blue california

Promise Health Plan

# 2024-2025
# Quality Improvement Health Equity Transformation Program Description Medi-Cal Product

Responsible Health Equity Office Staff

Name: Jennifer Nuovo, MD
Title: Chief Medical Officer
Email: jennifer.nuovo@blueshieldca.com

Name: Valerie Martinez, DrPH(c), MPH
Title: Chief Health Equity Officer
Email: valerie.martinez@blueshieldca.com

Name: Brigitte Lamberson, MPH
Title: Health Equity Principal Program Manager
Email: brigitte.lamberson@blueshieldca.com

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# I. Introduction and Background

The Blue Shield of California Promise Health Plan (BSCPHP, or Blue Shield Promise) Health Equity program was developed with consideration to evidence-based programs, white papers, policies, All Plan Letters (APL) and strategic plans and focuses its efforts on an equitable whole-system, person-centered approach reducing health inequities and health disparities among the membership and communities served. These considerations include but are not limited to the following:

## A. Centers for Medicare and Medicaid Services (CMS) Framework for Health Equity.

The framework sets the foundation and priorities for CMS's work strengthening its infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working to eliminate barriers to CMS-supported benefits, services, and coverage. This Framework reinforces the concept that to attain the highest level of health for all people, focused and ongoing attention must be given to addressing avoidable inequalities and eliminate health and health care disparities (CMS, 2023).

## B. California Department of Health Care Services (DHCS) 2022 Comprehensive Quality Strategy.

The Comprehensive Quality Strategy introduces DHCS' ten-year vision for the Medi-Cal program where members served should have longer, healthier, and happier lives. The strategy introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025. The Bold Goals will include focused initiatives around children's preventive care, behavioral health integration, and maternity care, focusing on health equity within these key domains. These goals were identified to ensure a comprehensive quality approach across multiple populations. To achieve DHCS' vision of eliminating health care disparities, DHCS has defined needed improvements in data collection and stratification, workforce diversity and cultural responsiveness, and disparity reduction efforts (DHCS, 2022; Reference figure 1).


*Figure 1. California Department of Health Care Services Bold Goals*

## C. DHCS California Advancing and Innovating Medi-Cal (CalAIM) Guide requirements.

California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The Department of Health Care Services (DHCS) is innovating and transforming the Medi-Cal delivery system. CalAIM is moving Medi-Cal towards a population health approach that prioritizes prevention and whole person care. The goal is to extend support and services beyond hospitals and health care settings directly into California communities. The vision is to meet people where they are in life, address social drivers of health, and break down the walls of health care. CalAIM will offer Medi-Cal enrollees coordinated and equitable access to services that address their physical, behavioral, developmental, dental, and long-term care needs, throughout their lives, from birth to a dignified end of life (DHCS Claim, 2023).

## D. DHCS All Plan Letter (APL) 23-021 Population Needs Assessment (PNA).

The PNA identifies member health status and behaviors, member health education and cultural and linguistics (C&L) needs, health disparities, and gaps in services related to these issues. The goal of the PNA is to improve health outcomes for our members and ensure that BSCPHP is meeting the needs of all our Medi-Cal members by identifying member health needs and health disparities; evaluating health education, C&L, and quality improvement (QI) activities and available resources to address identified concerns; implementing targeted strategies for health education, C&L, and QI programs and services.

Additionally, the newly released DHCS APL 23-025 Diversity, Equity, and Inclusion (DEI) Training Program Requirements is a core part of increasing capacity to deliver culturally competent care. The DEI training program will support creating a better relationship and connectivity with diverse members across populations who have been disadvantaged by the system. The training program will create an inclusive environment within Blue Shield Promise Health Plan and externally with Network Providers and other community-based contractors and staff with lived experience improving our members' outcomes by enhancing access to care, reduce health disparities, and overall better quality of care.

## E. California Department of Managed Health Care (DMHC) APL 22-028 Health Equity and Quality Measure Set and Reporting Process.

The DMHC has established the Health Equity and Quality Measure Set (HEQMS) and measure stratification requirements, which are provided in APL 22-028. The HEQMS were recommended with the goal of addressing long-standing health inequities and ensure the equitable delivery of high-quality health care services across all market segments, including the individual, small and large group markets, and the Medi-Cal Managed Care program.

The HEQMS will be effective Measurement Year (MY) 2023 through at least MY 2027. BSCPHP will comply with Assembly Bill (AB) 133 as implemented by this APL and future

DMHC guidance, consistent with applicable law, including Health and Safety Code section 1399.872. Pursuant to AB 133, the DMHC will promulgate regulations to codify these requirements by 2026.

The HEQMS is comprised of 12 Healthcare Effectiveness Data and Information Set (HEDIS®) and one Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measure:

1. Colorectal Cancer Screening
2. Breast Cancer Screening
3. Hemoglobin A1c Control for Patients with Diabetes
4. Controlling High Blood Pressure
5. Asthma Medication Ratio
6. Depression Screening and Follow-Up for Adolescents and Adults
7. Prenatal and Postpartum Care
8. Childhood Immunization Status
9. Well-Child Visits in the First 30 Months of Life
10. Child and Adolescent Well-Care Visits
11. Plan All-Cause Readmissions
12. Immunizations for Adolescents
13. CAHPS® Health Plan Survey, Version 5.0 (Medicaid and Commercial): Getting Needed Care

The DMHC will require health plans to report HEQMS measure rates at the statewide aggregate level by product line. The DMHC is adopting the NCQA Medicaid and commercial product line definitions.

### F. National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards for the Medicaid product line.

BSCPHP will obtain NCQA Health Equity Accreditation (HEA), as set forth by the DHCS contractual requirements. HEA focuses on the foundation of health equity work: building an internal culture that supports the organization's external health equity work; collecting data that help the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs; and identifying opportunities to reduce health inequities and improve care.

BSCPHP will adopt an actionable framework for improving health equity and prioritize health equity for our members and the communities we serve.

### G. California Health Care Foundation (CHCF) and NCQA White Paper. Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid.

BSCPHP's Health Equity Office will integrate health equity throughout the organization. The health plan has adopted the California Health Care Foundation (CHCF) and National Committee Quality Assurance (NCQA) recommended measurement framework for

accountability in Medicaid to advance health equity. This framework represents an effort to centralize health equity in quality measurement through a set of domains to track progress over time and assess performance.

The framework will inform development of quality improvement programs, help to focus resources on programs and/or interventions most likely to contribute to improving health equity, and provide an opportunity to align quality and performance strategies with equity centered approaches to address disparities and close gaps in health care and health outcome.

Thus, BSCPHP's Health Equity program has been designed to meet the considerations listed above. Additionally, the Health Equity program is comprised of activities, procedures, investments, member engagement, clinical programs, and provider partnerships that will help drive transformation of the health care system, improving quality, expanding access, and ensuring equity for all members.

The scope of the Health Equity Transformation Program Description covers services provided to BSCPHP Medi-Cal members.

## II. Blue Shield Promise Health Plan's Health Equity Mission

Blue Shield of California (Blue Shield), founded over 80 years ago, operates exclusively in California, understands our state's diversity, and lives by our values as a nonprofit BSCPHP's mission is "to ensure all Californians have access to high-quality health care at an affordable price," and we are guided by our vision to "create a healthcare system that is worthy of our family and friends and sustainably affordable" is based in equity.

BSCPHP is a licensee of the Blue Cross Blue Shield Association and is an affiliate of BSCPHP holds Health Plan Accreditation and Multicultural Health Care Distinction for its Medicaid product line from the National Committee for Quality Assurance (NCQA) and will be pursuing Health Equity Accreditation from NCQA in 2024.

The Health Equity Office (HEO) will serve to champion Blue Shield of California's holistic drive to eliminate disparities within the organization as well as within the counties served. Advancing health equity requires an honest examination of pervasive issues plaguing our communities like systemic racism, implicit bias, quality of services, and funding. It also requires stakeholder buy-in and tireless action; resiliency to advance efforts; connection to individuals who share their truth; and a workforce to translate those stories into action. None of this can be accomplished without authenticity, the ability to acknowledge the current state and challenges ahead, and the fortitude to advance equity efforts, fight for what's right, and protect our communities. By establishing an integrated cultural norm of collaboration and partnership, we will succeed in improving the lives of all Californians under our care. BSCPHP seeks to perform health equity work in a manner worthy of our family and friends. BSCPHP recognizes this requires strong, sustaining resources, and the organization's commitment and focus to advance health equity.

## III. Blue Shield Promise Quality Improvement Health Equity Transformation Program Values

BSCPHP's Health Equity program is founded in the following values.

1) Quality and Health Equity are one and the same. We cannot have a high quality, high-performing health plan without health equity. High quality, whole person care requires commitment and teamwork of the entire community. Driving quality, equity and the best possible outcomes for our diverse Medi-Cal population brings us closer to attaining our shared vision for all Californians.

2) We are never bound by convention. We cannot solve today's problems with yesterday's solutions. We step beyond the traditional role of a health plan to completely reimagine how we show up for our members. We are relentless in our drive to co-create novel solutions that have the power to significantly impact the health and wellness of Californians.

3) Trust is earned. We ground our work in a deep respect for an understanding of the root causes of trauma and inequities in communities. We understand our members' experience by being physically present in the neighborhoods where they live. Where we live. We listen deeply and center community wisdom in everything we do.

4) We can lead the transformative shift. We are collaborative at our core. We are physically present in the communities we serve. We bring our whole selves to the mission of eliminating disparities in the communities we serve.

## IV. Quality Improvement Health Equity Transformation Program Tenets

BSCPHP seeks to eliminate disparities within the organization, counties, and members served. Therefore, BSCPHP's' HEO will embed health equity into everything we do across the enterprise. The HEO will establish a process and framework for embracing the program values, solidifying a culture and a practice of equity across the organization, and in accordance with regulatory requirements. The HEO will work to implement the Quality Improvement Health Equity Transformation (QIHETP) program tenets and activities to support the drive to eliminate disparities among populations served (Reference figure 2).

