

2024 Cultural Competency Plan and Health Equity Program description

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Medicaid coverage provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

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Company overview

Wellpoint Texas, Inc. was formed June 19, 1995, and Wellpoint Insurance Company was formed June 3, 2011. Both are wholly owned subsidiaries of Wellpoint Corporation.

Purpose

Wellpoint is committed to addressing the social risks and social needs of our members and the communities where they live in a way that supports diversity, equity, inclusion, and cultural humility. Our commitment helps ensure individuals within the community and within our membership reach optimal health.

Introduction

This document outlines our *Health Equity Program*, which encompasses our culturally and linguistically appropriate services (CLAS) for our plan.

With the accelerated growth of minority populations, the face of healthcare continues to rapidly change. Wellpoint has a unique understanding of the healthcare and social needs of the members we serve that affords us the opportunity to effectively manage current and future healthcare concerns. Furthermore, we firmly believe that we must recognize and thoroughly understand the role that culture and ethnicity play in the lives of our members to ensure everyone receives equitable and effective healthcare.

To assist in the integration of the knowledge, attitudes, and skills reflective of a culturally competent organization, Wellpoint maintains a cultural competency plan that serves as the blueprint. It reflects a comprehensive, organized, and methodical approach to the strategic planning, development, implementation, and evaluation of cultural competency. It also serves as a guide in the ongoing developmental process of a multicultural competent service delivery system. The plan is descriptive, organized around objectives and strategies, and designed to provide a measurable approach to ensuring the cultural competence of Wellpoint as an organization.

Within this plan, cultural competency objectives and strategies are developed to run in a parallel course. And in this evolving demographic landscape, Wellpoint continually re-evaluates our approach.

Wellpoint addresses cultural competency through the following:

- Provides a high-performance organizational culture of social awareness, values, cultural sensitivity, and customer service that supports, attracts, and retains a diverse staff. Additionally, Wellpoint recruits and retains a culturally diverse and competent workforce that is similar to the STAR, STAR+PLUS, STAR Kids, and CHIP members we serve.
- Develops a comprehensive cultural competency training curriculum and ensures all associates receive culturally and linguistically appropriate education and training
- Ensures clinical assessment and plans of care reflect relevant cultural issues
- Provides language assistance services, at all points of contact, to members with limited English proficiency and/or impaired hearing at no cost to the member or provider
- Ensures member-related materials can be easily understood and are available in the member's language of preference
- Develops collaborative relationships with communities to address the health beliefs and needs of ethnic and cultural populations
- Ensures culturally competent care is delivered to all members. To this point, Wellpoint strives to credential providers who understand and appreciate the socioeconomic and cultural challenges that our members face in addition to their complex medical needs

- Assures stakeholder participation in the service delivery process to identify and evaluate community resources. Additionally, Wellpoint solicits feedback from members and community-based organizations regarding the cultural appropriateness of member materials and programs.
- Identifies opportunities to implement culturally sensitive initiatives that address disparities in healthcare under the direction of the health equity workgroup. This cross-functional group is the key to implementing a focused approach to clinical improvement initiatives. One role of the workgroup is to notify Health Care Networks if network gaps related to cultural and ethnic needs and preferences are identified.
- Conducts an annual population assessment of our membership that helps identify critical conditions and healthcare needs that require targeted initiatives to maximize improved outcomes

Wellpoint embraces delivering culturally competent services to the culture, ethnicity, values, beliefs, strengths, gender identities, disabilities, and desires of our members while preserving and elevating their dignity. Respecting our members includes recognizing, understanding, and honoring the role that culture, ethnicity, and other forms of self-identification play in their lives. This helps ensure that every member receives equitable and effective healthcare and support. Wellpoint remains committed to promoting the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, religions, disabilities, and regardless of sex or sexual orientation, in accordance with *Title VI of the Civil Rights Act* guidelines and the provision of auxiliary aids and services, in compliance with the *Americans with Disabilities Act, Title III, Department of Justice Regulation 28 C.F.R. § 36.303, 42 C.F.R. § 438.206(c)(2), and 1 Tex. Admin.Code § 353.411*. We recognize, respect, and respond to the needs and preferences of each member, value each individual's worth, and protect and preserve each individual's dignity.

