Health Equity and Cultural Competency Plan, 2024

KanCare

United Healthcare® Community Plan

Introduction

UnitedHealthcare is committed to enabling and delivering equitable care that reduces health disparities and improves health outcomes — an enterprise priority reflected in our mission. Ultimately, our Kansas plan is successful when we improve access to high quality and affordable care for all.

Our Health Equity and Cultural Competency plan supports the State of Kansas in its "efforts to reduce health disparities, improve Health Equity, and ensure that Covered Services are delivered in a culturally competent manner to all Members, including those with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity." (2.5.4.A.1. of Contract)

Developing and maintaining our Health Equity and Cultural Competency Plan

Cultural competency is at the heart of equity and key for serving our Members, meeting their special health needs, and honoring their unique circumstances. This plan is our blueprint for incorporating cultural awareness and equity-based strategies into the delivery of care to address disparities and a framework for advancing and valuing diversity within our organization. This Health Equity and Cultural Competency plan will be reviewed every year for accuracy. Our Health Equity Director is responsible for the development and maintenance of the plan and collaborates with other staff members to review it and ensure the information is accurate, reflects the work being done and provide feedback as needed.

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Framework

As an organization and as individuals who reside in the communities we serve, we are committed to ensure all our members receive equitable and effective treatment and supports in a culturally and linguistically appropriate manner. To support this, we have systems, policies, and procedures that facilitate 6 primary components of our health equity and cultural competency framework:

1. Maximizing **Culturally and Linguistically Appropriate Services (CLAS**), that recognize members' beliefs and customs and unknowledge the negative impact of implicit bias in the provision of services.

2. Establishing and expanding a **network of providers** that is well equipped to provide high quality culturally sensitive care across our state of Kansas.

3. **Evolving our workforce with a focus on recruiting and training local staff** who respect, reflect and support members' cultural backgrounds and diverse abilities, and support an ecosystem that aims to advance diversity, equity, and inclusion (DEI).

4. Identifying and addressing **Social Drivers of Health (SDOH)** by connecting members with internal and external supports and resources and ensuring that we have process in place to follow up and close the referral loop.

5. Being intentional at identifying disparities, and at designing, implementing, and evaluating **Health Equity strategies** that are informed by meaningful data analytics, and member and community voice.

6. Community and Member voice

1. CLAS: Maximizing CLAS and culturally humble care

This Health Equity and Cultural Competency plan is our blueprint for incorporating culturally and linguistically appropriate services (CLAS) as well as culturally humble care into the delivery of services our members receive from us and our clinical partners.

We support this by using ***innovative strategies*** to identify and support cultural and linguistic health literacy needs as well as decreasing barriers to care, knowledge, and communication:

A. **Addressing the preferred languages of Members in both the physical and behavioral health networks:** We regularly monitor our network against member files, GeoAccess reports, density reports and member feedback received through customer service and clinical staff, to assure our network composition is appropriate as it pertains to languages spoken. We also review utilization, referrals, requests, and leverage census data to gauge language access gaps or needs.

B. **Support effective Member communications:** As we communicate with Members, one thing is clear — we must provide information that is easy to understand. To respond to our members, need for clarity, we have developed the Just Plain Clear™ Communications Program. The program focuses on improving written and verbal communications, so they are understandable, accessible, and actionable. Since Jan. 1, 2014, all new Member materials must pass the Just Plain Clear scorecard prior to being released to the marketplace.

C. **Member materials within required reading levels:** Based upon our Just Plain Clear initiative, we use the readability assessment tools to ensure materials are at a sixth-grade reading level or lower. This tool rates and confirms that the materials we produce are easy to read, understand and act upon, and that they present Member information in a manner that most Members can easily understand.

D. **Alternative printed formats and services:** Language translation services are available for those Members who are blind or deaf, hard-of-hearing or speech-impaired. To accommodate Members with different communication needs, we offer interpretive services and can provide information in Braille, large print, and voice-recorded CD formats. If a Member has any questions, they can call the Member services number (listed in the Member Handbook and on the back of the Member ID card) for assistance.

E. **Assistance for Members with cognitive impairments**: For those Members with cognitive deficits related to either disease states (e.g., Alzheimer's) or mental illness (e.g., depression, schizophrenia), our Member Advocates are trained to assist the Member using empathetic listening and if necessary, engage the assistance of a care coordinator (for in-person Member assistance).

F. **Assistance for Members who have a hearing impairment**: The health plan uses the 711 TRS/TTY line to facilitate communication with hearing impaired Members and the health plan prints the telephone contact information on all Member mailings and marketing materials. Member advocates are trained on handling calls from TRS operators who assist hearing impaired Members. When the office is closed, the TRS operator can leave a message on the system requesting a call back. Those messages are returned by the next business day using TRS via 711.