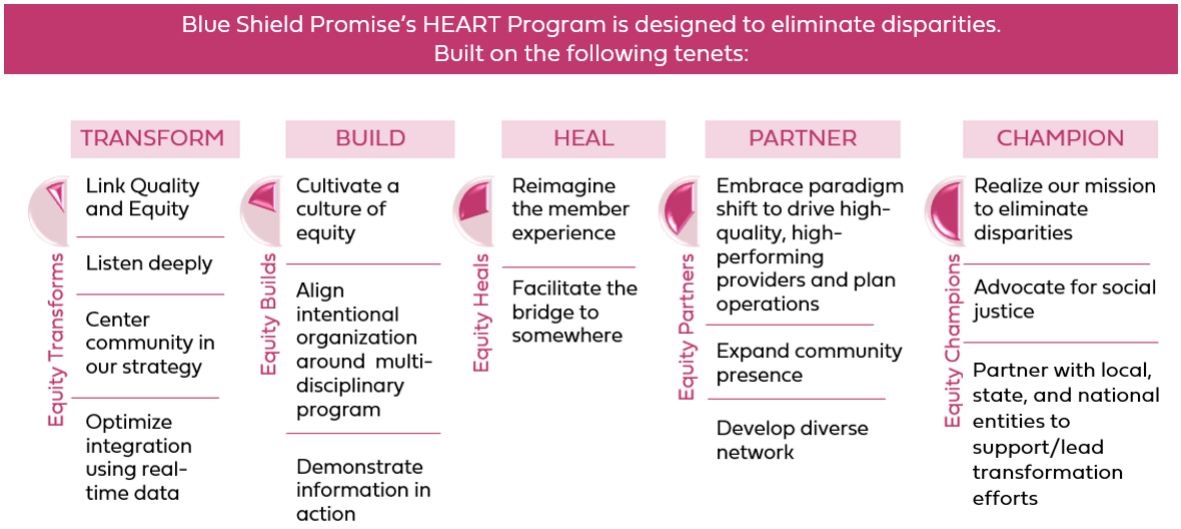


*Figure 2 Health Equity Transformation Program Tenets*

The following details the QIHETP activities for each listed lever as depicted in figure 2 above:

A. Transform. Transforming equity includes the necessary link between quality and equity, and listening deeply to our members, provider, and community partners. We will center our strategies on that feedback, leveraging real-time data, understanding that integration of multiple data sources is required to optimize our understanding of where disparities and inequities exist. BSCPHP's HEO will develop a series of action items to implement the Health Equity program. This includes creating a governance structure, defining health equity metrics, and developing a monitoring plan to identify disparities. The Health Equity Office will then develop interventions to address these health disparities.

B. Build. BSCPHP will launch the Health Equity Office (HEO). The HEO will develop a comprehensive Health Equity program that both meets regulatory requirements and supports BSP's commitment to addressing health disparities. In addition, BSP's HEO will develop a plan to monitor, identify, and address health disparities across populations. Building equity includes cultivating a culture of equity internally and externally with providers and community partners. BSCPHP's Health Equity Transformation Program will be multidisciplinary across the enterprise with alignment on equity principles.

C. Heal. BSCPHP will not only be equipped to best identify a member's needs but will facilitate coordination of care to address social drivers of health. Most importantly, BSCPHP will also confirm members are obtaining needed care, placing additional emphasis on members in most need. DHCS has issued several mandates requiring health plans to initiate health disparity work. Such mandates include requirements to identify specific member needs via the Population Needs Assessment (PNA), CalAIM program requirements (DHCS CalAIM, 2022), and stratified reporting of HEDIS® data for specific measures as outlined in the DHCS Comprehensive Quality Strategy 2022 report. These requirements will be integrated into this Health Equity program. BSCPHP is fully committed to launching the new Health Equity Office and will support disparity work as needs are identified.

D. Partner. BSCPHP will support providers and operations to maximize health care delivery, understanding that equity work extends beyond the four walls of an exam room. BSCPHP will not only support the member journey, but will also rely on partners, ensuring they are equipped to meet the unique needs of each and every member. BSCPHP will work diversify our provider network, supporting cultural competency, health equity training, attempting to dismantle systemic racism and teach skills to reduce implicit bias, all lending to an improved member experience while facilitating optimal outcomes.
E. Champion. BSCPHP is committed to bringing our whole selves to the mission of eliminating health disparities. We believe in the ability to catalyze lasting change. To reach health equity, we recognize that we must be steadfast advocates for social justice and be successful state partners leading health equity transformation. As we look ahead toward the future state, building the capacity of individuals, internal, and external stakeholders will be essential in reaching health equity.

## V. Activities

BSCPHP seeks to create a healthcare system that is worthy of our family and friends and is sustainably affordable. BSCPHP has defined a set of health plan strategies to achieve this goal. A health equity lens has been applied to each of these guiding principles to create a unique set of Health Equity Strategies.

| Activities | Health Equity Strategy |
|---|---|
| Doing what's right | Actively working on correcting systemic inequities in our health and social systems to address member needs and deliver a high-quality experience and integrate an internal culture of diversity, inclusion, and equity (DEI) |
| Being a trusted and reliable partner | Collaborating with community-based organizations, other managed care plans and all levels of government to implement tools, exchange information for the benefit of all, bring healthcare into the digital age and ensure the accountability and long-term affordability of health care |
| Keeping our members first | Driving whole person, person-centered care that meets that health needs of all members, addresses SDOH, reduces disparities, and gives every member the opportunity to attain their full health potential |
| Community engagement | Aligning with community-based organizations, public plans, and county partners to improve community health and meet members where they are born, live, work, worship, and play with innovative programs to improve health outcomes |
| Provider collaboration | Helping providers focus on delivering quality care by providing technology and resources that remove barriers, inefficiencies, and administrative burden |
| Continuous improvement | Developing innovative advancements powered by leading edge technology, grounded in comprehensive, real-time data designed |

| | |
|---|---|
| | to improve care integration, outcomes, and delivery of health care services |
| Creating a personal, high-quality experience | Integrate shared opportunities to meet the needs of the members served across departments to create a personal high-quality experience at various touchpoints across the organization. |
| Serving more people | Understand that health equity is intersectional, and diversity exists within the communities and members served. Ensuring all employees, contracted staff and providers take an annual sensitivity, diversity, cultural competency, and health equity training with the goal to change behavior with interpersonal interactions and address all people inclusively, accurately, and respectfully (CDC, 2021). |
| Being a great place to do meaningful work | Actively recruit employees who represent the ethnic and cultural community groups we serve or who have extensive experience working with diverse populations. |

*Table 1. Health Equity Strategies and Activities*

## VI. Health Equity Keywords

Health equity is a priority across the entire organization. The Health Equity framework drives our work in developing common language and shared understanding to achieve the transformation our members deserve. To facilitate this common language, health-equity related terms are defined in Appendix 1.

## VII. Quality Improvement Health Equity Transformation Program Structure

The Blue Shield Board of Directors (Board) is comprised of community and provider leaders and is ultimately responsible for the Quality Program. The Board approves the Quality Strategy, and is presented with related goals, metrics, and recommendations for BSCPHP. The Board provides oversight on performance against quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of all quality activities to the Board Quality Improvement Committee (BQIC).

The Quality Improvement and Health Equity Transformation Program's (QIHETP) governance structure includes the following, at a minimum:

1. BSCPHP's Governing Board maintains oversight of the Quality Improvement and Health Equity Committee (QIHEC) and participates in the QIHETP planning.
2. The QIHEC will report to the Health Equity Oversight Committee (HEOC) and Quality Management Committee (QMC), both report to the Quality Oversight Committee (QOC); the QOC then reports directly to the BQIC. In addition, for the remainder of 2024, the QIHEC will report to the Medi-Cal Committee. The Medi-Cal Committee reports to the Blue Shield of California Board of Directors via consent agenda. In 2025, the QIHEC will report to the Medi-Cal Committee.
3. QIHETP activities are supervised by BSCPHP's Medical Director or the Medical Director's designee, in collaboration with BSCPHP's CHEO.

4. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of QIHETP development and performance review.

As aforementioned and summarized below, is the Quality Improvement Health Equity Transformation Program governance structure (Reference figure 3).

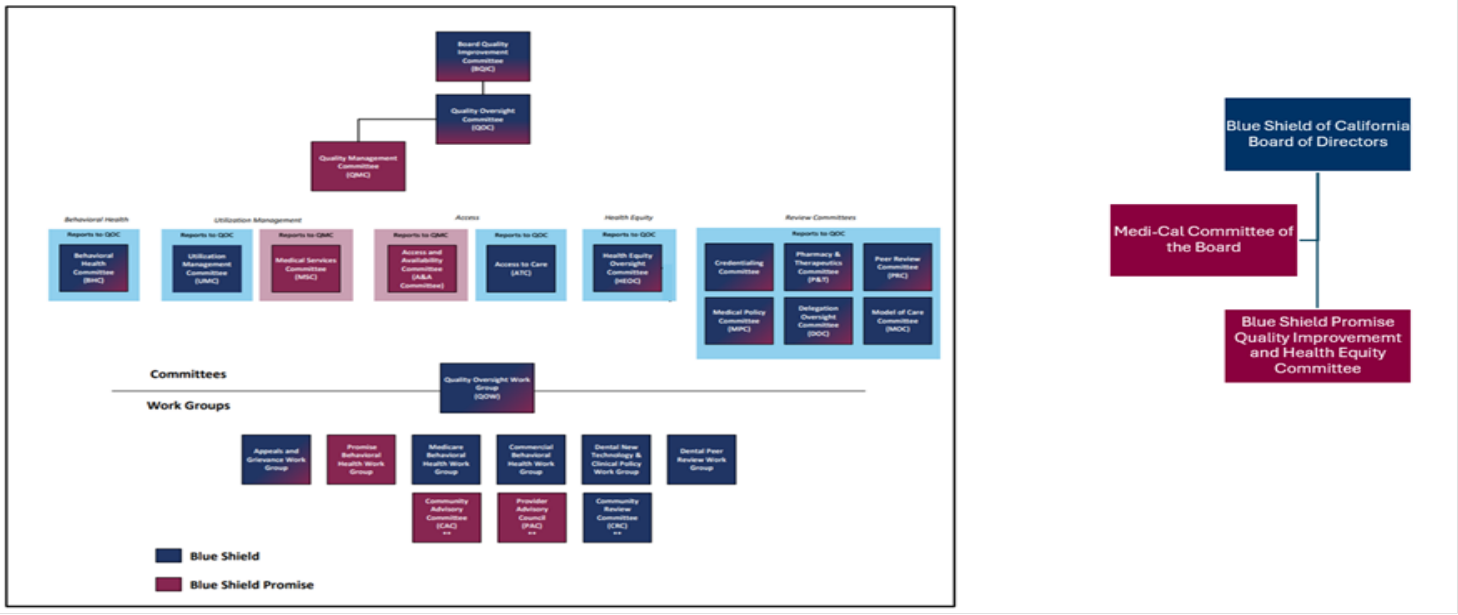


*Figure 3. Quality Improvement Health Equity Transformation Program Governance Structure*

BSCPHP's Quality Improvement and Health Equity Committee (QIHEC) reports to the Medi-Cal Committee of the Board. The Medi-Cal Committee of the Board reports to the Blue Shield of California Board of Directors via consent agenda.

## VIII. Quality Improvement Health Equity Committee

BSCPHP's QIHEC is charged with reviewing all Health Equity related activities and documents. The QIHEC will report to the Health Equity Oversight Committee (HEOC) and Quality Management Committee (QMC), both report to the Quality Oversight Committee (QOC). The QOC then reports directly to the BQIC. In addition, for the remainder of 2024, the QIHEC will report to the Medi-Cal Committee. The Medi-Cal Committee reports to the Blue Shield of California Board of Directors via consent agenda. In 2025, the QIHEC will report to the Medi-Cal Committee.

