2024

COMMUNITY HEALTH PLAN OF WASHINGTON'S

Health Disparities Report

COMMUNITY HEALTH PLAN
of Washington™

The power of community

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Land Acknowledgement

As Washington residents, our daily lives take place on the lands of Indigenous people. They cared for this land for thousands of years before it was stolen from them. Yet Washington's Indigenous people survive and thrive today and are a model of courage, resilience, and community.

We recognize that CHPW's headquarters in Seattle is on the traditional lands of the Coast Salish People. The Treaty of Point Elliott covers Seattle, signed under duress in 1855 before Washington was a state.

We further acknowledge that the treaties signed by tribal leaders almost 200 years ago include the promise of health care. Therefore, CHPW's work is not only a service but a responsibility.

We pledge to support our American Indian and Alaska Native neighbors as we work together toward healthy communities and uphold tribal sovereignty.

Special thanks to the following CHPW staff members who collected, analyzed, and/or prepared this report:

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About the Health Disparities Report

This Health Disparities Report is designed to provide an ongoing guide for Community Health Plan of Washington's quality and related strategies to improve the health outcomes for our members by looking at our progress across eight key health measures. We use the data in this report to identify gaps and opportunities in care delivery with our providers and community partners in our quest to help each member achieve their best health and well-being.

We acknowledge that our ability to identify disparities is limited by the scope of the data available to us. As you read this report, we ask you to consider the following:

- **These disparities are only part of the story.** Documented and researched disparities exist in almost every health care service, treatment, and outcome. Our report reflects key domains but may be missing disparities within these areas of care. For example, our report highlights disparities in accessing care for prenatal services while other disparities in care exist within birthing outcomes.
- **The data categories are broad and may hide disparities.** Racial and ethnic data collection and reporting is not perfect, and many times individuals do not see themselves within the available options. Disparities may not be evident from looking at the broad categories. For example, in the Asian category you have people with origins in Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

This report should encourage readers to further investigate disparities in care by looking at other local, state, and national data. CHPW is committed to continuing to create a more inclusive disparities analysis program and sharing data broadly with our communities.

About CHPW

Our Equity Framework

CHPW's overarching goal of "advancing health equity and whole-person care" is the umbrella under which all of our work lives, including addressing the disparities identified in this report.

Four objectives guide us towards the goal:

1. **Apply an equity lens to all our work**
2. **Reduce health disparities**
3. **Become an anti-racist organization**
4. **Create an equitable work environment**

We champion whole-person care that includes medical, behavioral, and oral health as well as the social drivers of health, described on page 8, as key to improving outcomes and reducing health disparities.

In 1992 a network of Community and Migrant Health Centers in Washington State formally established the Community Health Network of Washington (CHNW) and its subsidiary Community Health Plan of Washington (CHPW), a community-governed, not-for-profit health plan, to provide access to quality care for people — particularly those from marginalized communities — serve more than 300,000 Washingtonians through Medicaid, and Medicare Advantage, and Individual & Family (Cascade Select) Plans, across Washington. CHNW provides care to nearly 1 million individuals across the state through its federally qualified member Community Health Centers. CHPW supports our members and the communities we serve, our colleagues, and those we partner with, by giving each person what they need to thrive as we pursue fair systems and practices for all.

Advancing Health Equity is Core to CHNW/CHPW's Mission

Through our work together and with partners across the state of Washington, CHPW/CHNW strives to be a leader in creating positive, systemic change that improves the lives of our members and the communities we serve. Ensuring that all people – regardless of race, ethnicity, immigrant status, disability, age, gender orientation, or income – have an equitable opportunity to achieve their best health and well-being is central to who we are and why we were founded more than 30 years ago. We look at drivers of health in the broadest sense, with an integrated view of physical, behavioral, and oral health alongside environmental and social conditions and supports to seek better health outcomes for members individually and for populations experiencing health disparities more generally.

In order for us to advance strategies to mitigate such disparities, staff across the Enterprise have been reviewing member data collected annually since 2017 and creating interventions to address disparities and provide more culturally-responsive care. In 2022, we published the inaugural Health Disparities Report that offered a snapshot of data collected across eight key health measures. We're using these to consider how we can help achieve more equitable health outcomes for specific populations and as indicators for improved outcomes more universally.

Now, we are providing our second Health Disparities Report, highlighting the data across the same eight measures, as well as our key initiatives and collaborations in pursuit of our ultimate goal – reducing and eliminating disparate health outcomes for member groups identified. While the data itself has not changed dramatically in just a year, the report provides a way to hold ourselves accountable for focused and intentional engagement with our internal teams and external partners that equitably meets member needs.

There's no singular path to achieving health equity for all, but our milestones represent the hard work and dedication we've put forth to better serve our members and communities. The information provided in this report is an important step in beginning to understand the disparate needs of our members and patients, but we acknowledge that the intersectionality and complexity of their lives will continue to inform how we develop our work. For example, the effects of the COVID-19 pandemic that have disproportionally affected historically marginalized communities will have long-lasting consequences , even as our efforts to date have mitigated some of those harms. As we increase our understanding of our members' perspectives and life experiences, we can more intentionally focus our efforts on reducing health disparities such as those identified in this report.

Here are just a few highlights of our work you can read more about in this Health Disparities Report:

- CHPW welcomed its first Chief Equity Officer, Kelli Houston, who has provided additional leadership for our efforts to become an anti-racist organization.
- CHPW received the National Committee for Quality Assurance's (NCQA) Health Equity Accreditation.
- We completed our third year collaborating with our network of Community Health Centers to identify and address specific barriers to care through innovative programs and payment structures.
- Launched Member Advisory Councils to hear directly from our members about their experiences, needs, and recommendations for improving their experiences and access to care.
- We have convened regional care teams, comprised of clinical and non-clinical Plan staff in local communities throughout Washington, to focus on issues and solutions contributing to health disparities through engagement with community partners.

A new Health Disparities Report will be released every three years to track our progress in closing gaps in health outcomes and implementing better supports. While there always will be more work to be done to ensure all people have an equitable opportunity to live their healthiest lives, our commitment to health equity will continue to be a driving force behind the work we do to welcome, support, and inspire our members and patients on their path to their best health.

