

“Mountain Climber” Award Application Form 2025

Organization name: Organization 1

Organization type: Managed Care Organization (Health Plan)

Description of awards process:

We will convene a panel of judges from a diverse group of organizations that represent patients or other health care users and Bree stakeholders to review the awards submissions.

The panel members are blinded to the identity of the organizations and score each on both qualitative and quantitative criteria. Quantitative criteria include self-report score cards. Qualitative criteria include the questions on this form (below) and review of supporting documentation. Judges will be asked to rate your work on impact, patient satisfaction, comprehensiveness of strategies, adequacy of accountability processes, effectiveness of addressing Social Drivers of Health, and adaptability (to other organizations or programs).

FHCQ will post deadlines and award focus area timelines for each awards period on the FHCQ website and provide deadline information to nominees.

Nomination pathways:

For questions P1 and P2, please indicate which nomination pathway has nominated you for this award and answer the question appropriate for that pathway:

**P1 ) The Bree Collaborative topic: Diabetes Care**

Definition of implementation:

Implementation means use of a guideline in part or full during clinical practice, health care contracting, policy making, educational programs, or other health care related activities; and/or use of guidelines to fulfill elements of an initiative, regulation, or requirements.

**Please indicate the health care service for which Bree Collaborative has developed guidelines to be considered. This work should exemplify efforts in creating EQUITY within a single service line, program, or policy.**

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*List of Bree reports-*

*Obstetrics Care, Cardiology: Appropriateness of Percutaneous Coronary Interventions, Spine/Low Back Pain, Addiction and Dependence Treatment, End-of-Life Care, Potentially Avoidable Hospital Readmissions, Oncology Care: Early Treatment, Prostate Cancer Screening, Coronary Artery Bypass Graft Surgical Warranty, Behavioral Health Integration, Opioid Use Disorder Treatment, Pediatric Psychotropic Use, Warranty for Bariatric Surgery, Alzheimer’s Disease and Other Dementias, Hysterectomy, Dental Opioid Prescribing, Total Knee and Total Hip Replacement bundle, Collaborative Care for Chronic Pain, LGBTQ Health Care, Suicide Care, Lumbar Fusion Bundle and Warranty, Opioid Prescribing: Long-Term Opioid Therapy, Post Operative Opioid Prescribing, Palliative Care, Risk of Violence towards others, Shared Decision Making, Colorectal Cancer Screening, Oncology Care Inpatient Services, Primary Care, Sexual and Reproductive Health, Cervical Cancer Screening, Telehealth, Perinatal Bundled Payment Model, Opioid Prescribing in Older Adults, Outpatient Infection Control, Hepatitis C, Pediatric Asthma, Perinatal Behavioral Health, Complex Discharge, Diabetes Care*

**P2) The Washington Patient Safety Coalition (project):**

**Diabetes Care Work:**

Organization 1 has long been committed to advancing and being a leader in whole person care and health equity. To ensure that we are implementing strategies to effectively serve diverse populations, Organization 1 began releasing a Health Disparities Report in 2022 that identified strategic health equity priority metrics using three years of data. The eight measures that were the focus of the report covered four domains of care – Maternal & Child Health, Preventive Screenings, Chronic Condition Management, and Behavioral Health – which we believe are critical to the overall spectrum of care. Since that inaugural report, Organization 1 has implemented several strategies under the four domains of care to improve the identified disparities in care. These efforts and continued monitoring of the Domains of Care were captured in our 2024 Health Disparities Report. Today Organization 1’s 8 health equity priority measures include the HEDIS Prenatal and Postpartum Care, Well Child Visit Rates for 3-11 Year Olds, Breast Cancer Screening, Chlamydia Screening, Colorectal Cancer Screening, Diabetes HbA1c Control, Controlling High Blood Pressure, and Follow-up After Hospitalization for Mental Illness.