BSCPHP's QIHEC is responsible for Quality Improvement and Health Equity activities. The QIHEC is charged with reviewing and approving health equity activities. The QIHEC reviews Culturally and Linguistically Appropriate Services (CLAS), Population Needs Assessment (PNA), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS) results as related to health equity, results of the Health Equity

Advancements Resulting in Transformation (HEART) Measure Set, and the review, feedback, and approval of the annual written evaluation of the QIHETP.

The QIHEC will leverage member and community feedback to have an equity-centered approach to program management, planning, policies, and procedures.
The responsibilities of the QIHEC include the following:

1. Review and approve annual QI and Health Equity plan.
2. Develop, implement, maintain, and periodically update policies and procedures to ensure compliance with health equity requirements.
3. Analyze and evaluate the results of Quality Improvement (QI) and health equity activities, including but not limited to, the annual review of the results of performance measures, utilization data, consumer satisfaction surveys or Consumer Assessment of Healthcare Providers & Systems (CAHPS), and the findings and activities of other BSCPHP committees such as the Community Advisory Committee (CAC) and incorporate results into the design of quality improvement and health equity activities.
4. Institute actions to address performance deficiencies, including policy recommendations.
5. Ensure appropriate follow-up of identified performance deficiencies.
6. Implement and maintain a charter including the role, structure, and function of the Quality Improvement & Health Equity Committee.
7. Continuously monitor, review, evaluate and improve quality and health equity of covered services including clinical care services, case management, coordination and continuity of services provided to all members.
8. Review and provide feedback on BSCPHP Health Equity Accreditation activities, reports, and policies.

## Reporting

1. BSCPHP's CHEO or designee will provide a written summary of QIHEC activities, findings, recommendations, and actions following each meeting to the BQIC for the remainder of the year, in addition, to the Medi-Cal Committee and to DHCS upon request.
2. BSCPHP's CHEO or designee will provide a written summary of the QIHEC activities that will be made available publicly on the Plan's website at least on a quarterly basis.
3. BSCPHP's CHEO will produce an annual Promise Health Equity report to the QIHEC and DHCS upon request.
4. Designated staff will provide annual copies of all final reports of independent accrediting agencies to DHCS.
5. The HEO will post Quality Improvement and Health Equity Plan to the BSCPHP public website annually.

## Membership Composition

1. BSCPHP's QIHEC membership includes:
    a. Medical Director or designee as the Chair.

b. CHEO as the Co-Chair.
c. Representatives from leaders in BSCPHP functional areas.
d. A broad range of Network Providers, including but not limited to the following:
    i. Hospitals, clinics, county partners, physicians, and members.
    ii. BSCPHP Network Providers that are part of the QIHEC must be representative of the composition of the BSCPHP Provider Network and include, at a minimum, Network Providers who provide health care services to:
        1. Members affected by Health Disparities.
        2. Limited English Proficiency (LEP) members.
        3. Children with Special Health Care Needs (CSHCN).
        4. Seniors and Persons with Disabilities (SPD).
        5. Persons with chronic conditions.

The BSCPHP QIHEC meets quarterly and will conduct off-cycle meetings as needed. Formal minutes will be maintained for all meetings of the BSCPHP QIHEC.

## IX. Executive Leadership

BSCPHP' Health Equity Office (HEO) champions the holistic drive to eliminate disparities among members and communities served. The HEO structure is designed for maximal integration throughout BSCPHP to readily implement and prioritize policies, programs, and procedures to address health inequity.

The HEO is led by BSCPHP's CHEO who reports directly to the BSCPHP President and Chief Executive Officer (CEO). This reporting structure ensures that our top leaders and organization align to health equity across the enterprise.

The HEO is comprised of the following BSCPHP leaders:

A. President and Chief Executive Officer, BSCPHP: The President and CEO of BSCPHP reports to the COO of Blue Shield and is responsible for providing strategic leadership for BSCPHP by working with the Board and other management to establish long-range goals, strategies, plans and policies. This role provides oversight of quality plans and outcomes, ensuring the plans developed improve quality performance and drive equitable outcomes.
B. Chief Medical Officer, BSCPHP: The BSCPHP CMO reports to the BSCPHP President and CEO, and the SVP/CMO of Blue Shield, and works in conjunction with the VP, Clinical Quality, and the Clinical Quality organization to develop, implement, and evaluate the quality program. The CMO chairs the BSCPHP QMC and QIHEC and is responsible for oversight of all QI and HE activities.
C. Chief Health Equity Officer, BSCPHP: The CHEO will report directly to the BSCPHP President and CEO and will work cross functionally across the entire organization. The CHEO will work in partnership with DHCS to reduce health disparities and advance the DHCS Bold Goals 50x2025 Initiative.

D. Vice President, Clinical Quality, Blue Shield of California: the VP, Clinical Quality reports to the SVP/CMO and has direct operational accountability of the Clinical Quality department for BSCPHP. Functional responsibilities include quality assurance, clinical quality improvement, quality analytics, clinical quality review, and clinical quality member experience.

BSCPHP recognizes and fully supports the CMO playing a central role in the design and implementation of the PHM Strategy, which includes the implementation of Quality Improvement (QI) and Health Equity (HE) activities, and in engaging with local health departments. BSCPHP's Chief Medical Officer (CMO) is the leader accountable for the Blue Shield QI Program. In this capacity, the CMO is responsible for the design, priorities, work plan, activities, implementation, and evaluation of the entire scope of the QI Program. The scope of the QI Program, which is reviewed and updated annually, includes but is not limited to the PHM Strategy, QI and Health Equity initiatives, and provider collaborations including engaging with local health departments. Progress on the QI Program and PHM Strategy are reported quarterly to the Board Quality Improvement Committee (BQIC).

The CMO will also play a critical role in collaborating with the CHEO to drive the development, implementation, and measurement of initiatives to reduce health disparities and drive greater health equity. The CMO works with the CHEO to lead the Quality Improvement and Health Equity Committee (QIHEC), ensuring appropriate oversight and engagement in activities. BSCPHP recognizes that addressing health disparities and SDoH requires the commitment and engagement of the entire community. BSCPHP's CMO, therefore, works collaboratively with local health departments, community-based organizations, and our members to drive towards the most effective quality and health equity programs.

## X. Quality Improvement Health Equity Transformation Program Goals and Objectives

### A. Quality Improvement Health Equity Transformation Program Goals

BSCPHP's mission is to transform its health care delivery system into one that is worthy of families and friends and sustainably affordable. BSCPHP seeks to advance health equity by implementing health equity activities supporting BSCPHP's mission.

BSCPHP ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

BSCPHP has established the subsequent QIHETP program principles and will seek to implement the milestones listed (Reference figure 4).

1. **Advance Information in Action**: BSCPHP will integrate data and analytics platforms to generate valid, actionable, and meaningful information to increase quality and health equity.

2. **Build Sound Infrastructure and Operations**: BSCPHP will build the infrastructure to support the QIHETP. Integrate feedback provided by members, families and Network Providers, and community partners in the design, planning, and implementation of the QIHETP.

3. **Embed Equity**: BSCPHP will establish a process and multi-disciplinary framework for solidifying a culture and a practice of equity across the organization.

4. **Design Interventions that Matter**: BSCPHP will embed equity-focused initiatives across the enterprise to consistently prioritize addressing health disparities and in accordance with regulatory requirements and strategies. BSCPHP will utilize a health-equity lens to drive continual refinement of meaningful interventions, meeting members where they are. BSCPHP will work to identify disparities, develop data-driven, scalable, customized interventions that sustainably address health inequities.

| Information in Action | Sound Infrastructure and Operations | Equity Embedded | Interventions that Matter |
|---|---|---|---|
| • Develop a comprehensive data strategy for stratification and analysis of health disparities<br>• Capture and validate health equity related demographic data<br>• Enable a simplified reporting and analytics platform that drives the delivery of equitable, whole-person care | • Formulate Health Equity Office<br>• Establish the Office of Health Equity's operational governance framework in accordance with BSCPHP's current operating model and in alignment with regulatory requirements<br>• Define regular reporting and information flow/data analysis expectations<br>• Obtain NCQA Health Equity Accreditation | • Establish organiation-wide expectations that achieving health equity is everyone's responsibility<br>• Incorporate health equity informaiton sharing across BSCPHP | • Adopt a robust health equity intervention development process<br>• Develop customized interventions that target equitable whole-person care in marginalized populations and/or communities |

*Figure 4. 2023-2025 QIHETP Principles*

The QIHETP principles align with the QIHETP tenets in section IV, to transform, build, heal, partner and champion. For example, Advancing Information in Action activities integrate data and analytics platforms to generate actionable, meaningful information. Data will be used to identify disparities and develop data-driven, customized interventions that sustainably address health inequities linking quality and equity. Sound Infrastructure and Operations are the building blocks of the QIHETP. Establishing a HEO that champions integration and transformation that drives Quality and Health Equity in Medi-Cal. The HEO will establish regular reporting and information

flow/data analysis expectations across functional departments. Embedding Equity in everything and everywhere is part of our strategic approach to both healing and championing health equity, serving as a catalyst for change. Finally, the HEO will develop customizable interventions that target equitable whole-person care in marginalized populations and/or communities. This member-centric approach will provide the HEO with the opportunity to partner with cross functional departments and external community and provider partners.

Moreover, BSCPHP's HEO will operationalize program activities to meet the four program goals.

1. Advance Information in Action

   BSCPHP facilitates a simplified reporting and analytics platform that enables delivery of equitable, whole-person care for Promise members. BSCPHP will build and launch accessible, integrated data and analytics platforms that generate actionable, meaningful information, identity and sustainably address health disparities. BSCPHP recognizes that creative and multi-pronged solutions are urgently needed to capture and validate member data (e.g., Race, Ethnicity, Age, Language [REAL], Sexual Orientation and Gender Identity [SOGI], Social Determinants of Health [SDoH], etc.) that will uncover statistically significant health disparities. Real-time access to the most recent data as well as actionable, high-quality data is critical for key functions like Social Services, Enhanced Care Management (ECM), Population Health Management (PHM) to facilitate delivery of individualized and equitable care to members.