Mission statement

Wellpoint recognizes the increasing importance of delivering culturally relevant healthcare benefits, solutions, and education that address the diverse needs of individuals and families in the communities we serve. Wellpoint takes an interdepartmental collaborative approach to help ensure the implementation of culturally and linguistically appropriate healthcare related services to members with diverse health beliefs and practices, limited English proficiency (LEP), and variable literacy levels.

In addition, Wellpoint develops quality improvement activities to reduce disparities in care. Reducing health disparities requires systematic change that is targeted to the needs of individual members. On an annual basis, the plan evaluates available data on the race, ethnicity, and primary language of the member population. This analysis builds the foundation for understanding and reducing disparities. Data analysis, including root cause and barrier analysis, is conducted to identify the areas of greatest need, allowing the plan to address disparities within the population and improve care for all members. Cultural competency training and materials act as the foundation to improve care.

Culture competency

Cultural competency can be defined as the willingness and ability of a system to value the importance of culture and to display that value in the delivery of services. At all levels, a culturally competent system acknowledges and incorporates diversity, cultural self-assessment, attentiveness toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Cross, et.al, 1989).

Cultural factors may influence the way individuals:

- Define, evaluate, and communicate their problems.
- Seek help for their problems.
- Present their problems to service providers.
- Respond to intervention plans.

Wellpoint further defines cultural competency as the delivery of integrated healthcare within the context of a member's cultural beliefs, behaviors, practices, disabilities, and language preferences.

To gain a better understanding of our members, we routinely collect information on different cultural backgrounds. We also train and educate associates and participating providers regarding ways to promote effective interaction with members. This promotes respect for all individuals regardless of culture, language, age, ethnicity, race, or disability. Associate and provider cultural competence is then monitored through our quality improvement process. Additionally, Wellpoint assesses and monitors the cultural, ethnic, racial, and linguistic needs of members and adjusts network availability.

Laws and regulations

The three major federal legal standards related to cultural competency that Wellpoint adheres to are *Title VI of the Civil Rights Act of 1964*, federal *Executive Order 13166* and the CLAS standards. Additionally, the Texas Health and Human Services Commission (HHSC) has requirements relating to cultural competency that we follow.

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 states that entities, such as companies or corporations, receiving federal financial assistance shall not do any of the following based on protected status:

- Deny an individual a service, aid, or other benefit.
- Provide a benefit that is different or is provided in a different manner.
- Subject an individual to segregation or separate treatment.
- Restrict an individual in the enjoyment of benefits, privileges, etc.
- Treat an individual differently when determining eligibility.
- Select sites or facility locations that exclude protected individuals.

Federal Executive Order 13166

As a corporation that receives federal financial assistance, Wellpoint must comply with *Title VI of the Civil Rights Act of 1964* as well as *Executive Order 13166*, which sets forth that persons with limited English language skills have meaningful access to services.

Commitment to health equity

Health equity can be defined as the idea that everyone has a fair and just opportunity to be as healthy as possible, regardless of their circumstances. For health equity to exist, we must eliminate obstacles to health. Some of these obstacles arise because of discrimination based on race, age, disability, gender identity, sexual orientation, where someone lives or socioeconomic status.

The terms equity and equality are sometimes used interchangeably, but they are different concepts. Equality means that everyone is treated the same. Equity, however, considers each person's unique situation to ensure that everyone is operating on a level playing field. As the

saying goes, equality is giving everyone the same pair of shoes; equity is giving everyone a pair of shoes that fits. Equal does not always mean fair and right.

How do these concepts apply to health? The Robert Wood Johnson Foundation says health equity means that everyone has a fair and just opportunity to be as healthy as possible. Without it, some groups of people will — and do — unjustly experience higher rates of illness and death. Health equity hinges on factors such as race, ethnicity, gender, gender identity, religion, socioeconomic status, disability, and even where you live. Health disparities have an impact on everyone, causing higher illness and death rates and greater financial strain on communities and the nation. Individuals can only be as healthy as their communities. Our plan believes everyone deserves access to quality healthcare, clean air, stable housing, transportation, and nutritious food — access that leads to better health.