Sincerely,

Leanne Berge, Esq.
Chief Executive Officer

CHPW Milestones

COMMITTING TO HEALTH EQUITY

CHPW Equity in Action

Health Equity Accreditation
LEARN MORE

National Learning Collaborative
LEARN MORE

Achieving NCQA's Health Equity Accreditation

In August of 2023, CHPW officially received the National Committee for Quality Assurance's Health Equity Accreditation. **Health Equity Accreditation gives health care organizations an actionable framework for improving health equity.** CHPW has used these standards to guide our efforts.

The journey to becoming an anti-racist organization

The goal of becoming an anti-racist organization recognizes that to advance **health equity**, we must be able to recognize the systems, processes, and policies that prevent equity and then actively work to change them. CHPW acknowledges that racial injustice is the most pervasive and entrenched form of injustice that permeates the institutions and structures all individuals must access in our society – including health care. Racism is a root cause of widespread health inequities and disparities. We cannot create and strive for an equitable and healthy society without integrating organizational anti-racist practices within our work.

In 2023, CHPW's DEI team, led by our Chief Equity Officer, put this work into practice with the following accomplishments:

- ✓ Hosting a Town Hall Series with anti-racism experts to equip our staff and leaders with a better understanding of anti-racism.
- ✓ Creation of CHPW's Becoming an Anti-Racist Organization Toolkit to provide accessible tools and best practices for individuals, departments, and leaders to use.

No equity without tribal sovereignty

Central to our health equity efforts is our commitment to **tribal sovereignty**. CHPW's Tribal Affairs Administrator supports CHPW in respecting and understanding our unique responsibility to our American Indian and Alaska Native (AIAN) members. We acknowledge tribal providers as the best health care decision-makers for their communities and members and do not require tribal providers to contract in order to act as an in-network provider. We remove other operational barriers to care to ensure that AIAN members can access Tribal Residential Treatment facilities and receive culturally appropriate care.

Amplifying the voice of the community and our members

To support all **health equity** efforts, CHPW recognizes that we must ensure the voices of our members and communities are amplified. In 2019, we started working with the Center to Advance Consumer Partnership to develop a program to partner with our members. In 2023, we launched our newly designed Member Advisory Council (MAC) program. The MACs were designed to ensure equity is at the center of our engagement activities with members and to create an authentic partnership in advancing health equity for all. Through this program, CHPW looks forward to member partnership in helping us design programs, policies, and initiatives to address the inequities in their communities.

Health Equity: Everyone has a fair and just opportunity to be as healthy as possible and no one is disadvantaged from achieving this due to their social position or circumstances.

Tribal Sovereignty: Includes the right to govern one's community, the ability to preserve one's culture, and the right to control one's own economy.

SOCIAL DRIVERS

Driving Systemic Change

St. Leo Food Bank of Tacoma

Pallets of food were donated along with supplies and delivered to those experiencing housing insecurity.

CHC Tacoma

Collaborated with Community Health Care Tacoma to serve a large encampment in downtown Tacoma.

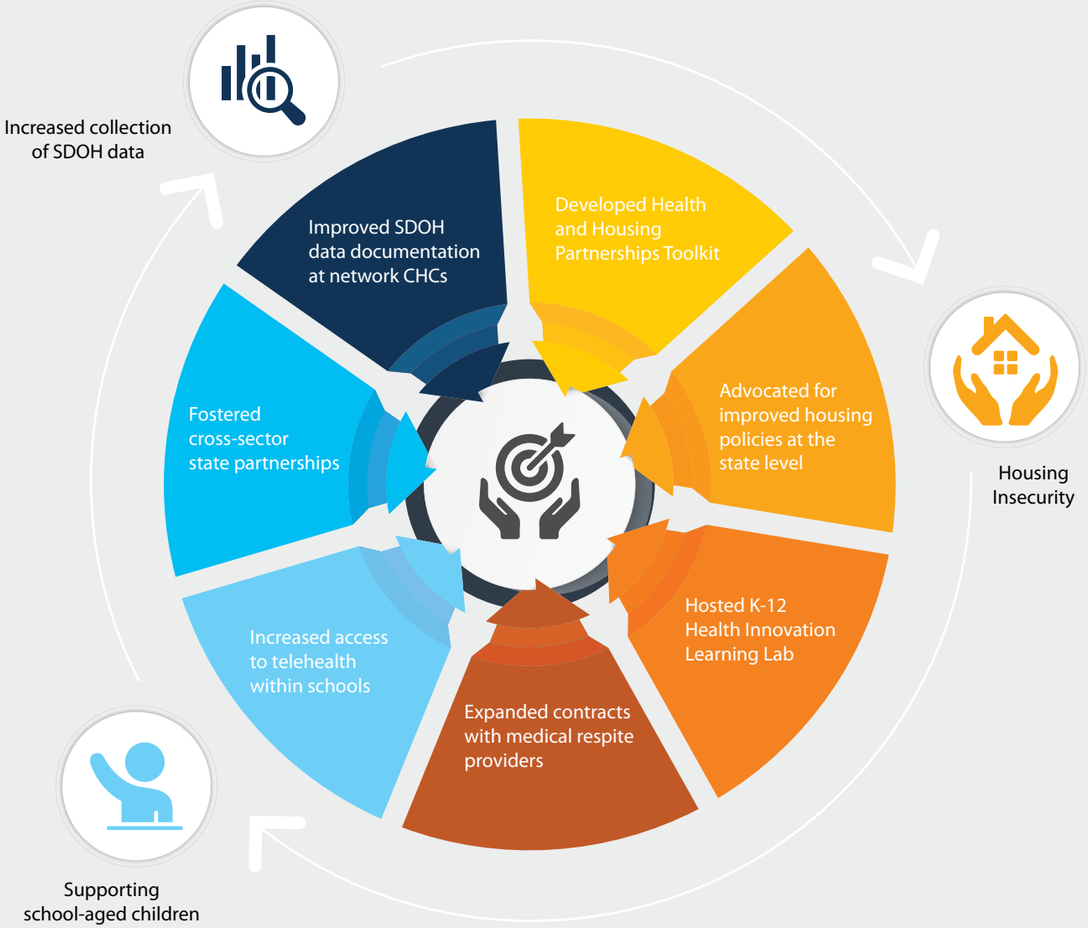
CHPW's goal to provide whole-person care includes the recognition that health care is heavily impacted by the **social drivers (determinants) of health (SDOH)** and our individual **social needs**. Addressing health equity includes addressing both social drivers and social needs. CHPW's SDOH Strategy has identified three main priorities: housing insecurity, opportunities to support school-aged children, and increased collection of SDOH data. CHPW has been leading efforts to increase SDOH data collection in partnership with our Community Health Center network.