Several programs and initiatives have been put forth to address each of these health quality priority measures. Special resources, attention, and efforts have been put in place to address Diabetes Care through the Diabetes HbA1c Control measure including specific programs to address disparities based on geographical location, race/ethnicity, spoken languages, Community Health Centers (CHCs), etc. Some of our programs include:

- A dedicated team of Certified Diabetes Care and Education Specialists (CDCES) Registered Dietitians (RDN) and a Case Manager Registered Nurse (RN) working collaboratively to provide a robust, evidence-based foundation for diabetes management. This multidisciplinary team

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empowers individuals with diabetes by offering comprehensive support and guidance tailored to their unique needs. Additionally, they utilize telehealth services, including regular phone calls, to ensure continuous, accessible support and personalized care throughout Washington State, decreasing barriers to accessing care.

- Our Health Coaches and Diabetes Educators team (see previous bullet) have partnered with the Equity & Quality Performance team to deliver at-home A1c tests paired with health coaching to provide education and support on diabetes management. Health coaches also provide diabetes management resources available at organization 1 and our CHCs as well as access to an at-home diabetes management tool.
- Under the Network’s Equity Transformation Incentive program, we provide funding and technical support to our CHC partners to create innovative, equitable interventions and programs to address healthcare inequities. Diabetes is a commonly chosen measure within this program.
- Our Regional Care Teams (RCTs) leverage their regional knowledge and relationships to address specific diabetes-related disparities in their regions. One team surveyed members of the community at a local event to identify how to better support them in managing their diabetes, sharing resources available at organization 1, and listening to what other barriers exist. Another team identified culturally responsive diabetes care and educational materials that were tailored to American Indian/ Alaska Native (AI/AN) members and is developing resources to train our staff. They hope to influence future workflow adaptations to drive culturally responsive care delivery.
- Organization 1’s Health Coaches and Diabetes Educators proactively reach out to members with gaps in A1c to offer health coaching and share educational materials. They then notify members’ providers of the A1c gap to ensure coordinated care.

**Equity award application form:**

**Q1)** How did your organization measure change in ***equity for the health outcomes*** for the topic the organization sought to address?

a) What metrics did you use?

We used the HEDIS measure HBD: Hemoglobin A1c Control for Patients with Diabetes, HbA1c Poor Control (>9.0%).

b) How did you revise or stratify these metrics to provide a better view of equity?

We combined three years of data and then stratified the metric by race, ethnicity, and language to identify inequities within our member population. We recognize that disparities that exist at the state or organizational level are not the same for each geographical, racial, ethnic, or linguistic community. To provide a better view of equity, it’s integral that we stratify these measures by various demographic indicators, so we can elevate specific inequities and take steps to work with and support these communities in improving their control of their A1c, and overall Diabetes management.

c) How did you determine appropriate benchmarks?

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There are several options discussed at the national level when it comes to comparing disparities/inequities data to an appropriate benchmark. Organization 1 engaged in conversations with internal staff, national equity leaders, community members, and others to determine the benchmarks are most appropriate to use for our equity work. Organization 1 uses two methods for identifying disparities. First, we use our statewide Organization 1 average as the benchmark to compare other racial, ethnic, and linguistic groups and look for disparities in care that are greater than 5%. Second, we look at the highest performing demographic group within the measure as the benchmark and compare other groups to the benchmark.

#### **Q2) How did your organization measure patient satisfaction?**

##### **a) What metrics did you use?**

Organization 1 is committed to ensuring that patient voice is incorporated into all of our programs and work. Ensuring patients feel satisfied and that they can share feedback on the programs we provide is integral to improving the care and services that we offer. We have a team of diabetes educators who solicit qualitative feedback and data insights on patient’s satisfaction with the diabetes care, services, and programs we offer at Organization 1. The feedback and insights gathered from conversations between members with diabetes and our care management/diabetes educator team also inform the resources we provide. We collect qualitative feedback for our diabetes programming and measure patient satisfaction through a member satisfaction survey that is distributed to any members who have engaged with diabetes education or care management. Survey questions include:

1. Did our Care Management team pay attention to you and help you with your needs?
2. Did you get the help you needed to manage your health?
3. Were you treated with courtesy and respect?
4. Were you asked if you needed help with food, transportation, housing or other resources?
5. If health information was sent to you, was it useful?
6. Did our staff ask you questions in a way that you could understand?
7. Did our staff follow up and call you when they said they would?
8. Do you feel that our services have helped you to achieve your health goals?