People who experience discrimination and its consequences can struggle with and lack access to stable housing, transportation, or consistent employment with fair wages. When these basic needs are not met, people are more likely to experience poor health, including chronic diseases and mental illness. Medicaid health plans for Wellpoint play a pivotal role in advancing health equity and creating a system that makes it a priority.



Wellpoint believes health equity is foundational to our business and affirms this commitment through:

- Establishing a company culture with a mission, vision, values, and strategy statements that define its importance.
- Setting corporate, national, and local improvement goals to monitor progress.
- Embedding health equity in the day-to-day operations of each leader and associate.

Wellpoint's Diversity, Equity, and Inclusion (DEI) Program

The following objectives, and associated initiatives, support our purpose, mission, strategy, and culture:

- **Diversity:** Improve representation of women and people of color in leadership:
 - Improve data transparency and leadership accountability of goals.

- Launch inclusive recruiting process (workshops, metrics, etc.).
- Increase participation in diversity sourcing events/activity at director levels.
- **Equity:** Leverage diverse perspectives to achieve business goals:
 - Continue transformation of Business Resource Groups (BRGs) to drive business impact.
 - Enable associates to deliver on health equity.
- **Inclusion:** Maintain an inclusive and trusting environment:
 - Devise and execute against strategic communications plan (Pulse, quarterly messages, newsletters, etc.).
 - Continue leading and listening sessions with updated/curated content.

Please see the *Human Resources Diversity, Equity, and Inclusion* program description for more information.

CLAS mission statement

The CLAS and *Health Disparities* program's mission is to help enhance the health status of its members by ensuring customer-focused and customer-driven services that are both culturally competent and linguistically appropriate.

Wellpoint recognizes the increasing importance of delivering culturally relevant healthcare benefits, solutions, and education that address the diverse needs of individuals and families in the communities we serve. Each health plan has an interdepartmental approach and collaboration to help ensure the implementation of culturally and linguistically appropriate healthcare related services to members with diverse health beliefs and practices, limited English proficiency, and variable literacy levels.

Our plan strives to align with the Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in health and healthcare (the national CLAS standards). Health equity is the attainment of the highest level of health for all people. Many individuals from various cultural backgrounds are unable to attain their highest level of health, and one of the most modifiable reasons is the lack of care and services that are respectful of and responsive to the cultural and linguistic needs of all. Health inequities result in disparities that directly affect the quality of life for all individuals. Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services. Wellpoint is committed to improving quality and eliminating healthcare disparities through the CLAS standards grouped by the themes below.

Principal CLAS standard

CLAS standard one: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Wellpoint believes cultural competence impacts every aspect of care and service including all medical plans and the provider network. From the broadest of operational perspectives, this plan provides senior management the direction for corporate, medical plan, and network processes as well as policies and procedures (clinical as well as administrative) to ensure their cultural relevance. Our plan also provides for the structured training of management, staff, and providers to assist in the integration of knowledge, attitudes, and skills reflective of a culturally competent organization. Therefore, identified cultural competency objectives and strategies address the total organization and network.

Theme one — governance leadership and workforce

CLAS standard two: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Program structure and accountability

At Wellpoint, promoting health equity is every associate's job. To oversee and monitor programs, goals and initiatives, a formal structure has been implemented. This section highlights committees and positions that are responsible for program implementation and success. Additional supporting resources (both corporate and local health plan) include analytics, quality, education, provider experience and relations, accreditation, survey management, and others.

Medicaid Quality Improvement Committee (QIC)

The Medicaid QIC is comprised of quality leaders and medical directors from all Medicaid health plans. This group serves as the oversight body for each plan's health equity program. It provides a forum for Wellpoint to discuss accomplishments, status around goals, barriers, and opportunities. Since the membership includes representation across all health plans, it is an excellent source for best practices, consultation, and guidance between markets.

Health Plan Quality Management Committee (QMC)

The QMC is comprised of multidisciplinary leaders. This local health plan committee provides a forum for interdepartmental participation in the quality and health equity programs. Its purpose is to review, monitor, and support implementation of the health equity strategy. Wellpoint health plans report directly to the QIC biannually.

