in disparities in health status or outcomes, nor will it produce affordable, high-quality health care for all Californians. To achieve equity, we must also turn our attention to transforming how care is delivered and paid for, and health equity must be a central focus of these efforts. The Affordable Care Act contained several provisions aimed at fundamentally changing the way health care is organized, delivered, and paid for in the U.S. health care system. These provisions are focused on improving the efficiency and quality of care that patients receive while shifting towards payment models that reimburse based on the value of care provided. The federal government has established a framework and ambitious goals for shifting the percentage of health care payments in the U.S. from a fee-for-service model to value-based payments.

Health Reform Efforts in California

Even before the ACA, California had dramatically expanded the use of managed care in Medi-Cal over the last decade. Today, 82% of Medi-Cal beneficiaries are enrolled in a managed care plan responsible for developing an adequate provider network, coordinating care for beneficiaries, and monitoring and providing quality care. However, the promise of managed care in Medi-Cal has not been fulfilled, as plan performance on quality measures is stagnant at best.(7) Yet the significant role of Medi-Cal managed care health plans in California present both opportunities and challenges for the broader delivery system transformation and payment reform this guide outlines. For example, although most Medi-Cal payments to providers are not based on fee-for-service, they also are not based on value, or conditional on quality improvement and cost reduction outcomes. And they have yet to be based on any measures of reducing disparities or advancing equity.

It is no surprise then that California is interested in transforming health care delivery systems beyond the current structures of the ACA. In 2019, Governor Newsom appointed a Commission tasked with developing a plan for a universal health care program in California, an idea that may be more feasible under a new federal administration. The Commission has committed to health equity as a core tenet of any new health care system.

There are areas of health care delivery transformation and payment reform where California has demonstrated national leadership. California's ACA health insurance marketplace is looked to as a national model for preserving consumer choices, holding down premium increases, and being an "active purchaser" in contractually requiring quality improvement – and the reduction of health disparities in hypertension, diabetes, asthma and mental health by its qualified health plans. Newly enacted state legislation (Assembly Bill 929, Chapter 812, Statutes of 2019) co-sponsored by CPEHN, reinforces the importance of Covered California using detailed utilization and encounter data to ensure that consumers can choose from plans that offer the best value and to evaluate the impact on the health delivery system through lower costs, quality improvement, and disparity reductions.

There are also many Medicare accountable care organizations (ACOs) and even some hospitals and health systems participating in federal bundled payment initiatives throughout California. For example, in 2018, there were 23 Medicare Shared Savings Program ACOs and 7 New Generation ACOs in California. And even before the ACA, California's commercial health plans have partnered with hospitals and health systems, large medical groups, and state and local governments to develop pay-for-performance initiatives and innovative commercial ACOs. Stakeholders such as the Integrated Healthcare Association, America's Physician Groups, and the Pacific Business Group on Health have championed and led delivery and payment reform innovations such as centers of excellence with bundled payments for hip and knee replacements.

However, the lessons learned from these ACA and commercial innovations have not been applied to other health plans, systems, and providers. For example, few public hospitals and health systems, community health centers, or solo and small group physician practices have participated in these innovations and have much less experience with alternative payment models and value-based payments. California has attempted to foster the adoption of pay-for-performance systems and stratification efforts of granular Race, Ethnicity and Language, and Sexual Orientation/Gender Identity data – known collectively as "REAL SO/GI" data. This is a significant initial step. However, if the most promising health system delivery transformation and payment reforms are not disseminated and replicated amongst all health systems and providers, California will have a two-tiered system of care – one with higher quality and more resources, and one with fewer resources and more responsibility to care for poorer, sicker, and more complex patients, which in turn will perpetuate and deepen disparities and inequities. For example, the ACA's penalties for avoidable readmissions had the unintended consequence of penalizing disproportionate share hospitals. Moreover, none of these Medicare or commercial innovations have had a focus on reducing disparities or advancing equity.

Persistent Disparities

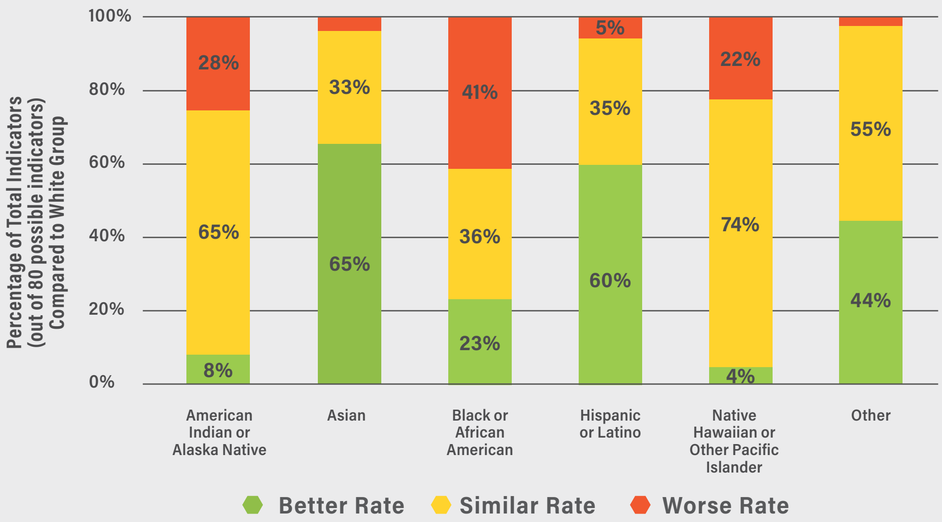
Despite these past, current, and proposed reforms, widespread racial disparities in health status and health outcomes persist. Race itself does not lead to these differences; rather, systemic racism in health care and throughout society is the driver of disparate health outcomes for communities of color. These disparities are often intersectional due to the way systems of racism, poverty, and sexism overlap.(8) In particular, communities of color continue to experience persistent disparities in the quality of care they receive as evidenced by a 2017-2019 review of approximately 80 quality indicators in the state's Medi-Cal program.

The Urgent Imperative

As COVID-19 cases and deaths accumulate, disproportionately impacting Blacks, Latinx, Native Hawaiians and Pacific Islanders, and American Indians, failures by policymakers and health systems to address racial disparities have taken on an especially stark tone, making it clear that continuing inaction to address racial disparities is deadly.(15) People of color who had received lower quality care and lived with chronic conditions long ignored by the health care system were more vulnerable to COVID-19, and their communities were disproportionately impacted by the virus. And although effective containment could have saved lives, it was virtually impossible as Black, Indigenous, and people of

DISPARITIES IN HEALTH CARE QUALITY

OVERALL RACIAL/ETHNIC HEALTH DISPARITIES FOR ALL INDICATORS FOR REPORTING YEARS 2017-2019



SOURCE: 2018 Health Disparities Report: California Department of Health Care Services

- Rates for the Black or African American group were worse than those for the White group for approximately 41% of quality indicators.
- Rates for the American Indian or Alaska Native group and Native Hawaiian or Other Pacific Islander group were worse than those for the White group for approximately 28 percent and 22 percent, respectively, of quality indicators in the analysis.
- Rates for Asian and Hispanic or Latinx groups were worse than rates for the White group for approximately 5% or less of quality indicators in the analysis.[9]

INEQUITABLE HEALTH OUTCOMES

MORE LIKELY

In California, Latinx are more likely to report being in poor or fair health.[10]

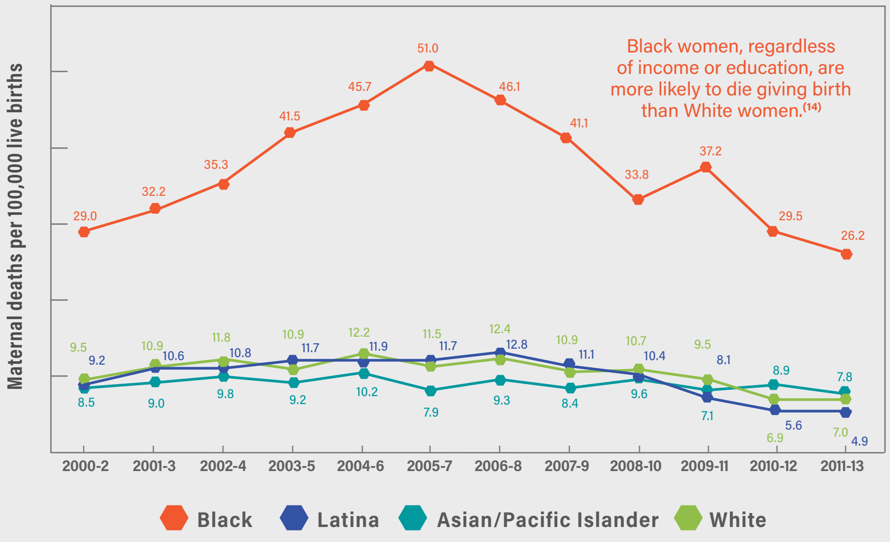
2X HIGHER

Blacks and Latinx have twice the prevalence of type 2 diabetes and are twice as likely to die from the disease than Whites.[11]

40% HIGHER

Asthma prevalence among American Indians and Alaska Natives is more than 40% higher than among Whites.[12]

MATERNAL MORTALITY, BY RACE/ETHNICITY
California, 2000 to 2013



Black women, regardless of income or education, are more likely to die giving birth than White women.[14]

SOURCE: California Health Care Foundation, 2019 Edition - Health Disparities by Race and Ethnicity

30% HIGHER

Blacks have exceptionally higher rates of asthma prevalence (30%).

4X HIGHER

Blacks have four times higher asthma emergency department visit and hospitalization rates.

2X HIGHER

Blacks have two times higher asthma death rates.[13]

color (BIPOC) were unable to access basic testing and treatment due to policymaker failures to appropriately allocate resources to communities heavily hit by the pandemic. In addition, many had no alternatives to continuing to work in high-exposure "essential" jobs. Moreover, as a result of well-founded mistrust of historically racist government and medical institutions, many were reluctant to seek medical help. COVID-19 has demonstrated how our health system has failed people of color and underscores the need to closely examine and eliminate the historic and persistent anti-black racism in our medical institutions. Ultimately the impact of unequal and discriminatory health care cannot be ignored. This guide focuses on the role of the health care system in creating health disparities and the imperative for it to address them.

Significant attention is also being paid to the role of social determinants of health, defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age," and "shaped by the distribution of money, power and resources" on health outcomes.(16) Social determinants such as housing, food, and economic security are most likely to negatively affect people of color. For example, on average, people of color earn less than Whites and are therefore more likely to face the impacts of economic insecurity; Those earnings gaps continue to increase. (17)

The COVID-19 pandemic also highlights how systemic racism in employment, housing, and other sectors exacerbates health inequities. Whether one can work from home, safely isolate in secure housing, access online education and telehealth, or order food and household supplies online – or be vulnerable to exposure by having to continue to work in "essential" jobs with frequent public contact, use public transportation, and live in insecure or overcrowded housing – has a direct relationship to health. Immigrants have been understandably reluctant to access COVID -19 testing and treatment because of the public charge regulation. Orders by public health officials to shelter in place and quarantine if infected exposed the deep cracks in our public health and social service infrastructure due to systemic underfunding, and the lack of adequate coordination of health care services with preventive, social, and economic supports. We still do not know what the long-term clinical consequences of having COVID-19 will be in terms of trauma and stress, loss of jobs, and disruption to education, but this should serve as an urgent wake-up call that we need a transformation of our health care system that centers on equity while addressing the social determinants of health now. This guide includes specific recommendations for how health systems can address the social determinants of health through an equity lens.

> ***"With COVID-19 and racism, everything is changing rapidly, there are shock waves; what are the long-term clinical consequences of having COVID-19 in terms of the impact of trauma and stress, of loss of jobs and disruption to education?"***
>
> ***– Health care provider, state responder panel***

Emerging Opportunities

Health systems and policymakers now operate in a changed landscape where the public increasingly expects action on racial inequities. In late May 2020, millions throughout the nation rose in anger and protest at the murder of George Floyd, an unarmed Black man, by police officers in Minneapolis, and at the continued violence perpetuated against Black people throughout the country. In response to broad public outcry, organizations and corporations across multiple sectors issued statements acknowledging systemic racism and made public commitments to conduct internal assessments and changes to advance racial justice, joining in calls for police reform and other public policy changes. Nationwide, dozens of cities and counties have responded to community calls to declare racism as a public health crisis.

And as disruptive as the COVID-19 pandemic has been to our lives, the collective experience of this public health emergency demonstrates that radical changes to health care delivery are both necessary and feasible. Health care delivery systems have broadly shifted to telehealth and virtual health care. In early April 2020, there was an extraordinary moment of national recognition that COVID-19 was disproportionately impacting Blacks – and then more data were analyzed and reported that COVID-19 was disproportionately impacting Latinx, American Indians, and Pacific Islanders. Many states, and local health departments scrambled to provide more comprehensive data about COVID-19 cases and mortality stratified by race and ethnicity while advocates pressured those who did not do so to correct this.

As the health care transformation enterprise surges forward, testing new models of health care delivery and payment, making systemwide improvements and shifting towards a value-based reimbursement of services, it is critical to ensure those efforts are centered on health equity and reducing disparities. The transformation of health care delivery and payment reform in California offers both a significant opportunity to address California's disparities or risk furthering them if delivery system and payment reform efforts do not appropriately and accurately address health inequities that harm people of color and those affected by medical oppression.

METHODOLOGY

In 2019, CPEHN partnered with six community organizations from around the state (Black Women for Wellness, Disability Rights Education and Defense Fund, Latino Coalition for a Healthy California, Asian Americans Advancing Justice-Los Angeles, California Consortium for Urban Indian Health, and Diversity Collective of Ventura County) to conduct focus groups. These focus groups sought to engage consumers with diverse identities and backgrounds, including race, ethnicity, sexual orientation and gender identity, primary language, disability status, age, and marital status. Discussions centered on key topics, including accessibility and quality of care, health care costs, doctor-patient engagement, and cultural sensitivity. During these six focus groups, 58 participants provided data for this guide.

Through these focus groups, we heard stories reflecting the diversity of health care experiences. We identified common themes shared by many diverse focus group participants, including people of color, LGBTQ+ and persons with disabilities, regarding their experiences accessing health care. These experiences include overarching barriers to accessing care, difficulty navigating coverage systems, stigmatizing or disrespectful treatment, lack of access to interpreter services and poor patient engagement *(see Appendix 1 for more information).*

We then co-hosted four regional convenings with focus group partners where we shared our findings and gathered additional feedback from 111 attendees consisting of health care consumers and providers, on barriers and potential solutions to improve access to affordable and high-quality physical, oral and behavioral health care. The focus group findings resonated strongly with the regional convening participants who shared similar experiences and priorities for change *(see Appendix 2 for details).*

There are many efforts in California and throughout the U.S. that are seeking to improve health outcomes across the spectrums of health through healthcare delivery system transformation and payment reforms – most notably, innovations in clinical care delivery and payment systems, and addressing the social factors such as housing that can negatively impact health outcomes. We paired our focus group and regional convening data with a landscape assessment of California's healthcare delivery system and payment reforms. We partnered with Families USA to look at promising models in other states that could be applicable in California in order to gain a better understanding of opportunities to improve California's physical, oral and behavioral health systems.