All questions are asked on a 5-option Likert scale from “no, definitely not” to “yes, definitely.”

Additionally, patients are asked how satisfied they were with the services and are asked to provide additional feedback/comments.

##### **b) What survey methods did you use?**

Our diabetes educators provide a survey after engaging with members for diabetes education to solicit feedback and ensure they are providing high quality care. See the specific questions above:

However, our North Central regional care team recognized a disparity among Hispanic/Latine members of their region who have diabetes. They went to Fiestas Mexicanas, a community event held during Hispanic Heritage Month, and distributed surveys to solicit patient feedback on their experiences with our diabetes resources, and what additional resources might help them better manage their diabetes.

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Surveys were offered in English and Spanish and, within one day, they received 95 unique survey responses. The themes and responses gathered from these surveys have been used to inform our current and future diabetes care work to ensure that it is culturally and linguistically appropriate and responsive to our members’ needs.

**Q3) How does your organization maintain accountability for equity within the program for the following areas:**

**a) Communication**

**a. In communication about the program with staff and leadership**

Our Health Disparities Reduction work is directly tied to our annual strategic plan goals. This year we included specific measures that are called out in our strategic plan – including our diabetes work. This holds staff and leadership accountable for working to address disparities and taking action to improve diabetes care. Our strategic plan goals are shared at the beginning of each year, and accessible to all staff year round. We provide monthly updates that are shared internally so that staff know where we are at and are all held accountable for embedding equity into our programming and overarching work. Organization 1 staff hosted an in-service meeting titled "Equity & Wellness/Chronic Condition Management Touchbase" with member facing teams to gain insight and provide feedback on culturally appropriate educational resources we are utilizing or lack thereof, to identify gaps and provide resources when needed. Follow up meetings were held to share resources, address gaps, and answer questions.

**b. In communication about the program with patients and families**

Our diabetes educator teams work with patients and families to better support them in managing their diabetes. They provide support and communication about all our resources, programs, and support systems, as well as soliciting feedback on how to make things better. This inherently builds accountability into our programming and ensures that patient and family voices are included. Our diabetes educators are making sure they provide culturally and linguistically appropriate education and that people living with diabetes feel they are a part of the care team, working together to design services, resources, and a plan to address and manage their diabetes together. They provide comprehensive diabetes education sessions covering essential topics such as nutrition, medication management, physical activity, food resources, referrals to community health workers and case management, and coping strategies. These sessions ensure Organization 1 members acquire the knowledge and skills necessary for effective self-management, thereby closing gaps in care. Additionally, when our North Central regional care team conducted their survey/outreach at Fiestas Mexicanas, they included a) patients who have seen a provider for their diabetes b) family members of patients with diabetes, and c) the community at large to solicit their feedback and ensure they know about the resources and care we provide.

**c. In communication about the program with community**

As mentioned earlier, Organization 1 believes that it is integral to embed community voices, perspectives, and feedback into all our work, including our diabetes care work. Our North Central and Greater Columbia regional care teams who recognized disparities related to the HBD measure in their region have worked with members from the communities experiencing diabetes-related disparities in their region to solicit their feedback, share the programs and resources that exist, and ask for their help

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and perspective in building out future programming. By including patients and families in decision-making and program development, we are ensuring equity and accountability are at the forefront of our work. By sharing our work with communities, patients and their families, we ensure that there is continuous accountability to improve the resources and care we provide. Additionally, several of the CHCs in our network are using the \$50,000 annual funding we provide each CHC participating in the Equity Transformation Initiative to create Equity programs to improve diabetes care in their communities and ensure that community members, leaders, and organizations are involved in designing programs and holding Organization 1 accountable for improving the care we provide. We are continually working to improve how we communicate the programs and resources available to our communities, ensuring they are informed and have access to support for managing their diabetes and support for their families.