   BSCPHP has committed to the following Information in Action strategies:

   a. Develop a Comprehensive Data Strategy for Stratification and Analysis of Health Disparities.
   b. Capture/Validate Health Equity-Related Demographic Data.
   c. Enable a simplified reporting and analytics platform that enables delivery of equitable whole-person care for BSCPHP members.
   d. Institute processes to close gaps in care and maintain ongoing data accuracy.
   e. Enable demographic data capture along each member-facing touchpoint.
   f. Develop and/or update internal staff and Provider trainings for BSCPHP (e.g., Navigators, Community Health Advocates, Care Managers, etc.) and network providers to include responsibilities and evidence-based best practices for capturing key demographic data.
   g. Define scope and milestones for enabling real-time user-customizable reporting and analysis (e.g., drop down menus, etc.) and advanced member segmentation/analytics that address health-equity focused questions, including establishing a clear understanding of the reporting needs for different functional areas and Subsequent development of the necessary health equity dashboards.
   h. Assess the value of third-party data and/or analytics, integrating where able.
   i. Define scope and milestones for accessing actionable data and analytics that address health equity-focused questions and allow our internal teams to:

i. Surface insights regarding complex health issues, ex. severe maternal morbidity or primary care deserts.
ii. Highlight disparities in health outcomes and access to healthcare.
iii. Generate custom, targeted analysis looking at a wide range of utilization measures, selected HEDIS measures, and provider access measures.
iv. Generate custom, targeted analysis using community-level social determinants of health data at zip code and census tract level.
v. Access provider-level and hospital-level reporting data for analysis.

j. Develop a cross-functional process that enables organization-wide access to actionable data and analytics that address health equity focused questions.
i. Identify areas where health disparities exist as seen by open care gaps.
ii. Track performance of ongoing outreach activities.
iii. Plan member outreach activities through a health equity lens.
iv. Display characteristics of members who did not engage in care and/or past outreach activities.
v. A wide range of HEDIS® and Align Measure Perform (AMP) program measures.
vi. Community-level social determinants of health data at zip code and census tract level.
vii. Provider group-level reporting.
viii. Use SDOH data to understand the unique journeys and challenges of members.

k. The data and analytics platform should also provide connectivity to county Health Information Exchanges (HIEs)/Community Information Exchanges (CIEs) which will support increased quality of care management and identification/engagement of community resources and partners. BSCPHP will select external data sources that best enables this connectivity and establish sustainable partnerships operating to enhance design of high impact interventions.

## 2. Sound Infrastructure and Operations

### Integration

BSCPHP's journey to create a health equity infrastructure throughout the enterprise started several years ago. Work was initiated within the enterprise-wide innovation unit to maximize creative, rapid solutions with a focus on Medi-Cal. Creating pillars of health equity, we anchored the organization in common language and process. Our journey culminated in the design and vision for the BSCPHP HEO.

BSCPHP's HEO supports and leads health equity projects across the organization. The CHEO leads the HEO and enterprise-wide initiatives, investments, and programs to drive health equity goals. The HEO structure is designed for maximal integration throughout the organization to readily implement and prioritize policies, programs, and procedures to address health inequity. The CHEO reports directly to the BSCPHP CEO. This reporting

structure ensures that our top leaders and organization align to health equity across the enterprise.

### Health Equity Office

The CHEO is supported by a team with deep expertise in structural racism, bias and discrimination, health equity, social work, evaluation, and community engagement, to embed the health equity framework work throughout the organization. The CHEO and key supporting staff are integral to ensuring all strategies and programs prioritize health equity and address health disparities. Their work will be highly cross-functional and require a team to execute effectively. Their roles maintain appropriate authority and decision rights to be effective throughout the enterprise. The HEO convenes regularly to review the QIHETP updates.

The HEO is comprised of the following BSCPHP staff (Reference figure 5):

a. President and Chief Executive Officer
b. Chief Medical Officer
c. Chief Health Equity Officer
d. Senior Director of Clinical Quality
e. Director of Clinical Quality
f. Health Equity Principal Program Manager
g. Health Equity Business Analyst

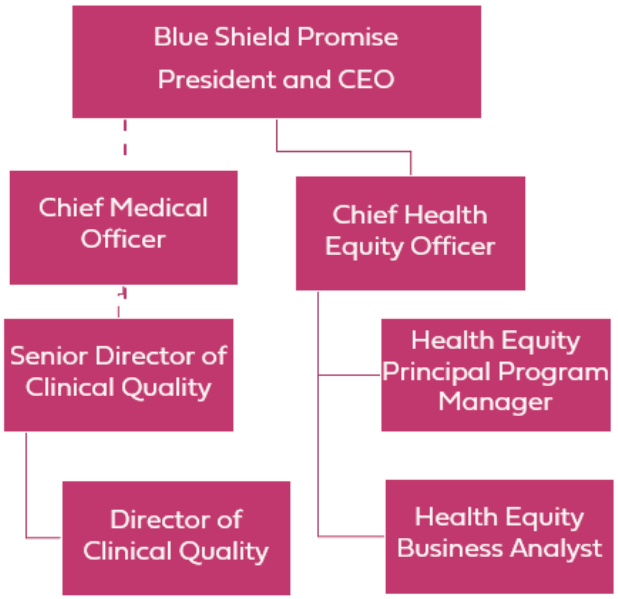


*Figure 5. BSCPHP Health Plan Health Equity Office Organizational Chart*

The President and CEO of BSCPHP reports to the Chief Operating Officer (COO) of Blue Shield and is responsible for providing strategic leadership for BSCPHP by working with the

Board and other management to establish long-range goals, strategies, plans and policies. The CEO provides oversight of quality plans and outcomes, ensuring the plans developed improve quality performance and drive equitable outcomes.

The BSCPHP Chief Medical Officer (CMO) reports to the Senior Vice President (SVP)/CMO of Blue Shield and works in conjunction with the Vice President (VP), Clinical Quality, and the Clinical Quality organization to develop, implement, and evaluate the quality program. The CMO is responsible for oversight of all QI and Health Equity activities.

The BSCPHPCHEO reports directly to the BSCPHP President and CEO and will work cross functionally across the entire organization to advance efforts to reduce disparities and inequities.

The Senior Director of Clinical Quality and Quality Improvement is responsible for the development and execution of the Medi-Cal clinical quality improvement strategy and works collaboratively with the CHEO to support QIHETP activities.

The Director of Clinical Quality is responsible for the strategy, development, and implementation of clinical quality improvement activities for BSCPHP.
BSCPHP's Health Equity Principal Program Manager is responsible for the execution and oversight of QIHETP activities.

**Governance**

Furthermore, BSCPHP has established an HEO operational model and governance in accordance with the organization's current operating model and in alignment with the requirements set for by the DHCS. BSCPHP has established committees, such as the implementation and maintenance of the Quality Improvement and Health Equity Committee (QIHEC) responsible for creating the QIHETP Annual Plan, the Community/Member Advisory committees, Provider Advisory Committee, and other committees as identified by leadership and the community.

Policies and Procedures

Additionally, BSCPHP's QIHTEP policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to:

a. Marketing strategy
b. Medical and other health services policies
c. Member and provider outreach
d. Community Advisory Committee
e. Quality Improvement activities
f. Grievance and Appeals
g. Utilization Management

BSCPHP develops new and modifies existing policies and procedures that result in reducing health disparities and increasing health equity in the Medi-Cal population; establishes equity-focused medical and other health services policies in alignment with DHCS goals and requirements; establishes a Community/Member Advisory Committee with the power to drive meaningful health-equity directed change; and establishes protocols for data presentation and the public posting of required and relevant Health Equity-related content on the BSCPHP website. Policies and procedures are reviewed and approved by the QIHEC.

BSCPHP has established a process for presenting data and information for various projects/initiatives such as the Annual QIHETP, meeting minutes from the quarterly QIHEC, Utilization management policies and procedures, Community/Member Advisory Committee, and collaborate with cross functional departments across the enterprise to expand health equity metrics beyond the required DHCS Medical- Managed Care Accountability Set (MCAS) or HEDIS® data.

### Monitoring and Oversight

The Health Equity Office, under the leadership of the Chief Health Equity Officer (CHEO) and Quality Improvement and Health Equity Committee (QIHEC) will review and monitor all QIHETP and QIHEC activities by maintaining a plan to identify and address health disparities across populations; and monitoring performance toward QIHETP goals.

The HEO will integrate and build on efforts enabling a central mechanism to systematically monitor the effectiveness of programs and interventions. Specifically, the HEO will analyze data gathered for a specific set of metrics as listed in the HEART Measure Set.

The HEO will: 1) establish a baseline analysis of the status, and 2) develop a process for rigorous monitoring and evaluation of improvement initiatives. Connectivity across this data capture diverse perspectives to deeply understand all discovered disparities our members experience, and speed the development of comprehensive, member-focused solutions with a sustainable impact and data to guide continuous quality improvement (CQI) efforts.

Written QIHEC progress reports describing actions taken, progress in meeting QIHETP objectives, and future opportunities for improvement will be submitted to the BQIC for the remainder of the year in addition to the Medi-Cal committee for formal review and approval. A comprehensive assessment and list of all QIHETP activities is presented in a fluid QIHETP work plan.

### Accreditation

BCPHP will seek to acquire the NCQA Health Equity Accreditation per DHCS contract requirements. BSCPHP will report the status of accreditation to DHCS per contract requirement.

## 3. Equity Embedded

BSCPCP is seeking to embed Health Equity into everything we do. BSCPHP will establish a process and expectations framework for solidifying a culture and practice of equity across the organization and in accordance with DHCS requirements. BSCPHP recognizes that achieving health equity is everyone's responsibility and the organization-wide expectation. BSCPHP provides staff training on Health Equity and Cultural Competency. BSCPHP seeks to recruit and retain a diverse workforce with varying cultural backgrounds, languages spoken, and lived experiences that are not only representative of the populations served but enable a culturally sensitive approach to member interaction.

BSCPHP's policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible throughout the enterprise. BSCPHP has convened the QIHEC co-chaired by the CMO and CHEO to thoroughly review and analyze all health plan policies and procedures, identifying areas that promote inequity. The HEO will advise recommendations to promote equity into policies, programs, and operations.

4. Interventions that Matter

BSCPHP will develop data-driven customized interventions that drive Quality and Health Equity in Medi-Cal, in partnership with key cross functional areas and in alignment with DHCS bold goals (Summarized in figure 1).

Further, BSCPHP will develop customized interventions that target equitable, whole-person care in marginalized populations and/or communities. BSCPHP recognizes consistent, incremental health equity work builds momentum over time leading to potentially exponential results. The deeply rooted systems of bias toward and oppression of marginalized people require relentless focus and determination.

BSCPHP will adopt a robust health equity intervention development process defining and solidifying a cross-functional process that enables the identification of disparity root causes and enables effective, sustainable intervention deployment. The development process will include reviewing root causes of disparities identified and prioritize based on importance and feasibility, defining multiple levels of influence to target such as patient, provider, community, etc., and delivery modes of communication such as print, social media, in-person, etc. BSCPHP will also define outcome and process measures and identify keys to sustainability.

## B. QIHETP Objectives

The HEO seeks to meet a set of objectives that contribute to accomplishing the QIHET program goals. Objectives are established by the HEO on an annual basis and revised as needed. Progress is assessed routinely and reported to the QIHEC. Results are incorporated into the QIHETP Annual Evaluation and reported to the QIHEC and other committees per the established governance structure.

| QIHET Program Objectives | |
|---|---|
| Goal | Objective |
| Information in Action | BSCPHP will develop a mandated Diversity, Equity and Inclusion and Health Equity training by 12/31/2024. |
| **Sound Infrastructure and Operations** | BSCPHP's QIHET program documents will be reviewed and approved by the governance process by 9/30/2024 |
| **Equity embedded in everything we do** | Prepare health equity integration plans, formal assessments, frameworks, and recommendation reports by 12/31/2024.<br><br>Assess the I have Health Equity Advancements Resulting in Transformation (HEART) Advocate Program and determine opportunities for the next cohort by 7/1/2024. |
| **Sound Infrastructure and Operations** | BSCPHP HEO will facilitate the QIHEC meeting with external partners by 3/21/2024. |
| **Interventions that Matter** | Conduct quarterly HEART Measure Set monitoring and analysis to identify health disparities and trends for interventions by 12/31/2024. |

*Table 2. QIHET Program Goals and Objectives*

## XI. Blue Shield Promise Internal Key Functional Areas and Responsible Departments

Health Disparities transcends across departments impacting multiple cross-functional areas, thus, BSCPHP's policy and procedures are designed to integrate and promote health equity, addressing inequities, where possible including but not limited to the following cross functional areas: Marketing strategy, Medical and other health services policies, Member and provider outreach, Community Advisory Committee, Quality Improvement activities, including delivery system reforms, Grievance and Appeals, and Utilization Management.