G. **Assistance for non-English-speaking Members:** Delivering a consistent Member experience as part of our "one-stop" service model includes focusing on the quality of the interaction with our Members and providing personalized service, including speaking to the Member in their preferred language. Accessible and appropriate linguistic services are the foundation of culturally proficient healthcare and upon enrollment into our health plan, the Member's need for linguistic and translation services is determined and noted in the Member's record. Interpretation services are available to members and providers for virtual and in-person visits. We offer free interpretation services for more than 240 languages 24 hours a days 7 days per week. In addition, we have Spanish speaking bilingual advocates working on the local Kansas team, and all member materials are in English and Spanish.

H. **Evaluating for linguistic and communication appropriateness:** To determine the need for changes/additions to verbal and written member services tools, we collect data on race, ethnicity and preferred written and spoken languages for members. We analyze this data to perform a cultural and linguistic assessment for Kansas service areas, including:
   1. Grievance and appeals
   2. Requests for translation services
   3. Requests for member information in alternate languages
   4. Requests for providers who speak specific languages
   5. Requests for special services for the hearing impaired
   6. When the health plan identifies a predominant language in more than five percent of members or potential enrollment base, we translate core marketing and health information materials into that language using CMS and State requirements, special needs issues and best-practice standards from professional organizations.

2. Provider network/access to quality and culturally sensitive care

A. Network adequacy and access to care

It is important to support members access to quality and impactful care. To support this, we develop and continually improve our provider network with an emphasis on the delivery of culturally sensitive and linguistically appropriate services. This requires foresight and a willingness to tackle complex service-delivery problems, while respecting the integrity of the culture and populations of those we serve. It also requires a clear sense of operational resources needed to manage a health care program that serves unique populations.

We analyze and monitor our network for diversity, cultural and linguistic gaps. Adequacy and diversity data is reviewed annually to verify members have access for needed health care services. Goals are established based on state contract requirements, the needs of the population, and trends. Performance is evaluated using multiple data sources. This includes capturing and evaluating member data from state member enrollment files, U.S. Census data for Kansas CAHPS 5.1H survey, actual enrollment data from the State, UnitedHealthcare Language Line utilization statistics, Health Screening tool (HST), Health Risk Assessments (HRAs) and grievances and appeals. Our Network Responsiveness Report provides additional details such as provider demographics and the number of physicians speaking languages other than English. Upon completion of the review, we identify gaps and actions to address them.

We understand that the needs of members in our rural and frontier areas are often different than members in the more urban areas of the state. These differences include access to care and available transportation. When developing the network in rural areas where there may be a limited number of providers, the health plan targets the available providers within the service area, which may include adjoining states or counties. In addition, the Kansas plan offers telehealth, which can increase access in professional shortage areas. We use Geographic Accessibility Reporting to compare access to the time, distance, and availability standards in the Model Contract to measure performance against standards.

Telehealth is a valuable tool for providing culturally competent care to home bound members or those who live in rural and frontier areas. Remote patient monitoring is a telehealth strategy that is included in the Frail Elderly (FE) waiver benefit package. We expanded this benefit to our Physical Disable (PD) waiver population using in lieu of funds and continue to offer the program to our members. We also assess for barriers to accessing telehealth and have added access to internet as one of our value added benefits (VABs) to support members on the waivers. We have contracted with a 24/7 telemedicine technology platform, to support member's needs and address gaps in care, through virtual visits via the Doctor Chat app or website.

B. Pioneer Project

The Pioneer Project goal is to create a network of providers in Kansas rural and frontier counties that a) seeks to include in network those out-of-state or out of network providers, most likely specialists, already providing care to UnitedHealthcare KanCare members; and b) assessing and evaluating the current network of primary care and specialty care providers to verify correct contracts and inclusion in the provider directory. These activities both help to increase availability of specialty providers and to ensure that members in rural and frontier counties do not encounter any obstacles in accessing local health system providers. The Pioneer Project offers many opportunities for UnitedHealthcare Community & State Kansas Health Plan to connect on a personal and professional level with providers and community organizations, thus creating relationships that reduce provider friction, reduce administrative costs, and create goodwill in the healthcare community.

C. Value Based Strategies

VBP models incentivize Providers to offer more holistic services, including pharmacy, specialty, BH and SDOH that focus on the overall health outcomes of Members. Linking payments to quality of care encourages the provision of comprehensive, coordinated services. Our Provider VBP agreements include incentives designed to promote integrated, whole-person care and to address disparities:

1. **Episodes of Care (EOC):** In 2022, we expanded our VBP suite to include EOC incentives for specialists focused on high-cost conditions and procedures and reducing health disparities. We have 11 Providers in Kansas enrolled in our asthma, maternity and diabetes EOC programs. Nationally, early results of our 47 active maternity EOCs across 13states show a 4% to 6% reduction in cost and 2% to 4% reduction in C-section births.