#### b) Education and training

Organization 1 offers an array of required annual, new hire, and optional training and educational opportunities to ensure all staff are accountable and have the education, training and knowledge to advance equity. We require all new staff to take equity training on Foundational Equity/Culturally and Linguistically Appropriate Services (CLAS) and have annual training that builds on concepts learned during onboarding. We have additional equity training for all member-facing teams to ensure we are providing culturally responsive care, linguistically responsive care and know about all translation and interpretation services, understand tribal communities and how to best serve and care for them, in addition to training on providing care to sexual and gender minorities. We regularly update resources and share them. We also provide staff training when requested or when a gap is identified. Our diabetes educators also fulfill additional learning requirements for their CDCES, RD, and RN credentials by completing CEU courses on diabetes management and/or relevant medical nutrition therapy topics through online webinars, in-person conferences, or other teleconference options. Additionally, Organization 1 hosts monthly townhall series on a variety of equity topics led by leaders in the space.

#### c) Through policies, procedures, or activities

We have several health equity-based policies and procedures (P&Ps). We have both a policy *and* a procedure on providing Culturally and Linguistically Appropriate Services (CLAS). This P&P ensures that all staff understand what it means to provide Culturally and Linguistically Appropriate Services and that Organization 1 adheres to all CLAS standards. P&Ps are reviewed and updated annually. Additionally, we have policies for our Health Equity Program Description and Evaluation documents. The Health Equity Program captures Organization 1's adherence to the Culturally and Linguistically Appropriate Services (CLAS) Standards and NCQA's Health Equity (HE) Standards. The primary goal of the Health Equity Program is to advance health equity, improve quality, and eliminate health care disparities. It details all our programs that advance health equity and then tracks and evaluates them. These documents, and thus these policies, hold us as an organization accountable for adhering to the CLAS standards and providing equitable and quality care and services. The program description and corresponding policies are also used to monitor and oversee our overarching Health Disparities Reduction work as detailed above – which includes our diabetes work.

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Additionally, we have shared resources with our diabetes educators and care management team on providing culturally and linguistically appropriate care which they have integrated into their programming, education, and work.

**Q4) How did your organization address social drivers of health? (list all that apply)**

**a) In workforce hiring, training, and development**

Organization 1 is currently developing a Social Drivers of Health (SDOH) training to go live in 2025. Currently, we include SDOH training in our CLAS/Health Equity training for new hires and in our annual training for staff. Additionally, we have developed a team dedicated to addressing SDOH, which continues to grow. We continue to educate staff on SDOH so that they are considering their role in addressing SDOH and how SDOH impacts our communities and members’ health so that we are thinking through this as we develop any programs or interventions. We are focusing on recruiting and hiring more diverse staff, particularly those who are bilingual and who have experience with the challenges of not having access to all health-promoting social drivers of health (SDOH). This ensures that their voices are incorporated into our work and programming to advance health equity.

**b) With programs and/or policies changes**

We have developed and are currently revamping our organizational SDOH strategy/infrastructure. One of the pieces of this is ensuring that we integrate SDOH into all our equity work and programming. SDOH and Health Equity are intrinsically related and thus we need to consider the social drivers of health impacting our members and driving/exacerbating inequities.

Organization 1 is committed to addressing SDOH across all programs and policies and is currently preparing for the National Committee of Quality Assurance (NCQA)’s Health Equity Accreditation Plus (HEA+) to show our commitment to health equity and SDOH and ensure that SDOH are integrated into all our work. HEA+ focuses on the collection, storage, and use of SDOH data, requires enhanced community-based partnerships and contracting, stakeholder engagement and meaningful evaluation efforts, and further stratification and evaluation for demographic factors (race, ethnicity, language, sexual orientation, gender identity, etc).

We have integrated SDOH into our diabetes care related work. Before developing programs to reduce disparities in controlling A1c or managing one's diabetes, we conduct a root cause analysis and specifically call out the SDOH-related barriers that may be impacting a community or individuals’ ability to adequately manage their diabetes or access resources in supporting them to do so. It is integrated into all the program development that we work to address social needs and SDOH in our program design – increasing access to healthy, affordable foods, providing translation and interpretation of education materials, and addressing transportation-related barriers, etc.