Central to addressing SDOH is investing in community partnerships with organizations that were created to address social needs. The Advancing Equity Fund, created in 2020, supports community-based organizations providing care and support systems for people from communities of color, Indigenous and Native communities, as well as immigrants and refugees, and those experiencing the greatest barriers to their best health and well-being. With this year's recipients, CHPW has provided a total of $980,000 to 68 community-based organizations across Washington state since 2020.

SDOH: Social drivers of health are broader factors influencing health, encompassing social, economic, and environmental conditions impacting overall well-being such as income inequality, education, and access to health care.

Social Needs: Social needs refer to the necessities individuals require for a healthy life, like housing, food, and transportation.

Key Accomplishments of CHPW's SDOH Strategy



7.69%
of CHPW members report that they are experiencing housing insecurity.

2.33%
are migrant farmworkers.

CHPW MEMBERSHIP

Demographic Profile

Total CHPW enrollment at the time of analysis was

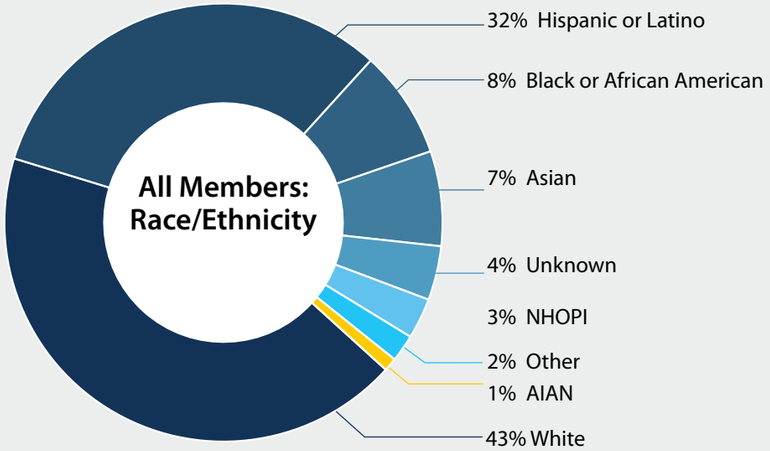
313,846

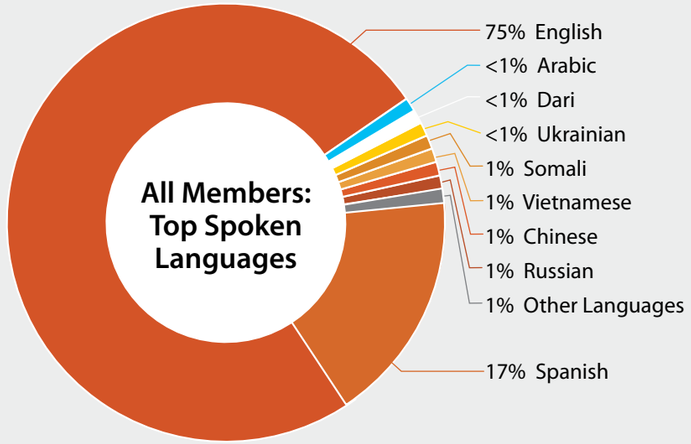
CHPW monitors the **race**, **ethnicity**, and language data of our members as part of our annual demographic analysis. This data allows us to track trends and changes and ensure we are providing culturally-responsive care.

We pay special attention to language data to ensure our members have access to language assistance services if they prefer to communicate in a language other than English. CHPW's top languages include English, Spanish, Vietnamese, Chinese, Russian, Somali, and Arabic.

There are many additional diversity dimensions that shape our identity and experience with health care. Diversity dimensions include personal identity factors such as race, ethnicity, language, age, **gender identity**, **sexual orientation**, and ability status in addition to many others. CHPW is actively working on increasing the diversity data that we have in order to support our understanding of our members and identify health inequities.

Race, Ethnicity and Language Data





Note: American Indian and Alaska Native is noted as AIAN and Native Hawaiian and Other Pacific Islander is noted as NHOPI throughout this report.

In 2023, CHPW Medicaid members reported speaking 102 different languages.

Race/ethnicity categories are not perfect – people may not identify with the categories available.

Race: A social construct that artificially divides people into distinct groups based on characteristics such as physical appearance, ancestral heritage, cultural affiliation, cultural history, ethnic classification, and the social, economic, and political needs of a society at a given period of time.

Ethnicity: Ethnicity is an indicator that separates people into social groups based on national heritage, values, traditions, language, political and economic interests, history, and ancestral origins.

Gender Identity: Distinct from the term "sexual orientation," refers to a person's internal sense of being male, female, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others.

Sexual Orientation: An individual's enduring physical, romantic and/or emotional attraction to another person. Gender identity and sexual orientation are not the same. Transgender people may be straight, lesbian, gay, or bisexual.

EQUITY DATA

Expanding Our Understanding

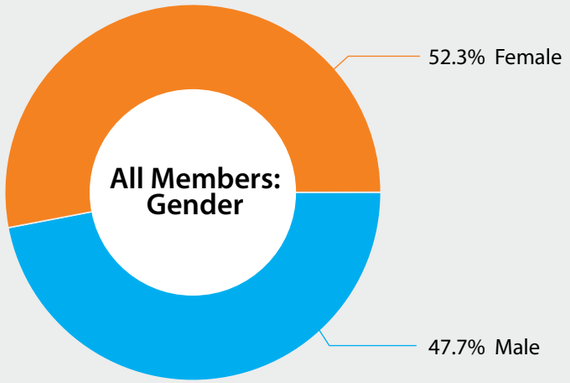
Inclusive data sets can improve our ability to understand disparities and address them.