To ensure that our analysis would result in both feasible and aspirational recommendations, we convened a workgroup of consumers, experts, and health care providers to share our findings and provide input into our analysis and recommendations along the way. *(See Appendix 3 for list of workgroup members)*. We also reached out to a panel of state and national experts including health plan representatives, safety-net providers, consumers, and experts in quality measurement and payment and delivery reform to gather their feedback and additional insights into the final recommendations which are detailed in this guide *(See Appendix 4 for a list of state/national responder panel members)*.

METHODOLOGY

OVERVIEW OF FOCUS GROUPS

Facilitator	Focus Group Location	# of people	Race/Ethnicity	Focus Group Language
Disability Rights Education and Defense Fund	Berkeley	7	African American, multiracial, white, Chinese American, Black immigrant	English and ASL
Black Women for Wellness	South Los Angeles	6	Black and African American	English
Latino Coalition for a Healthy California	Fresno, San Diego	15	Hispanic, Latino, or Spanish of Mexican descent	Spanish
Asian Americans Advancing Justice - Los Angeles	San Gabriel Valley	10	Cambodian, Chinese/Burmese, Chinese/Filipino/Spanish, Guatemalan, Korean, Nicaraguan, Thae, Vietnamese	English
California Consortium of Urban Indian Health	Sacramento	8	American Indian, multiracial	English
Diversity Collective of Ventura County	Ventura	12	White/Hispanic, Latino or Hispanic, Black or African American, White, German/Mexican, Asian Indian	English

SIX KEY STRATEGIES

In response to what we heard from community stakeholders and what we learned from our landscape research, CPEHN developed six key strategies with recommendations for how California could improve health care access, treatment, and outcomes for California's diverse communities through health care delivery system transformation and payment reforms.

While much of this guide is focused on the Medi-Cal program, it includes recommendations for other major purchasers including Covered California and CalPERS, where alignment is appropriate. Although a majority of the recommendations in this guide are directed to state health care purchasers, many of these recommendations are also directly applicable to health systems, health plans (public and commercial), and providers (hospitals, community health centers, medical groups, physicians and other primary care providers, dentists, behavioral health providers), and we urge their adoption as appropriate. Various recommendations are targeted additionally to other state agencies and commissions that license or otherwise engage with health plans, hospitals and providers.

The recommendations within these strategies are organized into those achievable in the short-term and those that require longer-term, fundamental shifts in our health care delivery system. It should be noted that we must begin the process of transformation now for the necessary radical changes to be possible.

Center Equity in Quality & Payment

Engage Patients, Families & Caregivers

Strengthen Culturally & Linguistically Appropriate Care

Improve & Integrate Physical, Behavioral & Oral Health Care

Hold Health Plans & Systems Accountable

Improve Social Determinants of Health

> *“What are the fundamental challenges in the current system? What would structural reform look like? What would going “all in” on equity look like?”*
>
> *– Health plan representative, state responder panel*

CENTER EQUITY IN QUALITY AND PAYMENT

In California, well-documented and persistent disparities exist by race, ethnicity, language, disability status, sexual orientation, and gender identity, amongst other socioeconomic factors. Because of their persistence, overall improvement or access cannot be assumed to also result in narrowing disparities. Failure to make health disparities reduction a central component of quality improvement efforts in physical, oral, and behavioral health will leave disparities in place and may even exacerbate them.(18) *However, California's health care purchasers, health systems, health plans, and providers still have a long way to go to improve access to community-based care, beneficiary demographic data collection and reporting and internal reforms in order to make the data actionable.*(19)

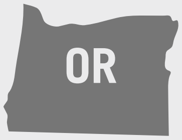
1.A. Embrace and Invest in Community-Based Care:

Rather than lay blame for disparate health outcomes on individuals for reluctance to seek care or on individual behaviors, we must acknowledge the history of racism, experimentation, exploitation, and exclusion in health care and how that affects the quality of care that people of color, individuals with disabilities, and LGBTQ+ people both experience and perceive today. All parts of the health care system must act with urgency and a willingness to create a radically different health system.

SHORT-TERM POLICY CHANGES:

- **1.A.1. Continue to fund new research, practices, and policies that increase understanding of health prevention and treatment needs in communities of color.** The vast majority of evidence-based practices were not designed for or appropriately standardized on communities of color. To remedy this, we must invest in developing and evaluating new and innovative programs and practices as well as modalities that have cultural significance outside of the delivery system. In addition, we must be prepared to invest even when there is a possibility of failure. Doing so is the only way to develop true advances in care. For example, in California, the Mental Health Services Act funds community-defined evidence practices (CDEP) as important interventions for reducing mental health disparities. California must continue to evaluate what "works" in health for communities of color and increase knowledge and awareness of these innovative practices.
- **1.A.2. Authorize and compensate effective community-based care, including home births performed by midwives and doulas, community-based mental health professionals and traditional healers, and dental therapists.** Remove cultural and regulatory barriers that prevent midwives and doulas from providing home births, and require Medi-Cal and commercial payers in California to cover home births performed by midwives and doulas according to evidence-based practices and guidelines.

STATE EXAMPLES



Certified nurse-midwives and licensed-direct entry midwives in Oregon can obtain prior authorization to provide out-of-hospital birth services for Oregon Health Plan members. (20)

Minnesota's Medicaid program reimburses for mental health patient education and care coordination provided by community health workers.(21)

New Mexico's Medicaid program reimburses traditional healers for providing traditional healing practices to Native American Medicaid members.(22)

Currently, ten states all provide for licensure of dental therapists, including Alaska, Arizona, Idaho, Maine, Michigan, Minnesota, Oregon, Vermont, Washington, and New Mexico.(23)

- **1.A.3. Compensate community-based mental health professionals and traditional healers for the evidence-based care they provide in their communities.** These services should be seen as core to health and wellness, and payers must recognize the value of community-based healing traditions.

1.B. Prioritize Tracking, Reporting, and Reducing Disparities:

California's health care system often perpetuates or even deepens inequities, particularly for communities of color. The populations most negatively impacted by social determinants have the least access to health care and experience the worst outcomes. To improve health care quality and reduce disparities, California must require health plans, systems, and providers to track, report, and improve health outcomes over time for key chronic conditions such as diabetes, asthma, hypertension, and depression. Holding health plans accountable for the quality of care provided to communities of color will create the incentives needed to ensure plans invest with broader stakeholders in appropriate strategies to address barriers to community health and reduce disparities.

- **1.B.1. Require all health plans and providers across all purchasers to collect and report health care utilization, claims, and quality data stratified by race, ethnicity, language, and other sociodemographic factors.** Health equity should be an explicit goal in all payment and delivery reform strategies with benchmarks tied to improvement in health outcomes for the entire population, and measurable reductions in existing disparities. Policymakers should set and align year-over-year targets for demographic data collection for all quality measures, reporting, and utilization across all major purchasers, and institute pay-for-reporting and pay-for-improvement incentives (in reporting and utilization/stratification) through withholds.

- **1.B.2. Adopt a uniform standard for the collection and reporting of demographic data to ensure it is consistent and comparable between programs.** Data should be disaggregated beyond the federal Office of Management and Budget standards to properly identify and target disparities experienced by smaller populations including Asian, Native Hawaiian and Pacific Islander, and American Indian/Alaska Native communities. Especially after the increased awareness of racial and ethnic disparities related to COVID-19 testing and treatment, there should be consumer education and engagement to highlight the importance of self-reporting and utilization of demographic data in all of health care. Many states are already ahead of California in this area.

- **1.B.3. Incentivize implementation of the 2015 federal Office of National Coordinator (ONC) for Health Information Technology standards:** Adoption of the 2015 federal ONC HIT standards (finalized in 2019) will help to facilitate collection of patient race, ethnicity, language, sexual orientation, gender identity, and social and behavioral risk data in electronic health records (EHRs); these standards facilitate both self-reporting and collection of disaggregated data; granular patient information regarding disabilities and accommodation needs should also be consistently collected, reported, and utilized.(26) The federal Quality Payment Program already incentivizes the use of these ONC standards for Medicare providers and California public and private purchasers could add aligned requirements and incentives.
- **1.B.4. Require payers to publicly report cost, quality, and equity data stratified by patient demographics** to ensure transparency and accountability of plans and providers to purchasers and consumers for more adequately managing the health of their populations, identifying disparities and actionable areas for improvement, and tying payments to equity related outcomes.
- **1.B.5. Require payers and providers to collect and report on patient demographic and social and behavioral risk data** to California's electronic health information exchanges, and any all-payer databases used throughout California. Implementation of CMS' new Interoperability Final Rule will help to ensure data flows more freely between payers, providers, and patients.

STATE EXAMPLES

Minnesota enacted a health reform law in 2008 which required the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state called the Minnesota Statewide Quality Reporting and Measurement System. Physician clinics and hospitals are required to report quality measures annually, which include reporting data on socio-demographic factors like gender, age, race, ethnicity, and preferred language. Minnesota payers can use the Quality Reporting System for performance-based contracting or pay for performance initiatives.(24)

Oregon, through its Coordinated Care Organizations, has also made progress toward financial incentives for equity. The state developed a health equity measure designed for people with LEP, Meaningful Language Access to Culturally Responsive Health Care Services, and incentive payments are based on measuring their performance in providing quality interpreter services.(25)

1.C. Implement Equity as a Strategic Organizational Priority:

Change starts with diversifying leadership and governance, which must be a top priority. Equity should be built into all of a health plan or systems' operations. DHCS and other health purchasers, systems, and plans must commit to equity at the highest levels.

- **1.C.1. Require payers, health systems, and plans to form internal equity infrastructure and staffing** to identify opportunities to adopt more equitable business practices throughout the entire organization. L.A. Care Health Plan, for example, is exploring different contracting strategies such as paying smaller providers up-front for their services, to make it easier for people of color and women-owned businesses to provide services to their members.

- **1.C.2. Simplify health plan-provider contracting** to make it easier for community-based organizations who assist with health navigation or social services, and are often trusted messengers in their communities, to join health plan networks and assist in providing team-based care and efforts to address the social determinants of health. As an industry, the health care system significantly influences not just the health of its members but the social determinants of health via job and economic opportunities. DHCS, Covered California and other purchasers should require these types of equitable contracting practices as they have the added benefit of ensuring greater provider diversity while at the same time, helping to build additional economic investment and employment opportunities in communities of color and the surrounding communities.
- **1.C.3. Incentivize payers and providers to implement evidence-based interventions to reduce disparities:** Robert Wood Johnson's Finding Answers: Disparities Research for Change found that promising interventions were frequently multi-factorial and culturally-tailored employing a multi-disciplinary team of care providers, including community health workers. Additionally, patient navigation and interventions that actively involved family and community members showed promise for improving health outcomes for vulnerable populations.(27) These and other evidence-based interventions should be encouraged and funded, especially now as telehealth is more widely adopted.
- **1.C.4. Establish an Equity Improvement Network** in California that can act as a clearinghouse for innovative ideas to advance health equity. The California Improvement Network (CIN), a project of the California Health Care Foundation and managed by Healthforce Center at UCSF, is a good model of how a network can work to help health care organizations drive and sustain change. Without a statewide infrastructure specifically focused on equity, even the best intended and planned initiatives will struggle with dissemination, replication, and scaling. There should be roles for patients, families, and caregivers in the Equity Improvement Network, to model how to engage and integrate them in this work.
- **1.C.5. Create robust consumer feedback mechanisms tied to payment:** Continuous measurement, expectations, and rewards for excellent consumer experiences are routine in other sectors but remain peripheral in health care. These mechanisms should allow for a deeper level of evaluation than the current consumer satisfaction surveys and should focus on the extent to which diverse health care consumers feel heard, seen, valued, and engaged. We need to collectively create a consumer-centered culture in all health systems where the needs, preferences, and health outcomes of patients, families, and caregivers drive continuous improvement, transformation, and payment.

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **1.C.6. Prioritize contracting with public health systems and plans in order to keep health care dollars in the community and accountable to those they serve.** A public, unified financing system in California, as policymakers are currently considering, could help to address some of the current shortcomings in California's health care delivery system by ensuring greater accountability and consistency between plans and providers and requiring more robust investments in prevention and community health. Consumers throughout California already are investing billions of dollars in their health care through taxes, premiums, and co-payments but are not seeing the full value of all those investments because of our fragmented and inefficient delivery system. Diverse Californians who continue to experience disparities see even less value, with the systemic ignorance, denial, and neglect of those inequities being tolerated as the way it always has been and seen as too difficult to fix. Current efforts to leverage financial incentives to drive health care innovation, while promising, are also limited in a system that is fragmented across different payers with individuals often moving between plans and coverage. In the interim, California should consider joining other states like Oregon and Washington in requiring local and regional payers – both public and private – to work together to improve health care quality, reduce disparities, address population health, and limit increases in the total cost of care. These types of multi-payer arrangements, such as Coordinated Care Organizations (CCOs), can increase transparency and accountability to the communities they serve.

> *“We create this fancy health care system, but we do not teach them how to use it.“*
>
> *Focus group participant, Orange County*

ENGAGE PATIENTS, FAMILIES, AND CAREGIVERS

Patients bring important and unique perspectives concerning their care or that of a family member, and their experiences navigating within and between the various systems of care. Informed and engaged patients, families, and caregivers are a crucial element of learning health systems but are often not meaningfully engaged.(28) If the goal is to move towards more patient- and family-centered care, then individuals and families must be engaged more directly in efforts to improve health care quality and strengthen systems of care through collaboration, communication, consultation, and co-ownership, and provided orientation, technical assistance, and other supports to facilitate participation.(29)

2.A. Remove Barriers to Engagement of Diverse Patients in Quality and Equity Efforts:

Meaningful engagement of patients, families and caregivers is often difficult to achieve due to a myriad of patient-related barriers such as low health literacy, lack of education and cultural and linguistic differences. Staff and provider-related barriers such as negative attitudes towards engaging patients, ineffective communication and high provider workloads can also hinder engagement. Many of these barriers can be addressed through better training and support. Financial incentives are also an important lever

SHORT-TERM POLICY CHANGES:

- **2.A.1. Provide appropriate supports to facilitate patient engagement and participation:** Health care purchasers should encourage health plans, systems, and providers to incorporate patient, family, and caregiver representatives and advisors into broader systems reform efforts such as safety, quality, and equity improvement initiatives, it will be necessary to provide appropriate supports such as orientation and training, interpretation and auxiliary aids, childcare, incentives such as stipends, transportation, and remote access to maximize engagement and reduce patient burden. These supports are especially important for patients/family members/caregivers from vulnerable communities, including Limited English Proficient (LEP), LGBTQ+, and persons with disabilities. Consumer advocates can also play a role in helping to prepare consumers to proactively engage on boards and advisory committees. For example, Asian Health Services' Patient Leadership Councils train patients as volunteer peer health advocates who can then train and support their communities with key health and advocacy issues. Similar best practices should be encouraged and shared widely to aid in the development of standards and appropriate measures to evaluate the effectiveness of particular patient engagement strategies. Providers should be trained on the benefits of patient engagement in improving health outcomes and health care quality more broadly and promising best practices should be shared.