2. **Community Plan Primary Care Professional Incentive (CP-PCPi):** This program incentivizes Providers for closing gaps in care across key HEDIS and CMS Core Set metrics, including BH measures and EPSDT visits, chosen annually and aligned with KDHE's quality strategy. It encourages Providers to advance integrated, whole-person care by incentivizing SDOH Z code billing around housing insecurity, food insecurity, employment status and incarceration. In 2022, there were 12,995 more care gaps closed than in 2021, and 111 Provider groups earned over $4.5 million in incentives.

3. **BH Provider Incentive (BHPi):** Much like CP-PCPi, this incentive is designed to support improved value, quality and advance Providers

from volume to value. Providers can earn bonuses by helping Members become more engaged in their health care treatment through peer support services. In 2023, 100% of Kansas Providers enrolled in BHPi earned bonuses.

4. **Health Equity Provider Incentive (HEPi):** In 2024, we are expanding these programs to include HEPi, a program designed to reduce observed disparities in HEDIS measures between populations or regions. We pay higher incentives to Providers who close HEDIS gaps for Members with observed disparities.

D. Provider education

Our plan offers education and tools to promote cultural awareness, culturally aligned and unbiased care, and health equity. We support our provider's network training and education with two educational platforms:

1. UnitedHealthcare Provider site: Educate providers to recognize the culturally diverse needs of the population and acknowledge the value of the diverse cultural and linguistic differences in the organization and the populations that they serve. https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html

2. Optum Health Education (OHE): A provider of interprofessional continuing education (IPCE). OHE is an accredited provider of medical, nursing, optometry, pharmacy, psychology, social work, dental and dietitian continuing education.

3. Fostering a diverse, equitable, and inclusive workforce and workplace

Our commitment to diversity empowers our employees to contribute their best work, collaborating to be the pre-eminent health and well-being company and community partner of choice. By leveraging the depth of a diverse workforce, we can better meet the needs of the increasingly multicultural clients, communities, individuals, and shareholders we serve.

A. Recruiting and training local staff

The plan understands that trust is earned and therefore we emphasize recruiting and training local staff who represent, respect, and support members' cultural backgrounds and diverse abilities. With this emphasis on local staff who represent our membership, we aim to earn each member's trust and provide culturally competent care.

We actively recruit and hire employees who represent the ethnic and cultural groups we serve or who have extensive experience working with diverse populations, including the perspectives of individuals with disabilities. We apply several strategies to recruit and hire a diverse staff that represents our membership and allow us to better engage our members. To enhance the ability to reach members, we also develop relationships with diverse community-based organizations. The specific strategies we use in Kansas include:

1. UnitedHealthcare hiring managers have access to resources including inclusive hiring guides, interview guides that help reduce bias in candidate selection, and specialized training about inclusive hiring.

2. We are dedicated to recognizing every individual for their unique experience and contributions. Some examples of our recruiting efforts include:

    a. **Empowering our employees to support our commitment to equity, cultural diversity and inclusion:** Our commitment to diversity and inclusion empowers our employees to contribute their best work, collaborating to be the preeminent health and well-being business and community partner of choice. At UnitedHealthcare, diversity of thoughts and perspectives are encouraged, along with a workforce that reflects the diversity of our Kansas membership.

    b. **Representation:** Diversity, equity, and inclusion topics are prominent on intranet sites, in townhalls, and in our physical and virtual environment. Marketing and images reflect people of all abilities and backgrounds.

c. **Voice of the employee**: Our annual Employee Experience Survey incorporates an Inclusion Index to measure and understand how employees feel about fairness, affirmation, safety, identity, and connection within our organization.

d. **Employee Resource Groups:** These are voluntary, employee-led groups based on a shared characteristic, demographic, or life experience. Groups are a resource for group members and the organization for building an inclusive culture and fostering understanding and belonging.

B. Empowerment through trainings and education

Having a diverse workforce allows us to meet the needs of the increasingly multicultural communities and individuals we serve. We provide culturally competent services to Kansas members of all cultures, races, ethnic backgrounds, languages, communications needs, disabilities, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each member. Our employees have access to a large array of educational offerings that support our goal of building and equipping teams to provide high quality culturally sensitive care. Some of the trainings are mandatory and others are optional. The trainings cover a wide range of competencies including:

1. Use of the member's primary language.
2. Use of clear communication with cultural understanding and respect.
3. Communication protocols for members with limited English proficiency.
4. Characteristics of and barriers facing individuals with special health care needs.
5. Cultural awareness and understanding of health disparities among different cultural groups.
6. Cultural beliefs related to health, illness, medical care, and end-of-life issues.
7. The need to treat each person with dignity and respect.
8. Dimensions of Diversity
9. Microaggressions
10. Unconscious Bias
11. Health Equity
12. Responding to Racial Justice
13. Inclusive leadership
14. How to avoid stereotypes and reach for understanding.
15. Understanding SDOH and their impact on health.