The HEO coordinates with functional areas (e.g., Grievances, Utilization Management, and Behavioral Health) within BSCPHP to identify and address disparities. Applying a health equity lens to program oversight across each functional area will be key in identifying health disparities and/or inequities across vulnerable populations.

The HEO seeks to engage functional areas in health equity planning and oversight. The roadshow experience between the Health Equity Office and functional area leaders facilitates identification of select health equity measures and allows for planning in recognition of the intersection between health equity in various functional areas. The goal of the roadshows is to discuss opportunities for health equity integration and identify specific health equity measures to monitor disparities. These multi-disciplinary measures comprise the HEART Measure Set. The HEO will then monitor the data for the selected measures and identify disparities and/or trends over time. Integrated data results and outcomes will be shared at the quarterly QIHEC meeting to provide transparent information sharing for cross-collaboration and understanding. Based on this analysis, and in partnership with

the cross functional areas at the direction of the CHEO, will implement initiatives to resolve the known health disparities, gaps, and opportunities (Reference figure 4).

Health Equity efforts will be integrated, targeting a wide range of inequities e.g., populations, measures, access to care, utilization, satisfaction, engagement, DEI, etc. For example, the CHEO will collaborate with BSCPHP C&L staff to review and update its cultural and linguistic services programs to align with the PNA. BSCPHP ensures its Network Providers cultural, and health equity linguistic services programs also align with the PNA.

The HEO will also integrate health equity activities externally, via engagement with members, providers, and community-based organizations. The CHEO will remain an active member of the Member Advisory Committee and Provider Advisory Committee, sharing updates and integrating feedback into the design and implementation of the QIHETP.

BSCPHP will also complete and submit to DHCS an annual Community Advisory Committee (CAC) report. The CHEO reviews the annual report to ensure CAC membership is representative of the Communities in BSCPHP's service area. The annual report integrates health equity by including a description of the CAC's ongoing role and impact in decision-making about health equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped initiatives and/or policies.

## XII. Health Equity Integration

BSCPHP's HEO will integrate health equity throughout the organization. The health plan has adopted the California Health Care Foundation (CHCF) and NCQA recommended measurement framework for accountability in Medicaid to advance health equity. Specifically, the measurement framework will support a robust, comprehensive approach to monitoring for disparities that may exist when assessing various health plan operations and data sources.

This framework represents an effort to centralize health equity in quality measurement through a set of domains to track progress over time and assess performance. The framework will inform development of quality improvement programs, help to focus resources on programs and/or interventions most likely to contribute to improving health equity, and provide an opportunity to align quality and performance strategies with equity centered approaches to address disparities and close gaps in health care and health outcome.

The framework includes six domains, each domain represents the perspectives of a range of internal stakeholders and partners. It also provides an opportunity to garner a consensus for measure selection across all impacted partners and build on the health equity strategic plan across the organization.  Building consensus is a critical factor to be successful in advancing and improving health equity. The health equity roadshows served as the forum to gather consensus and commitment to identifying measures that are most applicable to these framework domains. The identified measures were then categorized under the most applicable domain.

The framework six domains are as follows:

1. Equitable Social Interventions. Measures of unmet social needs and the interventions and services designed to address them.
2. Equitable Access to Care. Measures of access to high value health care services, including the timeliness and convenience of getting care.
3. Equitable High-Quality Clinical Care. Measures of clinical care process and outcomes, including prevention and management of chronic disease.
4. Equitable Experiences of Care. Member-reported measures of health care experience.
5. Equitable Structures of Care. Measures that assess an organization's culture and system of care for meeting the needs of individuals from diverse backgrounds and lived experiences.
6. Overall Well-Being. Self-reported survey metrics of physical and mental health and overall well-being.


*Figure 6. Health Equity Measurement Framework for Medicaid Accountability Domains*

Domains are structured to recognize overlaps within the domains. For example, access to care is a prerequisite for many measures of health outcomes, and social drivers of health can impact both access and overall well-being. Achieving equitable health care and outcomes will require success across domains.

The framework contains recommended quality metrics to support evaluation of each domain. Domains and associated measures reflect elements that contribute to or reveal equities and inequities in health care and health outcomes. The HEO and leaders from functional areas will identify measures as recommended in the CHCF and NCQA framework, and/or add additional metrics to meet state regulatory compliance.

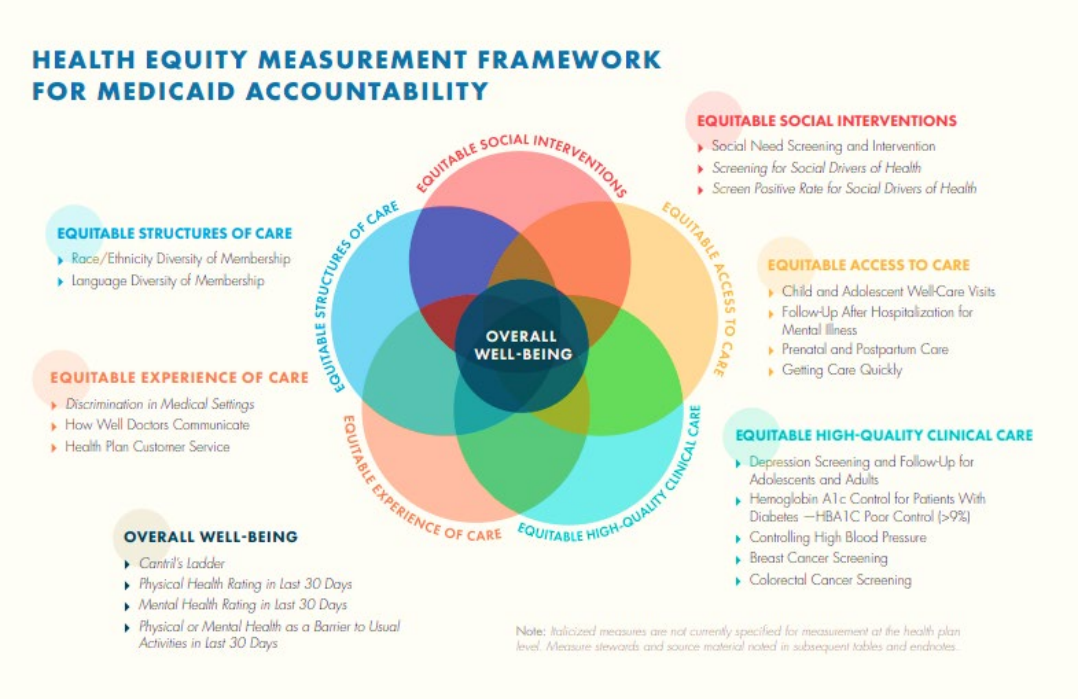


*Figure 7. Health Equity Measurement Framework for Medicaid Accountability Summarized*

Health Equity is integrated across the organization disparities transcend departments impacting multiple cross-functional areas and. BSCPHP will apply a health equity lens to program oversight across each functional area. As figure 7 demonstrates, data and analytic sets extend beyond HEDIS® measures. The six domains extend across cross functional departments throughout BSCPHP.

Select measures outlined in the HEART Measure Set will be stratified and analyzed for health disparities. When possible, metrics must be stratified by race, ethnicity, gender, age, and language spoken (REGAL) to inform health equity initiatives and mitigate health disparities. Key measures or metrics for each data set will need to be selected by the HEO in collaboration with each functional area. Reporting and dashboards will need to be designed for each data set and/or use case to monitor metrics and identify disparities and trends in each department. Identifying where the health disparities are will facilitate strategic implementation of targeted initiatives and sharing of results, outcomes, and lessons learned. Health equity efforts will be integrated targeting a wide range of inequities and will allow a cross sharing of transparent information for collaboration and understanding across departments providing insight into potential underlying reasons for variations.

BSCPHP's HEO, in collaboration with the leaders of each functional area, identified priority populations and focus areas to assess and monitor health disparities across the health plan. These areas of focus include:

- Quality HEDIS® measures
- Grievances and Appeals, Behavioral Health
- Provider Relations and Contracting

- Health Education
- Cultural and Linguistics
- CalAim and subsidiary population health management functional area
- Customer Experience
- Clinical Access Programs
- Maternal Health
- Utilization Management

The health equity measure set incorporates regulatory reporting requirements and stretches us to consider health equity in our oversight of metrics and outcomes. BSCPHP understands that health equity integration goes beyond establishing a health equity measure set. Integration includes a responsibility to ensure covered services continue to meet the needs of our members and are suitably integrated within the QIHETP. These were considered as the HEART Measure Set was developed.

Below is a detailed list of the health equity measures set selection by department. Oversight of the health equity measure set outcomes and/or performance results will follow the continuous quality improvement (CQI) process. The HEO will define an overall Health Equity Score, the number of measures from the HEART Measure Set that are meeting the target. The health equity measure set will be monitored at least quarterly and reported to the QIHEC. Reference Appendix 2 for the complete HEART Measure Set by department.

### A. Customer Experience

The member experience is critical to member engagement, satisfaction, and can influence member utilization of services. The HEO and Customer Experience department selected specific regulatory measures that meet both regulatory and health equity intent and purposes. Customer Experience will focus on:

- Call center metrics include tracking BSCPHP Customer Experience and vendor requested interpreter service calls by the member's preferred language.
- Tracking and trending the total number of multi-cultural/multilingual staff to ensure our Customer Experience member-facing staff are representative of our entire membership.
- Tracking and trending the total number of translated documents by language or alternative format requested by our members.

The Customer Experience team will also note any notable operational challenges that impact health equitable structures and access to care.

### C. Appeals and Grievances

BSCPHP tracks and report grievances to ensure that all determinations for our covered services are equitable and non-discriminatory. Our comprehensive Grievance and Appeal system allows us to perform root cause analysis utilizing data analytics. This creates an effective and efficient process for trend analysis used to improve the quality of clinical care and impacts to internal and external processes and behaviors. In support of our Health Equity infrastructure, our

member Grievance and Appeal data is assessed to appropriately identify trends related to evidence of social drivers of bias, health inequities, disparities, and inequality issues. The data gathered is shared with oversight committees and will be shared with BSPHP's HEO to support a broad approach to addressing these issues and improve our members' health outcomes.