CHPW understands that all diversity dimensions play a role in health care delivery and inequities in care. Since 2018, CHPW has been actively working on improving the data we have and its use in our health disparities analysis. While this report continues to only review its disparities by race, ethnicity, and language, CHPW has been actively working to collect sexual orientation, gender identity, and ability status. We hope in future iterations of this report we can utilize this data to better understand opportunities to advance health equity.

In 2021, CHPW began collecting member sexual orientation and gender identity data. These questions are new for many people in the health care setting and require thoughtful consideration. CHPW created training, updated policies and procedures, and continues to develop supportive resources to ensure we are a safe space for this data to be shared. Today, our report includes only the binary data categories of male and female, but we aim to have an inclusive understanding of our members' gender in future reports.

Ability status at CHPW has been historically limited to medical diagnosis of disabilities such as being deaf, blind, or hard of hearing. Using the Six Functional Limitation categories (see graph on page 13), we set out to have a more broadened understanding of the needs of our membership. Functional Limitation includes questions about cognition, mobility, self-care (such as dressing and bathing), and whether members can live independently.

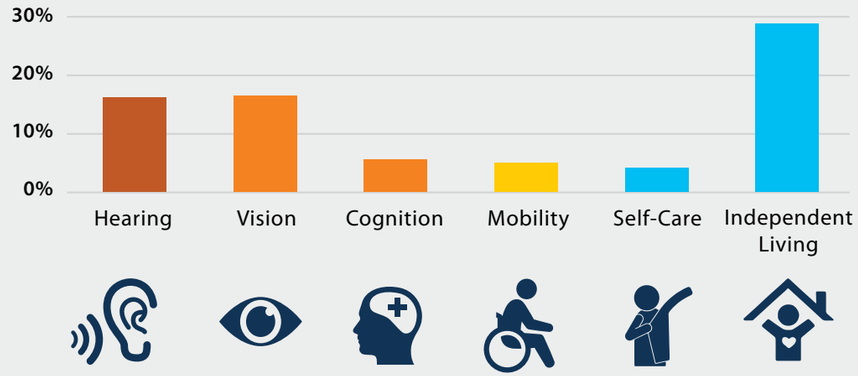
Gender and Disability Data



What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Neither exclusively male nor female (e.g. non-binary or nonconforming)
- ☐ Other:
- ☐ Decline to answer

Percentage of Members with a Functional Limitation



Note: These six categories represent the American Community Survey Functional Limitation categories. This represents self-reported data from members on their own functional limitations and where they may need support.

DISPARITIES OVERVIEW

Identifying Data Disparities

We've identified areas of opportunity and embarked on many improvement projects to close these gaps in care.

Health disparity refers to a difference in health outcomes between groups within a population. Health disparities stem from social, economic, or environmental disadvantages that exist in our society, which include many of the social drivers of health previously mentioned. The good news about health disparities is that many are preventable and with some intentional effort, we can begin to reduce them.

We use data to show us where disparities in health care are occurring. CHPW has been breaking out quality metrics by race, ethnicity, language, and line of business since 2017. Through this practice, we've identified areas of opportunity and embarked on many improvement projects to close these gaps in care. These projects include everything from translating member materials into new languages, developing new policies, and creating brand-new programs.

Health Disparity: The difference in health outcomes between groups within a population that is closely linked with social, economic, and/or environmental disadvantages.

CHPW's 8 Health Equity Priority Measures

This report focuses on CHPW's 8 Health Equity Priority Measures. While all health outcomes are important, we have chosen to align with national, state, and community health priorities. We hope that by addressing the disparities that exist in these measures, we'll start to impact all disparities.

1. **PPC: Prenatal and Postpartum Care (PPC)**
2. **WCV: Well-Child Visits (3-11 years)**
3. **BCS: Breast Cancer Screening**
4. **CHL: Chlamydia Screening in Women**
5. **COL: Colorectal Cancer Screening**
6. **HBD: Diabetes: HbA1c Poor Control**
7. **CBP: Controlling High Blood Pressure**
8. **FUH: Follow-Up After Hospitalization for Mental Illness 30-Day Follow-Up Age 6-17 and Age 18- 64 (New)**

Much of the data presented in this report was collected during the COVID-19 pandemic. COVID has had a significant impact on all health outcomes and early data shows it has increased many disparities. CHPW will continue to monitor disparities and acknowledge the impact of the COVID-19 pandemic.

Data Methodology

CHPW looks for race/ethnicity and language disparities that are greater than five percentage points different from our CHPW average and involve groups of more than 30 individuals. For HEDIS© measures, measurement includes data from 2020 — 2022.

Healthcare Effectiveness Data and Information Set (HEDIS)® is a set of standardized performance measures widely used by U.S. health plans to compare performance across domains of care and service. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

MATERNAL & CHILD HEALTH

Important Early Connections to Health Care

PRIORITY MEASURES

- **Prenatal and Postpartum Care**
- **Well-Child Visits (3-11 years)**

Prenatal and postpartum care visits are important to provide crucial support for new parents who are navigating major life changes and healing from their delivery. The postpartum visit is an opportunity to check in and connect members to needed services.