- **2.A.2. Build comprehensive incentives and tools for providers to strengthen and invest in patient engagement at the clinician level/point of care:** Lack of meaningful and respectful communication and care planning between providers and patients was a consistent theme of our focus groups. Throughout this guide, we have recommendations regarding moving toward more accountable payment arrangements with providers and plans, with a strong emphasis on population health, community-driven care teams, and accountability for measurable progress on health equity. As part of this urgently needed transition, purchasers and plans should pay for and measure greater provider engagement with patients. Health systems and plans should encourage and incentivize patient, family, and caregiver engagement to make it easier for providers to engage their patients in the continuum of engagement strategies, including shared decision-making and co-development of individual care and treatment plans that are driven by the patient's goals for health and well-being.

- **2.A.3. Continue to adopt more population-based payments such as capitation and global budgets:** A critical support to better patient engagement will come with a fundamental shift in payment strategies towards more population-based payments, such as capitation and global budgets that create more incentives for longitudinal and episodic providers to collaborate and improve quality, while reducing disparities across the continuum of care.

2. B. Give Patients, Family Members and Caregivers Real Decision-Making Power:

Health plans, health systems and providers are often compliance-based in their approach to engaging their patient populations which results in incomplete and ineffective results. Patient, family, and caregiver engagement is more effective when individuals and community members are not just given advisory roles but instead have the power to make decisions and are given some control over the resources being spent. This more equitable model of engagement is necessary to ensure providers are focused not only on quality improvement but also addressing the social determinants of health.

> ***"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."***
>
> *— Focus group participant, Orange County*

- **2.B.1. Require health plans, systems and providers to implement shared decision-making models of patient engagement:** If California is to move successfully towards a health care system that is truly patient, family, and community-centered, the state must ensure patients and families have access to the information, data, and governance roles to hold health plans systems, and providers accountable for quality, value, and equity. This will require updating arcane patient engagement structures such as Medi-Cal Managed Care plans' required Community Advisory Councils which are one of the essential methodologies for gathering cultural and linguistic information from its stakeholders and the community that it serves.(30) While these CACs are required to provide information, advice, and recommendations to MCPs on educational and operational issues with

respect to administration of the MCPs' cultural and linguistic services program, they are varied in terms of their levels of patient engagement and representation and are viewed even by health plan representatives as limited in their effectiveness and functionality. DHCS and other purchasers should require health plans, systems and providers to implement shared decision-making models of patient engagement, where consumers have real decision-making power in how resources are spent on patient and family engagement and community health initiatives more broadly.

- **2.B.2. Require Plans, Medicaid MCPs, large physician groups, and hospitals to appoint at least 51% patients, families and community members to their governing bodies:** Ultimately there should be increased participation of patients, families, and caregivers in organizational governance. For example, Federally Qualified Health Centers are already required to have 51% of patient/member-consumers on their boards. This should be a requirement for all safety-net providers: Medi-Cal health plans, physician groups, and hospitals.

> ***"If I didn't see any changes after being in the committee, I'd be discouraged. I would want to have some impact, even if it was small."***
>
> *— Focus group participant, Ventura County*

2.C. Tie Feedback to Meaningful and Measurable Quality Improvement and Disparities Reduction Goals:

Health care purchasers are increasingly emphasizing payment models that reward cost and quality. However, our current measurement systems do not often take into account patient-centered goals such as culturally and linguistically appropriate patient-provider communication which can result in more meaningful health outcomes.

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **2.C.1. Require plans, health systems, and providers to collect and report measures on individual patient experience and engagement**: These requirements should extend to oral and behavioral health and patients should be involved in measurement development. While admittedly, there may be fewer available measures for oral health, the Dental Quality Alliance is starting to develop a patient experience measure. This type of innovation should be encouraged and incentivized, and providers held accountable for demonstrating how they are following up on their findings to achieve meaningful improvement. Providers can also learn a lot from analyzing the consumer/user experience of health care and health systems to better understand what people perceive as value.

- **2.C.2. Adopt a human-centered design process that designs for equity by valuing the perspectives and knowledge of those most impacted by problems and potential solutions**. Instead of making assumptions about patient, family, and caregiver needs and designing health care improvement strategies based on those assumptions, patients, families, and caregivers should be considered co-designers at all levels of quality improvement. Human-centered design (HCD) can improve service delivery and program efficiency, build capacity and encourage work across silos. It is also an important way for purchasers, plans, health systems and providers to target limited resources to areas where they can have the greatest impact. This strategy has proven successful at the state and local levels. For example, California's Department of Social Services used HCD to eliminate barriers to accessing and using CalFRESH, California's food assistance program. Through HCD, the state designed online and mobile applications that offer an improved user experience, for example, by allowing users to transmit documents by taking photos of them with their phone than sending them via fax, scan, or snail mail, and reducing the time it takes to complete the application to less than 10 minutes.(31)

- **2.C.3. Develop new measures for patient experience and patient reported outcomes that include the perspectives of diverse patients as part of health system and payment reform initiatives:** Translated surveys (in addition to Spanish and including alternative formats such as large font, Braille or electronic formats), focus groups, patient town halls, community meetings, and other forms of patient feedback such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) supplemental questions from the cultural competence item set should be more widely used to measure the health care experiences of diverse patients, families, and caregivers. Aggregating data from multiple years or regions and other research methods to overcome the challenges of small patient sample sizes should be implemented. California should take the lead in developing new standardized patient experience measures that measure language access, cultural competency, and attention to disparities for our diverse patients. The ultimate goal should be to go beyond these measures to patient-reported outcome (PRO) measures, which is an emerging area of work at the National Quality Forum. These measures should be part of payment reforms.

STRENGTHEN CULTURALLY & LINGUISTICALLY APPROPRIATE CARE

> *"As a queer woman in health care, I have to explain my orientation, and why I don't need a pregnancy test. [Doctors] need to be open to how the community is different and diverse - we have different needs."*
>
> *Focus group participant, Ventura County*

STRENGTHEN CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

California's population is diverse; currently, Latinos are 38% of the population, and by 2025 they are expected to reach 42%.(32) California is also home to the largest Asian American and fifth-largest African American populations in the nation. Unfortunately the racial and ethnic breakdown of California physicians is not representative of the state's diverse population. In 2015, Latinos represented 38% of the population but only 5% of active patient care physicians.(33) Studies have found that patients in race and ethnic concordant relationships with providers are more likely to use needed health services, are less likely to postpone or delay seeking care, and report greater satisfaction and better patient-provider communication.

Furthermore, over 40% of Californians speak a language other than English at home, and an estimated six to seven million Californians (or one in five) are Limited English Proficient, meaning they speak English less than "very well."(34) These millions of Californians need language assistance services in order to effectively utilize health care. There is no systematic data collection on the language proficiencies, disability status, sexual orientation, or gender identity of health care providers to improve provider-patient concordance with all diverse Californians.

Strengthening access to culturally and linguistically appropriate care requires a multi-pronged approach that includes stricter enforcement of existing laws and policies, improvement of existing practices with particular regards to language assistance and provider training, payment incentives for improvement, and a sustained commitment to strengthening the racial, ethnic, linguistic and other diversity of the state's health care workforce. California state regulators, the Department of Health Care Services, Covered California, CalPERS, and other major purchasers should make the following policy changes within 1-2 years:

3.A. End Stigmatizing, Disrespectful, and Discriminatory Treatment Across all Provider Types:

Despite California laws and practices aimed at combatting these types of behaviors, racial and other discriminatory disparities in medical treatments and health status were raised across all seven of the focus groups and have also been well-documented in numerous studies. California's state purchasers and state regulators, including the Department of Managed Health Care and the California Department of Insurance, should:

SHORT-TERM POLICY CHANGES:

- **3.A.1. Vigorously enforce and reinforce existing state and federal non-discrimination laws, regulations, and policies:** State regulators and purchasers should work together to ensure adequate notice of these policies and complaint mechanisms and partner with consumer groups to ensure prompt responses to complaints.
- **3.A.2. Require payers to dedicate funding to educate consumers on consumer rights to equitable care.** Health care purchasers have a role to play in making sure consumers understand their rights and receive their benefits under state and federal law.
- **3.A.3. Require all complaint investigations to be conducted in a trauma-informed manner.** Reduce barriers to physical access to health care facilities, diagnostic and testing equipment, and emerging health technologies such as telehealth for individuals with disabilities.
- **3.A.4. Require hospitals, health systems, and providers to update policies and procedures that broaden the definition of "family members" to allow for critical assistance during in-patient stays**: Definitions of family members can be exclusionary of LGBTQ+ families and personal attendants for individuals with disabilities. It is important to balance infection control (for example, during COVID-19) with the impact of such restrictions on patient well-being, recovery, and healing; providers should also improve accommodation of families, including extended families, during clinic visits and family meetings to discuss a patient's health status and directives. Providers must recognize the importance and value of an independent family, caregiver, and peer advocate infrastructure (e.g., peer support specialists, family and caregivers in geriatric care, personal care attendants for individuals with disabilities) and adopt delivery and payment reform to financially support them. Additionally, health systems and providers should review policies and procedures limiting visitation hours or limiting access to patients.

> ***"As soon as they find out you're native, they ask you about your weight and diet. I've had a few experiences that made me feel like I didn't belong in this country and like I didn't deserve to get the services I needed."***
>
> *— Focus group participant, Sacramento*

- **3.A.5. Purchasers, health systems, plans, and providers should review and reinforce their non-discrimination policies and procedures**, staff and contract orientation, training and complaint and grievance procedures to ensure that all staff and contractors have increased awareness of these prohibitions against discrimination.
- **3.A.6. Health plans and facilities should designate a 504 or ADA coordinator and Ombudsperson** whose presence is advertised so that patients know who to talk with regarding questions or complaints.
- **3.A.7. Incentivize health systems and providers to participate in NCQA's Distinction in Multicultural Health Care, the Human Rights Campaign Healthcare Equality Index (HEI) for LGBTQ Health and other related diversity, equity, and inclusion indexes**: Covered California is proposing to require its health plans to meet the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care as a new 2022 contract requirement. Maine uses Accountable Communities as a part of their value-based purchasing strategy, and one of the ACOs, Penobscot

Community Health Center (PCHC), which is also the largest FQHC in the state, has consistently been recognized as a top performer in the HEI.(35) 765 healthcare facilities across the nation participated in the HEI evaluation in 2019.(36) The only states not to have healthcare facilities that participated in the HEI evaluation in 2019 are Alaska, Georgia, Idaho, Montana, South Carolina, South Dakota, and Wyoming.(37)

3.B. Strengthen Access to and Quality of Interpreter and Language Services:

California has strong state laws and standards for language access (oral interpreters, written translations, and auxiliary aids and services), but there is weak enforcement, lack of dedicated funding, and no incentives for improvement. State purchasers, health systems, plans, providers and state regulators should:

SHORT-TERM POLICY CHANGES:

- **3.B.1. Enforce state laws and standards and provide dedicated funding for language access services for individuals who speak languages in addition to English and individuals with disabilities** including those who use sign language, Braille, and auxiliary aids and services; the prohibition on the use of children as interpreters, except in cases of emergency, should be reinforced. For example, New York State requires all hospitals to develop a language access plan, appoint a language access coordinator, and provide interpreters to patients within a specific timeframe.(38)

> ***"The interpreter service at the hospital is horrible... every time my grandmother goes to the hospital, I go to interpret. It makes [going to] the hospital a greater hassle."***
>
> *— Focus group participant, Orange County*

- **3.B.2. Measure interpreter need, access and quality of interpreter and language services in medical care and patient navigation through health plan needs assessments and "secret shopper" testing** of access to and quality of interpreter services and auxiliary aids and services provided by health plans, counties, administrative services organizations, hospitals, providers, and other contracted entities.

- **3.B.3. Improve the readability and accessibility of California state agency, health plan, hospital, and provider decision-making support tools and resources** including forms, health plan booklets, notices, and online information; and increase the number of translated materials and field testing of these tools and resources for California's diverse linguistic populations, at a minimum, in Medi-Cal threshold and concentration languages.(39)(a) While there has been a significant number of informational materials about COVID-19 in Spanish and other languages, not all materials have been translated, and not in all the Medi-Cal threshold and concentration languages.

- **3.B.4. Expand the availability and capacity of health care interpreters, especially for languages with increasing need, such as Central American indigenous languages.** California purchasers, plans and health systems must continually assess and expand the availability and capacity of health care interpreters to keep up with the state's changing demographics and needs. The state has a critical role in continually assessing and re-evaluating these needs.

- **3.B.5. Ensure access to trained and qualified interpreters at all state and local call centers** including Covered California, Medi-Cal, Medi-Cal Dental, health plans, etc. and at all points of contact with health care providers.