Enrollee/member advisory committees

Each health plan has at least one active member advisory committee. It provides advice to the health plan regarding health education and outreach program development to ensure that materials and programs meet cultural competency requirements, are understandable to the membership, and address the health education needs of the membership; assist in the review, development, implementation and evaluation of member health education tools for the outreach program, review the health education plan and make recommendations on health education strategies, to provide a forum for consumers to provide guidance and recommendations to the health plan, to provide feedback on quality improvement interventions and to serve as an advocate representative to the health plan committee and other committees within the program structure, as needed.

In addition, these committees serve as a venue for member education regarding their rights and responsibilities, behavioral health, grievances and appeals process, preventive care, Healthy Rewards program, fraud, waste and abuse reporting and plan benefits, and other pertinent subjects as needed.

Membership is composed of health plan members who represent the major cultural groups served. We strive to include individuals representing the racial/ethnic and linguistic groups constituting at least five percent of eligible individuals. In addition, representatives from the following teams may be included in the membership: Health Promotion, Quality Management (QM), Member Services, and Case Management (CM). Other participants included on an ad-hoc basis are participating providers, advocacy groups, and community health educators and partners.

The health equity program obtains substantial input and participation from the community served, to ensure that it meets the needs of the population. This information and input are presented to the QMC and is utilized to improve the quality of the services provided.

Health equity director

The health equity director is responsible for planning the program structure and for the process to identify social risks, social needs, and subpopulations. In addition, the health equity director is responsible for the involvement of community members and the membership served, the process to prioritize identified social needs and risks, and application of science-based quality improvement methods to reduce health disparities. In addition, they are responsible for the health equity accreditation program.

Whole health director

The whole health director is responsible for establishing, informing, monitoring, and accomplishing the integrated whole community health strategy including all health equity efforts.

Theme two — communication and language assistance

Disparities

Health disparities are differences in health outcomes that are experienced by some groups of people and not by others. The first step to identifying and understanding where disparities exist is through population, individual member, and community assessments. Where individual member information is not available, community, state, federal data, and literature reviews may be used to supplement available member information and draw conclusions about disparities.

Population assessment — race, ethnicity, and language

When available, member self-reported data is used for both population level and member level assessments. The *834 State Enrollment* report is the primary source of self-reported data for Medicaid and CHIP products. Efforts to improve the percentage of self-reported data are underway with a goal of collecting 100% of member information. Until that goal is met, alternative sources and methods are used to develop a population assessment.

The following systems or technologies are used to estimate the characteristics of our membership:

- **Ethnic technologies (E-tech):** This system combines analysis of first names, middle names, surnames, and name rules with its proprietary Enhanced Neighborhood Analytics (ENA) system for geographic data. It predicts the ethnicity, religion, and language preference of an individual.
- **RAND Corporation:** Using its Bayesian Improved Surname and Geocoding (BISG) methodology, RAND can indirectly estimate race and ethnicity.

Additionally, language needs will be assessed based on the following thresholds, annually:

- A threshold language assessment will be conducted using *American Community Survey* (ACS) data and reports languages spoken by 5% or 1,000 eligible individuals, as outlined in NCQA's population language profile standard.
- A threshold language assessment will be conducted using ACS data and reports languages spoken by 1% or 200 eligible individuals, up to 15 languages, as outlined in NCQA's population language profile standard.

Interpreter services

In support of effective communication with health plan associates and providers, oral interpreter services are available at no cost to members 24 hours a day, seven days a week. This includes sign language interpreter support. Members are informed of the availability of and how to access interpreter services in the member handbook and member newsletter, and providers are informed via the provider manual. This member information is provided in English and Spanish. These languages consist of more than ten percent of the entire membership. The use of minors, family, and friends as interpreters is discouraged. Written or oral translation of written materials in other languages will be provided as per member request.

Members with hearing impairments can utilize the Member Services 711 TTY number during business hours, and after-hours members can use the relevant service contact number or the National Relay 711 TTY line for assistance, as identified in the member handbook.

Quality of interpreter services

Interpreter services meet quality standards established by contractual agreement and regulatory agencies. They maintain documentation supporting their quality systems and the competency of their interpreters.

