

UNITED
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Culturally Responsive Care in Colorado:

**WHAT PEOPLE WANT AND HOW
TO ADDRESS A “ONE-SIZE-FITS-ALL”
HEALTH CARE SYSTEM**

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Additionally, the thoughtful effort that went into the creation and implementation of the Colorado Option health insurance plan should not be overlooked. While the focus of our report is broader than just the Colorado Option and related culturally responsive network requirements, this foundational and innovative policy provides a strong framework to build from so all Coloradans can access culturally responsive care. This is thanks to the members of the Colorado General Assembly, state regulators, advocates, community members, and many other stakeholders who put tireless work into making it a reality.

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I feel like health care is one size fits all and that size is white.

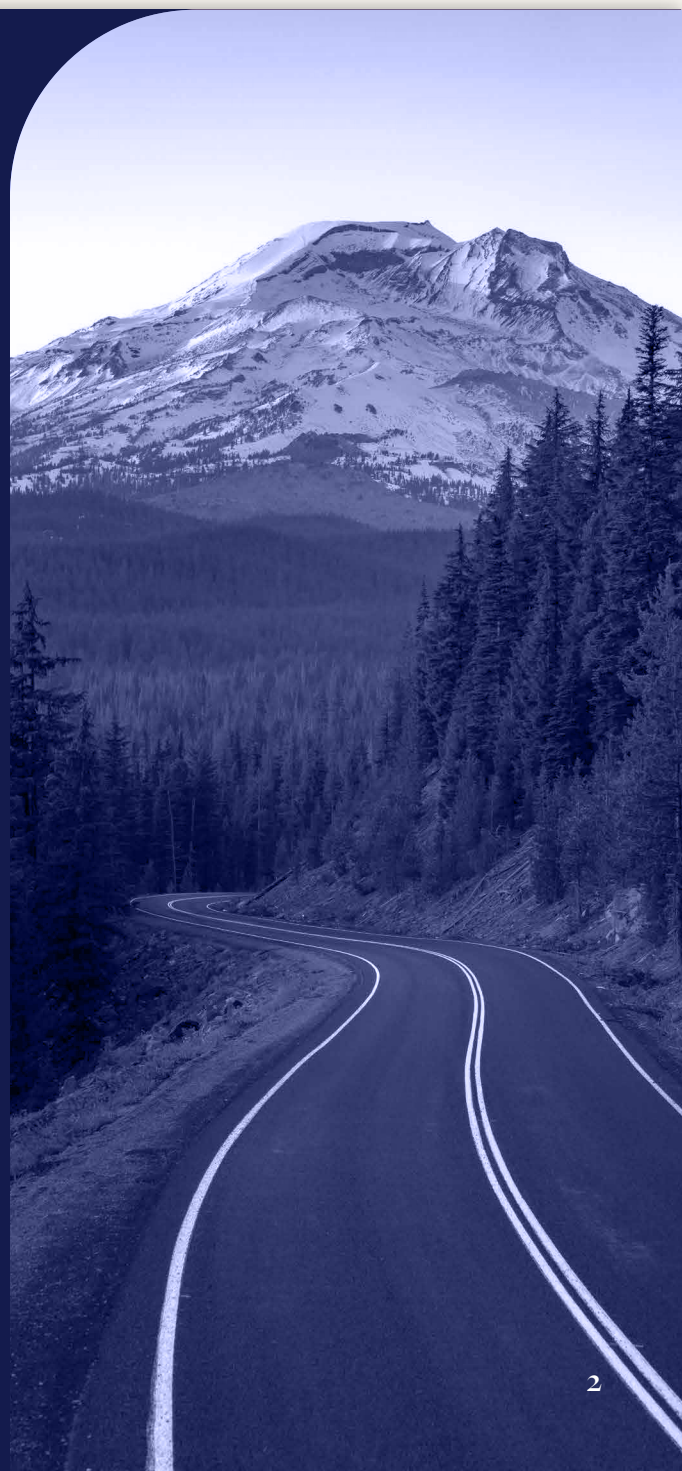
– ASIAN WOMAN, SUBURBAN COLORADO

Executive Summary

Colorado has long been a leader among states in developing innovative policies that improve the health and wellbeing of their residents, including through the recent adoption of “culturally responsive provider networks” as part of the Colorado Option standardized health plans. Despite this, the health care system remains fraught with issues stemming from structural racism and more needs to be done to reduce inequities. This report aims to capture Coloradans’ perspectives on finding and accessing culturally responsive health care and offers a series of recommendations for policymakers in Colorado and other states looking to advance access to culturally responsive care.

Background

United States of Care worked with partners in the state to support the passage and ongoing implementation of the Colorado Option, the state’s public health insurance option, which included requirements for the development of first-of-its-kind “culturally responsive” provider networks. With over 80,000 people now enrolled in the Colorado Option, we sought to better understand the unique health care needs of Coloradans and how improved access to culturally responsive can better serve what they want and need from the health care system. Through a series of key informant interviews, in-depth interviews, and community conversations with people, providers, and other stakeholders over the course of 6 months, we captured their collective views on finding and accessing culturally responsive care. These perspectives built the foundation for subsequent policy recommendations we hope policymakers can act on to ensure people’s unique cultural identities are taken into account when they seek and receive health care.





KEY FINDINGS

We completed 10 virtual key informant interviews with people representing various health care stakeholders in Colorado, including advocacy, government, and academic institutions; seven virtual in-depth interviews with health care providers practicing in Colorado; and four in-person community conversations (three in English, one in Spanish) with diverse groups of patients, including people of color, those who identify as LGBTQIA+, people with disabilities, and those that live at the intersection of these identities.

Here's what they had to say:

- Patients have low expectations of our health care system, with an understanding that it does not need to be perfect—but they feel **the status quo makes them feel disrespected**;
- Patients have a desire to have **their identity**—whatever that may be— **not impede their access to care and not be disregarded when receiving care**;
- **Implicit bias** among health care providers, health insurance carriers, and other health care professionals, **and a lack of understanding** about unique population-based needs (such as gender-affirming care or technology accommodations) **are negatively impacting patients' experience in receiving care**;
- There's a **lack of diversity in Colorado's health care workforce** and those that are able to practice in underserved and diverse communities face administrative burdens, high cost of living, low compensation, and high turnover; and
- A **fragmented system**, including a lack of standardization across data collection efforts and administrative requirements, **leads to rushed appointments**—and patients are left feeling burdened.