16. Understanding housing-related needs and resources.
17. Food access and its relationship with health. Connecting to resources.

The health plan utilizes a variety of training methods, including online training modules, and live presentations to expand our clinical staff's ability to deliver culturally and linguistically appropriate care and services, which are particularly important during care planning. UnitedHealthcare employees have access to many educational platforms where they can choose to take learning modules. Some training modules offer continuing education credits (CME/CEU/CCM). Relevant training modules include:

1. Leveraging the Growing Autism Workforce
2. Keeping Perspective Despite Life's Challenges
3. Communicating Across Cultures
4. Communicating with a Cross-Cultural Audience
5. Diversity on the Job: Diversity and You
6. Diversity on the Job: The Importance of Diversity and the Changing Workplace
7. Improving Communication in Cross-Cultural Relationships
8. Managing Workforce Generations: Working with the 21st-century Generation Mix
9. Understanding Workplace Diversity
10. Communication to Support Members in Crisis
11. Behavioral Analytics Training
12. Advancing Health Equity Education Series
13. Care Philosophy training
14. Addressing Maternal Mortality
15. Driving Health Equity though Technology and Service Innovation
16. Caring for the LGBTQ + Community

Our team has four main platforms for mandatory and optional online learnings:

1. Health Equity University
2. Optum Health Learning system
3. My Learning
4. LinkedIn Learning

4. Social Drivers of Health

Meeting eligibility requirements inherently puts our members among the most vulnerable in our community. Limited income, coupled with unmet social needs for basic living essentials like food and stable housing, can significantly impede one's ability to care for their physical and mental health.

To relieve the impact of unmet social needs on health, well-being, and disparities, we wave SDOH support into all that we do. We identified, address and track our members SDOH needs holistically, support communities cooperatively and promote health equitably by establishing meaningful relationships with providers and local CBOs.

We embed SDOH screenings in all members touch points including those in care coordination, to identify needs, provide closed-loop referrals and track their success.

A. **Identifying social needs** is the first step in addressing them. Our strategy is to leverage each member touch point as an opportunity to screen for SDOH needs, regardless of their participation in care coordination.

    1. The following is a summary of our **strategies to identify SDOH needs**:

        a. Member assessments include SDOH questions: health screening tool (HST), health risk assessment (HRA), maternal initial risk evaluation (MIRE).
            i. Those on care coordination have more detailed assessments to support their complex needs (7.4.1.D.19)
        b. Member services SDOH screenings: System prompt, proactive SDOH screenings and referral offer on all inbound calls.
        c. Incentivize Provided-Submitted Z codes: Ingest applicable Z codes into our SDOH registry and pay provider incentives for submission of these codes.
        d. Data sharing with Epic: Seamlessly ingest Provider-identified needs from Epic. We will seek to expand to other EMR systems.
        e. CBO and clinical referrals to UnitedHealthcare team: Identify needs for those we jointly serve and coordinate to make sure they receive full scope of available benefits and supports.

    2. **Tools to improve engagement**
        a. SDOH staff training: Increase SDOH awareness and how to address member needs.

b. Empathy and motivational interviewing training: Improves empathetic conversations to foster trust and engagement.
c. Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE) questions: Uses evidence-based tools as our basis.
d. Provider training on screening and coding: Promotes adoption.

Because it is our mission to help individuals live healthier lives and make the healthcare system work better for everyone, and in alignment with the requirements of the scope of services 7.4.B.13, our approach to understand our members' social needs applies to every member regardless of whether they are in care coordination. If, through this process, we learn that the member has more complex SDOH needs, we can also trigger enrollment in care coordination for longitudinal support, consistent with the scope of services 7.4.1.D.19. Given the members in care coordination have complex health and social needs, we administer more detail assessments and provide additional documentation in their care plans.

B. Tracking Members social needs

The way we identified SDOH need determines the system in which the data is stored. For instance, member services advocates document everything in an integrated service desktop solution, Maestro. Our interdisciplinary team uses Community Care, our clinical IT platform, while providers use their medical records.

To unify these systems, we have developed an SDOH registry that routinely draws from various data sources, serving as a consolidated SDOH data repository. After processing and quality assurance, this registry becomes a rich source of member and community insights.

This data enables us to identify needs and devise strategies to address them at individual and community levels. While our SDOH registry forms our backend infrastructure, member level information is accessible through our integrated SDOH referral tool, UnitedHealthcare Community Connector.

C. Individuals responsible for following up identified SDOH needs

While getting connected to resources to satisfy unmet social needs is critical, it is often who connects you to those supports and how they make you feel that makes a lasting impact. To make sure our members are understood and supported, especially with the

most essential needs, we bolster our interdisciplinary team with highly specialized, Kansas-based SDOH staff who implement tailored strategies that align with the SDOH needs most reported by our members.