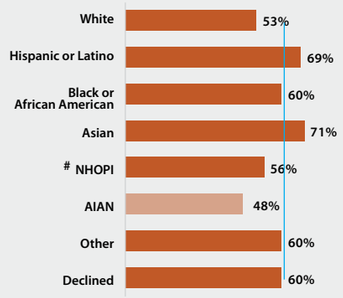
The early years of a child's life are a critical time to build healthy habits and establish early connections with the health care system. School-aged children are encouraged to receive well-child visits that incorporate developmental screenings and health education. These visits also include an important vaccine schedule that prevents illness and disease. CHPW currently has the following programs to support these efforts:

- CHPW's "Healthy You, Healthy Baby" maternal and child health program includes education, personalized goal setting, connection with local resources, and a free breast pump with education about feeding.
- CHPW is partnering with state and national leaders on increasing access to doulas and midwifery services for Medicaid enrollees.
  LEARN MORE
- Children up to 11 years of age receive birthday cards that encourage annual well-child visits and provide an incentive. These birthday cards are currently sent in English, Spanish, Chinese, Russian, Vietnamese, Somali, Arabic, Dari, and Ukrainian based on the member's preferred language.
  LEARN MORE

Prenatal and postpartum care: A prenatal visit is one that occurs within the first trimester. Several other visits are planned throughout the pregnancy to monitor the baby and birthing individual's health. A postpartum visit occurs between 7 and 84 days after delivery.

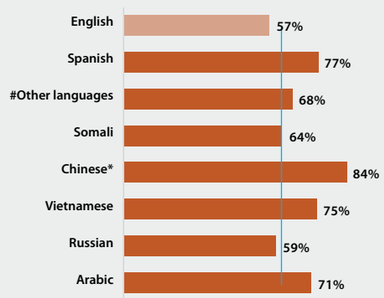
Medicaid members who are AIAN are less likely to receive a postpartum visit after delivery

Postpartum Care by Race/Ethnicity



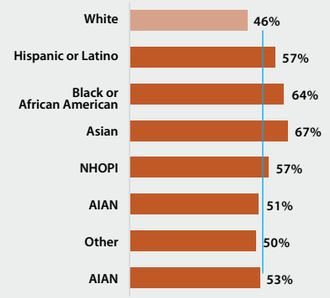
Medicaid members who speak English are less likely to receive a postpartum visit after delivery

Postpartum Care by Language



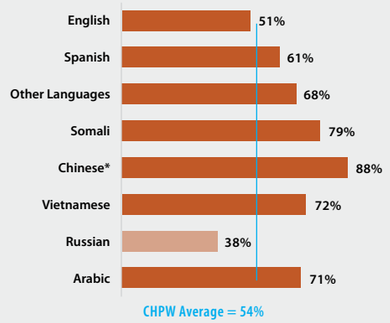
Medicaid members who are White are less likely to receive timely prenatal care

Timeliness of Prenatal Care by Race/Ethnicity



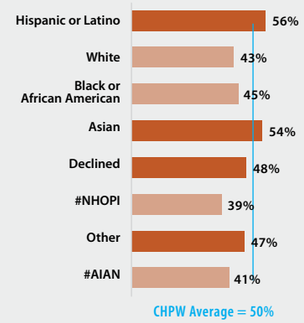
Medicaid members who speak Russian are less likely to receive timely prenatal care

Timeliness of Prenatal Care by Language



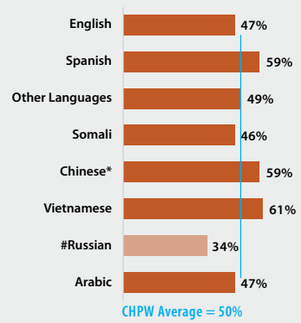
Medicaid members who are White, Black or African American, NHOPI, and AIAN are less likely to receive an annual well-child visit

Child and Adolescent Well-Care Visits (Age 3-11) by Race/Ethnicity



Medicaid members who speak Russian are less likely to receive an annual well-child visit

Child and Adolescent Well-Care Visits (Age 3-11) by Language



80%
of pregnancy-related deaths in Washington are preventable.
LEARN MORE

11%
of birthing individuals in Washington, report symptoms of postpartum depression and it is expected many more experience it.
LEARN MORE

Graphs Key
- Medicaid
- Medicaid–>5% Disparity

AIAN: American Indian and Alaska Native

Declined: Declined to Provide a Race/Ethnicity

NHOPI: Native Hawaiian and Other Pacific Islander

*Chinese Language includes Cantonese, Chiu Chow, Mandarin and Toishanese dialects.

PREVENTIVE SCREENINGS

Prevention Is Key

PRIORITY MEASURES

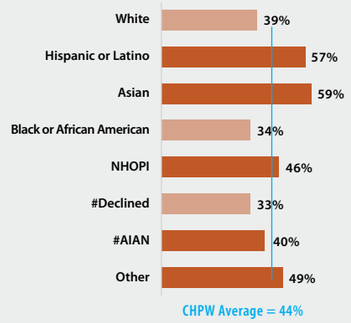
- **Breast Cancer**
- **Chlamydia**
- **Colorectal Cancer**

Every year, we recommend our members visit their primary care provider. Annual visits provide an opportunity to get preventive health screenings. Early preventive screening helps to catch and treat diseases in their early stages. We continue to see disparities by race and language in adult preventive care measures nationally, and within our population at CHPW. Several CHPW programs currently support reducing these disparities:

- CHPW's educational outreach campaign targets members with a gap in care for Breast Cancer Screening. We partner with a mobile mammography vendor and host events in the community in collaboration with the CHCs. Our Breast Cancer Screening Rewards Program incentivizes members with a $25 reward.
- CHPW's educational text outreach campaign targets members with a gap in care for Chlamydia Screening. These text messages are sent in the top languages spoken by members.
- CHPW's in-home colorectal cancer screening program, FITCHEK, sends members at-home test kit packages. CHPW incentivizes members to complete and return kits using a $15 gift card. Results are sent to both the members and their providers.