Policy Recommendations

Despite laudable efforts to make progress in better meeting the needs of Colorado's underserved communities, there are several areas for continued improvement based on the views of Coloradans. While truly providing people with culturally responsive care involves much more than one agency and even the health care system itself, the state's culturally responsive network requirements provide a strong foundation to begin this critical work. To that end, we offer the following policy recommendations to further improve access to culturally responsive care:

1 Develop and train a culturally responsive health care workforce.

- Establish standard culturally responsive care curriculum requirements for providers entering the workforce.
- For providers already practicing in Colorado, establish training and continuing medical education (CME) requirements related to culturally responsive care.
- Expand training requirements for plans' customer service representatives to non-Colorado Option plans.
- Increase the amount of funding dedicated to developing and implementing culturally responsive care training.

2 Recruit and retain a diverse health care workforce.

- Create a health care workforce diversity task force or similar entity to analyze and implement programs intended to recruit and retain providers from underrepresented communities.
- Further incentivize both diverse providers to practice in Colorado and health care employers to recruit diverse professionals.

3 Advance culturally responsive care through health insurance.

- Expand network adequacy requirements to ensure more diverse providers are included and more Coloradans benefit from the existing requirements.
- Improve provider directory standards across non-Colorado Option plans to ensure patients can identify providers best suited to meet their cultural and health care needs.
- Increase access to services that are high-value and known to reduce disparities.
- Require health equity or cultural responsiveness accreditation for health plans and providers.
- Utilize a streamlined credentialing process for providers

4 Address additional barriers to reduce gaps in access to culturally responsive care.

- Explore ways to better coordinate and provide whole-person, patient-first care such as integrating health care and housing or transportation.
- Expand the reach of language accessibility requirements.
- Embrace opportunities to improve and expand internet access and digital literacy in underserved rural communities.

Introduction

Across the nation, people share a common desire¹ for a health care system that works when, where, and how they need it. Despite this, the health care system remains difficult to access for many, with issues stemming from structural racism.² In 2021, Colorado established a new health coverage plan called the “Colorado Option” through the passage of HB21-1232.³ This new public health insurance option delivers comprehensive benefits while keeping the premium and out-of-pocket costs affordable for consumers.

Colorado Option plans are required to have “culturally responsive” provider networks, which underscore the commitment Colorado policymakers have made to advancing equity through public policy. Culturally responsive care acknowledges and provides an inclusive atmosphere where patients’ cultural beliefs are respected and taken into account when providing care. While policymakers in Colorado have made great strides in recent years to reduce inequities, more can be done to construct culturally responsive provider networks.

Many of the changes needed require new approaches, as well as continued investment, resources, collaboration, dedication, and time. The 2021 Colorado Health Access Survey,⁴ which explored Coloradans’ needs related to culturally responsive care, highlights why policymakers should pursue new approaches and policies to improve access to such care, including that:

- 25% of Coloradans seeking culturally responsive care were unable to receive it.
- Coloradans who needed culturally responsive care were nine times as likely to receive less-respectful or lower-quality treatment.
- Nearly one-fifth of Coloradans who needed culturally responsive care reported skipping care due to fear of unfair treatment.
- Nearly 400,000 Coloradans reported needing culturally responsive care to respond to their needs related to language access, sexual orientation, culture, disability, and/or experience with trauma.

The subsequent 2023 Colorado Health Access Survey sheds even more light on people’s experiences with the health care system. **The number of Coloradans experiencing disrespectful treatment when receiving medical care nearly doubled since 2021. More specifically, Black (9.7%) and Hispanic (5.8%) Coloradans reported higher levels of disrespect compared to their white counterparts (4.4%).** Age, income, weight, and race were among the top reasons why people felt disrespected, with 31% of respondents who reported experiencing disrespect believing that it was due to their race, and 21.7% believing it was due to their culture. Further, young adults between 18 and 25 were three times more likely than other age groups to say that they felt disrespected, which could indicate an erosion of trust in the health care system amongst the next generation.⁵

2022 Colorado Fast Facts



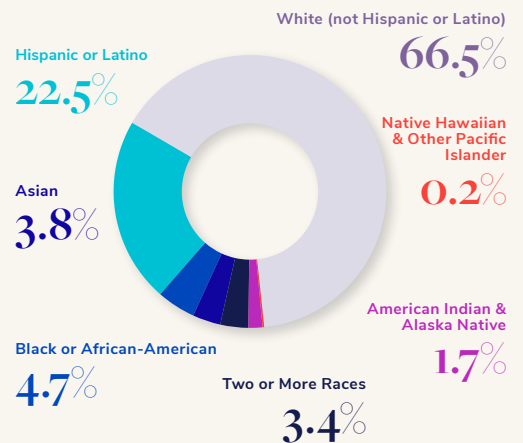
Total Population

5,841,039

United States Census Bureau 2023 QuickFacts

Race & Ethnicity

United States Census Bureau 2023 QuickFacts



Language

Migration Policy Institute:
2022 State Immigration
Data Profiles: Colorado

Speaks English Only: 83.8%

Speaks Language Other than English: 16.2%

LANGUAGES SPOKEN OTHER THAN ENGLISH

Spanish: 68% (608,758)
German: 2.9% (26,116)
French, including Cajun: 2.8% (24,969)
Chinese, including Mandarin & Cantonese: 2.7% (24,516)
Amharic, Somali, or Other Afro-Asiatic Languages: 2.4% (21,848)
Russian: 1.9% (17,269)
Vietnamese: 1.8% (16,520)
Korean: 1.7% (15,228)
Other: 15.7% (140,167)



The requirements in the Colorado Option create a strong framework for future efforts. This report identifies ways that Colorado policymakers, and other states looking to Colorado as an example, can build on these requirements and lead to improvements that help ensure people feel heard, and that their cultural beliefs are respected and taken into account when they seek and receive health care.

Defining Cultural Responsiveness

Cultural responsiveness strives to validate, understand, and affirm the different cultures of a diverse population and cultural competence focuses on the ability to account for how an individual's race, ethnicity, cultural background, language proficiency and/or literacy defines and impacts their experience. While these terms are often used interchangeably and both include similar attributes, for the purposes of this report, we define these two terms slightly differently. For example, while a provider may not know everything and be fully competent about each patient's culture, they can be responsive to the fact that their patients have unique needs that require tailored approaches. Culturally responsive care seeks to close gaps in accessing high-quality care and improve access and health outcomes for people with various identities, regardless of their culture, race, ethnicity, language, geography, and ability.

Culturally responsive care acknowledges and provides an inclusive atmosphere where patients' cultural beliefs are respected and taken into account when providing care.