**c) What measures did your organization use to evaluate the effectiveness of the efforts to address social needs?**

When it comes to our diabetes care related work, SDOH clearly impacts an individual or community’s ability to manage their diabetes. We as an MCO have a responsibility to address and reduce the SDOH-



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related barriers at the systems level that may be negatively impacting our diabetes care. It’s been shown both at Organization 1 and on a state and national level that access to food, transportation, education, cost, and many other things are all barriers to addressing and improving diabetes care so proactively sought to address these in our programming to provide the most culturally responsive, whole person care. While we have anecdotally seen and heard the value of this in our diabetes care efforts, we have not specifically measured the effectiveness of each effort. Though it’s been evident before and after addressing SDOH, the importance of addressing these barriers and their impact on diabetes care and other disparities.

**Q5) What strategies did your organization use to:**

**a) To understand patient needs**

Before designing programs meant to address patients’ needs, it is integral that we sit back, listen and learn from communities so we can truly understand and address their needs. Our diabetes educators call and speak with our members with diabetes to understand their needs and how we can best support them and to provide individualized, whole-person care, setting tailored goals to support effective diabetes self-management. Additionally, the survey conducted by our North Central regional team very intentionally did this. The entire goal of the survey was to better understand patients’ needs so that we can be responsive to them.

**b) To develop community partnerships**

Partnering with communities is incredibly important to addressing and reducing disparities, advancing equity, and improving the care and services we provide. Our Regional Care Teams (RCTs) are from and engrained in the communities and work to build and strengthen community partnerships to improve the care we provide. We trust the RCTs to help us understand who should be at the table and the proper community partnerships for each of our efforts. Additionally, as an MCO founded by our CHCs who are inherently, and intentionally, built from and within the communities, it helps strengthen our ties with the CHCs and other community partners. Lastly, we have other teams across the organization whose roles and responsibilities are to strengthen our partnerships with community – community-based organizations, accountable communities of health, etc.

**c) To address power imbalances**

We are working to equip all staff with equity knowledge to address power imbalances. We recognize the value everyone at every level contributes to addressing equity. We all have different lived experiences, perspectives, and strengths that bring so much value to this work. Our Regional Care Team (RCT) model inherently addresses this as teams are built of a variety of staff from different divisions/teams including member-facing staff, leadership, those from the community, and individuals with lived experience who come together to design more inclusive programs, projects, and partnerships. We also intentionally include staff at all levels as voting members within our Health Equity Committee to ensure this same representation exists.



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**Q6)** Describe the ease of implementation in embedding equity into this program. What helped facilitate an equitable approach to the development or improvement of this program? (e.g. staffing diversity, leadership buy-in, community feedback, regulatory changes, funding changes, etc.)

The program itself is built from our Health Disparities Reduction/Health Equity campaign, so equity is at the forefront and foundation of this work. However, we constantly find ways to better involve equity and facilitate a more equitable approach. Before starting this work, we recognized the importance of leadership buy-in, we needed their support to really make this a priority for the organization. We couldn't do this without the buy-in and support of our leadership. Leveraging and valuing our staff, community partners, and CHCs who are diverse and have various expertise and experiences really enhance our ability to make our diabetes programming equitable. Making sure various voices, and people are involved in the development and planning of our program is instrumental to taking a true equitable approach. And most important of all, is doing true stakeholder and community engagement to embed patient and community voice into all our programs and decisions. We are working to do a better job at this through various avenues – community advisory councils, member advisory councils, and other committees, town halls and focus groups. Additionally, as an organization built by and for the community, and founded by CHCs, equity isn't just what we do, it's who we are. We have committed to equity through NCQA's Health Equity Accreditation (HEA), which we have continued to achieve over the years and maintain; and the new HEA+ which ensures we are being true stewards of equity and incorporating it into all we do. However, there are many barriers to truly incorporating equity into all we do, and this was certainly the case and continues to be the case in our diabetes work.