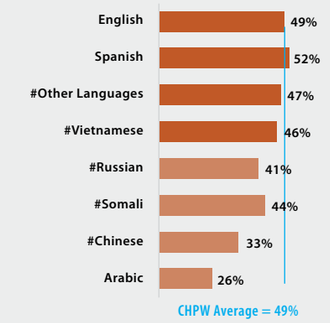
Medicaid members who are White, Black or African American, or Declined are less likely to receive Breast Cancer Screening

Medicaid Breast Cancer Screening by Race/Ethnicity



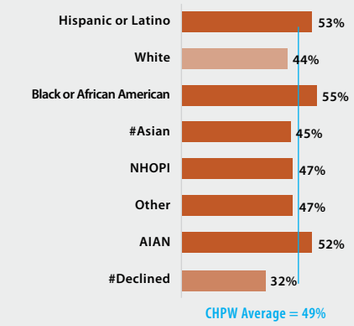
Medicaid members who speak Russian, Somali, Chinese, and Arabic are less likely to receive Chlamydia Screening

Chlamydia Screening in Women by Language



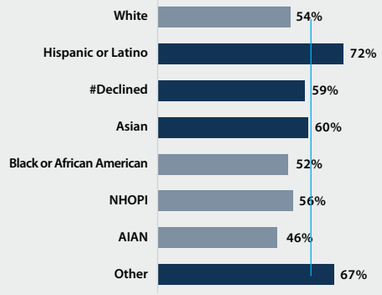
Medicaid members who are White or Declined are less likely to receive Chlamydia Screening

Chlamydia Screening in Women by Race/Ethnicity



Medicare members who are White, Black or African American, NHOPI and AIAN are less likely to receive Breast Cancer Screening

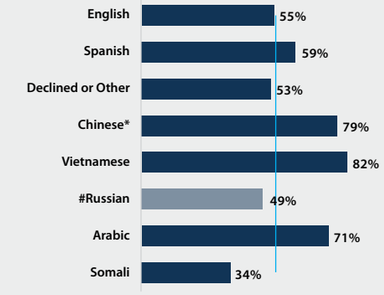
Medicare Breast Cancer Screening by Race/Ethnicity



Medicare members who speak Russian are less likely to receive Colorectal Cancer screening

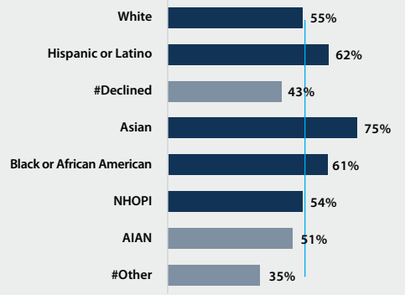
Somali has too small of a denominator to draw conclusions

Colorectal Cancer Screening by Language



Medicare members who are Declined, AIAN, or Other are less likely to receive Colorectal Cancer Screening

Colorectal Cancer Screening by Race/Ethnicity



26%

Breast cancer screening every two years has been shown to reduce breast cancer deaths by at least 26%.

LEARN MORE

1.5 M

There are more than 1.5 million colorectal cancer survivors in the United States, thanks to screening and treatment.

LEARN MORE

Graphs Key

- Medicaid
- Medicaid–>5% Disparity
- Medicare
- Medicare –>5% Disparity

AIAN: American Indian and Alaska Native

Declined: Declined to Provide a Race/Ethnicity

*Chinese Language includes Cantonese, Chiu Chow, Mandarin and Toishanese dialects.

Other: Members from Other Racial/Ethnic Groups

DIABETES & BLOOD PRESSURE

Managing Health Conditions

PRIORITY MEASURES

- **Diabetes Care**
- **High Blood Pressure**

Maintaining a healthy blood pressure is important to preventing future illness. High blood pressure is linked to heart disease, stroke, kidney failure, and other serious conditions. Controlling high blood pressure can reduce the risk of these complications by over 50% and ensure members live longer, healthier lives.

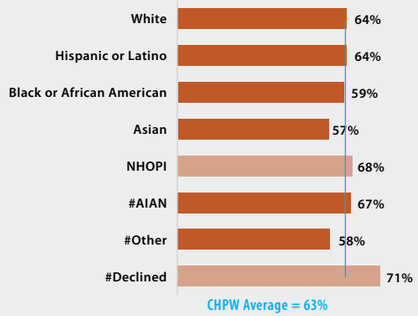
Diabetes is a chronic health condition that affects over 30% of Americans. Diabetes can cause serious health problems and damage vital organs. CHPW is committed to helping members better manage their diabetes and therefore prevent future health problems. Several CHPW clinical and nonclinical staff programs currently exist to support these efforts:

- Regional Care Teams are creating culturally and linguistically appropriate programs to improve diabetes care in communities with the highest rates in their area of the state, which include Spanish speakers and AIAN members.
- CHCs have used CHPW funding to create programs aimed at improving diabetes care for their members.
- CHPW Health Coaches outreach members who are pre-diabetic, share educational materials on diabetes, and work to ensure members receive a HbA1c test annually.

Poor HbA1c control: A hemoglobin A1c (HbA1c) test is a blood test that shows your average blood sugar levels over the past 2-3 months. An HbA1c level greater than 9.0% indicates poor control of diabetes.

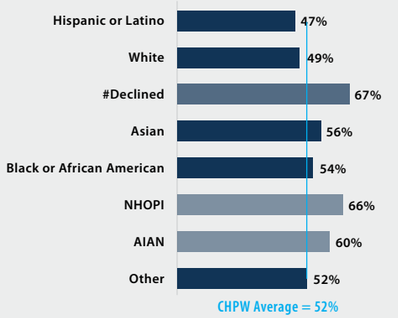
Medicaid members who are NHOPI or Declined are more likely to have poor HbA1c control

Medicaid CDC HbA1c Poor Control by Race/Ethnicity (Lower rate is better)



Medicare members who are Declined NHOPI, or AIAN, or are more likely to have poor HbA1c control

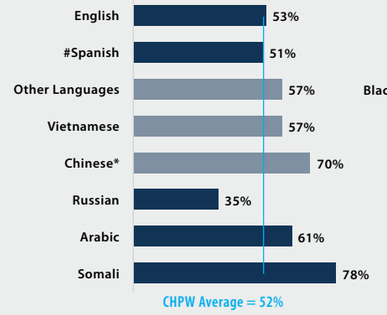
Medicare CDC HbA1c Poor Control by Race/Ethnicity (Lower rate is better)



Medicare members who speak Other, Vietnamese, or Chinese or are more likely to have poor HbA1c control

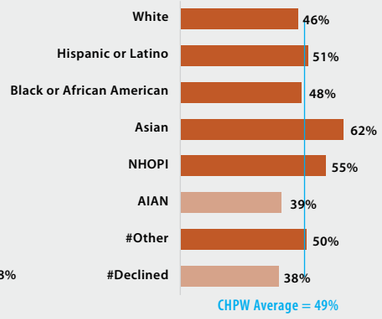
Conclusions cannot be made for Arabic and Somali due to small denominators