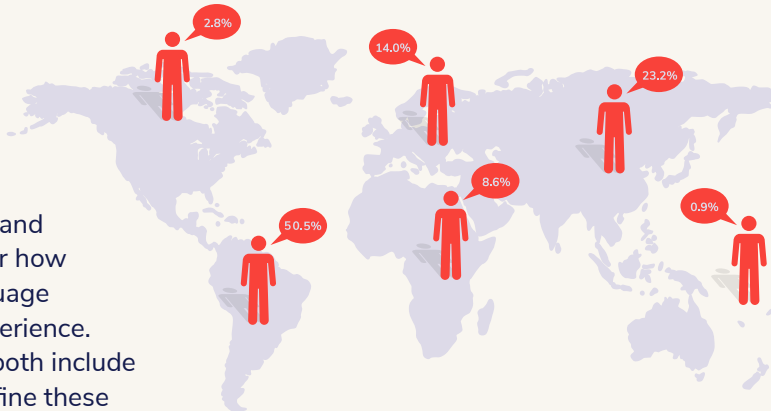
It encourages clear and concise communication as well as empathy and understanding, which improves patient satisfaction and health care outcomes.¹⁵ The concept of culturally responsive care is largely borne out of cultural responsiveness in education.¹⁶

Health care professionals – such as doctors, nurses, and front office staff – form most people's first point of contact with the health care system. To ensure that all patients, regardless of their background and culture, receive culturally responsive care, health care professionals must be conscious of their own biases, prejudices, preconceptions, and cultural beliefs and how they may be different from someone else's. It is critical for practitioners to be well-versed in a variety of cultural customs, traditions, beliefs, and practices surrounding health care so that they can meet their patients' unique needs.

Immigration

Number of U.S. Born People in Colorado, 2022: 5,282,398

Number of Foreign Born People in Colorado: 557,528 (9.5%)



Foreign-Born Population, Place of Birth:

Born in Latin America: 50.5%
Born in Asia: 23.2%
Born in Europe: 14.0%
Born in Africa: 8.6%
Born in Northern America: 2.8%
Born in Oceania: 0.9%

Foreign-Born Naturalized Citizens: 48.9%
Foreign-Born Noncitizens: 51.1%

United States Census Bureau 2023 QuickFacts

Estimated **Number of LGBT Adults**
294,500 (6.8% of the total state population)

Williams Institute, 2023

Estimated **Rural Population**
722,419 (12.2% of the total state population)

Colorado Rural Health Center, 2022

Estimated **Number of Disabled Adults** 1,015,417 (2021 Data)¹⁰

Centers for Disease Control & Prevention, 2021

We understand that this is a tall order, so how health care professionals choose to respond is equally as critical as their understanding of cultures and identities different from their own. This entails being considerate of patients' modesty, privacy, and spiritual and religious beliefs, among other factors. Being aware of cultural differences helps to reduce prejudices and prevents patients from being stereotyped according to their cultural background.

Understanding and accepting the patient's cultural norms – even if it deviates from the provider's – is a necessary component of culturally responsive care.

About the Colorado Option and Culturally Responsive Network Requirements

Beginning in 2023, carriers offering Colorado Option plans are required to develop culturally responsive provider networks that, "to the greatest extent possible, reflect the diversity of its enrollees' race, ethnicity, gender identity, and sexual orientation, in the area the network exists." These regulations were part of the legislation's overall goals of reducing disparities and improving access and health outcomes.¹¹ These requirements, described in aim to address critical gaps people face in Colorado in accessing culturally responsive care.

As part of the development of these networks, Colorado established a number of rules¹² and processes to ensure that Colorado Option plans support the advancement of health equity in the design of their provider networks.

These include requirements¹³ for Colorado Option plans to:



Collect demographic data that providers and enrollees voluntarily submit on their race and ethnicity, sexual orientation and gender identity, and ability status.



Provide cultural competence or anti-bias training for customer service representatives.



Adhere to training requirements for providers and providers' front office staff, which gradually increase to 90% of Colorado Option providers and front office staff having undergone cultural competence or anti-bias training by January 1, 2025.



Include certain providers in their networks, including at least 50 percent of available essential community providers, which includes federally-qualified health centers, Ryan White programs, safety net clinics, and rural health clinics.



Provide access to certified nurse midwives that meet regulatorily-set time and distance standards.



Include additional information in provider directories, including information about multilingual providers, providers with extended and weekend hours, translation and interpreter services, and accessibility services.



Ensure enrollees have access to language assistance services.

Our Findings: What Culturally Responsive Care Means to People

From May to August 2023, United States of Care engaged in a series of in-depth discussions with health care stakeholders to understand Coloradans' perspectives about culturally responsive care in the state. Through conversations with government agencies, advocacy organizations, academic institutions, and health care providers, we discovered both a genuine understanding of why culturally responsive care is so important to people and a willingness to improve upon the status quo. A deeper dive into the experiences of patients with a variety of racial and ethnic backgrounds, cultural differences, sexual orientations, abilities, and intersections of these identities, pinpointed areas to improve patient-centered culturally responsive care delivery within the health care system.¹⁶

Our findings emphasize the complex connection between health care access and culturally responsive care. All stakeholders emphasized how critical it is to have equitable access to health care services, including access to providers who have similar backgrounds as the patients they serve and/or who are competent in providing care to diverse patients. Additionally, stakeholders shared concerns that people lacked access to health coverage and that providers do not have adequate training or educational opportunities on how to deliver culturally responsive care. Patients reported frustration with their current health care options, where rushed appointments, too much emphasis on prescription drugs as remedies, and implicit biases held by providers sometimes lead them to lose interest in seeking health care services at all. Unfortunately, this is consistent with national trends of people of color regularly reporting unfair or disrespectful treatment due to their race or ethnicity.¹⁷



About 18% of Black adults, 12% of American Indian/Alaska Native adults, 11% of Hispanic adults, and 10% of Asian adults

say they have been treated unfairly or with disrespect by a health care provider in the past three years because of their race or ethnic background.¹⁷

We also heard a number of personal accounts about having to switch providers because they felt disrespected or judged due to their identity. The process of seeking providers, scheduling appointments, and planning for medical care was a significant source of stress, alongside racism, homophobia, transphobia, and additional reported social issues. For example, one person spoke about not wanting providers to compare her baby to traditionally white medical standards, wanting them to both understand and respect her cultural diet. Another person who identifies as transgender reported challenges of being repeatedly deadnamed (calling a transgender person by their birth name when they have changed their name as part of their gender transition) by providers. A Hispanic woman said her doctor told her that she was “already living in the U.S. and needed to change her beliefs now,” when discussing mental health, thus dismissing her beliefs, Hispanic culture, and background. The discrimination that patients from marginalized communities experience when seeking care can serve as a psychosocial stressor,¹⁸ perpetuating existing inequities and directly linking to negative health outcomes.¹⁹

Patients living in rural settings also expressed feeling like there is a limited number of health care providers and a high turnover of doctors and nurse practitioners for people who do not identify as cisgender, heterosexual, white men. More often than not, it can be exceedingly difficult for people of color and LGBTQ+ individuals to find a provider who looks like them, comes from a similar cultural background, and can be trusted and understands their patients’ unique needs.