- **3.B.6. Include measurable improvements in culturally and linguistically appropriate services such as improved access to qualified health care interpreters, in payment reform incentives and outcomes.** For example, beginning in 2021, the Oregon Medicaid program will be using access to needed language services as a quality performance incentive measure Coordinated Care Organization program.(40) Additionally, Massachusetts has a Culturally and Linguistically Appropriate Services Initiative (CLAS). This initiative implements national CLAS Standards into all programs classified under the Department of Public Health (DPH), including those agencies that receive grants from DPH.(41) North Carolina has a similar CLAS program implemented among the state's local health departments, community health centers, health professionals, and community-based organizations.(42)

3.C. Increase the Racial, Ethnic, Linguistic, and other Diversity of Health Care Providers, Strengthen Team-Based Care, and Integrate CHWs, Promotoras, Peer Specialists, Personal Care Attendants, and Traditional Health Workers (e.g., Doulas, etc.):

Seven million Californians, the majority of them Latinx, African American, and Native American, now live in Health Professional Shortage Areas, a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers. These shortages are most severe in some of California's largest and fastest-growing regions, including the Inland Empire, Los Angeles, San Joaquin Valley, and most rural areas.(43) The California Future Health Workforce Commission's 2019 report includes several actions the state can take to build and support the robust and diverse health workforce required to meet California's changing demographics and growing demands for health care services. Given the expected continued growth in

---

a. **The COVID-19 pandemic has reinforced the importance of the availability of health information in multiple languages. While the CDC, health departments, health plans, hospitals and health systems, and providers have not always provided multilingual information, there was a broad amount of health information developed and disseminated about COVID-19 in dozens of languages.**

health jobs, strategic investments in health workforce development and diversity also make economic sense as part of California's post-COVID-19 recovery. The State of California (Office of Statewide Health Planning and Development, the Department of Consumer Affairs (CDCA), higher education institutions, Department of Education, Department of Employment and Development, local workforce investment boards, etc.) and policymakers must:

SHORT-TERM POLICY CHANGES:

- **3.C.1. Collect and report more systematic and updated data on the race, ethnicity, language proficiencies, disability status, sexual orientation, and gender identity of all health care providers licensed by California:** California should enforce and expand on AB 2102 (Ting), co-sponsored by the California Pan-Ethnic Health Network (CPEHN) and the Latino Coalition for a Healthy California (LCHC) which facilitates the collection of demographic data on allied health professions by race, ethnicity, gender, and spoken languages to include other demographic data categories for all health professions.
- **3.C.2. Review California laws and regulations regarding scopes of practice, licensing, prescribing, and supervision** to allow more mid-level providers such as nurses, dental hygienists, and therapists to practice at their highest level to optimize existing health professional capacities to serve the most number of Californians; any expansions of scopes of practice should not be limited to Medi-Cal or other public programs but should be applicable statewide.
- **3.C.3. Increase the availability of health navigators, CHWs, promotoras, peer support specialists and other traditional health workers, and personal care attendants by adopting federal and state reimbursement models, training, and career pathways.** For example, in Minnesota State, legislation and a Medicaid state plan amendment allow for direct Medicaid reimbursement of certified CHWs for care coordination and patient education services. MCOs established via Section 1115 waiver authority are contractually required to cover CHW services. CHWs are directly reimbursed for the select services defined in state law. The state pays MCOs a per-member, per-month capitated payment, which is used to pay CHWs who serve members of that MCO.(44)

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **3.C.4. Implement recommendations for the ongoing racial, ethnic, linguistic, and other diversification of California's health care workforce**, including strengthening and supporting internal health career pathways and support for the integration of internationally trained health professionals.
- **3.C.5. Increase the availability of language concordant providers through greater recruitment at health professions education institutions, and support through scholarships and loan programs.** Public and private financing is critical to ensuring greater diversity and representation in our health care professions. California can play a role by leveraging and sharing federal and state funds to increase workforce diversity.

> ***"The doctor would come out and have a ridiculous comment about not having met blind people in her entire life. She asked, 'do I drive,' ridiculous things like that. Most of the time, my thing is, if I don't speak up they won't know and I won't get the care I need."***
>
> *— Focus group participant, Alameda County*

3.D. Integrate Equity and Cultural Humility into Continuing Education and Training of Health Care Providers:

California has implemented state and federal cultural competency requirements, including a requirement that all physician continuing education includes a cultural competency component and a requirement for counties to develop and annually update cultural competency plans for the provision of specialty mental health and substance use disorder services (SUDS).(45) Additionally, Medi-Cal managed care plans and qualified health plans in Covered California are required to report how they will meet the needs of culturally and linguistically diverse members. While these steps are promising, California's demographics continue to evolve, as do best practices in cultural competency training and education. California purchasers and policymakers should work with health systems, plans, and providers to:

SHORT-TERM POLICY CHANGES:

- **3.D.1. Require providers to undergo annual, ongoing, and continuing training of all providers on cultural competency** that is updated annually to reflect California's changing demographics, revised learnings, and best practices for caring for racially and ethnically diverse consumers, including LGBTQ+, persons with disabilities, and people who hold multiple, marginalized identities; align training requirements and opportunities to maximize participation and reduce duplicative requirements.
- **3.D.2. Require academic medical centers and health professions education and training institutions to incorporate ongoing/continued training on patient and family-centered care, implicit bias, cultural humility, strengths-based approaches, and trauma-informed care into updated curricula**; encourage trainings to include

the testimonials and participation of diverse patients, families, and caregivers. For example, Medi-Cal now encourages and provides payment for screening for adverse childhood events (ACEs).

- **3.D.3. Require all health plans to update and publicly report on their cultural competency plans annually, with requirements for measurable improvements:** This should include county mental health plans and Drug Medi-Cal organized delivery systems, across all state purchasers.

3.E. Leverage Opportunities to Expand Access to High Quality, Culturally and Linguistically Appropriate Services through Telehealth and Other Innovations Resulting from COVID-19:

While telehealth technology and its uses are not new, recent policy changes during the COVID-19 pandemic have reduced barriers to telehealth access and resulted in more widespread adoption of virtual care as an important modality for the delivery of primary, oral, behavioral and specialty care. Plans, purchasers, and providers should:

- **3.E.1. Evaluate the scope and reach of telehealth services (both video and phone modalities):** As health systems and providers shift to telehealth and virtual health, purchasers should evaluate and identify gaps and best practices in terms of access, care coordination (which can be particularly challenging when providers are also working from home) and outcomes for diverse populations for physical, behavioral and oral health across the continuum of care; continued payment for telehealth after COVID-19 should not be based on a fee-for-service transactional model but integrated into broader system transformation and payment reform that expands access, improves quality, reduces disparities, and provides more options for all health care consumers.

- **3.E.2. Require plans to pay for essential patient supports to facilitate panel management that can ensure telehealth is efficient, comprehensive, and equitable:** These can include equipment and devices to monitor one's health at home (e.g., smart tablets, blood pressure monitors, weight scales, glucose monitors etc.) that are expensive to purchase and not universally covered by one's plan.
- **3.E.3. Authorize reimbursement for telehealth services for team-based care**: Services should include those provided by nurses, home visits, encounters with community health workers and promotoras, and other alternative visits such as virtual dental homes using telehealth technology to link specially trained dental hygienists in the community with dentists in dental offices and clinics. Allow individuals who have multiple or complex conditions to access health care asynchronously, e.g., going in for a blood draw or imaging at their convenience, including beyond "business hours", and optimize contacts/"touches" with the entire health care team, including through authorization of shorter, more frequent telehealth check-ins to address different parts of one's individualized treatment/health improvement plan rather than trying to address all issues through rushed in-person visits with one's physician/primary care provider.

STATE EXAMPLES

New York's Medicaid program, reimburses non-traditional providers for appropriate telephonic services through health homes, including peer support specialists, certified diabetes or asthma educators.(46)

- **3.E.4. Improve access to interpreter services including auxiliary aides:** Better integrate remote video and telephonic interpreters (who can themselves be physically located almost anywhere) and auxiliary aids and services. Minnesota's Medicaid program reimburses providers for language interpreter services for sign language services administered telephonically or through telemedicine.(47) In-person interpretation should continue to be used, especially for sensitive clinical encounters such as sharing a diagnosis and discussing end-of-life directives.
- **3.E.5. Integrate popular apps such as FaceTime, WeChat, WhatsApp, etc.** that are already used by many individuals in racial, ethnic and other underserved communities in a post-COVID system. Ensure that patient privacy is protected and that personal health information is not stored or compromised through these third party apps.

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **3.E.6. Review alternative access standards to ensure cultural and linguistic access:** Utilize telehealth technologies to expand access to culturally and linguistically appropriate providers both beyond "business hours" and even beyond existing provider networks. For example, a Korean-speaking patient in San Francisco could access a Korean-speaking cardiologist in Los Angeles for a consultation.
- **3.E.7. Eliminate technological barriers to accessing telehealth:** Digital divide issues for limited English proficient individuals, individuals with disabilities, residents of rural communities, and low-income households who cannot access or afford high speed internet will need to be addressed through free or subsidized equipment such as tablets or smartphones, and expansion of universal broadband, free WiFi, and subsidized/discounted Lifeline assistance programs. DHCS and MCPs should leverage Alternative Payment Mechanisms (APMs), which could support these efforts, for example, by allowing Community Health Workers to educate patients on e-health literacy or to get actual tablets/computers into patient hands.

"In an ideal world [there would be] health care for everyone that encompasses all health, whether it is your oral health, mental health, reproductive health. Ideally, it will be nice if when we are supposed to go to see the provider, that is the time we will be seen for everything, whatever has to happen"

— Focus group participant, Orange County

IMPROVE AND INTEGRATE PHYSICAL, BEHAVIORAL, AND ORAL HEALTH CARE

California's health care delivery system is fragmented, particularly for Medi-Cal beneficiaries who must navigate across multiple complex managed care and fee-for-service delivery systems in order to access physical, oral, and behavioral health. Medi-Cal managed care plans provide physical and mild-to-moderate mental health care services. County-based delivery systems provide serious mental illness and substance use disorder services. Dental care is provided by a separate fee-for-service delivery system or a dental managed care plan, depending on the county. This complex array of systems is confusing and difficult for patients to navigate, often leading to avoidable gaps in care and treatment. Better care coordination will improve health outcomes, reduce inefficiencies, and address disparities in access to critical services. State purchasers, health systems, plans, and providers should:

CLINICAL HEALTH:

4.A. Invest in and Support Patient and Family-Centered Care:

Patient-centered care can improve quality and advance health equity by providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensures(48) Patient- and family-centered care should include engagement of parents, adult children, and other family members and caregivers as appropriate and designated by patients. California purchasers and policymakers should:

- **4.A.1. Require Plans and Providers to implement and incentivize advanced primary care models such as Patient-Centered Medical Homes (PCMHs)**: For example, the state of Oregon set goals for the percentage of its Medicaid providers that are recognized as patient-centered primary care homes (PCPCHs); Now over 90% of Oregon Medicaid beneficiaries are assigned to a PCPCH for primary care.(49)
- **4.A.2. Provide adequate access to specialty care:** California's state regulators and purchasers should enforce existing federal and state network adequacy requirements to ensure access to specialty care for all communities, especially for Medi-Cal beneficiaries and patients at community health centers.
- **4.A.3. Develop and implement more measures and metrics tied to care coordination, referrals, and follow-up:** Investigation into care coor-

dination definitions, practices, and interventions has been sponsored by several national organizations, including the Agency for Healthcare Research and Quality (AHRQ), the Institute of Medicine, and the American College of Physicians.(50) While the evidence is starting to build about the mechanisms by which care coordination contributes to patient-centered high-value, high-quality care, the health care community must continue to determine how to measure the extent to which this vital activity is or is not occurring.

- **4.A.4 Provide reimbursement for team-based care, including models that integrate community health workers, promotoras, peer specialists, personal care attendants, and traditional health workers who bring lived experiences that are reflective of and more responsive to community needs:** For example, Pennsylvania's Medicaid Patient Centered Medical Home program requires that practices deploy a community-based care management team, including nurses, pharmacists, social workers, peer recovery specialists, peer specialists, and CHWs. These teams coordinate with providers and managed care organizations to support individuals with complex care needs, develop care plans, and connect individuals to community resources.(51)

- **4.A.5. Incentivize care coordination services to be delegated to trusted community-based organizations:** If care coordination services are delegated to an external entity, health plans should be required, or at a minimum, encouraged to partner with CBOs, especially those that are already providing care coordination services. For example, in California Accountable Communities for Health (CACHI) sites, CBOs such as Be There San Diego, have demonstrated the capacity to act as a bridge between community-based organizations, care coordinators on their staff, and health plans.(52) DHCS should support partnerships with CBOs by working with payers to invest in and develop the infrastructure needed to ensure appropriate data exchange between purchasers, plans, health systems, and CBOs.

BEHAVIORAL HEALTH:

4.B. Increase Access and Utilization of Behavioral Health Services in both Medi-Cal Managed Care Health Plans and Commercial Health Plans:

Despite federal and state laws that require parity for access to behavioral health care, behavioral health care continues to be extremely challenging for consumers to access in both commercial health plans and Medi-Cal. Consumers face obstacles such as lack of education about how to access behavioral health care, health plan denials, long wait times, shortages of culturally and linguistically appropriate providers, and poor quality of care. Recent data shows disparities in access to behavioral health services for adults in Medi-Cal managed care plans, with consumers of color and limited-English proficient beneficiaries having much lower access to behavioral health services than their White and English-speaking counterparts. Particularly since COVID-19 appears to be disproportionately exacerbating the behavioral health needs of low-income communities of color, it is critical that consumers can access behavioral health services through their Medi-Cal managed care plan, and that these services are culturally and linguistically responsive. California should take additional actions to hold Medi-Cal managed care health plans accountable for their performance, including:

- **4.B.1. Vigorously enforce state and federal parity laws:** Regulators should proactively monitor the consumer experience with access to behavioral health services in both commercial and Medi-Cal plans and should aggressively enforce the law where violations are found. Particular attention must be paid to access challenges from consumers with limited English proficiency, people of color, LGBTQ+ people, and people with disabilities. In particular, regulators must ensure that consumers can seek behavioral health services directly and that health plans are no longer requiring that consumers first seek assistance via primary care or obtain a referral for behavioral health care.

- **4.B.2. Increase culturally and linguistically appropriate outreach to consumers about the availability of behavioral health services in their Medi-Cal managed care health plans:** Both utilization data and our focus groups findings demonstrate that the majority of Medi-Cal consumers are not aware that they are entitled to behavioral health services for mild to moderate concerns through their health plan. Consumers have a greater awareness of the county behavioral health system, even though most people with a behavioral health need should be obtaining services from their health plan.
    - DHCS should require health plans to undertake significant outreach efforts through a culturally and linguistically competent statewide awareness campaign.
    - Plans should partner with trusted community messengers and ensure that their providers can respond to an increased demand for care. Health plans should also conduct outreach to primary care providers to ensure that they have the tools to make effective referrals to behavioral health care. People of color often first report behavioral health challenges in primary care, so providers must be equipped to assist their patients as they navigating the system.
- **4.B.3. Require greater accountability of Medi-Cal managed care health plans for abysmally low utilization rates of mental health care services for adults:** Six years after its implementation, the mental health benefit should be considered mature, and health plans should be held accountable for poor performance. DHCS should fully leverage its regulatory authority to improve health plan performance, specifically concerning access to mental health care. Regulatory actions may include rate adjustments, penalties, or corrective action plans. Arizona's Medicaid program utilizes a quality structure that includes Medicaid and the Children's Health Insurance Program and encompasses their acute and long-term care contractors, the Arizona Department of Health Services, the Division of Behavioral Services, and Children's Rehabilitative Services. Arizona Medicaid establishes minimum performance standards, goals, and benchmarks based on national standards for which each contractor is held accountable across each state agency. Failure to meet minimum performance standards results in contractors receiving a Corrective Action Plan. Arizona Medicaid requires contractors to evaluate each corrective action annually to determine if improvements have been made. The Arizona Medicaid agency evaluates the effectiveness of the CAP during annual site visits.(53)
- **4.B.4. Strengthen access to community-defined evidence practices (CDEPs):** Develop Culturally Defined Evidence Practices (CDEP) that specifically address the unmet needs and strengths of a cultural group. These services include tribal practices, refugee gardens, and culturally-specific support groups, which can be an important component of a behavioral health system that assists diverse communities. The Mental Health Services Act (MHSA) already resources some community-defined evidence programs, but greater investment is needed. These practices could be reimbursed by Medi-Cal through a State Plan Amendment as an additional service under the Medi-Cal preventive services benefit, or alternatively as part of the in-lieu of services (ILOS) that Medi-Cal managed care plans can offer under the proposed Cal-AIM framework.