The HEO and Appeals and Grievances Department selected specific regulatory measures that meet both regulatory and health equity intent and purposes. Measures include:

- The percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period.
- Percentage of Discrimination grievances based on all grievances received during the measurement period.

## D. Cal Aim

California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. Health Equity is naturally integrated and interspersed throughout CalAim.

CalAim seeks to transform health care for Californians through providing access and transforming health (PATH), population health management, enhanced care management, community supports (or In Lieu of Services), new dental benefits, behavioral health delivery system transformation, services and supports for justice involved adults and youth, statewide managed long-term care, integrated care for dual eligible beneficiaries, Medi-Cal's strategy to support health and opportunity for children and families, a standard enrollment with consistent managed care benefits, and a delivery system transformation.

The HEO and CalAim functional area leaders including the Population Health Management Department, Quality Department, and Behavioral Health will collaborate to report and monitor metrics required for monitoring. These metrics are a mix of guided CalAim program measures, population health management program metrics, behavioral health program metrics and select Quality MCAS priority measures that tie back to DHCS' bold goals. In collaboration with the HEO, all functional area leaders will stratify the select health equity set by race, ethnicity, gender, age and language (REGAL) to identify any disparate populations within our membership for select measures.

## E. Quality

Quality metrics support measurement of outcomes such as preventive care screenings and chronic disease management. The Quality department closely monitors the Medi-Cal Accountability Set (MCAS) comprised of metrics assessing utilization, preventive care screening, and management of chronic health conditions. Quality and health equity intersect as related to disparities exist between reported MCAS results.

Further, select MCAS measures and DHCS Bold Goals also intersect with the CalAim program. These measures will be monitored to assess disparities and differences between populations, especially among populations of focus. Additionally, the Quality Department will also track the CAHPS® Getting Care Quickly measure by REGAL. The Health Equity Office will collaborate with the Quality department on the DHCS Bold Goals.

## F. Behavioral Health

The scope of the Health Equity Transformation Program extends into the delivery of behavioral health services. The HEO and Behavioral Health Department will monitor the recently released CalAim metrics related to behavioral health and DHCS bold goals required for monitoring. These metrics will be stratified by the REGAL dataset. Additionally, the Behavioral Health Department will track the total number of prenatal and postpartum depression screenings. This will help us to identify any disparate populations within our prenatal/postpartum membership and identify any other populations that may be impacted by mental illness specifically among our most vulnerable populations including adolescents, homeless, and LGBTQ+ members for select measures. Reference Appendix 2 for the complete HEART Measure Set as it relates to behavioral health.

## G. Provider Contracting and Relations

Provider contracting supports the delivery of health care services via an adequately accessible, culturally competent network. The HEO and Provider Contracting and Relations team have committed to monitoring the percentage of providers that reflect the needs of the Medi-Cal population within our service areas, for example, the percentage of providers who speak the threshold language per geographic area if possible.

Furthermore, BSCPHP will also ensure Network Providers complete cultural competency, sensitivity, health equity, and diversity training and provided for employees and staff at key points of contact with members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees).

The CHEO will collaborate with BSCPHP staff to ensure that the Network Provider bi-annual mandatory training includes information on all member rights specified in Exhibit A, Attachment III, Section 5.1 (Member Services), and diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training).

This process includes an educational program for Network Providers regarding health needs to include but not be limited to, the seniors and persons with disabilities (SPD) population, members with chronic conditions, members with Specialty Mental Health Service needs, members with substance use disorder needs, members with intellectual and developmental disabilities, and Children with special health care needs. Training includes Social Drivers of Health and disparity impacts on members' health care. Attendance records will be reviewed and maintained by BSCPHP staff. The Provider Contracting and Relations Department will

work closely with the Health Education and C&L Department to track health equity provider training.

Finally, the Provider Contracting and Relations Department will work closely with the Clinical Access Programs Department to monitor the percentage of Physical Accessibility Review Survey (PARS) requirements met by the facility site review (FSR) audit to assess for accessibility for our disabled members. These select outcomes metrics will allow us to identify the need to address health disparate areas across functional areas.

## H. Health Education and Cultural and Linguistics

The Health Education and Cultural and Linguistics (HE / CL) team support member education activities, staff and provider training. They also ensure materials and programs are culturally competent, advising recommendations to support health literacy, alternative formats, and interpreter services. The HE / CL team supports the development and implementation of health equity provider training. The HEO and Health Education and Cultural and Linguistics (HE/CL) teams selected relevant health equity measures including:

- tracking of cultural competency training is completed by member facing staff.
- tracking health education materials available in all threshold languages within service areas.
- total number of trainings completed track the utilization of interpreter services in partnership with Customer Experience.
- tracking the rate of bilingual member-facing health plan staff to ensure enough coverage is representative entire membership.
- tracking cultural and linguistic grievances filed by members.
- stratified Diabetes Prevention Program enrollment outcome metrics by REGAL.

## I. Maternal Health

The Maternal Health department supports the delivery of perinatal services. The HEO and Maternal Health team will monitor existing metrics to measure health disparate populations including metrics that directly address the DHCS bold goals. The Maternal Health functional area will track rate of maternal morbidity stratified by REGAL, and c-section rates stratified by REGAL to identify any disparate trend within our population. In partnership with the Behavioral Health department, the Maternal Health functional area will also track maternal mental health screening and positive mental health screening results by REGAL and the total rate of members with a positive maternal mental health screening referred to behavioral health services. The selection of these metrics is sound and evidence-based to have determined disparate populations most commonly seen among our Black, African American, and Hispanic or Latino populations.

## J. Clinical Access Programs

The Clinical Access Programs department supports the delivery of clinical programs including the Facility Site Review program, Initial Health Assessments, and the Early, Preventive,

Screening and Development Treatment (EPSDT) program. The HEO and Clinical Access Programs selected specific metrics across various areas managed by the Department. The HEART measure set for this functional area will support identification of any health disparities among the EPSDT population and provider network through the medical record review and facility site review audits. The Clinical Access Programs functional area will:

- stratify outcomes measures specific to the percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period.
- track compliance rate for FSRs and ensuring providers are completing "Site personnel receive training on member rights" to ensure our provider network is meeting minimally language assistance program requirements.
- track initial health assessment rate completion and stratify by REGAL to determine if there a specific vulnerable population identified to be disparate and have a need for a targeted intervention.

The HEO will continue to meet with functional areas across the health plan to build upon the BSCPHP Integrated Health Equity Measurement Set to ensure the measure set is all encompassing and includes all impacted departments. The HEO will optimize use of the Health Equity Measurement Framework to identify disparities and inequities occurring between populations.

BSCPHP's HEO will maintain a Health Equity Integration Plan (HEIP) documenting planned activities and outcomes to integrate health equity across the following functional areas listed below:

- Health Education and Cultural and Linguistics
- Growth, Community Engagement, and Marketing
- Network
- Population Health Management
- Grievances and Appeals
- Utilization Management
- Medical Services: Case management; Population Health Management Maternal Management, Health Education, and Quality

The purpose of the HEIP is to ensure that contract requirements to integrate health equity into functional areas are met. The process will also include planning, implementation, and actions needed to maintain a set of health equity activities for each functional area, identified activities rooted in evidence-based best practices and Blue Shield Promise's Health Equity Guiding Principles. Each functional area will be able to successfully demonstrate they are integrating and prioritizing health equity into program plans and operations (Reference Appendix 3).

All activities, action item plans, outcomes continuous quality improvement process will be reported to various health plan committees for oversight process and shared accountability. Escalation criteria will be included as part of the tracking and monitoring process.

## XIII. National Committee for Quality Assurance Health Equity Accreditation

Blue Shield of California (Blue Shield) and BSCPHP have taken steps toward achieving health equity. Blue Shield of California Covered California (Cov CA) product was recently awarded the NCQA Health Equity Accreditation (HEA). Additionally, BSCPHP holds Health Plan Accreditation and Multicultural Health Care Distinction for its Medi-Cal product line from the NCQA.

BSCPHP's commitment to quality improvement and health equity is deeply rooted in our values. Health Equity accreditation is important to BSCPHP because it demonstrates our ongoing commitment to improving health equity. Health Equity accreditation focuses on the foundation of health equity work: building an internal culture that supports the organization's external health equity work; collecting data that help the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs; identifying opportunities to reduce health inequities and improve care.

BSCPHP will adopt an actionable framework for improving health equity and prioritize health equity for our members and the communities we serve. We will use data to identify and address disparities in care to support better health outcomes, reduce unmet social needs and minimize overall costs of care; align our organization and work culture with diversity, equity, and inclusion principles; catalyze a culture that prioritizes and incorporates equity into plan operations by creating a consistent infrastructure for improving outcomes and narrowing disparities; and simultaneously meet DHCS contractual requirements.

Subsequently, BSCPHP will obtain NCQA Health Equity Accreditation in accordance with DHCS contractual requirements. BSCPHP will ensure reporting of accreditation activities by providing copies of reports from the NCQA to the DHCS. Including but not limited to accreditation status, survey type, level; provide accreditation agency results and recommended actions and/or improvements, correction action plans, and summaries, and denote accreditation expiration date.

## XIV. Monitoring and Oversight

Ongoing monitoring is a key mechanism to evaluate progress of quality activities, as outlined in the Work Plan, and are submitted to the BQIC for the remainder of the year, in addition to the Medi-Committee who reports to the Blue Shield of California Board of Directors via consent agenda for review and approval at least quarterly. Quality reports are submitted to DHCS on a quarterly basis.

BSCPHP's BQIC and the Medi-Cal Committee will review and monitor all QIHETP and QIHEC-related policies and procedures. The BQIC and the Medi-Cal Committee directs necessary modifications of QIHETP and QIHEC policies and procedures to ensure compliance with health equity regulatory requirements.

BSCPHP's BQIC and the Medi-Cal Committee coordinates with the QIHEC to approve the overall QIHETP and the annual plan of the QIHETP. The BQIC and the Medi-Cal Committee will regularly receive written QIHEC progress reports describing actions taken, progress in meeting QIHETP objectives, and future opportunities for improvement. A comprehensive assessment and list of all QIHETP activities is presented in a fluid QIHETP work plan.
As part of the initial monitoring plan, the QIHETP work plan will integrate required reporting that addresses regulatory intensive requirements and tracks and trends the HEART Measure Set. The

work plan activities will support a data driven strategy to inform resources and initiatives to reduce disparities. BSCPHP's HEO in partnership with cross-functional areas and/or departments will continuously collaborate to build a robust health equity measure set, identify priority populations, and focus areas, and prioritize initiatives to address disparities and inequities.