Community based organizations or resource centers, such as LaRaza and Mi Casa Resource Center, were deemed critical for information and resource sharing that could not otherwise be found from their provider network or doctor’s office. There were suggestions made that health insurance companies provide a list of providers by their religion, culture, and language to increase trust. Some participants described difficulty finding a Latino or Hispanic doctor. A few people mentioned receiving a list of doctors from their insurance provider and being told to pick and choose from what’s available, noting that these lists were not curated for the Spanish language or cultural background of the medical provider. Finding the right provider adds to the stress of receiving needed medical care.

For patients that speak languages other than English, the availability of appropriate language and translation services were identified as essential while seeking care. People shared that language and translation services should be more than just calling into a hotline and that in-person assistance from people from a similar cultural background would be more beneficial. Additionally, people we spoke with that identified as Hispanic or Latino noted a preference for receiving care from medical personnel who speak Spanish over language interpreters, as this could contribute to confusion and misunderstandings. Even having a doctor who at least speaks Spanish is preferred, even if they do not identify as Hispanic.

Terminology is very important. Because sometimes, parents take their seven-year-olds to translate for them when they go to the doctor. A seven- or nine-year-old honestly doesn’t have the capacity or a way to correctly express things. They have to figure out a better way to do things when someone comes in who doesn’t speak the language. Because that’s not acceptable.

– LATINA WOMAN, DENVER

Patients we spoke with had seemingly low expectations. While the system did not need to be perfect, the status quo often made them feel disrespected and not seen as a whole person. Patients expressed the desire to be treated with more respect and dignity, saying they wanted to feel heard and be taken seriously. Their identities should not impede their access to care nor be disregarded while receiving care.

Additional summaries of our key findings from stakeholders’ and patients’ perspectives on culturally responsive care and the current health care system can be found in Appendix 1. These findings were grouped into key areas that led to the development of our policy recommendations, based on the following overarching themes:

- **Training for providers and plans on culturally competent care is highly variable, inconsistent, and lacks continuity.**
- **Provider workforce and retention issues are pervasive, with the workforce itself reflecting a lack of diversity, providers being challenged by insufficient reimbursement, and patients finding it hard to even access care due to shortages or availability in certain geographic areas.**
- **Data collection and reporting requirements are subpar, stemming from systemic and administrative challenges between plans and providers.**
- **Overall barriers to accessing culturally responsive care persist, stemming from cultural, religious, language access, transportation needs, and lack of providers with needed expertise.**

Policy Recommendations

While Colorado's Division of Insurance (DOI) has built a strong framework through various regulations they have implemented and authority they have successfully leveraged, providing people with culturally responsive care involves much more than one agency and it involves more than just the health care system. Based on an analysis of our listening data, the existing policy, regulatory, and workforce landscape²⁰ in Colorado, and broader health care system trends, we have identified four key areas for Colorado – and other states looking to Colorado as an example – to focus their efforts to advance culturally responsive care:

- 1 Develop and train a culturally responsive care workforce.**
- 2 Recruit and retain a diverse health care workforce.**
- 3 Advance culturally responsive care through health insurance.**
- 4 Address people's barriers to accessing culturally responsive care.**

Recommendations outlined below have components that Colorado policymakers can advance through state legislation and/or regulation, but some recommendations require federal action to be fully realized. For example, Colorado does not have jurisdiction over all health plans offered in the state, and federal legislation like the Employee Retirement Income Security Act (ERISA) that regulates most employer-based insurance cannot be modified by a state. Colorado should work within its legislative and regulatory scope to advance culturally responsive care within the state and engage in federal-level conversations about advancing culturally responsive care as a nation. Finally,

While these recommendations are specific to Colorado, many of them can be easily adopted or adapted by policymakers in other states and by health policy leaders working in the private sector to guide their own efforts to improve access to culturally responsive care.

Develop and train a culturally responsive care workforce.

To best serve patients with diverse needs and identities, it is critical that health care providers supplement their lived experiences by receiving training and education on providing culturally responsive care. Cultural competency training for health care providers has been shown to improve provider knowledge, skills, and attitudes about cultural responsiveness.²¹ Furthermore, a 2020 study demonstrated cost savings from culturally tailored communication programs for multidisciplinary care management teams.²² There is also some evidence indicating that training providers in culturally responsive care can increase patient satisfaction.²³ It is critical that any training provided is effective, and that any training requirements should be thoroughly evaluated to ensure they are meeting their goals, such as improved satisfaction and health outcomes for patients from historically marginalized communities.

It's disheartening how often I have to teach the medical professionals about their own jobs, their own policies about what's medically necessary. I'm looking for a new doctor because I think he's just googling how to treat me because he has no idea.

– BISEXUAL WOMAN, URBAN COLORADO

Providers can receive education and training on culturally responsive care ahead of licensure, such as during medical school or nursing school, or periodically after licensure and during practice through continuing medical education (CME) courses. While organizations overseeing medical education and residency in the U.S. are starting to implement curriculum requirements for culturally competent care, the content and implementation of these courses varies drastically between institutions.²⁴ This leads to vast discrepancies in the level of culturally responsive care training that medical students and, later, practicing providers receive. For example, a 2020 study found that only two-thirds of physicians reported having any cultural competency training and fewer than one in five physicians reported that training in cultural competency was required for new physicians who joined their practice.²⁵ Additionally, the respective accrediting bodies for nurses and nurse practitioners, physician assistants, dentists, and behavioral health professionals have each established standards requiring some culturally responsive care or cultural competence training; similarly, the level of training required differs across profession types.²⁴ These discrepancies indicate a need for a more standardized approach to training health care providers on culturally responsive care.



Colorado can continue to develop and train a culturally responsive care workforce by:

1

- **Establishing standard culturally responsive care curriculum requirements for all health care providers entering the workforce.** In 2005, New Jersey passed legislation requiring all colleges of medicine to offer cultural competency training²⁶ and in 2006, Washington passed legislation that required all programs that educated health care professionals “in professions disciplined by credentialing authorities” to integrate “multicultural education” into the basic education curriculum.²⁷ Colorado could apply similar curriculum requirements so providers entering the field are trained in providing culturally responsive care. As curriculum requirements are established, there should be thorough review and assessment of the best training options available, to ensure that they are meeting the goal of improving care provided to people.
- **Establishing anti-bias or cultural competence and cultural responsiveness training requirements for providers already practicing but not already required to have such training through participation in the Colorado Option plans.** Providers participating in Colorado Option plan networks are currently required to receive cultural competence, anti-bias, or similar training about the health needs of patient populations who experience higher rates of health disparities and inequities. These requirements should be expanded to apply to more health care professionals beyond just physicians. For example, Connecticut requires cultural competence training for certain providers, including physicians and nurses, doulas, and marriage and family therapists.²⁹
- **Adding CME requirements related to culturally responsive care for providers already practicing.** CME training is one avenue to create a better baseline set of knowledge about culturally responsive care among providers, especially given that only two-thirds of physicians report having completed cultural competency training.³⁰ The Colorado State Medical Board currently does not have CME requirements for physicians, except for those who prescribe opioids.²⁵ Most other states require between 25-100 hours of CME every few years.³¹ For example, physicians in Washington D.C. are required to complete three CME hours on HIV/AIDS and two hours on LGBTQ cultural competency as part of their renewal process every two years. There is an opportunity for Colorado to add similar CME requirements for physicians and health care providers focused on health equity, anti-bias, or culturally responsive care to close the current gap in knowledge.
- **Requiring training for non-Colorado Option plans’ customer service representatives, including brokers and navigators:** Training requirements should be robust to ensure that people’s needs are met at the various touch points they have with the health care system, including interactions with customer service representatives. Similar to current requirements for Colorado Option plans, other plans across the state should be required to have staff complete cultural responsiveness and/or anti-bias training. Colorado should consider establishing training requirements through the Department of Labor and the Division of Professions and Occupations to leverage their regulatory authority over more employers of people working in health insurance customer service, including those employed by third-party administrators or other plans not regulated by the state.
- **Increasing the amount of funding dedicated to establishing and maintaining training programs.** Adequate funding is needed to support any training and training requirements put in place. Colorado’s recent passage of HB22-1267 is a strong step toward expanding provider training on culturally responsive care,³² and similar approaches can be utilized in order to maximize these resources.

BRIGHT SPOTS

In 2022, Colorado enacted HB22-1267 to create a culturally relevant and affirming health care training grant program for certain providers working with priority populations, including communities of color, the LGBTQ+ community, and the disability community.³² Nine organizations across the state were selected to conduct these trainings, which will continue through the summer of 2024.³³ Additionally, Colorado DOI Regulation 4-2-80 requires carriers of Colorado Option plans to ensure that their customer service representatives and participating providers and front office staff complete anti-bias or cultural competence training using a phased approach over the next two years.¹²

2

Recruit and retain a diverse health care workforce.

People from historically marginalized demographic groups are highly underrepresented in medicine compared to the U.S. population as a whole. Black people represent about 13% of the U.S. population³⁴ but only make up just over 5% of physicians,³⁵ over 4% of dentists,³⁶ and 6.3% of nurses.³⁷ Similarly, over 18% of the U.S. population is Hispanic,³⁴ but fewer than 7% of physicians³⁸ and fewer than 7% of nurses³⁷ are Hispanic. While data on LGBTQ+ participation in the clinical workforce is limited, it suggests significant underrepresentation.³⁹ Literature on workforce composition with regards to disability status is emerging, but similar trends hold true; in 2021, an estimated 13% of the U.S. population was reported to have a disability,⁴⁰ in contrast to the estimated 3.1% of physicians with disabilities that same year.⁴¹

Creating more diverse care teams has positive implications for patient care and outcomes; for example, a 2019 meta-analysis found that more diverse care teams were associated with improvements to patient outcomes, innovation, care team communication, and risk assessment.⁴² Colorado can mitigate disparities by recruiting and retaining a health care workforce that better reflects the diverse identities of its patients.

There are many challenges to diversifying the U.S. health care workforce, especially for professions that require graduate-level education, which can have systemic barriers to entry for underrepresented populations. However, there are opportunities to improve the recruitment and retention of a diverse health care workforce, including providing greater support for and admitting more diverse candidates into health care education programs, including developing pathway programs that support students from diverse backgrounds as they work toward careers in health care.



The ability to practice medicine is very privileged, and those who need it are not.

– QUEER PERSON, RURAL COLORADO

While the health care sector itself serves a critical role in hiring and retaining a diverse workforce, Colorado policymakers can also work to recruit and retain a more diverse health care workforce by:

- Creating a health care workforce diversity task force.** Colorado can establish a task force to study, analyze, and help to implement programs to recruit and retain all types of providers from underrepresented communities, similar to the process employed for behavioral health providers beginning in 2021.⁴³ In doing so, the state can look to Illinois, which established its Diversity in Health Care Professions Task Force in 2020.⁴⁴ Among its many objectives, the Task Force holds an explicit mission to diversify the Illinois health care workforce. In particular, it works with health care institutions of higher learning to design “exceptional pipeline programs, to collect and track data related to bridge health disparities in underserved and historically marginalized communities, and to ultimately optimize health and health care for patients.” In recent years, the Task Force has focused on surveying institutions of higher health care education and engaging stakeholders about their diversity, inclusion, and justice data, policies, and practices in order to work towards this goal.⁴⁵
- Identifying further ways to bring diverse health care professionals into Colorado’s health care workforce.** Colorado can utilize a range of promising approaches to improving diversity within the workforce. This should include funding initiatives and providing resources for programs that provide additional entry points into the health care workforce from high school to the undergraduate and graduate setting, especially for low-income and/or first-generation students. These can include dual-enrollment programs, apprenticeships, and “pathway” programs that collectively provide students with diverse backgrounds a pathway to those entering a certain career field, as well as expanding financial aid and loan forgiveness programs to support students in the undergraduate and graduate setting entering the health care workforce. An example of this is SB23-288, which allocates \$100,000 to develop a scholarship fund for aspiring doulas in Colorado.⁴⁶ Furthermore, the state can modify or expand existing programs to achieve these aims, including existing loan forgiveness programs for primary care.⁴⁷ Finally, health care employers in Colorado should consider creating opportunities and incentives for advancement from entry-level health care roles into more advanced practice and leadership roles.
- Exploring incentives for health care delivery organizations to recruit and retain diverse care teams to areas of need.** Colorado should explore ways to incentivize health care employers to recruit and retain diverse care teams that better serve diverse patient populations of Colorado. Similar programs already in existence in Colorado, such as the Rural and Frontier Health Care Preceptor Tax Credit, can be looked to for examples and lessons learned.⁴⁸ This initiative should consider not just physicians, but all providers playing a critical role in delivering collaborative, patient-first care.⁴⁹ Another way to recruit and retain diverse care teams to areas of need is to expand recruitment to include community health workers and additional non-clinical health care providers. Partnerships between health care organizations, community health workers, and other community-oriented health care providers can increase representation of target populations in care teams.

Even the most well trained cis provider is not going to be as equipped as a queer one would be.

– QUEER PERSON, RURAL COLORADO

Address additional barriers to reduce gaps in access to culturally responsive care.