4.C. Invest in a Broad Array of Behavioral Health Integration Models:

Under the Cal-AIM proposal, California has suggested one form of integration where one entity – Medi-Cal managed care plans - would be responsible for the physical, behavioral, and oral health needs of their members. We question an approach that would place health plans at the center of this model, driven primarily by payment efficiencies rather than system and provider integration, and instead recommend exploring alternatives. Currently, health plans are responsible for the physical health care for consumers living with serious mental health conditions but have consistently failed to deliver appropriate care. As a result, people living with serious mental illness continue to die, on average, 10 to 20 years younger than their counterparts, primarily due to poorly-managed chronic physical health conditions. California could instead:

SHORT-TERM POLICY CHANGES:

- **4.C.1. Continue to support the centrality of community health centers, county health systems and other models of integrated physical, oral, and behavioral health:** Community health centers, which include federally qualified health centers as well as free and low-cost community clinics, can serve as examples of fully integrated services. Many community health centers also staff school-based health services, bringing integrated care into school settings. California purchasers should require health plans to leverage and support these existing models of integration through contracting and financial incentives, including alternate payment models (APMs). DHCS can help to facilitate and encourage greater adoption of APMs by striving to shorten the current 3-year delay in payments – and penalties – for quality performance as a result of the lag time in accessing comprehensive data. Additionally, the state must work with CMS to ensure the dollars from any savings get re-invested and stay in the health care delivery system.

- **4.C.2. Preserve and strengthen the role of the community behavioral health safety net.** California's counties provide a broad range of behavioral health services, in addition to services that support the social determinants of health. Counties, public hospitals, and community health centers have decades of specialized case management and care coordination experience for complex populations. California's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit is a good example of integrated care for children, including those with special health care needs. There is an opportunity for increased coordination between these entities, as well as others like rural and district hospitals and the University of California academic health centers, in order to provide better access to care. In addition, the Department of Health Care Services should require health plans to invest in and leverage this existing infrastructure and provide resources and assistance to ensure physical and programmatic accessibility, language access, and cultural competence across population groups.

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **4.C.3. Integrate medical services into the county behavioral health safety net so at risk or high-risk populations receiving behavioral health services within the county behavioral health safety net can access physical health care in a trusted setting**: People living with serious mental illness often report discriminatory or stigmatizing treatment in health care settings, and therefore may shy away from seeking out care. Offering care within the specialty mental health system could ensure that services are coordinated and that consumers are treated with a greater degree of respect and knowledge about their mental health condition. Patients should always have the option to receive care where they choose, and access to care should not be conditioned on receipt of other county services (e.g., housing).

4.D. Integrate a Culturally and Linguistically Appropriate, and Comprehensive Drug-Medi-Cal Organized Delivery System for Communities of Color:

While communities of color have similar mental health and substance use treatment needs to White people, their ability to access services is much lower. Their involvement in the criminal justice system is also much higher due to racism and implicit bias. One way to address racial and ethnic disparities in the criminal justice system is to provide substance use prevention and treatment to communities of color in community settings. Stigma and discrimination associated with accessing services are other barriers to treatment for many communities of color. Access to integrated care should also be expanded, as services for prevention and treatment of substance use disorders have traditionally been delivered separately from other mental health and general health services, yet communities of color are likely to seek help in a primary care setting.

SHORT-TERM POLICY CHANGES:

- **4.D.1. Expand California's Drug Medi-Cal Delivery system outreach and treatment services in communities of color.** Stigma and discrimination

associated with accessing services are barriers to treatment for many communities of color. However, outreach and engagement, particularly by indigenous or peer workers, can facilitate access to care for hard to reach populations in communities of color. We should not limit the value, length, or intensity of outreach and engagement services needed for providers, particularly indigenous and peer workers, to serve communities.

- **4.D.2. Develop and fund other population-specific outreach and treatment services in Asian, Native Hawaiian and Pacific Islander, Latinx, Black, and LGBTQ+ communities.** Behavioral health services based on community-defined evidence derive from a community's ideas of illness and healing or positive attributes of cultural or traditional practices. These services originate within the community and the organizations that serve them and can range from mental health treatments to community outreach to other services and supports.
- **4.D.3. Pilot an Indian Health Plan (IHP) SUDS-ODS**: California has one of the largest American Indian populations in the United States, and is home to 723,225 individuals of American Indian sole and mixed-race descent (2010 U.S. Census). Existing systems of care do not appropriately serve the American Indian and Alaska Native (AIAN) communities, who, as the Department of Health Care Services recently noted, experience death rates involving opioid pain medication higher than among any other racial or ethnic minority group. AIANs are eligible to receive health care services on or near Indian reservations and in urban Indian communities from the Indian Health Services, a federally funded payer of last resort that is fragmented and chronically underfunded. DHCS should work with AIAN communities to pilot an Indian Health Plan (IHP) SUDS-ODS to provide substance use services to the AIAN population.

ORAL HEALTH:

4.E. Expand Access to Preventive Dental Care through Payment Reform:

California's Medi-Cal dental system produces significant disparities in access to oral health. In California, people of color make fewer visits to the dentist or dental clinic, and more older adults of color have lost teeth to decay and gum disease than White adults. Children, in particular, suffer lifelong consequences of limited access to early and preventive dental care. California could adjust current payment structures in Medi-Cal dental to incentivize preventative care over surgical or specialty care. For example, New Jersey's Medicaid program offers primary care physicians an incentive payment for pediatric dentistry referrals.(54) To achieve this, California could create an evidence-based advisory group for the Medi-Cal dental program to guide decisions and make sure they are based on the best evidence and science and not merely on cost.

> ***"We need to bring oral health care to where people are; the solutions are structural; the current system is optimized for providers, for their convenience and profit; we need to re-balance/align those incentives with value-based payments."***
>
> *— Oral health expert, state responder panel*

SHORT-TERM POLICY CHANGES:

- **4.E.1.Improve coordination and integration of dental care:** Dental care should be viewed as a core element of health care and incorporated into the delivery system. In the short term, DHCS should explore new payment models and other avenues for improving the coordination of dental care within the fee-for-service system, including for dually eligible Medicare and Medi-Cal beneficiaries, such as the integration of Dental Transformation Initiative pilot projects including virtual dental homes and financial incentives for coordination. Changes should not include any expansion of the dental managed care model currently in place in Sacramento and Los Angeles counties, as these managed care pilots continue to fail consumers and demonstrate less access to care compared to the fee-for-service model. In fact, this model should be eliminated, as the Governor has previously proposed.

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **4.E.2. Invest in core elements of access to dental care, including workforce and consumer outreach:** Even in the Medi-Cal fee-for-service system, access remains poor, particularly for people of color. DHCS should continue to invest in the workforce, such as through grants and loans, and the state should consider expanding both the workforce - such as expanded scopes of practice for registered dental hygienists in advanced practice and licensing dental therapists - and in care modalities such as the virtual dental home. DHCS should step up its outreach efforts to communities of color, particularly by investing in trusted community messengers and health navigators.

- **4.E.3. Move towards full integration of physical, oral, and behavioral health care services through pilot programs:** Currently, Medi-Cal beneficiaries must navigate multiple complex delivery systems in order to meet all of their health care needs receiving physical, mental health and oral health care services from different health care systems. DHCS is interested in testing the effectiveness of full integration of these services under one contracted managed care entity. This is also a potential promise of universal coverage proposals. With any of the approaches to integration, in order to ensure that any pilots improve quality and advance health equity, the Department of Health Care Services should:

    - ▹ **4.E.3.a. Measure and identify existing gaps in the utilization of behavioral and oral health care services by race, ethnicity, language, and other sociodemographic factors** and require entities wishing to become Medi-Cal pilots to work towards closing them.

    - ▹ **4.E.3.b. Ensure appropriate safeguards to protect consumers, especially during any transition period for consumers moving between entities and systems of care.** Informing materials and notices should be translated and shared with Limited-English Proficient beneficiaries. The state should ensure continuity of care, network adequacy, data-sharing, and care coordination with other services for transitioning members.

HOLD HEALTH PLANS & SYSTEMS ACCOUNTABLE

> ***“The Medi-Cal doctors, it’s really hard to get appointments with them. We became regulars at the emergency room because of that.”***
>
> *— Focus group participant, Sacramento*

HOLD HEALTH PLANS AND SYSTEMS ACCOUNTABLE

California has strong consumer protections in state and federal law, but wide variation in quality between plans and across regions. Despite years of effort, health plan quality in the state's Medi-Cal program is often inconsistent. Many plans fall short on delivering the basics, including the provision of language assistance services, ensuring timely primary and specialty care access, and providing reasonable accommodations for people with disabilities. In the near term, California must strengthen its oversight and accountability of health plan performance through clearer delineation of roles between the state and insurance regulators and stronger contracting and procurement tools to drive health care quality and address disparities. At the same time, the state must also encourage health plan and health system innovation through the adoption of alternative payment models and financial structures that incentivize quality of care and lay the groundwork for broader system and payment reforms by demonstrating feasibility and effectiveness. Better health plan oversight is a precondition for effective innovation in health care payment and system transformation. In comparison to other states, California lacks the leverage to ensure proper oversight and accountability over plans for implementation of the new population health management, whole person and enhanced care management requirements under the Cal-AIM proposal.(55)

5.A. Strengthen Health Plan Oversight and Accountability:

California has strong state laws and standards to regulate health care services plans including managed care organizations. These standards help to ensure patients, families and caregivers can see their doctors and specialists in a timely manner, access free translation and interpretation services, and receive treatment for certain mental health conditions, amongst other requirements. However, enforcement of state laws is often weak with little to no long-term consequences. State purchasers and regulators should:

SHORT-TERM POLICY CHANGES:

- **5.A.1. Explicitly condition and prioritize the use of public dollars to contracting with health plans that can meet minimum quality performance standards and demonstrate an ability to meet the needs of diverse consumers:** At a minimum, DHCS should ensure that contracted Medi-Cal health plans provide consumers with access to care that is culturally and linguistically responsive. Health plans that are unable to meet the access standards in law today or that fail to meet benchmarks for quality of care across multiple measures and populations should no longer be eligible to contract with DHCS to provide services to Medi-Cal beneficiaries. To effectuate these changes, DHCS should establish a standard procurement schedule for its eligible managed care plans as other major purchasers like Covered California and CalPERs have done, using contracts to more effectively implement policy changes tied to quality improvement, disparities reduction, and population health management. Every state purchaser should work more proactively with regulatory agencies tasked with monitoring health plan compliance to ensure health plans subject to procurement are meeting minimum quality performance standards and requirements such as network adequacy, timely access, after-hours availability of services, language access and physical accessibility standards, and explicit reduction of disparities, amongst others. Additionally, each state purchaser should institute a robust process to receive and act on public comment on model contracts, procurement qualifications, and evaluation criteria.

- **5.A.2. Increase transparency and timely public reporting of quality measures, including the experiences of diverse patients, and progress towards identification and year-over-year reduction of disparities.** Health plans are now required by federal, state, and private purchasers and regulators to report on dozens of health care quality measures, but consumers and community advocates have limited access to the data, especially in a timely and actionable manner. The Integrated Healthcare Association partners with the Department of Managed Health Care to report quality performance data from health plans and medical groups and publishes the California Regional Health Care Cost & Quality Atlas that reports cost and quality data across Medicare, Medi-Cal, and commercial plans. Consumer stakeholders should be brought into these discussions. Additionally, California state purchasers should make comprehensive de-identified claims data, encounter data, prescription drug data, social service data, oral and behavioral health data, and cost data on out-of-pocket costs, reinsurance, and negotiated rates more transparent and timely. Stratification of data by race, ethnicity, and language is a critical underpinning to many of the recommendations in this guide. As detailed in the next recommendation, DHCS and Covered California should leverage better reporting to hold health plans accountable through withholds, penalties, or sanctions for quality improvements, including the identification and reduction of disparities.

5.B. Leverage Financial and Payment Arrangements to Drive Innovation and Reductions in Disparities:

Health plan rates and how plans contract with providers could be more closely tied to improved performance on quality and disparities reduction requirements. The state of California should:

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **5.B.1. Develop contracts with Medi-Cal Managed Care Plans (MCPs). and other health plans that include financial incentives and disincentives for overall quality and specific equity performance measures that are significant enough to drive behavior change:** Measures may include larger withholds or penalties. The state should also consider more aggressive strategies such as shared savings, claw-backs, and prohibiting the regional expansion of poorly performing plans. Oregon's CCO program has pioneered the development of statewide equity measures for purposes of Medicaid MCO incentives.

- **5.B.2 Revise Medi-Cal and Covered California rate setting to focus on providing accessible and effective care for those who have historically not engaged with the health care system:** Eliminate perverse incentives that reduce rates when quality improves and increase rates based on avoidable hospital utilization.

- **5.B.3. Apply lessons from the use of incentives in commercial and Medicare ACOs to Medi-Cal and Covered California,** including integration of ACOs and other innovative delivery system reforms (such as the California Accountable Communities for Health Initiative) to drive quality improvement and reduce the total cost of care. State Medicaid ACO models are already operational in Minnesota and Massachusetts. Alternative payment arrangements and financial structures for plans and providers are an effective strategy that state purchasers should use more proactively to encourage innovation to improve health outcomes, health care quality, reduce disparities, and address the social determinants of health.(56)

- **5.B.4. Incorporate robust risk adjustment for patient social risk factors into all or some risk-based payment programs:** As DHCS and other state purchasers incorporate requirements for value-based provider payment in their contracts with health plans, they should also require appropriate adjustment for patient social risk so that providers are not penalized for taking care of sicker, more complex patients, including those with social needs. Achieving equitable care may require greater resources and more intensive care for patients with social risk factors than more advantaged patients. Providers that serve a disproportionate share of higher-risk patients should benefit from organizational capacity investments, and pay-for-improvement and risk-adjusted improvement targets that allow more time to achieve. Risk adjustment must not be based on prior utilization and costs, or racially-biased algorithms that fail to identify risk or need for those who have historically been locked out of health care.