What were some of the main barriers to success in your setting?

A) Barrier 1 –

- a. What was it? Finding culturally and linguistically responsive diabetes resources that are relevant to our communities and being able to validate them, training staff on them, etc.
- b. How did you identify it? We listened to our communities and did our own research and recognized this was a significant gap. This also happened through trial and error, we have seen resources get translated and when they go to get validated, they don't translate correctly. Additionally, when trying to partner with CHCs we heard feedback that even if we have the resources, the time and capacity to train staff on them or find and fund bilingual staff is a real barrier.
- c. How did you address it? We are working to develop, translate, and validate tools of our own and are constantly attending webinars and training, researching, and connecting with leaders and researchers in the field to identify new resources. We are trying to work with at least one CHC this year on developing and providing truly culturally and linguistically responsive diabetes education (in English and Spanish) for our Hispanic, Latine, and Spanish-speaking members paired with access to diabetes management tools (Continuous Glucose Monitors (CGMS) and at-home A1c tests) and hope to pilot it and then repeat it with other CHCs if it's successful. Additionally, we are working to hire member-facing staff dedicated to providing

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culturally and linguistically appropriate care and increasing the number of bilingual staff.

B) Barrier 2 –

- a. What was it? The complexity of providing self-management tools (CGMs) – cost, workflows, reimbursement, requirements for eligibility, staffing capacity, training, patient comfort, etc.
- b. How did you identify it? We had conversations with providers, CHCs, researchers at UW, our diabetes educator team, our finance/reimbursement team, etc. and everyone kept sharing or emphasizing the complexity of providing diabetes self-management tools like CGMs which we initially thought would be an easier way to address other barriers and improve management of and control of diabetes/A1c
- c. How did you address it? In all honesty, we are still working to address this! We have been meeting with internal teams, external experts, and researchers to help us think through innovative approaches to providing CGMs to our communities. CGMs are fairly new and so we are all, across the industry and nation, continuing to try to find ways to make them affordable and accessible for folks who could really benefit from having access to them. We are working to train staff and have conversations with CHCs on the importance and value of CGMs while we internally work to address some of the financial/administrative/approval barriers so they can be more accessible to patients. We continue to have conversations with staff who have used and trained folks on CGMs or patients who have tried them to understand the barriers, fear and stigma so we can try to proactively address these issues. We continue to read new research and attend webinars/trainings on CGMs to be best equipped to address these barriers.

C) Barrier 3 –

- a. What was it? Patient experience in receiving / understanding self management tools and feeling they are accessible and responsive to their needs
- b. How did you identify it? Our diabetes educators, staff in/from the community, patients and people with diabetes who we have talked to, and CHC staff we have partnered with have all echoed the barrier they’ve felt or heard from patients which is that patients do not feel diabetes management tools and resources are always accessible, affordable, or responsive to their needs.
- c. How did you address it? We are working to listen to communities on what they want and need, which we did through our survey in North Central. By listening, we can understand what our communities and patients want/need and ensure we are responsive to their needs. Additionally, we are working to develop and enhance our educational resources and make sure we share these broadly so that patients feel the resources are accessible and available to them.

**Q7)** Please include other information that you believe made this project successful in terms of equity. You may want to consider such aspects as types of staff education, changes in workflows, use of data, culture change work, details on payment or contracting solutions, collaborations, etc.

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**Examples:** It is helpful to attach any examples of documents relevant to your project such as screen shots, workflow map, policy language, contract language, process prompts, posters, communication language, etc.) These can be attached in the email or attached through the submission portal. In previous years, successful applicants have attached charts and graphs, screen shots, sample documents as examples. Please make sure that your examples are de-identified.

Organization 1 has included the following documents to supplement our response:

- Diabetes A1c Fishbone Diagram (Root Cause Analysis)
- At Home A1c Workflow
- A1c Pilot Program FAQ
- North Central RCT Diabetes Project Poster (*presented at the Sea Mar Latino Health Forum 2024*)

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For FHCQ use only:

Nomination #