While plans have to follow certain federal and state rules, they have the ability to design coverage in a way that advances equity.⁵⁰ Because plan design involves many variables, such as what providers are in-network, what services are covered, and with what associated cost-sharing,⁵¹ health insurance plans can be better leveraged as an intentional way to advance health equity and, specifically, the provision of culturally responsive care. For example, a plan's provider network forms the pool that people can choose from to find a provider who meets their needs. The providers that a plan chooses to include in their network therefore impacts people's access to culturally responsive care, as choosing an out-of-network provider may result in significant costs to the person seeking care. Benefit design also impacts a person's access to culturally responsive care, as failing to include certain services (e.g. doula services or gender-affirming care) limits a person's access to care that may be culturally appropriate for them. Colorado Option plans are required to have and design standardized benefits that improve racial health equity and decrease racial health disparities.³ These and other requirements can be expanded to other non-Colorado Option plans, including Medicaid and CHIP.

To continue advancing culturally responsive care for more people across the state through health insurance, Colorado can:

- **Expand network adequacy requirements.** While Colorado has made great strides towards improving network adequacy,⁵² more can be done to ensure that culturally responsive providers are a part of people's provider networks. People should be able to pick from an array of in-network providers, and Colorado can expand current rules for Colorado Option plans so more plans have more standards around provider networks. Colorado can expand the state's Essential Community Provider (ECP) definition⁵³ to include additional safety net providers, as well as require plans to include doulas, certified nurse midwives, community health workers, and providers who serve high-risk and underserved communities. As noted, Colorado Option plans are required to include certain providers, such as certified nurse midwives, in their networks, and similar requirements for non-Colorado Option plans would mean more Coloradans benefit. Community-based doulas, for example, have been demonstrated to improve health outcomes⁵⁴ across demographics, including people with multiple intersecting identities,⁵⁵ all while reducing perinatal spending.^{56 57} They also provide culturally sensitive support⁵⁸ for marginalized birthing people, particularly for Black women, who face crisis-level maternal mortality rates⁵⁹ and disproportionately experience discrimination during their birthing journey.⁶⁰



- Improve provider directories.** People should be able to easily identify which provider meets their needs, and provider directories should include further information about provider and front office staff to help make that happen. Colorado Option plan provider directories already must include information about whether the provider and/or front office staff speak a language other than English, the availability of translation and interpreter services in languages other than English for individuals with limited English proficiency, and whether they offer extended and weekend hours to account for people who are unable to see a provider during “traditional” hours.¹² This is a strong starting point for what other plans should be required to include in their provider directories. Plans can do more to provide enrollees with other helpful information, including distance to public transit, additional culturally responsive care and continuing medical education training they’ve received, specific cultural expertise they have, and additional demographic data about health care professionals in the plan’s network. However, providing people with access to certain demographic data, such as a provider’s sexual orientation and/or gender identity, should only be done so with the consent of the provider.
- Protect people’s access to needed services.** In 2021, more than 1 in 4 transgender youth and more than 1 in 5 genderqueer and/or nonbinary youth in Colorado reported attempting suicide,⁶¹ underscoring the urgent need for policymakers to ensure plans are not able to utilize practices that hinder access to culturally responsive care. Regulators should limit the use of utilization management tools,⁶² like prior authorization, that often place an unfair burden on patients,⁶³ such as those needing gender-affirming care.⁶⁴ Additionally, regulators should work to curb the abuse of health insurance denials, paying particular attention to the impact that claims denials have on limiting access to culturally responsive care. While some federal nondiscrimination protections exist,⁶⁵ more can be done to ensure patients are truly protected, including monitoring compliance, safeguarding patients from the unintended consequences of using algorithms and artificial intelligence, and establishing the tools and expertise necessary to hold health insurance companies accountable.
- Increase access to services that are high-quality, cost-effective, and known to reduce disparities.** The Colorado Option provides a strong framework for Colorado to further build out to promote access to services that are proven to reduce health disparities. Colorado Option plans provide primary care, pre- and post-natal visits (including home care), and mental health and substance use disorder treatment care without copays and not subject to the deductible.⁶⁶ In addition, they are also required to provide first-dollar coverage for certain “high-value” services focused on reducing racial disparities, including for certain diabetic care and services, which was identified as a key area of focus during stakeholder meetings.⁶⁷ These rules and processes should be required of additional non-Colorado Option plans, including the rest of the Affordable Care Act (ACA) Marketplace plans and the state employee health plan. Incentives could be provided to align non-state regulated plans benefit design with those in the state-regulated market.





- **Requiring health equity or cultural responsiveness accreditation for health plans and providers.**

Starting with Colorado Option plans and eventually expanding to other state-administered plans, Colorado should require that health insurance plans be accredited in health equity or cultural responsiveness. To ensure consistency across plans, the DOI should identify at least one accreditation option for plans to meet, such as the National Committee for Quality Assurance's (NCQA) Health Equity Accreditation⁶⁸ or the Utilization Review Accreditation Commission's (URAC) Health Equity Accreditation.⁶⁹ In addition, the state should consider requirements for providers to obtain similar accreditations as well, which NCQA,⁶⁸ URAC,⁶⁹ and The Joint Commission⁷⁰ all offer to providers. Finally, Colorado should create opportunities for public comment on health equity accreditation requirements to ensure that the requirements are meeting the needs of the community.

- **Utilizing a streamlined credentialing process for providers.** Colorado should utilize a streamlined process and system to incorporate components of cultural responsiveness training in credentialing requirements to ensure more providers are able to practice. In our conversations with stakeholders, for example, behavioral health providers identified credentialing delays as a barrier to meeting the growing need for services. This disproportionately impacts access to behavioral health care for Black and Hispanic Coloradans, who are more likely than white Coloradans to have serious psychological distress but less likely to receive treatment.⁷¹ A centralized credentialing process with less administrative burden helps to ensure people have access to a diverse set of providers, including behavioral health providers. This process could also be used to collect information about providers, including demographic data and continuing medical education and/or culturally responsive care training(s) providers have completed.

We have to learn how to approach people... You don't have to be Mexican to take care of Mexicans, or be from El Salvador to take care of people from El Salvador. But, we have to inform everybody and learn about those cultures so we can approach them in their own cultural space and language.

– HEALTH CARE PROVIDER, COLORADO

Address additional barriers to reduce gaps in access to culturally responsive care.

Conversations with stakeholders in the first phases of this work revealed that, even when health care providers and health plans have services in place that facilitate better access to culturally responsive care, patients may not be aware of what they are or experience barriers outside the health care system that prevent access to them.

Addressing barriers to care in Colorado requires a multi-pronged approach. Collecting better data on the social determinants of health that affect Coloradans,⁷² implementing services through providers and health plans that address these needs, and improving communication with people seeking care – including language access – are pathways forward.