### A. Priority Populations and Focus Areas

The HEO leverages the Population Needs Assessment to identify member demographics, utilization trends, top diagnoses, and quality outcomes. The HEO and impacted cross functional departments have identified the following priority populations and focus areas as opportunities to assess for differences between populations, disparities, and inequities:

1. Maternal health
2. Pediatric health
3. Members with open care gaps
4. Over- and under-utilization of services
5. Member experience
6. Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+)
7. Justice-involvement
8. Housing insecurity

These clinical focus areas are designed to complement the significant CalAIM initiatives that are targeted at specific high-risk and align with the vulnerable populations as outlined by the DHCS' Comprehensive Quality Strategy, 2022. The HEO will conduct comprehensive assessments to assess utilization of services, outcomes, and experiences to identify gaps in service delivery and opportunities to increase utilization, design or improve program activities, increase inclusivity, expand access, establish collaborative partnerships, etc. Addressing the needs for these vulnerable populations will help reduce disparities and inequities that may exist for vulnerable populations.

### B. HEART Measure Set

The HEO and impacted functional area and/or department have met in an introductory roadshow series experience to collaboratively develop a health equity measure set. The health equity measure set is built on the CHCF and NCQA recommended measurement framework for accountability in Medicaid to advance BSCPHP health equity work. The health equity measure set incorporates regulatory reporting requirements and stretches us to consider health equity in our oversight of metrics and outcomes.

The HEART Measure Set is fluid and may change over time. The HEO and designated area will work together to conduct a comprehensive assessment and analysis of the health equity measure set. Each measure will be stratified, at a minimum, by race, ethnicity, age, gender, and/or language. Oversight of the health equity measure set, outcomes and performance results will follow the CQI process. The health equity measure set will be monitored at least quarterly and reported to the QIHEC and other relevant workgroups. Reference Appendix 2 for the complete HEART Measure Set by department.

## XV. Quality Improvement Process

BSCPHP uses a continuous quality improvement (CQI) process to measure performance, conduct quantitative and qualitative analysis, and assess and identify barriers and opportunities for improvement. Interventions are implemented to improve performance and are measured to determine effectiveness of the interventions.

BSCPHP's quality improvement and health equity programs are comprehensive and designed to monitor, evaluate, and improve the quality and equity of care and services delivered to members and providers objectively, systematically, and continuously. BSCPHP is responsible for all quality improvement and health equity functions applicable to our business and members. Quality improvement and health equity are not delegated.

BSCPHP recognizes that quality and health equity are deeply intertwined, and we cannot have a high-quality plan without equity. BSCPHP's HEO and Quality team collaborates to conduct quality improvement and health equity activities in all areas and dimensions of clinical and non-clinical member care and service. BSCPHP annually develops a QIHETP work plan steeped in health equity that outlines quality improvement activities for the year and focuses on reducing health disparities. The plan is reviewed by the CHEO and CMO and submitted to the QIHEC, QOC, BQIC, and the Medi-Cal Committee for review, comment, and approval.

BSCPHP seeks to meet the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS and meet health disparity reduction targets for specific populations and measures as identified by DHCS. BSCPHP applies the principles of CQI to all aspects of service delivery through analysis, evaluation, and systematic enhancements as related to health equity, including quantitative and qualitative data collection and data-driven decision-making, using up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field, incorporate feedback provided by members, families, and Network Providers in the design, planning, and implementation of its CQI activities, and incorporate other issues identified by BSCPHP, DHCS, DMHC, and/or NCQA (Reference figure 8).

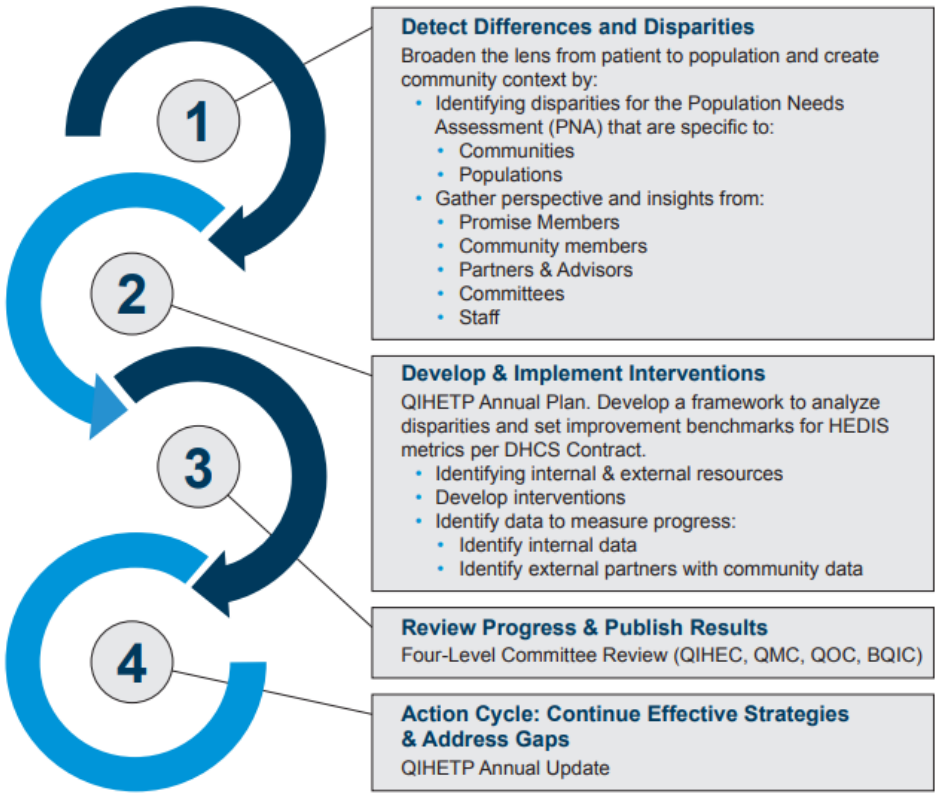


*Figure 8. Principles of Continuous Quality Improvement in Action*

BSCPHP will ensure the identification, evaluation, and reduction of health disparities by:

- analyzing data to identify differences in quality of care and utilization, as well assessing as the underlying reasons for variations in the provision of care to its members;
- developing equity-focused interventions to address the underlying factors of identified health disparities, including Social Drivers of Health (SDOH);
- meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (External Quality Review (EQR) Requirements, Quality Performance Measures);
- deploying mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient prescription drugs;
- analyzing multiple data sources (e.g., Encounter data, pharmacy data, utilization data, health outcomes), stratifying by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS;
- deploying mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 20-003, and W&I Code sections 14197 and 14197.04; and

- deploying mechanisms to continuously monitor, review, evaluate, and improve quality and health equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, behavioral health, and ancillary care services.

As part of the CQI process, BSCPHP disseminates and monitors the use of clinical practice guidelines. The CHEO reviews clinical practice guidelines to assess opportunities to integrate into the QIHETP.

BSCPHP will develop interventions designed to address PHM and Social Drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity. BSCPHP will develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. BSCPHP will deploy a member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services. BSCPHP will ensure that the QIHETP requirements are applied to the delivery of both physical and behavioral health services.

Additionally, the CHEO collaborates with Quality department staff as they conduct and participate in Performance Improvement Projects (PIPs), including any PIP required by CMS, in accordance with 42 CFR section 438.330 as directed by DHCS. BSCPHP will participate in statewide collaborative PIP workgroups. BSCPHP complies with the PIP requirements outlined in APL 19-017 and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs. PIPs will include measurement of performance using objective quality indicators including: 1) Implementation of equity-focused interventions to achieve improvement in the access to and quality of care, 2) Evaluation of the effectiveness of the interventions based on the performance measures, and 3) Planning and initiation of activities for increasing or sustaining improvement. BSCPHP will report the status of each PIP as requested by DHCS.

## XVI. Annual Review of the Health Equity Transformation Program Description

The Health Equity Transformation Program Description may be amended to reflect changes in scope and identified needs resulting from new or revised regulatory and/or accreditation requirements or significant changes in membership, provider scope, scope of services or operations occurring during the year. The Health Equity Transformation Program Description is reviewed at least annually and is approved by the QIHEC, QOC, BQIC, and the Medi-Cal Committee.

## XVII. Quality Improvement and Health Equity Work Plan

The QIHETP Action Plan lists all actions and milestones needed to formally build and implement BSCPHP's QIHETP. The Action Plan will be managed by the HEO (Reference Appendix 4).

The initial goal for the QIHETP is to at minimum meet all state requirements and achieve DHCS Request for Proposal (RFP) content for implementation readiness. The QIHETP Work Plan outlines key activities for the year, and includes any activities not completed during

the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the QIHEC, HEOC, QOC BQIC, and the Medi-Cal Committee. The QIHETP Work Plan is a fluid document, updated as needed throughout the program year. BSCPHP prepares a comprehensive assessment of QIHETP activities no less than 12 months apart that includes. The scope of the annual work plan includes the following:

1. Goals and objective descriptions.
2. Planned equity-focused interventions and activities.
3. Performance target or measurable goals.
4. Time frame for all yearly planned activities including initiation and completion.
5. The person(s) responsible for each activity.
6. Root cause and corrective action if an activity is at risk.
7. Examples of monitoring previously identified issues.
8. Reporting requirements and frequency.
9. Status updates.
10. Summary of Population Health Management (PHM) interventions to address Social Drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity. BSCPHP will incorporate PHM findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management and Coordination of Care).
11. Assessment of quality performance measure results with a plan to address deficiencies as related to health equity that include BSCPHP Network Providers.
12. Incorporates methods to address External Quality Review (EQR) technical report and evaluation report recommendations as related to health equity.
13. Utilizes data from various sources to include performance results, encounter data, grievances and appeals, utilization review, and consumer satisfaction surveys to analyze delivery of services and quality of care for Network Providers.
14. Details methods for equity-focused interventions to identify patterns for over- or under-utilization of physical and behavioral health care services.
15. Summarizes community engagement with commitment to member and family focused care, and uses CAC findings, member listening sessions, focus groups/surveys, and uses information to inform policies.
16. Incorporates PHM findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management and Coordination of Care).
17. Uses Performance Improvement Project (PIP) findings and outcomes, consumer satisfaction surveys, and collaborative initiatives.
18. Track and trend the HEART Measure Set.
19. Monitor interventions targeting priority populations and focus areas.

The Workplan is revised as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement. The status of QIHETP Work Plan items is reported as appropriate to the QIHEC, QOC, BQIC, and the Medi-Cal Committee.
A written summary of the QIHETP and QIHEC activities, findings, recommendations, and actions will be prepared after each QIHEC meeting and submitted to the BQIC, the Medi-Cal Committee,

and DHCS upon request. BSCPHP shall make the written summary of the QIHEC and QIHETP activities publicly available on the BSCPHP website at least on a quarterly basis.

BSCPHP's CHEO coordinates submission of QIHETP and QIHEC documents to DHCS. The CHEO ensures QIHETP reports are publicly available on BSCPHP website and annually.

## XVIII. Annual Evaluation

BSCPHP 's HEO assesses the effectiveness of the QIHETP via a formal evaluation process. The QIHETP Evaluation is prepared at least annually. Findings from the annual QIHETP Evaluation are considered at the time of the QIHETP revision.

The assessment of activities in the QIHETP Work Plan is conducted to evaluate the success of individual activities in meeting the specific goals and objectives of the QIHETP. The annual review of the QIHETP ensures that the overall program is comprehensive, meets current industry standards and is effective in continuously improving the quality of health care and services delivered. Identified opportunities are addressed in the following year's program and work plan.