Since 2019 the Kansas plan has had a dedicated SDOH team with a focus in the main SDOH domains. Our SDOH team has expertise in the areas of housing, food access, education, and employment. The following points describe the roles of those responsible for following up on identified SDOH needs.

1. **Roles that support all Members**

    a. **Service Advocates**: at the end of inbound calls advocates offer additional support, conduct an SDOH screen and, if needs are identified and the member wants assistance, use UnitedHealthcare Community Connector to connect the member with resources.
    b. **SDOH Navigators:** Specially trained member service advocates who can make outbound calls in Kansas, support individuals with fail closed loops, helping the individuals connect to resources until their social need is met.

2. **Interdisciplinary team roles that support all Members**

    a. **Housing Navigator:** Assess members housing needs, identifies barriers affecting housing stability, helps develop a housing plan and navigates member to resources. The housing navigator also manages housing programs and trains staff and community partners.
    b. **Food Access specialist**: Works on nutrition education strategies, provides trainings and education for our healthcare service team, and works with clinical and community partners for food access related strategies. The food access especially also manages our internal food access programs.
    c. **Employment and education specialist:** Develops expertise on which employment based resources exist and how to effectively use them to support our members. Manages the education value added benefits of $200 for education support. Directly supports members seeking employment or looking to increase income through upscaling. The employment and education specialist develops strong relationships with workforce centers in Kansas and any other organizations that provide education or employment related supports.

3. Kansas-based team roles that support those in Care Coordination

a. **Community Health Workers:** CHW's engage members to complete needs assessments and develop personalized care plan. CHWs collaborate with local partners to secure resources and encourage members to promote self-management.
b. **Care Coordinators:** Work with at-risk members to develop individualized care plans. If the member faces complex social needs, our coordinators engage with CHWs and the specialized SDOH leads as appropriate.
c. **Peer Support Specialists:** These unique members of the care team apply their expertise with substance use disorder or behavioral health conditions to engage members in care, including to help them remove SDOH barriers.

D. Process for connecting members to available resources

Once we learn a member has an identified SDOH need, we determine whether they want our assistance and navigate to available resources. Our ideal order of supports begins with connecting members to additional benefits they could be eligible for, then relevant internal programming and value-added benefits, and finally local CBO provided supports. As part of our commitment to address SDOH needs, we offer special programs for urgent needs such as food delivery and housing stability, where appropriate. Generally, the process for connecting members to available resources will follow one of these paths: support offered by UnitedHealthcare such as additional benefits or by external resources such as CBOs.

1. Tools to connect our Members to resources

a. findhelp: findhelp is our main tool to make free or reduced cost SDOH resources information available via UnitedHealthcare Community Connector. It is also available as a free tool for Providers and members.
b. Integrated referral intake system (IRIS): Given its family focused, Iris's is used primarily to link members to maternal and child services.
c. Internal SDOH resources and value-added benefits guide: To raise awareness of UnitedHealthcare resources, we created a two-page summary of our internal programs and how to access them. It serves as a comprehensive guide to creating awareness and promoting engagement that can be used by our team, providers, and community-based organizations.

d. SDOH domain job aids: These include tips like how to effectively search for key resources internally and externally and by geography.
e. Designated staff as the lead experts for SDOH needs: As part of our integrated care team, specialized roles for food, housing, employment, and education share their knowledge and support with the service team, and clinical and community partners.

E. Method and tools to track Member access to SDOH supports

Connecting our members to resources does not necessarily mean they can access them, so we track our SDOH referrals to not only close the loop but confirm that the underlying need has been met. While industry standards consider a loop closed when feedback is received from the resource a person was referred to, our approach is more comprehensive.

We supplement CBO- provided loop closure with automatic member level outreach, striving to directly understand whether we are meeting our Members needs. We take this endeavor seriously, using multiple tools that, when taken together, will highlight whether a gap exist between a need and the resources available to meet that need.

1. Method

To verify we have the most comprehensive view of members access to necessary resources, we use a range of tools, including closed-loop referral platforms and geographic information systems, that together track individual access to SDOH supports and community level accesses, positioning us to make relevant insights to support our members and Kansas communities.

2. Tools to track Member access to SDOH supports

a. UnitedHealthcare Community Connector: We have developed a versatile tool that integrates with leading SDOH referral platforms and our internal systems, making it easier for our teams to view information within the workflow, regardless of the platform the information comes from. It facilitates effortless data connecting with CBOs. Currently, the tool operates using findhelp in Kansas. Its integration with other systems allows for interchangeability between platforms, without disruptions to our users. This means we can switch platforms if deemed more suitable without any inconvenience to our users.

b. findhelp: A comprehensive, nationwide online social care platform that connects users with free or low-cost social services. As the most expansive network among referral platforms, with over 5,000 listings in Kansas, findhelp enables both the referrer and the recipient to close the loop, enabling accountability and efficiency.