STATE EXAMPLES

Minnesota's Integrated Health Partnerships receive a capitated population-based payment adjusted for social risk factors experienced by their patient population, including poverty, homelessness, mental illness, substance use disorder, and children protection involvement. Minnesota's experiences and other recent work developing social risk adjustment are summarized in a recent publication by Princeton's State and Health and Value Strategies program.(57)

> *“Some providers are completely disconnected from their communities. Sometimes they just say ‘eat healthy’ but they don’t realize that it is expensive.”*
>
> *— Focus group participant, San Diego*

IMPROVE THE SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are "conditions in which people are born, grow, live, work, play, and age that shape health."(58) Despite significant shifts towards improved quality and value in health care, purchasers, systems, and providers continue to focus primarily on acute and chronic care instead of upstream prevention and community health interventions that would prevent disease, morbidity, and mortality. There is increasing recognition that the delivery of health care by itself cannot ensure optimal health, let alone address the underlying root causes of health inequities. Without acknowledging and explicitly addressing the adverse social determinants of health - where and how individuals, families, and communities live, work, study, worship, and play - health care may actually inadvertently perpetuate those inequities by only focusing on those that are already sick from preventable conditions.

These unmet social needs have been highlighted and aggravated by COVID-19 and the economic downturn. Focusing on population health management provides an opportunity for health care, social services, and other systems, agencies, and organizations to work together to improve the health outcomes of the communities they serve.

At the state government level, California already has committed to a "health in all policies" approach, engaging the Department of Health Care Services (DHCS), Department of Public Health, Department of Social Services, and other state departments and agencies in looking at the health impacts of all policies and funding priorities. In the Cal-AIM proposal, DHCS acknowledged the importance of addressing these upstream social determinants of health by including and partially funding population health management strategies. If California can build new funding flows and administrative structures focused on population health management, it can provide an opportunity for health care, social services, and other systems, agencies, and organizations to work together to improve the health outcomes of the communities they serve. More specifically, DHCS, Covered California, state purchasers, health systems, plans, and providers should:

> ***Social Determinants of Health:***
> *Conditions in which people are born, grow, live, work, play, and age that shape health.*

6.A. Invest in Prevention:

The U.S. spends more on health care than any other country. Yet we rank lower than several other nations in life expectancy, infant mortality, and other health life indicators.(59) When people receive preventive care, such as immunizations and cancer screenings, housing and other social supports, they have better health and lower health-care costs. State purchasers should:

SHORT-TERM POLICY CHANGES

- **6.A.1. Develop and implement population health management for all levels of health risk:** Comprehensive population health management provides interventions for all populations; those at highest risk, those with emerging or rising risk, and those at low risk of poor health and high health care utilization. A preventive approach that optimizes health and well-being for the entire community should be the goal, with appropriate physical, behavioral, and oral health interventions available for all community members. Unfortunately, one of the limitations of Cal-AIM was the focus and investment primarily on the most costly, top 5% of the patient population to the detriment of everyone else. Other states have started to take a broader approach by directing Medicaid funds to social determinants of health, including states like Massachusetts, Oregon, Minnesota, and Washington State, who are working on basing Medicaid in whole person health. Since much of this work is still developmental, there should be robust evaluation and support to replicate emerging best practices.

STATE EXAMPLES

Seeking to address health-related social needs better, the Michigan Department of Health and Human Services (MDHHS) funded five Community Health Innovation Regions (CHIRs), which are partnerships of community members, local government, health care providers, payers, local government agencies, and businesses.(60)

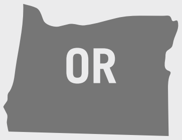
North Carolina is currently taking the broadest approach: Under North Carolina's Medicaid transformation initiative, Medicaid managed care organizations will be responsible for screening their whole enrollee population for social need, and they will be allowed to pay for evidence-based interventions that address housing instability, food insecurity, transportation barriers and interpersonal violence/toxic stress.(61)

- **6.A.2. Require plans to eliminate bias in risk-stratification and segmentation:** DHCS, Covered California and other purchasers should require contracted health plans to make the methodology or algorithm they use to conduct stratification and segmentation public and mitigated for racial and other biases.

- **6.A.3. Require broad patient- and family-centered screening, referral, and linkages for health-related social needs** to identify social and environmental barriers to wellness and target interventions to address them, including patient-, family-, and caregiver engagement, shared decision-making, and activation. These screenings should be age-appropriate and consider the diverse families and households that Californians are part of. For example, California community health centers have been implementing the PRAPARE screening tool. There is also an increasing number of interactive platforms that host local directories of social service providers, including ones shared across health systems. There should be follow-up about referrals and linkages, and continuous quality improvement processes to ensure continued accessibility and quality of the social and other services utilized. At the population level, health plans and providers should be required to use this data to improve care through payment reforms or other interventions targeted to specific communities, including working collaboratively and partnerships to address gaps in comprehensive culturally and linguistically appropriate services.

- **6.A.4. Authorize and incentivize funding for health-related social needs:** California should follow the lead of other states that are leveraging federal funds to improve housing, access to healthy food, employment, and other life conditions through value-added, in-lieu of, and flexible services, and other payments.

STATE EXAMPLE



The Oregon Health Authority has provided detailed guidance to its Medicaid coordinated care organizations on how to bill for health-related housing and other social needs.(62)

Other states and payers have used "Z codes" to bill for these services. These services should leverage existing and potential new funding sources rather than "medicalizing" all social needs. COVID-19, the economic downturn, and increased awareness of structural racism and over-policing also have created opportunities for re-evaluation and re-prioritization of economic and social needs in state and local government budgets outside of health care spending. Community benefit requirements on hospitals and health plans can also be leveraged to prioritize investments in health-related social needs. A new hospital rating index from the Lown Institute shows California hospitals lagging in community investments and other equity indicators.(63)

6.B. Support Stronger Linkages between Health and Social Safety-Net Providers:

Promoting and achieving health and well-being will require much needed investment in cross-sector partnerships and collaboration in order to ensure effective communication across systems. State purchasers should:

SHORT-TERM POLICY CHANGES

- **6.B.1. Require Medicaid managed care plans and other health plans to contract with community- based organizations (CBOs) for appropriate social services, and for outreach, engagement, education, assessment, and follow-up services:** Whole Person Care pilots are examples of successful partnerships between health plans and CBOs. The positive experience of Medi-Cal managed care plan contracts with Long Term Services and Supports, especially Home and Community-Based Services, is another example of the need for strong linkages and contracts with community-based providers. The COVID-19 pandemic has highlighted how important it is to improve the integration and coordination of health care services with existing community-based social and human services. DHCS and other purchasers should support technical assistance for both health plans and CBOs in setting up data, coding, reporting, technology, and other systems to share information and facilitate these linkages; intermediaries such as local health departments and county health systems can also support these linkages. This recommendation will work best if combined with the other Medicaid financing and administration changes recommended in this section.

STATE EXAMPLE

Massachusetts requires ACO contractors in its large Medicaid ACO program to screen for "health-related social needs" and to have referral relationships with CBOs for services related to those needs, as well as requirements for network contracts with CBOs that focus on Behavioral Health (BH) and Long-Term Services and Supports (LTSS) to provide care management. Advocates have identified significant progress (and challenges) in Medicaid-CBO relationships under this new ACO program.(64)

- **6.B.2. Support comprehensive electronic health information exchange among all health care systems and providers, and with other public assistance programs** (SNAP, WIC, housing assistance, etc.) to streamline eligibility decisions and share appropriate information to support comprehensive patient-and family-centered services.

Electronic health information exchange in California is still a patchwork of incomplete linkages; there needs to be more state-level leadership to create more comprehensive access to and utilization of health information exchange technologies. Linkages to other state and county systems for streamlined eligibility (e.g., the successful use of CalHEERS to support enrollment in both Medi-Cal and Covered California), and more "no wrong door" policies should be implemented and expanded beyond enrollment to support the health and other needs of individuals and families. Technical assistance and adoption of technological advances needs to be ongoing and built into these initiatives.

6.C. Require Local/Regional Collaboration and Investments in Community Health:

Ultimately, promoting and achieving health and well-being requires identifying and addressing regional population health needs, eliminating health disparities, achieving health equity, and investing in community health. The success of regional interventions requires a collaborative approach with shared responsibility distributed across public, private and non-profit sectors. State purchasers should:

LONG-TERM POLICY CHANGES:

The following recommendations are structured for policymakers to implement over 3-5 years:

- **6.C.1. Move towards greater public accountability for community partnerships in governance:** The shift toward health care funding for social determinants of health described in this section will require new capacity at the community level to oversee and coordinate between community needs and priorities, the health care system, public health, and human services delivery. State agencies, including DHCS and Covered California, should consider leveraging California's Accountable Communities for Health Initiative (CACHI), which has established pilot projects in 13 regions throughout the state with community voices built into local governance structures, to facilitate and help lead programs like Cal-AIM and its associated Enhanced Care Management and Population Health Management components.(65) At a minimum, DHCS and Covered California should require health plans to have some relationship with the local public health system and to participate in regional accountable communities for health (ACH) models. Many states, including Oregon, Massachusetts, Washington State, Michigan, Rhode Island, and Minnesota, are successfully implementing similar innovations as cited elsewhere in this guide.(66)

- **6.C.2. Require health plans, local health systems and health departments to collaborate with community representatives and each other on periodic community health needs assessments and to coordinate investments in community health:** A transparent, multi-sector approach to identifying and addressing community health needs, with active community stakeholder engagement and a robust relationship with local public health systems will not only reduce the risk of poor health outcomes but will also optimize collective investments and impact towards improved outcomes for everyone in that community. This is another example where California has adopted a "health in all policies" approach but has failed to follow through and support this type of cross-governmental and cross-sectoral partnerships. While there are some voluntary efforts to share data, engage community representatives, and collaborate on community needs assessments and community health improvement plans, these should be requirements for all localities and regions. Efforts like California's Healthy California for All Commission to develop unified financing for California's health care delivery systems could help overcome disincentives to invest in population health because of churn and high turn-over.

CONCLUSION

In California, pervasive and systemic inequities resulting from decades of structural racism have led communities of color to have a higher burden of chronic disease, less access to health care, and, ultimately, shorter life expectancies. The COVID-19 pandemic is magnifying these inequities and should serve as an urgent call to action for California's health care purchasers, health systems, plans, and providers. Unfortunately, California has fallen behind other states in implementing the critical reforms necessary to ensure equitable, quality health care for all Californians. However, these six strategies and twenty-one key recommendations are important first steps towards achieving a more equitable health care system and health outcomes in California. They include actions that can be immediately implemented and collective actions that will take more time, resources, and trust to build and develop. Centering equity as part of health system transformation and payment reform efforts now is imperative if we are to achieve our vision of a more equitable health care system where health care is comprehensive and affordable, where everyone is treated with the same level of dignity and respect, and where everyone achieves the best possible health outcomes, regardless of their income, sex, race, ethnicity, primary language, LGBTQ+ status, disability or immigration status.

> ***These six strategies and twenty-one key recommendations are important first steps towards achieving a more equitable health care system and health outcomes in California.***

ACKNOWLEDGEMENTS

Published by: The California Pan-Ethnic Health Network. December 2020.

This report was researched and written by:

Cary Sanders, MPP
Senior Policy Director/CPEHN

Carolina Valle, MSW
Senior Policy Manager/CPEHN

Kiran Savage-Sangwan, MPA
Executive Director/CPEHN

Ignatius Bau, JD
Health Policy Consultant

Feedback, additional contributions, and technical assistance provided by:

Eliot Fishman, JD
Senior Director of Health Policy/Families USA

Sophia Tripoli, MPH
Director of Health Care Innovations/Families USA

Cheryl Parcham, MSW
Director of Access Initiatives/Families USA

Amber Hewitt, PhD
Director of Health Equity/Families USA

Other CPEHN contributors include Mihae Jung, MSW, Director of Community Advocacy; Weiyu Zhang, MPH, Community Advocacy Manager; Jeffrey Kho, Grants and Project Manager, Aviva Prager, People and Systems Manager, and Monika Lee, Communications Manager.

About the Authors:

The **California Pan-Ethnic Health Network (CPEHN)** is a multicultural health policy organization dedicated to improving health of communities of color in California. CPEHN's mission is to advance health equity by advocating for public policies and sufficient resources to address the health needs of the state's new majority. We gather the strength of communities of color to build a united and powerful voice in health advocacy. More about CPEHN can be found here: www.cpehn.org

We'd like to thank our focus group convening partners, advisory working group members, and additional partners who contributed to the recommendations in this report.

Nourbese Flint/Black Women for Wellness, Vicente Torres/Diversity Collective Ventura County, Silvia Yee/Disability Rights Education and Defense Fund, Jeffrey Reynoso, DrPH MPH and Rosa Flores/Latino Coalition for a Healthy California, Heng Lam Foong and Doreena Wong/Formerly with Asian Americans Advancing Justice - Los Angeles, Virginia Hedrick/California Consortium for Urban Indian Health, Doretha Williams-Flournoy, Formerly with California Black Health Network, Mike Odeh/Children Now, Kristen Golden Testa/The Children's Partnership, Margarita Pereyda/LA County DHS Correctional Health Services, Michelle Doty Cabrera/County Behavioral Health Director's Association, Huong Le, DDS/Asian Health Services, Giovanna Guiliani/California Health Care Safety-Net Institute, Tri Do, MD/Community Health Center Network, Peter Long/Blue Shield Health Plan, Hector Flores, MD/White Memorial Family Residency Program, Julio Porro, MD/Central California Alliance for Health, Tangerine Brigham/Alameda Health System, Rakesh Patel, MD/Neighborhood Health Center, Andie Patterson/California Primary Care Association, Christopher Perrone, MPP/California Health Care Foundation

This report was made possible by the generous support of The California Health Care Foundation:

California
Health Care
Foundation

Graphic Design by: Emily Masterson
Printing by: Firefighters Print & Design

APPENDIX 1

Focus Group Findings: Priorities for Change

CPEHN partnered with six community organizations from around the state, including Black Women for Wellness, Disability Rights Education and Defense Fund, Latino Coalition for a Healthy California, Asian Americans Advancing Justice-Los Angeles, California Consortium for Urban Indian Health, and Diversity Collective of Ventura County. We heard from a total of 58 participants. While each of the seven focus groups we conducted was distinct, several common themes came to light.

PARTICIPANTS REPORTED:

Overarching barriers to accessing care: Even though most participants had health care coverage of some kind, many complained of major barriers to accessing care, including excessive wait times and high out-of-pocket costs that made it difficult to get care when they needed it. Some participants also discussed lack of accessibility, including transportation access issues, particularly those in the Central Valley and those who needed to use a culturally-appropriate provider.

"The Medi-Cal doctors, it's really hard to get appointments with them. We became regulars at the emergency room because of that."
– Focus group participant, Sacramento

"The clinic where I go has transportation but you have to make an appointment on time to access it...some of the patients...ask me for a ride. They are Mixteco or the elderly. They don't like to travel very far for fear of getting pulled over by the police."
– Focus group participant, Fresno

"We didn't have dental [coverage] so we would have to travel across the border to actually get dental [services] because we could not afford it here."
– Focus group participant, Orange County

"It can be difficult giving a urine sample because I have to do it in my own toilet and the doctor says there is no other way [but to use their toilet]. Sometimes my wheelchair doesn't fit in the room."
- Focus group participant, Alameda County

Difficulty navigating coverage system: Consumers had a broad range of complaints regarding interactions with insurance, including a lack of accurate provider directories (especially for mental health providers), unhelpful customer support lines, confusing paperwork, and eligibility issues that prevented them from using their coverage.