Wellpoint, at a minimum, annually assesses utilization of interpreter services as well as individual and staff experiences with language services by reviewing utilization reports and member feedback.

Member materials

Wellpoint translates written materials into non-English languages at no cost to the member. In Texas, all member materials are distributed in both English and Spanish as required by our contract with HHSC. For other languages, member materials will be translated upon member request. All member documents are distributed with a Language Assistance Program (LAP) notice.

Members with hearing and/or visual impairments can request materials in alternative formats such as Braille, audio CD, and large print. Written member materials meet contractual and regulatory reading grade-level requirements to help support the cultural and linguistic diversity of the membership.

Quality of translated materials

Translation vendors meet quality standards established by contractual agreement and regulatory agencies. Such vendor contracts contain quality assurance requirements that must be adhered to. Translation vendors are required to submit an affidavit of accuracy and attest to meeting established quality standards for written materials translations.

Gender identity and sexual orientation data

Wellpoint is developing a strategy to collect our membership's gender identity and sexual orientation data by using standardized methods. This will improve the services provided and it is a part of our commitment to reduce and eventually eliminate health disparities. It will also improve health outcomes and reduce cost.

To achieve this, we are seeking to engage our members with a soft-touch outreach that will eventually lead to the disclosure of their data, once they understand how their healthcare will improve. We are striving to be culturally sensitive, as we understand that there may be various stances on this topic. Our priority is privacy, and the non-discriminatory uses of the

data. The enterprise has decided to utilize the Sydney Health app for this purpose. This app will connect members to healthcare resources. Currently, we are working on specifics on how to utilize the information.

Wellpoint has engaged PRIDE and SOMOS BRGs to help us develop the correct format to the data gathering questions. We are developing soft-touch social media as a creative way to build awareness and amplify the health plan's commitment to health equity that links to a blog or web content. Blog or web content will focus on how the member's health plan is committed to changing the face of healthcare and addressing health disparities such as emotional/substance issues among the LGBTQIA+ community. All content will be developed in English and Spanish.

Our framework for collecting gender identity of our membership includes a method that will not stigmatize those who do not identify as male or female. This includes:

- Direct collection of sex assigned at birth.
- Direct collection of gender identity.
- Direct collection of pronouns.
- Sharing pronoun information with patient and member-facing staff.

Provider network

Each health plan is dedicated to contracting with providers and other health professionals who value and are committed to serving a diverse population, and can meet the cultural, ethnic, racial, and linguistic needs demonstrated by our members. To support this effort, the health plan provides cultural competency training during orientation and on an ongoing basis in a variety of formats (webinars, online resources on the provider website, individual training as needed).

Cultural competency training for providers, including office staff, is member focused and can include:

- The importance of cultural awareness, sensitivity, and an understanding and appreciation of diversity.
- Importance of the members' beliefs about illness and health, and about traditional home remedies that may impact what the provider's treatment methodology is trying to accomplish.
- Methods and styles of communication that are effective with respect to culture, language, and literacy levels in order to support a positive interaction between the patient, providers, and office staff, as well as health plan staff.
- How to access language support services for members, and how to interact with LEP patients during in-person visits.
- How to access language assistance resources available from the health plan, including language identification cards.
- Documenting members' preferred language in the medical record.
- Maintaining request or refusal of interpreter services in the medical record.
- Discouraging the use of family and friends, particularly minors, as interpreters.
- Assisting members with filing a complaint or grievance.

Each health plan seeks to maintain a provider network that reflects the demographics of the membership and can support the needs of diverse members. The adequacy of the contracted provider networks is assessed based on member population and other variables such as member language preferences. Every year, we analyze the capacity of our network to meet

the membership language and cultural needs. If gaps are identified an action plan is developed and implemented to address the gaps.

We also maintain a provider database that includes languages spoken by providers. Information on the linguistic availability of providers is required on provider credentialing applications, and the information is entered into a database system, which is used to produce and update the provider directory. Updates to provider demographic data, including language and ethnicity, are entered into the database as received from provider offices. Members can use the provider directory to obtain information on languages spoken by provider offices, or they can contact Member Services. The health plan attempts to collect race/ethnicity data, but providers can choose not to do so.