I feel like insurance doesn't care about [culturally responsive care] because it's not something they [insurance companies] do. Outside of ethnicity, I don't think they've ever asked anything else. If they were to ask, "Are you looking for a doctor who fits your needs, or what you consider culture?" And you put in a few key phrases, and then they pull from doctors files, and give you that information - that's not something that I have come across.

– PERSON OF COLOR, URBAN COLORADO

To advance progress toward increasing access to culturally responsive care, Colorado can:

- **Explore ways to better coordinate and provide whole person, patient-first care.**⁴⁹ Patients want to be treated with respect and want their providers to listen to and respond to their unique needs, with an understanding that current provider incentives and the fee-for-service model don't work.⁷³ This can include innovative approaches to integrating health care and housing, or providing more access to transportation to help the growing number of Coloradans reporting transportation as a barrier to accessing health care.⁷⁴
- **Expand the reach of language accessibility requirements.** Colorado should expand the reach of language accessibility requirements to include state-administered plans beyond the Colorado Option standardized plans to reach more people across the state. Colorado could also consider language accessibility requirements for all providers, which would capture providers who aren't in state-administered plan networks. Language accessibility requirements should be comprehensive, including both written materials and verbal and/or signed communication from providers, front office staff, and customer support representatives. These policy changes would address key health disparities based on language: Coloradans who speak a language other than English at home (1 in 6) are less likely to have received care from a general doctor in the last year and are twice as likely as English speakers to feel like they were treated with less respect or received worse care in health care settings compared to those who speak English at home.⁷⁵ Critically, there has been a nearly 30 percent increase in the population of people with limited English proficiency (among those not born in the U.S.) in Colorado from 2000 to 2021, demonstrating a growing need in the state.⁷
- **Embrace opportunities to improve and expand internet access and digital literacy in underserved and rural communities.** Communities of color and rural communities are less likely to access affordable, high-speed broadband, preventing people from accessing telehealth services and critical information about their health care.⁷⁶ Colorado should continue to fund and seek out improvements to its broadband infrastructure in the areas most impacted by the digital divide, as well as work with community partners to increase digital literacy in accordance with the state's proposed Digital Access Plan.⁷⁷

Considerations for Policy Recommendations

As we consider the best policies to advance, there are a few guiding principles that cut across recommendations that should be factored into all of the recommendations we outlined above:

- **Stakeholder engagement and lived experience should drive policy development and implementation.** United States of Care developed the policy recommendations in this report based on focused conversations with a diverse group of people in communities across Colorado. Future policy design should similarly prioritize the perspectives of people facing the biggest barriers to care, including people of color, LGBTQ+ people, disabled people, people who don't speak English or who speak English as a Second Language (ESL), immigrants, and people who hold additional intersecting identities. These perspectives need to be included from the outset and proactive steps should be taken to ensure diverse representatives of the communities that the policy is targeting are heard from. Colorado has a track record of strong stakeholder engagement, including through the development of culturally responsive network requirements,⁷⁸ and should ensure that its diverse communities are involved in every step of the policy process, from engaging community representatives in policy development, to soliciting input from communities on policy implementation and roll-out, to evaluation.
- **Policy changes should incorporate data collection that can track and evaluate efforts.** It is important that efforts include ways to collect data and measure and track progress over time. Building a truly culturally responsive care framework requires a strong baseline understanding of where the state currently is, and there are limitations to what is known about Colorado's health care demographic landscape currently. Colorado Option standardized plans must collect voluntary demographic data from patients and providers,¹² and these rules can go further so that more information is known about patients and providers. In addition to informing current efforts, data collection allows policymakers to use data and outcomes to build on policy changes that are working well and inform any needed future policy changes. As efforts continue, evaluation should track progress towards meeting specific milestones and include measurements related to access to care, reducing disparities, health outcomes, people's experiences, and provider satisfaction. Many entities within Colorado are already working on advancing data strategy to advance health equity,⁷⁹ and policymakers should consider ways to coordinate these efforts in a way that incorporates culturally responsive care.



...To see and have a Mexican doctor would make me feel at ease. If someone of my own race was taking care of me and understands where I come from...it's special.

– LATINO MAN, URBAN COLORADO

- **Colorado can better align policy change across the state.** There are ample opportunities for Colorado to align its culturally responsive care strategy across all programs the state oversees. Our recommendations are in response to the needs that patients and stakeholders identified, and many of the solutions can be implemented in the individual market, Medicaid, the Children's Health Insurance Program (CHIP), and/or other programs the state oversees and/or regulates. For example, efforts in the individual market can be aligned with the state Medicaid program's Equity Plan, which outlines a strategy for the agency to improve their data collection approach to better understand health inequities and has significant overlap with efforts to advance culturally responsive care more broadly.⁷⁹ As Colorado considers new policies, it is important to account for how these requirements can impact the administrative burden for health care providers and to explore approaches that minimize additional administrative burden so that care teams can focus on directly providing culturally responsive care to their patients.
- **Enforcement mechanisms are a key consideration in policy development.** For most policies, enforcement mechanisms are needed to ensure that the policy is being adhered to, and these can often work in tandem with monitoring and evaluation efforts. The DOI's enforcement of the requirements for Colorado Option plans is a good starting point and can serve as potential enforcement levers the state has for future policies in this area. For example, Colorado Option plans are

required to submit action plans if they don't adhere to DOI requirements, including if they are unable to build culturally responsive networks or fail to collect demographic data from providers.¹² These requirements were amended to improve issuer compliance,¹³ showing how policymakers can utilize the regulatory process to respond to changing dynamics and be deliberate about implementing new processes.

- **Culturally responsive care should be considered for all health care providers, not just physicians.** Health care providers across the care continuum can play a role in delivering culturally responsive care. A 2018 study found that patients in an ICU had 86% of their care time with a nurse present, 13% with a physician present, and 8% with critical support staff (e.g. respiratory therapist) present,⁸⁰ illustrating that policies that target physicians only may miss opportunities to move the needle on cultural responsiveness across a person's health care experience. Limiting policy recommendations to solely physicians overlooks the rest of the care team and reduces the potential impact of the policy. Throughout our recommendations, we specify when policies should target physicians or a specific type of health care provider, but otherwise encourage policymakers to think about entire care teams and the broader delivery system, including nurses, advanced practice providers, behavioral health specialists, community health workers, and customer service and front office staff.