c. IRIS: Our maternal team also uses provider led bidirectional platform for maternity and family services created by the Kansas University. We have used Iris in Sedgwick and in the Kansas City metro area since 2020 and plan to expand our use to new areas .

d. Automatic telephonic outreach: While CBO can close the loop of referrals received through findhelp, we supplement this with information provided by our members directly. Once a referral is documented in UnitedHealthcare Community Connector, it automatically launches a phone call to the member to assess whether the referral met their needs or whether they need additional assistant.

e. Member UnitedHealthcare HRSN Insights Dashboard: This dashboard tracks number of SDOH screenings that occur, needs identified, referrals made and needs met. Needs are categorized into domains (example food, transportation) and data can be stratified by geography, race, ethnicity, language, and other factors to tailor hyper local interventions.

f. CBO Insight Dashboard: This dashboard offers comprehensive summaries of our SDOH referrals. It displays the count of referrals to each CBO categorized by SDOH domain and location and shows the referral success rate.

g. SDOH Clinical Dashboard: Shows the intersection of 53 clinical diagnosis, our members' SDOH indicators and key demographics, which enable us to consider social needs when designing clinical initiatives and policy advocacy.

As a standalone, each tool contributes data elements or insight on member access to necessary social supports. For example, our closed-loop referral engine allows the referral entity to report on whether the member referred to the organization ultimately accessed their service. Our automatic telephonic outreach to the member supplements this closed-loop data with the members account of whether they accessed their referred

support, whether they no longer need support, or if they would like more assistance with resolving their need(s). These tools are critical to tracking access at the member level.

Because social needs often result in system-level barriers, we are committed to tracking access at a population level. Together, the member and the CBO Insight Dashboard highlight the degree to which our members successfully access the supports they need allowing us to visualize differences in SDOH needs, referrals, loops closed and needs met by geography, language, race or ethnicity, age and gender so we can identify potential disparities.

F. Natural disasters

We use geographic information systems, not only for monitoring social needs but also for tracking member impact during natural disasters and weather events. Recognizing that environmental hazards disproportionally affect vulnerable communities, we have developed a responsive alert system, consistent with requirements in the scope of service 7.4.1.C.22. This system triggers when a member requires uninterrupted services is potentially affected by environmental hazards.

For example, if adverse weather forces a power outage affecting an individual on a respirator, our system alerts the interdisciplinary team. This triggers a disaster flag for outreach, prompting the care coordinator to liaise with our housing navigator, making sure temporary shelter is secure until electricity is restored. This proactive approach allows us to support our most vulnerable members effectively during a crisis.

G. Cocreating healthier communities

Although our primary focus is implementing specific interventions to address health disparities among our members, we also actively participate in payer-agnostic initiatives and advocacy efforts that enhance the overall health of the wider Kansas community.

Central to this is building community capacity and collaborative partnerships with local organizations. Our team stablishes strategic partnerships and strategic investments with the goal of providing valuable supports that facilitate expansion of current or new resources or interventions that are led by identified needs in community.

We work closely with community and clinical partners all around the state. We participate in multiple coalitions, community-based meetings, and organized groups to share our expertise and resources, and to learn from community, colleagues, and community leaders.

With the goal of increasing capacity and impact of existing community supports for SDOH needs, we provide funds in the form of small and large grants. These are examples of investments in the past few years:

1. American Heart Association: Our $275,000 donation (2023 – 2024) contributed toward a partnership with the four Kansas tribes via food access and nutrition efforts.
2. Kansas Department of Health and Environment (KDHE) Nutrition Programming: Our $175,000 donation (2021 – 2023) helped KDHE reach 3,105 people. KDHE uses local partnerships to address SDOH in the Wichita community, delivering health education, food access and nutrition programming in the Evergreen and Fairmount neighborhoods and among the refugee and LGBTQ+ communities.
3. Kansas Food Bank Warehouse, Inc.: Our $30,000 donation (2021 – 2022) supported 24,985 people and purchased 854,976 meals distributed to students who struggle with emotional and behavioral regulation.
4. COPE: $80,000
5. Kansas Statewide Homeless Coalition: $50,000
6. Livewell Finney County: $50,000
7. Kansas Birth Justice Society: $30,000
8. Workforce Centers: $50,000 to support expansion of technology supports, computers and internet access.

5. Identifying Disparities and Developing Health Equity Based Strategies

Health disparities are avoidable differences in health status among a subgroup of the population, including differences that occur by race or ethnicity, disability, sexual orientation, gender or gender identity, geography, preferred language, education, or income and living environment.

Society often links these disparities to social, economic, and environmental disadvantages and structural inequities that affect historically marginalized communities. Health disparities encompass a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

To address disparities, UnitedHealthcare uses targeted strategies that aim to improve the quality of life and care provided to underserved groups. Informed by the experience of 20 UnitedHealthcare affiliate plans earning Health Equity Accreditation, we have established systems and processes to evolve our understanding of health disparities and inequities that are consistent with NCQA standards.