Medicare CDC HbA1c Poor Control by Language (Lower rate is better)



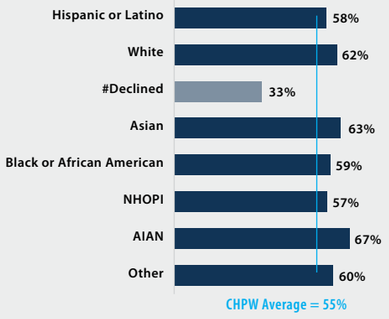
Medicaid members who are Declined or AIAN are less likely to have controlled high blood pressure

Medicaid Controlling High Blood Pressure by Race/Ethnicity



Medicare members who Declined are less likely to have controlled high blood pressure

Controlling High Blood Pressure by Race/Ethnicity



1 in 4

Washington adults have been told by a health care professional that they have high blood pressure.

LEARN MORE

40%

Keeping diabetes under control can lower risk of diabetes complications by 40%.

LEARN MORE

Graphs Key

- Medicaid
- Medicaid–>5% Disparity
- Medicare
- Medicare –>5% Disparity

AIAN: American Indian and Alaska Native

Declined: Declined to Provide a Race/Ethnicity

*Chinese Language includes Cantonese, Chiu Chow, Mandarin and Toishanese dialects.

Other: Members from Other Racial/Ethnic Groups

BEHAVIORAL HEALTH

Mental Health Access

PRIORITY MEASURES

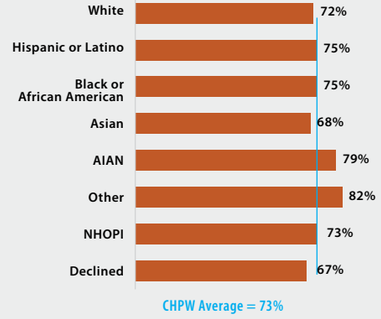
- **Follow Up after Hospitalization**

Behavioral Health in Washington State, like in many parts of the United States, is a critical issue that affects a significant portion of the population. In 2021, it was estimated that over 57.8 million adults in the U.S. were living with mental health issues. CHPW is committed to supporting and increasing access to services for those living with a mental illness. Several programs currently exist to support these efforts:

- CHPW collaborates with the Managed Care Organizations (MCOs) across Washington State, the Health Care Authority, and the Department of Health to focus on connecting those in need of mental health services with available services. This work specifically focuses on children and youth from Black, Indigenous, and People of Color (BIPOC) communities to improve systems of care, including providers (clinician bias), interpretation services, and access to clinicians and providers of color.
- CHPW prioritizes virtual care services, partnering with organizations like Charlie Health and Boulder Care to offer mental health support, including substance use treatment.
- CHPW partners with WEconnect, a software application where members can access virtual peer support and incentives that promote substance use disorder recovery behavior.
- The Mental Health Integration Program helps primary care clinics incorporate mental health screening and treatment into their practice.

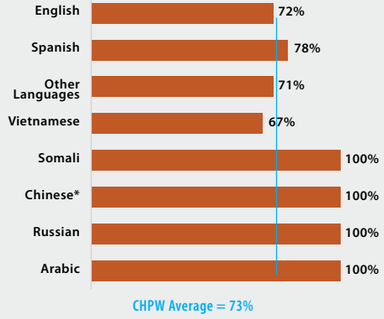
Conclusions cannot be made for Asian, AIAN, Other, NHOPI, or Declined members due to small denominator sizes

FUH 30-Day Follow-Up Age 6-17 years by Race/Ethnicity



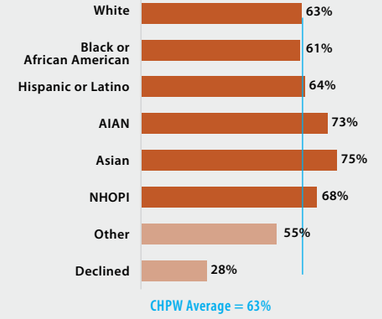
Conclusions cannot be made for Other, Vietnamese, Somali, Chinese, Russian and Arabic speakers due to small denominator sizes

FUH 30-Day Follow-Up Age 6-17 years by Language



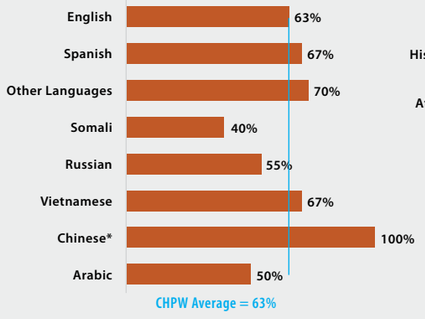
Medicaid members who are Other or Declined are less likely to receive follow-up after hospitalization for mental illness

FUH 30-Day Follow-Up Age 18-64 years by Race/Ethnicity



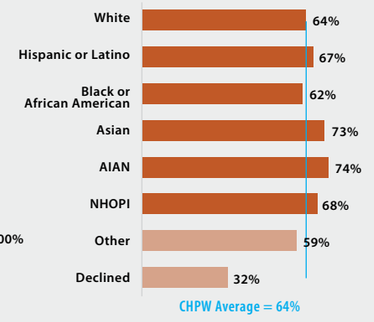
Conclusions cannot be made for members who speak Somali, Russian, Vietnamese, Chinese and Arabic due to small population sizes

FUH 30-Day Follow-Up Age 18-64 years by Language



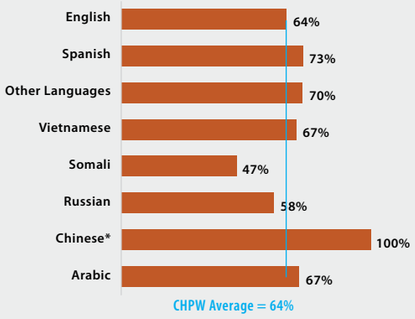
Medicaid members who are Other or Declined are less likely to receive follow-up after hospitalization for mental illness

FUH 30-Day Follow-Up Total by Race/Ethnicity



Conclusions cannot be made for members who speak Somali, Russian, Vietnamese, Chinese and Arabic due to small denominator sizes

FUH 30-Day Follow-Up Total by Language



1 in 5
adults in Washington experience a mental health condition each year.