Health plan member handbooks are difficult to use, "kind of overwhelming sometimes... every year, it's like a textbook, and I may only go over one or two sections. I'm concerned about my health yet the system is so hard to navigate; medical groups are too confusing, which to choose?"
– Focus group participant, Los Angeles

"I feel puzzled with this enrollment process. I tried to enroll my son with Medi-Cal, and it was difficult. And a lot of this Medi-Cal stuff doesn't happen until three months after you apply."
– Focus group participant, Berkeley/Oakland.

Stigmatizing or disrespectful treatment: Participants shared many stories of being mistreated by providers, often in ways that made them reluctant to seek further care. Individuals reported experiencing unwelcome comments, unwarranted assumptions about a person's lifestyle based on a person's language, race, sexual orientation, gender identity, disability status, and/or size and weight. Additionally, participants felt their holistic needs were ignored with their treatment instead tailored to their identity or to one condition at the risk of neglecting others.

"It feels like I am treated differently because I don't speak English and sometimes I have to really advocate to get appointments when I need them…it really upsets me that the treatment doesn't seem fair."
– Focus group participant, Fresno

"As soon as they find out you're native, they ask you about your weight and diet." "I've had a few experiences that made me feel like I didn't belong in this country and like I didn't deserve to get the services I needed."
– Focus group participant, Sacramento

"The doctor would come out and have a ridiculous comment about not having met blind people in her entire life. She asked, 'do I drive,' ridiculous things like that. Most of the time, my thing is if I don't speak up they won't know and I won't get the care I need."
– Focus group participant, Alameda County

"I took my daughter to the ER, and my sexual orientation gives me a lot of anxiety. My doctor asked me …who is the mother? Those questions aren't asked when a male and female take a child to the ER… There's a lot of fear on my end and I'm gauging how they see me and my daughter. It sounds paranoid, but in the back of my mind, I'm worried: what if this person doesn't like gay people?"
– Focus group participant, Ventura County

Lack of accurate interpreter services and notification of rights to these services: Participants described inconsistent provision of interpreters and inconsistent quality of interpretation. Participants with limited English proficiency described the lack of reliable interpreters as a significant barrier to access.

"The interpreter service at the hospital is horrible… every time my grandmother goes to the hospital, I go to interpret. It makes [going to] the hospital a greater hassle."
– Focus group participant, Orange County

"My language is Spanish and I always speak Spanish, but they never offered me an interpreter."
- Focus group participant, Fresno

Poor patient engagement: Participants complained of poor engagement with their provider, which kept them from feeling adequately cared for. These manifested in excessively short appointments and inadequate or lack of explanation about medication, medical procedures, or home care instructions. Patients also felt rushed to make decisions or bombarded with paperwork. Lack of language concordance was another complaint.

"My doctor told me to google my illness instead of explaining it,"
– Focus group participant, Los Angeles

"My mom was given so much medication and everyone was too busy to break it down and explain. These were all medications I had never heard of and it would have been nice if someone had explained what each was…"
– Focus group participant, Orange County

"It doesn't feel like I'm taken care of, and I feel like a transaction. Paying money is a transaction but I am person,"
– Focus group participant, Los Angeles

FOCUS GROUP CONVENERS:

- **Nourbese Flint, MA**, Program Manager, Black Women for Wellness
- **Vicente Torres, MPH**, Former Program Coordinator, Diversity Collective Ventura County
- **Silvia Yee, JD**, Senior Staff Attorney, Disability Rights Education and Defense Fund
- **Jeffrey Reynoso, DrPH, MPH**, Executive Director and **Rosa Flores**, Senior Program Manager, Latino Coalition for a Healthy California
- **Heng Lam Foong, MS**, Former Program Director, Asian Americans Advancing Justice - Los Angeles
- **Virginia Hedrick, MPH**, Executive Director, California Consortium for Urban Indian Health

APPENDIX 2

Regional Convening Findings:

CPEHN held four regional convenings with over 111 attendees in Oakland, Fresno, Los Angeles, and Orange County. Attendees heard about the successes and challenges when accessing care faced by communities of color, LGBTQ+, and persons with disabilities and were asked their thoughts on how to create a more equitable health care delivery system.

On the whole, the focus group findings resonated strongly with participants of the regional convenings. They shared similar barriers and experiences of difficulty navigating the health care system and accessing culturally and linguistically appropriate care, feelings of discrimination and stigmatization, frustration with the high cost of care, particularly for oral health, and the lack of access to mental health providers and services.

Given the diverse set of participants, it was also possible to garner feedback from providers as well. Their perspectives often echoed those of the non-clinician participants. Notably, one mentioned that "providers have difficulty navigating [the] health care system" as well, which leads to challenges with care coordination and creating accommodations for patients that need them. Providers reported not feeling supported in ensuring effective communication, or making accommodations (e.g. accessing interpreter services). Several reported experiencing high workloads due to understaffing and see time pressure as compromising their ability to treat patients holistically. A provider in Fresno talked about "provider burn-out" and the "revolving door" with doctors in a system where quality measures don't always equal better care. These multi-faceted constraints not only lead to lower quality of care but also negatively impact crucial elements of the process, such as accurate charting for patient medical records. Knowing these shared frustrations, some providers wondered how they could educate themselves on practicing cultural humility without placing the burden to educate them on individual patients.

There were also some participants from health plans, including staff whose role it is to engage diverse, hard-to-reach communities. They were, sadly, not surprised by the findings as one participant noted, "what's frustrating is that so many of these issues (e.g., lack of culturally and linguistically competent care) have been around for so long and we're working so hard to address these but they are still such a problem." Several of these participants also shared their own stories of difficulty navigating the health care system, accessing oral and mental health care, feeling stigmatized and disrespected, and disenfranchised from a profit-driven health system. Collectively, having the voices of patients, providers, and advocates within the same conversations created useful suggestions for potential solutions reflected in more detail in our Roadmap. Regarding solutions, attendees discussed the need to:

Value diverse patient engagement to improve systems: It is important to improve trust between patients and providers. Improving the experience at the point of entry (e.g., choosing a clinician, making appointments, interacting with front line staff) would result in better care. This includes creating more opportunities for feedback on health care experiences, listening more, listening with empathy, and increasing connections between the physical health care system and mental/behavioral health systems. Together, these items could improve provider accountability and ensure that they positively resolve issues such as complaints, lack of care, and reduce medical errors. The idea of creating a universal rating system, akin to a letter-based grading system used by health departments to evaluate restaurants, was presented as a potential public accountability measure.

Integrate physical, oral, and behavioral health: Rethinking where care delivery happens can lead to improved encounters. Many communicated the desire to see more community partnerships that involve patients and end-users (e.g., family members or loved ones that assist in care) in conversations related to the settings people use to access clinicians—working to "bring care into the community" and focus more on preventative care resonated with many. Additionally, creating more support for telehealth models and increasing the "one-stop-shop" model (i.e., what is currently employed by Kaiser Permanente) were offered as effective approaches. This would similarly decrease barriers found in care coordination by connecting oral health, mental/behavioral health, and various approaches to physical health in ways that are less physically distant. This was particularly important to those living in small and rural communities. Towards this end, the idea of creating a universal electronic health record was considered a potential alternative to improve communication and coordination between providers in more seamless ways. Emphasizing preventative care (across all types of health care services) was also voiced as an important potential solution.

Improve access to language assistance services: Participants had several recommendations to help improve language access, including better notification of patient rights to language assistance services, a complete review of all standardized documents to ensure that appropriate translations in languages in addition to English are available, and requiring agencies like the Department of Health Care Services to partner with community organizations to do an in-language review of translated materials. Participants also suggested creating a consumer checklist of questions that patients and their families can ask as a way to advocate for themselves during visits. These could be distributed among communities with flyers translated into the appropriate languages.

Improve access to culturally and linguistically appropriate care: Attendees spoke of the importance of improving access to culturally and linguistically appropriate care, including more providers who are language concordant and from the communities they serve, as well as improved trainings and curricula on cultural competence, cultural humility, implicit bias, and trauma-informed care.

- **Facilitate workforce diversity:** Providers suggested reforms to the system that could attract more diverse providers. These include revisiting and revising the responsibilities that different clinicians (e.g., doctors, nurse practitioners, etc.) have during health care encounters. On the insurance level, revising how insurance carriers incentivize providers, improving on-time payment systems, and improving reimbursement rates for physicians in California could lead to more new physicians staying in the state after their initial training. Similarly, providing incentives for providers serving rural communities was discussed. Looking towards the future, provider participants suggested additional funding for grants, scholarships, fellowships, and other pipeline models for those pursuing careers in medicine from historically underrepresented communities. This would directly impact not only workforce capacity but also improve perceptions of care by underserved communities who are currently unable to access culturally and linguistically concordant care.
- **Improve provider training:** Participants also discussed the need for better provider training with an emphasis on cultural humility. This involves education on the history of communities being served including ethnic studies, which should be a required course for medical professionals, training on how to display cultural awareness, implicit bias training, and also personal willingness to employ these strategies by all who interact with patients – not just providers but front-line staff as well. Similarly, this knowledge needs to be institutionalized as a norm with the understanding that ongoing training is necessary. Also, creating education around these issues for patients can improve how they can advocate for their care. This can reduce internalized stigma, reduce the stress of interacting with the health care system, and improve overall health outcomes for those from marginalized communities. Specific recommendations were made around including more LGBTQ+ affirming and knowledgeable providers and those with shared life experiences of their clients (including OB/GYNs from LGBTQ+ communities, diverse racial and ethnic physicians, and providers living with disabilities).
- **Invest in navigators and community health workers:** Many participants spoke about the importance of health navigators, peer advocates, and community health workers to support patients and caregivers in advocating for their care. Participants called for creating 'centering programs' like those that offer group support for expectant parents, increasing funds for health care peer advocates, making ombudspersons more accessible, and investing in peer support groups. Aligning with this

was the overarching theme of ensuring that patients can rely on existing systems instead of being forced to coordinate their care.

Address the social determinants of health: Participants wanted to see a health care system that better integrates health with social services in order to address the social needs of consumers. Participants wanted to see more linkages between health care providers and community-based organizations (CBOs). Some recommended allowing providers to prescribe food and shelter (e.g., real referrals, not just a phone number to call). Additionally, they would like to see health systems place more attention to addressing the social determinants of health: housing, jobs, fair wages, and childcare, all of which impact health outcomes.

Invest in public community-owned health care systems and community health: Many participants echoed similar perspectives taking issue with what is often referred to as the 'corporate model' of care, which depends on a 'one size fits all' model that looks to economize resources in ways that can be broadly scaled and replicated. Participants commented that this does not work well for diverse communities as it fails to account for the significant differences between communities – especially rural ones in comparison to urban ones. These ideas helped inform proposed solutions. "Healthcare is a right and not a privilege" was a standout response, with participants advocating for this central idea to be the new perspective that informs structural change to health care systems. Lending to this, many mentioned exploring a single-payer system. Suggestions for this ranged from adopting prevalent socialized medicine systems in Europe, adopting a version of the Canadian medical system, and looking at some version of "Medicare for All." Also, some envisioned dismantling the current system and reimagining a new one absent of health insurance barriers. Participants would like to see a shift towards non-profit and community-owned models of care. Overall, there was a consensus that systemic solutions would shift the current model to one that put an imperative on intentional inclusivity for all it served.

Eliminate other barriers to care: Making services more affordable and cost-effective for patients was important. Suggestions included shifting insurance guidelines to make premiums income-based and scaled so that most patients had no out of pocket costs. Additionally, participants suggested increasing affordability for prescription medication and lowering costs across all types of health care services. An emphasis was placed on creating more services that were free or without out of pocket costs to patients.

APPENDIX 3

Working Group participants

CONSUMER GROUPS:

Silvia Yee, JD, Senior Staff Attorney, Disability Rights and Education Defense Fund

Doretha Williams-Flournoy, **MS**, Former Executive Director, California Black Health Network

Heng Lam Foong, MS, Former Program Director, Asian Americans Advancing Justice - Los Angeles (AAAJ-LA)

Doreena Wong, **JD,** Policy Director, Asian Resources, Inc.

Mike Odeh, MPP, Director, Health, Children Now

Kristen Golden Testa, MHS, Director of the California Health Program, The Children's Partnership

HEALTH PLANS, SYSTEMS AND PROVIDERS:

Margarita Pereyda, MD, CMO, LA County Department of Health Services Correctional Health Services

Michelle Doty Cabrera, Executive Director, County Behavioral Health Director's Association*

Huong Le, **DDS, MA,** Chief Dental Officer, Asian Health Services

Giovanna Guiliani, MBA, MPH, Executive Director, California Health Care Safety-Net Institute

Tri Do, **MD, MPH,** Medical Director, Community Health Center Network

Virginia Hedrick, **MPH,** Executive Director, California Consortium for Urban Indian Health

Peter Long, PhD, Senior Vice President of Health Care and Community Health Transformation, Blue Shield of California

Hector Flores, MD, Medical Director, White Memorial Family Residency Program

Julio Porro, MD, Medical Director, Central California Alliance for Health

Tangerine Brigham, MPP, Chief Administrative Officer, Alameda Health System

Rakesh Patel, MD, MBA, Chief Executive Officer, Neighborhood Health Center

Andie Patterson, MPP, Vice President of Government Affairs, California Primary Care Association

*CPEHN Board member

APPENDIX 4

Panelists

STATE RESPONDER PANELISTS

Rebecca Boyd Anderson, RN, MSN, Director of Population Health, Partnership Health Plan

Peter Long, PhD, Senior Vice President of Health Care and Community Health Transformation, Blue Shield of California

James Kyle, MD, MDiv, Director for Medical Improvement, LA Care Health Plan

Diana Zuniga, Associate Director of Regional Collaboration, LA County Department of Health Services, Whole Person Care Initiative

Maria Lemus, Executive Director, Vision y Compromiso

Veenu Aulakh, MSPH, President, Center for Health Care Innovations

Ann Boynton, Director, Payer Strategies & Value Based Contract Management, UC Davis Health

Jim Mangia, MPH, President and CEO, St. John's Well Child Health Care

Dolores Yanagihara, MPH, Vice President, Strategic Initiatives, Integrated Health Care Association

Lupe Alonzo-Diaz, MPA, President and Chief Executive Officer, Physicians for a Healthy California/ California Medical Association

Michelle Doty Cabrera, Executive Director, County Behavioral Health Director's Association*

Paul Glassman, DDS, MA, MBA, Associate Dean for Research and Community Engagement, College of Dental Medicine, Northstate University

Winston Wong, MD, MA, Medical Director of Community Health, Kaiser Permanente, Chairperson and Acting CEO, National Council of Asian Pacific Islander Physicians

*CPEHN Board member

NATIONAL RESPONDER PANELISTS:

Marshall Chin, MD, MPH, Director, Finding Answers, Solving Disparities through Payment and Delivery Reform, University of Chicago Department of Medicine

Sarah Coombs, MPH, Director for Health System Transformation, National Partnership for Women and Families

Sinsi Hernández-Cancio, JD, Vice President for Health Justice, National Partnership for Women and Families

Shantanu Agrawal, MD, MPhil, President and Chief Executive Officer, National Quality Forum

Deborah Roseman, MPH, Principal Project Specialist, America's Essential Hospitals

Laurie Norris, JD, Senior Policy Advisor for Oral Health, Dental Quality Alliance

Tenly Biggs, MSW, Public Health Analyst, Office of Minority Health, Centers for Medicare & Medicaid Services

Jennifer Snow, MPA, Director of Public Policy, National Alliance on Mental Illness

Mara Youdelman, JD, LLM, Managing Attorney, National Health Law Program

Sunny Stevenson, JD, Director, Federal Relations, National Council of Urban Indian Health

Josh Traylor, MPH, Director, Health Care Transformation Task Force

Mark McCllelan, MD, PhD, MPA, Director, Duke-Margolis Center for Health Policy, Duke University

Tricia McGinnis, MPP, MPH, Executive Vice President and Chief Program Officer, Center for Health Care Strategies

Jennifer Babcock, MPH, Senior Advisor for Medicaid Policy and Director of Strategic Operations, Association for Community Affiliated Plans

John Sawyer, Senior Advisor, Waxman Health Strategies

ENDNOTES

(1) Healthy People 2020. https://www.cdc.gov/nchs/healthy_people/hp2020.html

(2) Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

(3) Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

(4) "California Health Care Spending," Kathryn Wilson, Wilson Analytics, September 8, 2017. https://www.chcf.org/publication/california-health-care-spending/#:~:text=Health%20spending*%20in%20California%20totaled,billion%2C%20or%20%247%2C549%20per%20person.&text=*%20Personal%20health%20care%2C%20which%20excludes,activities%2C%20administration%2C%20and%20investment.