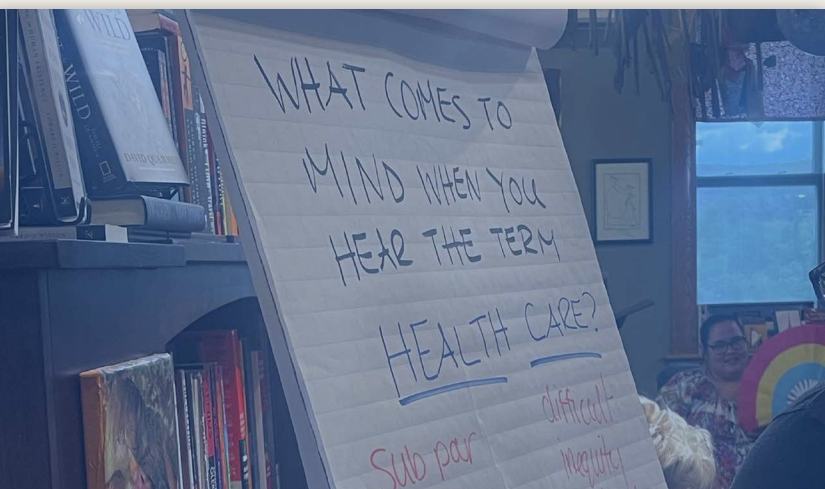
CONCLUSION

As policymakers consider the above recommendations to advance culturally responsive care in Colorado, it is important to consider how the state can align its efforts to provide culturally responsive care with broader trends in the health care system at large. Some of the recommendations included in this report require federal policy changes to have a more expansive reach, including policies that affect plans solely regulated by the state of Colorado. As opportunities emerge at the federal level, policymakers should consider ways to advance culturally responsive care as well, including updates to ERISA.

Additionally, health care staffing shortages are reaching crisis levels, with rapidly declining participation in the nursing workforce,⁸¹ serious primary care provider shortages in rural areas,⁸² and a projected physician shortage of 124,000 physicians by 2034.⁸³ Policymakers should align efforts to recruit and retain health care workers with initiatives to drive diversity in health care teams. Another example is the trend toward increased use of artificial intelligence (AI). AI in the health care market is projected to be valued at \$187 billion by 2030, compared to just \$11 billion in 2021.⁸⁴ The rising use of AI in health care requires careful consideration of its implications as a tool to advance health equity and a risk factor in exacerbating existing health disparities.

While this report provides a framework for improving people's access to culturally responsive care in Colorado, we hope that it inspires other states and the federal government to pursue similar policies as well.

Despite laudable efforts to make progress in better meeting the needs of Colorado's underserved communities, there are several areas for continued improvement based on the views of Coloradans. While truly providing people with culturally responsive care involves much more than one agency and even the health care system itself, the state's culturally responsive network requirements provide a strong foundation to begin this critical work. To that end, we offer the following policy recommendations to further improve access to culturally responsive care:



Appendix 1

ADDITIONAL RESOURCES

- The Integration of Culturally Responsive Care in Medical Education
- Advancing Equity Through Health Insurance Coverage: Examples from the States
- A State Checklist for Advancing Equity Through Health Coverage
- Colorado Option Advances Equitable Access to Health Care Through Implementation of Culturally Responsive Provider Networks

Appendix 2

ABOUT THE PROJECT AND ADDITIONAL LISTENING FINDINGS

Project Methodology

The research for this project spanned a total of four phases from May to July 2023, whereby United States of Care conducted intensive listening and qualitative research to understand various perspectives, attitudes, and approaches toward culturally responsive care in Colorado. This methodology offered us a unique way to have meaningful conversations with Coloradans to truly understand their experiences and perspectives while being able to ask follow-up and clarifying questions. Throughout the four phases of this work, we spoke with key informants, providers, patients, and conducted a policy analysis to identify areas for improvement. This methodology offered us a unique way to have meaningful conversations with Coloradans to truly understand their experiences and perspectives while being able to ask follow-up and clarifying questions.

In Phase 1, we conducted 10 virtual key informant interviews with persons representing various health care organizations in Colorado such as advocacy, government, and academic institutions with a history of past involvement or interest in the Colorado Option, network adequacy, and/or culturally responsive care. Participants in Phase 1 represented organizations that engage in policy and/or consumer advocacy; support physicians, clinics, or Federally Qualified Health Centers (FQHCs); advocate for Indigenous communities; or serve as consultants for various health care initiatives.

In Phase 2, we completed seven (7) virtual in-depth interviews with health care providers practicing or operating in Colorado with the goal of understanding how the implementation of the current culturally responsive network requirements under the Colorado Option are working, the barriers and challenges that exist for these stakeholders, and what can be done to address the challenges. Participants in Phase 2 represented clinicians practicing in primary care, oral health, and nursing, with many primarily serving patients in marginalized communities.

In Phase 3, we facilitated four (4) in-person focus groups with a diverse group of consumers (patients) with a variety of intersecting cultural identities including people of color, people who identify as LGBTQIA+, and people living with disabilities. The focus groups were facilitated in three cities across Colorado including Denver, with and one focus group conducted of which one was facilitated in Spanish.

In Phase 4 of this project, we developed a set of policy recommendations for the state of Colorado—and other states pursuing culturally responsive care—that were informed by an analysis of the qualitative data and policy research about Colorado's health care delivery system, network adequacy, and cultural responsiveness to create a roadmap for the state to close gaps and improve access to culturally responsive care for all people.



APPENDIX 3

Key Themes from Three Phases of Listening to Coloradans

THEME	WHAT WE HEARD IN LISTENING TO HEALTH CARE ORGANIZATIONS	WHAT WE HEARD IN LISTENING TO PROVIDERS	WHAT WE HEARD IN FOCUS GROUPS WITH COMMUNITY PARTICIPANTS
TRAINING FOR PROVIDERS AND PLANS	<p>Lack of interest or understanding among some providers and carriers of culturally responsive care, limiting a shared desire to change the status quo.</p> <p>Absence of ideal entity to create, oversee, or enforce new or existing training or educational materials related to culturally responsive care.</p>	<p>Limited uptake or awareness by providers about cultural competence and culturally responsiveness training, including through continuing medical education (CME).</p> <p>Observations of implicit bias among other providers.</p>	<p>Patients not feeling providers have background, training, or expertise to be able to understand their unique needs or treat them with respect.</p> <p>Lack of communication and education about available resources and services for unique care needs between plans, providers, and patients (such as gender-affirming care, cultural needs, or technology accommodations)</p>
PROVIDER WORKFORCE AND RETENTION	<p>Lack of health care workforce diversity and providers not matching the patients and communities they serve.</p>	<p>Challenges working with multiple payers, including reimbursement rates, credential processes, and administrative burden.</p>	<p>Difficulty accessing providers in specific geographic areas that historically experience high turnover, such as rural communities</p>
DATA COLLECTION AND REPORTING REQUIREMENTS	<p>Lack of strong and consistent data collection across plans and providers particularly with demographic data of patients and providers.</p>	<p>Difficulty adhering to or understanding various reporting and data collection requirements, including lack of standardization across payers and administrative burdens.</p>	<p>Not being able to locate data on plan providers that serve populations with specific cultural, religious, gender affirming care, or language access needs.</p>

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