A. Approach to identifying disparities

We follow industry best practices for using data and information to identify and address disparities, including the use of predictive analytics, integration of multiple data sources, use of real-time data and application of evidence-based interventions. In addition to publicly available data, we have a comprehensive suite of internally developed population health analytic tools to analyze outcomes and disparities. We supplement quantitative data with qualitative data, including feedback from Member, Provider and community advisory groups; feedback from our own care coordinators and CHWs; and analysis of State priorities.

The following diverse analytic tools and sources inform our population health strategies, allowing us to identify health disparities and design initiatives that drive toward more equitable outcomes:

1. Index of Disparity (public): We apply the index of disparity formula, a nationally used and vetted measure to assess differences among groups, to subpopulations within our membership, including by race and ethnicity, income level, education level and primary language. We use this tool to identify disparity reduction targets and action plans.

2. HEDIS® quality measure dashboard (public and internal): In addition to using publicly available HEDIS data, we developed a customizable dashboard that analyzes Member-level detail for HEDIS measures by race and ethnicity, age, county, and ZIP code. We use this information to design quality improvement projects at the population level and to address disparities for HEDIS measures within population subgroups.

3. Hot-spotting and Population Insights (Pop-I) tools (internal): We use these tools to identify risk factors, geography and demographic data, including ethnicity, diagnosis, type of utilization, cost of care and BH or substance use. Our Hot-spotting and Pop-I tools enable us to view the data at both a population and individual Member level. These tools tell us where our strategies are effective for each Member and across KanCare to pinpoint opportunities to deploy new or expand current strategies.

4. SDOH dashboards (internal): Our SDOH dashboards track SDOH data from screening through needed resolution and overlay SDOH needs with Members' clinical conditions (e.g., percentage of Members with a food insecurity and diabetes diagnosis). Data can be stratified by geography, race, ethnicity, language and other key demographics, enabling us to understand core social issues that often influence health outcomes and drive disparities.

5. Maternal dashboard (internal): We identify Members' needs in our maternal dashboard to address health disparities across measures such as gestation age, birth weight, premature delivery and NICU admission and average length of stay.

B. Addressing health disparities for KanCare Members

It is important to understand unique health disparities that exist within a demographic subgroup defined by age, gender, race, geographic area and/or disability status. We use member and claims-based data to complete population-based analytics to identify areas where health disparities exist and introduce initiatives and interventions to reduce these health disparities. We also use this data to evaluate and assess reductions in health disparities over time where initiatives are in place.

Our team has a Population Health Action Plan where goals, interventions, and times lines are captured. This action plan outlines several clinical priorities and action steps to address identified health disparities, and/or specific gender and age groups, based upon monthly and/or quarterly analysis of utilization and health outcomes data. We also have a Health Equity plan, which aligns with some of the Population Health Action Plan goals, but it is more focused to respond to NCQA requirements.

The Population Health Action Plan and the Health Equity Action plan utilize the same framework and system to identify disparities, design interventions and evaluate progress:

- **Step 1:** Identify population and priority problems.
    a. We use data and information to identify and address disparities, including the use of predictive analytics, integration of multiple data sources, use of real-time data and application of evidence-based interventions.
    b. We supplement quantitative data with qualitative data, including feedback from Member, Provider and community advisory groups; feedback from our own care coordinators and CHWs; and analysis of State priorities.
    c. We use the index of disparity to identify disparities and reduction targets (public tool)
    d. HEDIS dashboard: Member level detail and stratification based on race/ethnicity/language/age/gender/zip code
    e. Hot spotting and Population Insights.
    f. SDOH Dashboard.
    g. Maternal Dashboard.
    h. External data sources: Kansas Health Maters, KDHE, Health Rankings, March of Dimes, etc.
- **Step 2:** Understand the needs and causes of the problem: literature review, provider and member feedback, structural inequities, implicit bias, etc.
- **Step 3:** Set improvement goals: Equity Focus Population Health Goals
- **Step 4:** Aling and Develop Interventions to eliminate the disparity (our interventions are shaped by member voice, literature review and the voice and feedback from experts inside and outside UnitedHealthcare walls)
- **Step 5:** Continuously monitor
- **Step 6:** Adapt and evolve

C. Avoiding potential bias in Utilization Management

In health care, unintended bias includes subconscious prejudices that health care professionals may harbor and inadvertently apply when treating patients, potentially leading to disparities in service delivery, fueling disparities in health outcomes. Often influenced by factors such as race, gender, socioeconomic status or age, unintended bias can influence medical decisions, affect. patient-Provider communication and contribute to health inequities. UnitedHealthcare is proactive in identifying unintended bias to reduce inequities and improve Member experience. To reduce the potential for bias among our UM team in determinations, we use the following tools:

1. InterQual evidence-based clinical criteria and technology to promote standard of equitable, evidence-based care.
    a. InterQual criteria updated to change measures for assessing kidney injury severity to ensure consistency across patients with different racial backgrounds
    b. InterQual raises awareness of potential racial bias if a hospital lab uses an outdated method to calculate GFR. If we identify a hospital still uses the old race-inclusive method, the medical director can intervene, adjust for this bias and encourage the hospital to update its practices.