Population, individual, and community assessments — social drivers of health (SDOH) and social risks

We understand the negative impacts of social drivers and that social risks can result in a higher incidence of preventable disease, later recognition and treatment of diseases, difficulty navigating the health system, and adhering to self-care regimens and more expensive but less effective treatment. Understanding and taking action to address social risk factors and social needs are part of the Wellpoint health equity strategy and program.

Beginning in 2020, Wellpoint launched an enterprise-wide social driver strategy and roadmap to streamline current, limited, and disparate SDOH data into the company's big data fabric to increase insights and smart design making. Developing and building a meaningful foundation requires acquiring and standardizing both internal and external social drivers' data and ensuring connectivity between various IT systems. Our goal is to deliver a tool which will provide insights and reporting capabilities to better understand populations, members and communities' characteristics and needs; understand the correlation between member and social needs and health outcomes; and monitor the effectiveness of Wellpoint programs.

Three tools have been developed and continue to be refined or enhanced:

Close to Home (public data only): This geospatial interactive map highlights food insecurity, food deserts, and other publicly available SDOH data to make it easy for stakeholders to visualize factors potentially influencing their population's health outcomes and behaviors. It was first launched at the end of 2020, surrounded by educational content, to visually highlight the prevalence of food scarcity and related data points at the ZIP code and county levels.

Member Community Atlas & Insights (public and member data): ACAI enables internal teams with an understanding of member population needs, risks, insights, and trends (both clinical and social), an understanding of community needs across American populations and a tool to benchmark and compare performance within a market and across other Wellpoint markets.

Community Connective Care (member data only): This tool uses social analytics to identify member needs and to effectively employ solutions.

SDOH Effectiveness Reporting (Find Help): This tool allows local and enterprise teams to ensure SDOH interventions are meeting member needs. This report provides data around assessments, referrals (closed loop) and program use.

Whole health strategy

At Wellpoint, our whole health strategy is grounded in a person-centered model that integrates members' physical, behavioral, pharmacy, and social needs to proactively address

the wide-ranging factors that contribute to health outcomes. Foundational to our strategy is a data-driven approach that embodies continuous quality improvement, a deliberately defined process that is designed to improve health outcomes and ensure health equity by design.

Overview

Each Medicaid health plan for Wellpoint conducted a local whole health analysis of its products to offer a snapshot of the member population (based on physical, behavioral, and social driver factors), identify health priorities aligned with local and state concerns, and include customer feedback from the member, provider, and regulator perspective. The data analysis revealed multiple key population health opportunities.

To facilitate these activities, the health plan established chronic conditions and maternal and child health workgroups. The workgroups completed an inventory of current interventions per domain, established metrics and baseline measurements, defined clear goals, brainstormed new tactics and strategies, and developed an execution plan.

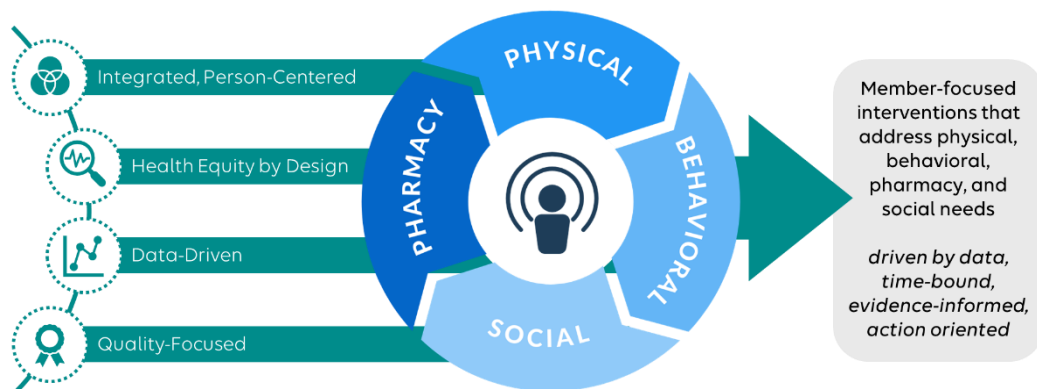
While there are clear intersections between goals and interventions and HEDIS® related efforts to impact chronic conditions and maternal and child health. This assessment allowed the team to dig deeper into disparities by race, ethnicity, language (REL), and region. It also provided an opportunity to launch innovative interventions designed to address those disparities.