Approximately 10% of Washington's youth have experienced at least one major depressive episode in the past year.

Follow-Up After Hospitalization (FUH): The acronym FUH stands for Follow-Up After Hospitalization for Mental illness.

Graphs Key

- **Medicaid**
- **Medicaid–>5% Disparity**

AIAN: American Indian and Alaska Native

Declined: Declined to Provide a Race/Ethnicity

*Chinese Language includes Cantonese, Chiu Chow, Mandarin and Toishanese dialects.

Other: Members from Other Racial/Ethnic Groups

Glossary of Terms

Anti-Racism: The active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably.

BIPOC: BIPOC stands for Black, Indigenous, people of color. The term is used to highlight the unique relationship to whiteness (as a culture and concept of 'normal') that Indigenous & Black people – specifically Black Americans – have, and how this shapes the experiences of and relates to white supremacy for all people of color within a US context. Note that this term is not widely used and has recently gained elevated mainstream exposure.

Culture: A social system of meaning and custom that is developed by a group of people to assure its adaptation and survival. These groups are distinguished by a set of unspoken rules that shape values, beliefs, habits, patterns of thinking, behaviors and styles of communication.

Disability: A continuing condition that restricts everyday activities. The Disability Services Act (1993) defines disability as: a disability is attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of those impairments. The ADA (Americans with Disabilities Act, 1990) defines a person with a disability as someone who has a physical or mental impairment that substantially limits one or more major life activity; this also includes people who have a record of such an impairment, even if they do not currently have a disability. This also relates to people who don't have a disability but are regarded as having one. The ADA makes it unlawful to discriminate against a person based upon that person's association with a disability. Another important movement that is grounded in disability justice is the concept of "access intimacy". For more learning, check this out: leavingevidence.wordpress.com/2017/04/12/access-intimacyinterdependence-and-disability-justice/

Discrimination: To distinguish, single out or make a distinction of differences between things or treating someone as inferior based on race, gender, sexuality, national origin, age, ability, religion or other characteristics.

Diversity: The psychological, physical, and social differences that occur among all individuals, such as race, ethnicity, socioeconomic status, religion, age, gender, sexual orientation, mental/physical ability, etc.

Equity: The fair treatment, access, opportunity and advancement for all people, while at the same time, striving to identify and eliminate barriers that have prevented the full participation of some groups.

Equity Lens: A transformative quality improvement tool used to impact the planning, decision-making and resource allocation processes that lead to more equitable outcomes, including policies and programming. At its core, it's a set of principles, reflective questions and processes that focuses on individual, institutional and systemic levels of engagement and application. An approach to ensure policies, programs and decisions result in equitable outcomes for historically oppressed and marginalized populations.

Ethnicity: A social construct that divides people into smaller social groups based on characteristics such as shared sense of group membership, values, behavioral patterns, language, political and economic interests, history, and ancestral geographical base. Examples of different ethnic groups are: Cape Verdean, Haitian, African American (Black); Chinese, Korean, Vietnamese (Asian); Cherokee, Mohawk, Navajo (Native American); Cuban, Mexican, Puerto Rican (Latino); Polish, Irish, and Swedish (white).

Gender Identity: One's most innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their assigned sex at birth (ASAB).

Health Disparity: A difference in health status between social groups. Disparities in relation to equity can mirror social inequality and can be identified by stratifying data by race, ethnicity, gender, sexual orientation, socioeconomic status, income, etc. Health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities. Health disparities exist in all age groups, including older adults.

Health Equity: Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination.

Inclusion: Inclusion is the recognition of the involvement and empowerment of all people. The inherent worth and dignity of everyone is honored and respected, and the environment (workplace, educational institution, etc.) promotes and sustains a sense of belonging; by valuing and practicing respect for the talents, beliefs, backgrounds and ways of living of its collective members.

Race: Describes categories assigned to demographic groups based mostly on observable physical characteristics like skin color, hair texture, eye shape, etc. This is a social and political concept – not scientific, and it is a powerful force rooted in social, economic and political purposes. Race is a powerful social category forged historically through oppression, slavery and conquest.

Racism: Racism is a system in which one race maintains supremacy over another race through a set of attitudes, behaviors, social structures, and institutional power. Racism is a "system of structured dis-equality where the goods, services, rewards, privileges, and benefits of the society are available to individuals according to their presumed membership in" particular racial groups. A person of any race can have prejudices about people of other races, but only members of the dominant social group can exhibit racism because racism is prejudice plus the institutional power to enforce it. (Barbara Love, 1994. Understanding Internalized Oppression).

Sexual Orientation: The sexual attraction toward other people or no people. While sexual activity involves the choices one makes regarding behavior, one's sexual activity does not define one's sexual orientation. Sexual orientation is part of the human condition, and all people have one. Typically, it is attraction that helps determine orientation.

Social Drivers of Health (SDOH): An alternative term to Social Determinants of Health. When addressing policies, systems, and structures that fuel racial inequities in areas that influence a person's health, such as health care, housing, and access to healthy food and transportation, "social drivers of health" is more accurate. When using the term "determinants" it can have a sense of finality, stripping individuals of their agency to manage their own health and well-being, and minimizing accountability amongst policymakers and those in power for the social and political decisions that create these inequities—as though struggles to access food or housing are predetermined and thus cannot be changed.

Social Needs: Social needs are needs such as housing, food, employment, education, etc., that are addressed at the individual level. Social risk factors are the specific adverse social conditions that impact health. Screening for social risk factors helps to identify those risks. An individual's social needs are identified social risk factors that they have chosen to prioritize.

Tribal Sovereignty: Includes the right to govern one's community, the ability to preserve one's culture, and the right to control one's own economy.

Whole-Person Care: The coordination of health, behavioral health, and social services in a patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.