(5) "Federal Health Care Reform Generated Broad Coverage Gains Through 2015, But these Gains are Now in Jeopardy," by Scott Graves, California Budget and Policy Center, November 2016. https://calbudgetcenter.org/resources/federal-health-care-reform-generated-broad-coverage-gains-2015-gains-now-jeopardy/

(6) Insurance rates declined for American Indian Alaska Native from 14% to 4% however numbers are unstable due to smaller sample size (source: CHIS 2010-2015).

(7) Andrew B. Bindman, Denis Hulett, Isabel Ostrer, and Taewoon Kang ,"A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade," September 2019. The California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2019/09/CloseLookMediCalStatewideQualityTrends.pdf

(8) Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum. 1989:139–167. [Google Scholar] [Ref list]

(9) "2018 Health Disparities Report," Managed Care Quality and Monitoring Division California Department of Health Care Services, February 2020. https://www.dhcs.ca.gov/Documents/CA2018-19-Health-Disparities-Report.pdf

(10) "2019 Edition – Health Disparities by Race and Ethnicity: The California Landscape," October 24, 2019. California Health Care Foundation. https://www.chcf.org/publication/2019-edition-health-disparities-by-race/

(11) Burden of Diabetes in California California Department of Public Health Chronic Disease Control Branch September 2014. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/FINAL%20Rpt%20(1877)%20DM%20burden%202014_9-04-14MNR3.pdf

(12) "Asthma Prevalence in California: A Surveillance Report," California Department of Public Health and Breathing California, January 2017. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/CDPH%20Document%20Library/Asthma_Surveillance_in_CA_Report_2017.pdf

(13) Ibid

(14) "California Health Care Almanac - Health Disparities by Race and Ethnicity: the California Landscape" California Health Care Foundation, October 2019. https://www.chcf.org/wp-content/uploads/2019/10/DisparitiesAlmanacRaceEthnicity2019.pdf

(15) "COVID-19 has shown that California must fix inequities in health care," Kiran Savage-Sangwan, Cal Matters, May 19th, 2020. https://calmatters.org/commentary/covid-19-has-shown-that-california-must-fix-inequities-in-health-care-for-communities-of-color/

(16) World Health Organization, Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Commission on Social Determinants of Health final report. https://apps.who.int/iris/bitstream/handle/10665/43943/978924 1563703_eng.pdf;jsessionid=365271ACE2052888542881700EEDCA8B?sequence=1. Published 2008. Accessed April 1, 2019.

(17) Kochhar, Rakesh and Fry, Richard. "Wealth Inequality Has Widened Along Racial, Ethnic Lines Since End of Great Recession." Pew Research Center. December 12, 2014. August 26, 2016. https://www.pewresearch.org/fact-tank/2014/12/12/racial-wealth-gaps-great-recession/

(18) Weinick, Robin M.; Hasnain- Wynia, Romana, "Quality Improvement Efforts Under Health Reform: How to Ensure That They Help Reduce Disparities – Not Increase Them," Health Affairs Vol. 30, No. 10: Agenda for Fighting Disparities. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0617

(19) "2015–16 Disparities Focused Study 12-Measure Report," Managed Care Quality and Monitoring Division California Department of Health Care Services July 2018. https://www.dhcs.ca.gov/dataandstats/reports/Documents/MCQMD_Disp_Rpts/CA2015-16_FS_Disparities_12-Measure_Report_F3.pdf

(20) Oregon Health Authority (2017). Provider Guide for Reimbursement for Out-of-Hospital Birth Services. Available at: https://www.oregon.gov/oha/hsd/ohp/Tools/Out%20of%20Hospital%20Birth%20Reimbursement%20Guide.pdf

(21) Minnesota Department of Health. CHW Toolkit: Summary of Regulatory and Payment Process. Available at: https://www.health.state.mn.us/facilities/ruralhealth/emerging/docs/chwreg2016c.pdf

(22) Willging, C. E., Goodkind, J., Lamphere, L., Saul, G., Fluder, S., & Seanez, P. (2012). The impact of state behavioral health reform on Native American individuals, families, and communities. Qualitative health research, 22(7), 880–896. https://doi.org/10.1177/1049732312440329

(23) Melley, K. (2019). New Mexico's Passage of Dental Therapy Law Builds National Momentum for Changing Provision of Dental Care Amid Oral Health Crisis. Community Catalyst. https://www.communitycatalyst.org/news/press-releases/new-mexicos-passage-of-dental-therapy-law-builds-national-momentum-for-changing-provision-of-dental-care-amid-oral-health-crisis

(24) Minnesota Department of Health (2019). A Measurement Framework for a Healthier Minnesota: A Report to the Minnesota Legislature. Available at: https://www.health.state.mn.us/data/hcquality/docs/frameworkreport.pdf

(25) "Health Equity Measurement: Meaningful Language Access to Culturally Responsive Health Care Services," State Library of Oregon Government Information and Library Services. https://libguides.osl.state.or.us/health_equity/measure_language

(26) See ONC 21st Century Cures Final Rule: https://www.healthit.gov/curesrule/ and CMS' Interoperability and Patient Access Final Rule: https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

(27) "A Roadmap to Reduce Racial and Ethnic Disparities in Health Care," Finding Answers, Disparities Research for Change, Robert Wood Johnson Foundation, 2014. https://www.solvingdisparities.org/sites/default/files/Roadmap_StrategyOverview_final_MSLrevisions_11-3-14%20%284%29.pdf

(28) Committee on the Learning Health Care System in America; Institute of Medicine; Smith M, Saunders R, Stuckhardt L, et al., editors. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington (DC): National Academies Press (US); 2013 May 10. 7, Engaging Patients, Families, and Communities. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207234/

(29) "Person Centered Engagement at the Organizational Level: Change Package," Center for Consumer Engagement in health innovation," https://www.healthinnovation.org/change-package/introduction/about-the-change-package

(30) MMCD Policy Letter 99-01: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL1999/MMCDPL99001.pdf

(31) "Design Thinking for Better Government Services," Marta Milkowska, July 24, 2018. https://www.innovations.harvard.edu/blog/design-thinking-better-government-services-human-centered

(32) "Growth Will Put Pressure on Infrastructure," Public Policy Institute of California (PPIC), February 2015. https://www.ppic.org/content/pubs/report/R_215HJ3R.pdf

(33) "Health Disparities by Race and Ethnicity: the California Landscape," California Health Care Foundation, October 2019, https://www.chcf.org/wp-content/uploads/2019/10/DisparitiesAlmanacRaceEthnicity2019.pdf

(34) U.S. Census Bureau, American Factfinder, Percent of People 5 years and over who speak a language other than English at home," 10/24/2017. https://cdn.cnsnews.com/attachments/census-other_than_english.pdf

(35) Penobscot Community Health Center. Penobscot Community Health Care Recognized as Leader in Health Care Equality, August 31, 2020, Available at: https://pchc.com/news/2020/08/penobscot-community-health-care-recognized-as-leader-in-health-care-equality/

(36) Human Rights Campaign, Healthcare Equality Index 2020, 2020, Available at: https://hrc-prod-requests.s3-us-west-2.amazonaws.com/resources/HEI-2020-FinalReport.pdf

(37) Human Rights Campaign, Healthcare Equality Index 2020, 2020, Available at: https://hrc-prod-requests.s3-us-west-2.amazonaws.com/resources/HEI-2020-FinalReport.pdf

(38) Language Access Legal 'Cheat Sheet,' New York Lawyers for the Public Interest, Inc.: https://www.nylpi.org/images/FE/chain234siteType8/site203/client/Language%20Access%20Legal%20Cheat%20Sheet%20Final%20-%20February%202012.pdf

(39) See AB 318: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB318, sponsored by CPEHN and Western Center on Law & Poverty

(40) Oregon Health Plan, Section 1115 Waiver Quarterly Report: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-2-qtrly-rpt-jan-mar-2020.pdf

(41) Commonwealth of Massachusetts. Linguistically Appropriate Services (CLAS) Initiative. Available at: https://www.mass.gov/culturally-and-linguistically-appropriate-services-clas-initiative#:~:text=of%20Public%20Health-,Culturally%20and%20Linguistically%20Appropriate%20Services%20(CLAS)%20Initiative,well%20as%20individuals%20with%20disabilities.

(42) North Carolina Department of Health and Human Services. Current Programs and Services, NC Culturally and Linguistically Appropriate Services (NC CLAS) Program, Available at: https://www.ncminorityhealth.org/services/current.htm

(43) "Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission," February 2019. https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf

(44) "Building Capacity for Community Health Worker Integration: Three Key Steps State Policymakers Should Take during the COVID-19 Crisis and Beyond," Families USA, July 2020. https://familiesusa.org/wp-content/uploads/2020/07/HE-267_Integrating-CHWs_Report_7-21-20.pdf

(45) "Revised Addendum 4/2002 Required Components for Implementation Plan: Consolidation of Specialty Mental Health Services (Phase II) Plan For Culturally Competent Specialty Mental Health Services," https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03_Enclosure.pdf

(46) New York Department of Health (2020). New York State Medicaid Update: Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVID-19 State of Emergency. Special Edition Volume 36 Number 9. Available at: https://www.health.ny.gov/health_care/medicaid/program/update/2020/no05_2020-03_covid-19_telehealth.htm

(47) Youdelman, M. (2017). Medicaid and CHIP Reimbursement Models for Language Services. National Health Law Program Available at: https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf

(48) Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press; 2001.

(49) "Strengthening Primary Care," CPEHN brief, February 2020. https://cpehn.org/sites/default/files/cpehn_strengthening_primary_care_-_final.pdf

(50) "Care Coordination Measures Atlas," Agency for Healthcare Research and Quality, December 2010: https://pcmh.ahrq.gov/sites/default/files/attachments/Care%20Coordination%20Measures%20Atlas.pdf

(51) Center for Health Care Strategies, Inc. Enhancing Team-Based Primary Care Approaches: Opportunities to Advance Primary Care Innovation through Medicaid Managed Care, August 2019, Available at: https://www.chcs.org/media/PCI-Toolkit-Team-Care-Tool_090319.pdf

(52) Be There San Diego: https://cachi.org/profiles/san-diego-county

(53) Quality Assessment and Performance Improvement Strategy. Arizona Health Care Cost Containment Program. Available at: https://www.azahcccs.gov/resources/Downloads/QualityStrategy.pdf

(54) Center for Health Care Strategies, Inc. Oral Health Integration in Statewide Delivery System and Payment Reform, May 2016, Available at: https://www.chcs.org/media/Oral-Health-Integration-Opportunities-Brief-052516-FINAL.pdf

(55) CPEHN Advancing Health Equity Through Systems Transformation and Payment Reform: “Oversight and Accountability of Managed Care Plans,” February 2020. https://cpehn.org/sites/default/files/cpehn_data_oversight_and_accountability-_final_.pdf

(56) “Raising the Bar: How California Can Use Purchasing Power and Oversight to Improve Quality in Medi-Cal Managed Care.” April 2019. Cailfornia Health Care Foundation: https://www.chcf.org/wp-content/uploads/2019/04/RaisingBarCAUsePurchasingES.pdf

(57) “Risk Adjustment Based on Social Factors: State Approaches to Filling Data Gaps,” State Health and Value Strategies, August 2020. https://www.shvs.org/wp-content/uploads/2020/08/FINAL_SHVS-Risk-Adjustment-Brief.pdf

(58) Healthy People 2020. https://www.cdc.gov/nchs/healthy_people/hp2020.htm

(59) Centers for Medicare and Medicaid Services (US), Office of the Actuary, National Health Statistics Group. National health expenditures 2009 highlights. [cited 2011 Aug 22]. Available from: URL: http://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf.

(60) Greater Flint Health Coalition. State Innovation Model (SIM). Available at: https://gfhc.org/state-innovation-model-sim/

(61) North Carolina Medicaid Reform Demonstration. Centers for Medicare & Medicaid Services Waiver Authority, April 25,2019, Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf

(62) “Health-Related Services Brief,” March 2020. Oregon Health Authority. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf

(63) Lown Institute Hospitals Index: https://lownhospitalsindex.org/why-this-matters/

(64) Elena Byhoff, Lauren A. Taylor, Massachusetts Community-Based Organization Perspectives on Medicaid Redesign, American Journal of Preventive Medicine, Volume 57, Issue 6, Supplement 1, 2019, Pages S74-S81, https://www.sciencedirect.com/science/article/pii/S0749379719303253

(65) California Accountable Communities of Health Initiative: https://cachi.org/

(66) “Oversight and Accountability of Managed Care Plans,” February 2020. California Pan-Ethnic Health Network. https://cpehn.org/sites/default/files/cpehn_data_oversight_and_accountability-_final_.pdf

Published by: The California Pan-Ethnic Health Network. December 2020.