Approach

Wellpoint stratifies this work through focused domains, including maternal child health, chronic conditions, behavioral health and substance use disorder, prevention and vaccines, and rural health and network. The output of this domain-based approach is a portfolio of data-driven, time-bound, evidence-informed interventions. The whole health domains support the local market work by engaging strategic partners across the enterprise to share best practices, deliver on existing capabilities, and provide subject matter expertise.

Wellpoint has created various tools to serve as the analytic foundation to whole health interventions, allowing the market to review data across demographics, geography, clinical conditions, and social needs. These tools drive highly localized population assessments, in which the markets identify areas of opportunity that guide intervention development. The interventions are measured and monitored through the tracking of key performance indicators (KPIs), that are stratified by age, race/ethnicity, and gender.

A shared ownership of the whole health approach shapes the local strategy with each functional area contributing to improve social, physical, pharmacy, and behavioral outcomes. Additionally, a local whole health director facilitates the whole health plan, and a health equity director ensures interventions include a lens that addresses disparities considering race, language, geography, sexual orientation, or identity. The model aligns existing work to drive efficiency, identify synergies, and deliver innovative, personalized solutions determined by the priorities of each unique market.



Theme three — engagement, continuous improvement, and accountability

Program goals

Broadly, whole health efforts aim to identify the trends, successes, gaps, and disparities among its target population with the goal of ensuring access to quality care and improved health outcomes. Applying the disparity lens ensures that disparities are analyzed beyond REL and region, a frequent practice for our health plan, to include as much data as possible on the social, cultural, environmental, and systemic factors impacting members.

The health plan's health equity director and whole health director, in collaboration with other key departments and community input, annually identifies opportunities for improvement of CLAS and reduction of health disparities. This is accomplished through committee meetings, workgroups, and community advisory committee meetings. Members of the community represent a critical component of the goal identification process, as the health plan ensures CLAS and health disparities needs are communicated during community advisory committee meetings.

Upon identification of the annual CLAS improvement and health disparities reduction goals, appropriate and necessary activities are incorporated into the QM work plan. Such activities are monitored by the health plan committee and QIC.

Evaluating program effectiveness

Whole health efforts are supported by corporate partners and are led locally by the whole health director and health equity director. A steering committee has been established to oversee strategy and initiatives. As needed, workgroups dedicated to each domain have been, and will be, established to work through data analysis and intervention planning with all relevant team members. Data will be tracked quarterly to monitor progress towards goals.

Case management

To meet the needs of our members, our case management program addresses both short-term and long-term member needs. By addressing the member's unique needs, the program aims to improve present and potential physical and behavioral health outcomes. Case management services may include a combination of telephonic and field-based services delivered by a multidisciplinary team to ensure medical, behavioral, and social service needs are defined and addressed in a personalized care plan.

Non-clinical factors that can impact a member's health include but are not limited to socioeconomic conditions, housing, food insecurity, education, social support, and access to healthcare.

This Operating Procedure Guideline (OPG) guides the process for identifying, assessing, managing, and implementing interventions for members with social drivers of health (SDOH) needs within Physical Health Case Management in the current case management documentation system.

Community partnerships

Health plans have multiple collaborative relationships with community partners that help solidify its role as **The Local Plan**. Partnerships can be initiated by either the health plan or a community-based organization (CBO)/faith-based organization (FBO). Any collaboration must align with community and whole health goals, state/government priorities, business landscape, geographical areas, and focus areas that address health disparities and racial justice.

There are different types of collaborations, partnerships, and relationships. They can be grouped into the following main categories:

Sponsorship: A transaction between the health plan and an entity in which financial or non-financial consideration is exchanged in return for a measurable marketing benefit to the health plan or any of its health plan subsidiaries, such as advertising, signage, or event participation. Sponsorships can include, but are not limited to, CBOs, FBOs, federally qualified health centers (FQHCs), local/statewide/national conferences, coalitions, schools, government agencies, etc.