2. Latest clinical guidelines to assess medical appropriateness, including guidelines to eliminate race-based medicine.

D. Governance, Committees and Accreditation

1. **National Health Equity Advisory Board:** The Health Equity Board is comprised of leading experts and advocates as well as Community & State health plan consumers and/or caregivers (as appropriate). The goals of the Health Equity National Advisory Board are to:
    a. Serve as a forum for feedback and reactions to UnitedHealthcare's efforts to embed health equity into our core business functions.
    b. Provide feedback and direction for UnitedHealthcare's initiatives impacting member disparities and health inequities.
    c. Help stimulate behavioral change across our organization and the overall Medicaid system to support efforts to reduce health inequities faced by Medicaid enrollees.
    d. Inform UnitedHealthcare's position and thought leadership on addressing health inequity.
    e. Help influence policy and program design changes needed to support the prioritization of health equity in the Medicaid program and Medicaid managed care organizations.

2. **Quality Management Committee:** This committee provides oversight into health equity advancement and implementation of interventions. The committee structure is assessed annually to determine the adequacy of program resources and practitioner/leadership involvement. The QMC reports to the organization's Board of Directors.

3. **Accreditation:** The Kansas plan, submitted application to achieved NCQA Health Equity Accreditation on June 11, 2024. Health Equity Accreditation shows our health plan's commitment to building an internal culture that supports health equity, providing culturally and linguistically aligned services, and identifying and reducing health disparities.

6. Member and Community Voice

Listening and learning from our members, providers and community partners is a key aspect of our culturally competency and Equity plan. We have different strategies in place to gather feedback and learn about the community we serve as well as to get feedback on our equity-based strategies and plans.

A. **Member Advisory Committee:** The Member Advisory Group is the voice of our members, legally authorized representatives, and non-members in the communities we serve. We cultivate new Member Advisory Group members who can expand the group's collective cultural awareness. We invite candidates from a variety of cultural backgrounds, life experiences and geographic areas, who can contribute to the goals of the Member Advisory Group. Ensuring a diverse group improves our ability to influence changes that will enhance the services that we provide to our members. We use feedback from members, including those who participate in our Member Advisory Group, to continually refresh and improve our cultural competency and health equity plan and related policies and procedures, processes, communication, and training programs. As recommended in the KanCare 3.0 contract section 7.12.O.4, we will include health equity topics on at least two of the Member Advisory meeting every year.

B. **Member Experience Manager:** In 2022 we conducted a member listening tour across the State of Kansas. From working back to school events, to partnering with local RHC's, as well as 'United We' sessions, members were asked questions that would trigger conversation and where UnitedHealthcare can learn from their experience. Throughout these sessions we asked questions about benefits, how members can trust their insurance plans, and requested feedback about online portals, and asked about what we did well. It gave a safe place for KanCare Members to voice their concerns and provide ideas. From these sessions, we worked with Senior Leadership, management, and member services teams, to make adjustments that can better meet Member's needs. For example, a renewed focus on hiring for members services across the entire state; and offering more relevant Value-Added Benefits.

C. **Provider Advisory Committee:** This committee consists of UnitedHealthcare Community Plan of Kansas Plan leadership from clinical and operational areas of the health plan, along with practitioners within our network. The PAC is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of medical care within the network.

D. **Community Advisory Committee:** This committee provides insights on Kansas health care issues and trends. The committee provides input and guidance on

the health plan's strategic direction for advancing health equity and addressing community needs. In addition, the CAC serves as a forum for representatives of Community Based Organizations (CBOs) to provide feedback and insights about experiences and needs of people within their communities and members of our health plan.

E. **CAHPS® Survey:** We use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey as an indicator to understand how well we are meeting health care organizations meet member expectations.

F. **NPS® Survey:** The NPS® is a one-question market research metric that measures how the health plan is perceived by members. Data collected via NPS® can indicate how satisfied members are and provide insight into opportunities for improvement and innovation.

G. **Member Outreach:** Member Advocates conduct interviews with members to identify barriers to care, service issues, and commonly asked questions. Interview information is collected and analyzed by demographic group to inform performance improvement activities.

H. **Community Outreach:** Our Community Outreach Representatives (CORs) engage community members and providers. They provide bi-directional information sharing: communicating health and benefits information to members, provider, and community needs to the health plan.

2025 Goals

Area of improvement	Goal
Provider Network	Increase Cultural Competency education/training attestation rate by 2% over 2025.
Quality	Increase provider use of Z-Codes/LOINC on claims by 1% from 2024