Grant agreement: A document drafted and maintained by the health plan's legal department which constitutes a mutual acknowledgement between the health plan and a not-for profit corporation or grantee providing a *W-9* negotiated into an agreement. The grant agreement provides project details and expected use of funds, a program summary explaining the terms of the agreement, services provided by the grantee, expected outcomes of the program and any additional services.

Foundation grant: As the philanthropic arm, the Foundation promotes the organization's commitment to improving lives and communities by addressing health equity and focusing on improving the health of the socially vulnerable through strategic partnerships and programs within our communities.

Data driven partnerships: Health plans have numerous relationships with organizations that are based on identification of shared priorities, similar target populations, and an expectation for improved outcomes through collaborative efforts. These partnerships are not identical in structure but all aim to impact key population health and health equity priorities. Most partnerships in this category include the development of a contract or Memorandum of Understanding (MOU) with various levels of data sharing and expectations around performance measures.

Community resources

Find Help is one of the community resources used to link our members to a variety of services. One of the many benefits of this resource is that the referral source, which could be a case manager (CM), is able to track the referral. The community organization is also able to track the referral status. This means that both the health plan and the community organization will

be able to tell whether the member received the help, was ineligible or did not respond. This allows the case manager to complete the cycle.

Anytime that a member is connected to a program or resource this will be shared via email or text, the member would be able to apply on the program's website and obtain a direct referral to the program. The case manager can actively connect a member to a program via email or text, complete an external application, call the program's phone number, and log a referral and print the program's information.

When a referral has been submitted, the member will receive an email or text with information about the program and next steps. The company providing the program will also receive an email with the contact information of the member and be able to see the referral on their referral dashboard. The case manager will see the referral (and all updates) on the People I'm Helping dashboard in the Community Resource Link. This process allows for prompt and secure access to community resources.

Targeted OB case managers also refer to My Advocate after identification of high-risk members and ensures hands on support throughout pregnancy. My Advocate is an interactive communication platform educating pregnant members on the importance of prenatal, postpartum, and newborn follow-up visits and care.

The Event Notification System (ENS) provides pregnancy alerts to improve early identification of pregnancy complications. Alerts are reviewed daily by CMs to ensure members are outreached to and their needs assessed.

Health equity annual evaluation

Reducing health disparities requires systematic change that is targeted to the needs of individual members. At least annually, the health plan evaluates data on the race, ethnicity, primary language, social needs, and social risks of the member population. This analysis builds the foundation for understanding and reducing disparities. Data analysis, including root cause and barrier analysis, is conducted to identify areas of greatest need, allowing the health plan to address disparities within the population and improve care for all members. Cultural competency training and materials function as the foundation to improve care.

In addition to goal and measurement identification, our plan, in collaboration with other key departments, establishes an annual written evaluation of health equity goals and measurements. The annual evaluation includes:

- A description of completed and ongoing activities for disparities reduction.
- Trending of measures to assess performance.
- Analysis of results and initiatives, including barrier analysis.
- Evaluation of overall effectiveness of the program and of the interventions to address health equity.

Annually, the health plan utilizes the results of the healthcare disparities and language analysis to:

- Identify and prioritize opportunities to reduce healthcare disparities.
- Identify and prioritize opportunities to improve CLAS.
- Implement at least one intervention to address a disparity.
- Implement at least one intervention to improve CLAS.
- Evaluate the effectiveness of an intervention to reduce a disparity.
- Evaluate the effectiveness of an intervention to improve CLAS.

Throughout the year, information about or aspects of the health equity program are shared with associates, members, and community representatives to obtain their interpretation and feedback.

Health equity work plan

The work plan is based on the annual evaluation findings. It is developed annually and reviewed consistently, at least quarterly. It contains a list of measurable goals for the improvement of CLAS and the reduction of healthcare disparities. Its purpose is to monitor the progress made on the goals and document and follow up in any new opportunity identified.

The work plan addresses the following:

- Network cultural responsiveness
- Language services
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the CLAS program

Monitoring against the goals includes the measures that will be collected, frequency of monitoring and staff responsible for monitoring report review and sign off. The work plan, the annual evaluation and the program description are approved by the Corporate Quality Improvement Committee.