During the first quarters of each calendar year, a written report based on activities of the previous calendar year is compiled and is then submitted to the QIHEC, HEOC, QOC BQIC, and the Medi-Cal Committee.

The evaluation includes a detailed description of completed and on-going QIHETP activities that include trending of BSCPHP's HEART measure set to assess performance, an analysis of the overall effectiveness of the QIHETP and ability to identify and reduce disparities. The HEO incorporates recommendations for QIHETP revisions as received from functional area leaders, committees, members, and Network Provider.

An executive summary is presented to the QIHEC, HEOC, QOC, BQIC, and the Medi-Cal Committee for review and action which may include acceptance, clarification, modification, and follow-up as appropriate. An informational summary of the annual evaluation is available to members, member representatives, and providers.

## XIX. Data Sources

BSCPHP's QIHETP provides a formal structure to monitor the QIHETP and services provided to members and to act on identified opportunities for improvement. BSCPHP ensures through monitoring, that the provision and utilization of services meets professionally recognized standards of practice.

Quality improvement and health equity is a data-driven process. BSCPHP uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives.
Data sources include, but are not limited to:

1. Healthcare Effectiveness Data and Information Set (HEDIS®): HEDIS® report as submitted to NCQA for the reporting year.
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS®): CAHPS® 5.0H survey conducted during the measurement year.
3. Provider Satisfaction Surveys (PSS): A provider satisfaction survey assesses provider satisfaction and access. The PSS is conducted to meet the Department of Managed Health Care (DMHC)'s Timely Access and the California Department of Insurance (CDI's) Network Adequacy requirement.
4. Customer Experience call data: collection, measurement, and reporting of performance metrics within the call center as it relates to DHCS and DMHC language assistance program requirements.
5. Pertinent medical records: medical record review results as minimum necessary.
6. Appointment access surveys: A provider satisfaction survey to assess provider appointment access and satisfaction.
7. Geo-access data: information about geographic locations and geo-access data by member and provider ratio.
8. Encounter and claims data: ICD-10 codes received via member encounter and claims data.
9. Member and provider complaint data: Cultural, linguistics, or discrimination related complaints data suggestive of disparity from the measurement year.
10. Appeals data: Cultural, linguistics, or discrimination related appeals suggestive of disparity from the measurement year.
11. Pharmacy data: data collection and compilation of data for various drug codes received.
12. Case management/care coordination data: data and procedures for resolving cases to identify morbidity and mortality data.
13. Utilization reports: Case review data, including over- and under-utilization.
14. Authorization and denial reporting: prior authorization and claims denials reporting, ICD- 10 claims denied.
15. Statistical, epidemiological, and demographic member information: validated individual member data as of measurement year and/or year end.
16. Enrollment and disenrollment data: enrollment and disenrollment data within the measurement year.
17. Race, Ethnicity, Gender, Age, and Language (REGAL) data: data collection on a member's race, ethnicity age, and language preferences.
18. Sexual Orientation and Gender Identity (SOGI) data: data collection on a member's sexual orientation and gender identity preferences.
19. Vendor performance data: competency assessment results for language assistance, and behavioral health data

## XX. Confidentiality and Information Security

All information related to the QIHETP process is considered confidential. All data and information, inclusive of but not limited to minutes, reports, letters, correspondence, and reviews are stored in designated, secured locations, and access is granted based on minimum necessary standards. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee. All QIHETP

program activities including correspondence, documentation and files are protected by State Confidentiality Statutes, the Federal Medical Information Act SB 889, and the Health Insurance Portability and Accountability Act (HIPAA) for patient's confidentiality. Only designated employees by the nature of their position will have access to member health information as outlined in the policies and procedures.

All persons attending the QIHEC, or its related committee meetings are informed of the Confidentiality Statement annually. All BSCPHP personnel are required to sign a Confidentiality Agreement upon employment.

No persons shall be involved in a review process of quality improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical and/or financial decision making, and all committee members, committee chairs, and the Chief Medical Officer sign a statement of this understanding.

## XXI. Resources

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5. California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-011: Population Needs Assessment retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
6. California Department of Managed Health Care (DMHC) APL 22-028 Health Equity and Quality Measure Set and Reporting Process retrieved from https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx
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11. DHCS California Advancing and Innovating Medi-Cal (CalAIM) Guide (2023) retrieved from https://www.dhcs.ca.gov/calaim.
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Accessing Medical and Behavioral Health Care. Retrieved from https://www.macpac.gov/wp-content/uploads/2022/06/Access-in-Brief-Experiences-in-Lesbian-Gay-Bisexual-and-Transgender-Medicaid-Beneficiaries-with-Accessing-Medical-and-Behavioral-Health-Care.pdf

17. National Alliance to End Homelessness (2023). Homelessness Statistics. California. Retrieved from https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/california/?emailsignup&gclid=EAIaIQobChMIpfDA8p65_gIVxx-tBh12mA2JEAAYAiAAEgJIt_D_BwE
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# XXII. Appendices

Appendix 1. Health Equity Keywords

Appendix 2. Health Equity Advancement Resulting in Transformation (HEART) Measure Set

Appendix 3. Health Equity Integration Plan

Appendix 4. Quality Improvement Health Equity Transformation Program Action Plan

## Appendix 1: Health Equity Keywords

| Term | Definition |
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| **Anti-Racism** | The work of actively challenging the values, structures and behaviors that uphold systemic racism (Reference: Adapted from Racial Equity Tools). |
| **BIPOC** | Acronym for Black, Indigenous, and People of Color; the term is used to acknowledge that Indigenous and Black people have been most impacted by whiteness, both historically and in the present day. This shapes the experiences of and relationship to white supremacy for all people of color within a U.S. context (Reference: ccdconline.org). With the term BIPOC, "People of Color" include those who identify as Hispanic or Latino, Asian, or Native Hawaiian or other Pacific Islander. |
| **Color Blindness** | The idea that we intentionally or unintentionally ignore race, culture, or ethnicity and focus on commonalities. By only focusing on the commonalities, we dismiss the differential experiences of BIPOC and the systems of oppression that cause harm and continue to cause harm. |
| **Communities** | Groups of people who are impacted by policies and programs. In the context of equity work, "community" refers to people who have historically been left out of the decision-making process. A community is not necessarily limited by geographic boundaries (Reference: ccdconline.org). |
| **Community Engagement** | A two-way exchange of information, ideas and resources that offers opportunities for communities to exercise power in decision-making. It considers the diversity of communities, including culture and race, and creates an inclusive and accessible process (Reference: ccdconline.org). |
| **Disadvantaged Population** | Population for whom social, political, economic, and power resources are not available (Reference: Adapted from National Collaborating Centre for Determinants of Health). |
| **Discrimination** | The unequal treatment of members of various groups based on race, gender, social class, sexual orientation, physical ability, religion, and other categories (Reference: Racial Equity Tools). |
| **Ethnicity** | Denotes groups that share a common identity-based ancestry, language, or culture (Reference: MultiCare).<br><br>At BSP, we adhere to the minimum standards set by the federal Office of Management and Budget (OMB). The two OMB minimum standard ethnicity categories are: Hispanic or Latino and Not Hispanic or Latino (Reference: census.gov). |
| **Equality** | Everyone is treated the same regardless of the starting point or context (Reference: ccdconline.org). |

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| | Equality is not the same as equity. Equity involves trying to understand and give people what they need. Equality, in contrast, aims to ensure that everyone gets the same things regardless of need (Reference: aecf.org). |
| **Equity** | When everyone, regardless of who they are or where they come from, has fair and just opportunities to thrive. This requires eliminating barriers like racism, discrimination, and bias and repairing injustices in systems such as poverty, education, health, criminal justice, and transportation (Reference: ccdconline.org). |
| **Health Equity** | The condition in which everyone has fair and just opportunities to be as healthy as possible, and no one is disadvantaged in achieving this potential, including population groups that historically have been excluded or marginalized.<br>Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions Paula Braveman (Reference: nih.gov). |
| **Health Equity Lens** | "…brings to focus the impact policies and practices have on shaping the economic, social and built environments which can lead to health inequities." (MDH-Statewide Health Improvement Program Health Equity Implementation Guide FY2014-]15) (Reference: state.mn.us).<br><br>"a tool for planning, decision-making and resource allocation that leads to more equitable policies, programs, and processes. Shifts the way we make decisions and think about our work." (Multnomah County Equity and Empowerment Lens) (Reference: state.mn.us). |
| **Health Equity Action Lens** | Blue Shield of California named framework that is a series of questions to apply a health equity lens to move from theory to practical action. Answers to these questions provide the groundwork for building or renewing health equity efforts to deliver on the possibilities of our health equity strategy. |
| **Health and Healthcare Disparities** | Health and healthcare disparities are the metrics we use to measure progress toward achieving health equity. A reduction in health and healthcare disparities (in absolute and relative terms) is evidence that we are moving toward greater health equity Paula Braveman (Reference: nih.gov).<br><br>Example: Differences in Covid-19 case and death rates among BIPOC communities |
| **Health Inequities** | Occurs when unfair and avoidable differences in upstream drivers of health and healthcare disparities are seen within and between |

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| | population groups including those that historically have been excluded or marginalized.<br><br>Example: Lack of sufficient specialty care providers among BIPOC neighborhoods due to payment structures |
| **Intersectionality** | The complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups (Reference: merriam-webster.com). It requires that efforts addressing one form of oppression take others in account. |
| **Levels of Racism** | **Personally Mediated Racism**<br>Prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race (Reference: Camara Jones – AJPH).<br><br>**Institutional Racism**<br>Differential access to goods, services, and opportunities of society by race. It is embedded in the custom, practice, and law (Reference: Camara Jones – AJPH).<br><br>**Internalized Racism**<br>Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth (Reference: Camara Jones – AJPH). |
| **LGBTQ+** | An acronym for individuals who identify as lesbian, gay, transgender, queer (or questioning), as well as individuals with non-conforming identities across sexual orientation and gender identity spectrums. Adapted from (Reference: ccdconline.org). |
| **Lived Experience** | An individual's experience of living with inequities. It necessitates a recognition that the people with lived experience of inequities are experts in impact and need. Soliciting and integrating perspectives of those with "lived experience" is vital to the success of health equity efforts (Reference: ihi.org). |
| **Marginalized Populations** | Populations relegated to an unimportant or powerless position within a society or group based on perceived social, political and economic dimensions (Reference: merriam-webster.com). |
| **Multilevel Drivers (micro, meso, macro) can also be referred to as** | Drivers that impact health at the individual (micro), community (meso), and system (macro) levels.<br><br>Upstream (meso and macro) interventions and strategies focus on improving fundamental social and economic structures to decrease barriers and improve supports that allow people to achieve their full |

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| **Upstream and Downstream** | health potential (Reference: National Collaborating Centre for Determinants of Health).<br><br>Downstream (micro) interventions and strategies focus on providing equitable access to care and services to mitigate the negative impacts of disadvantage on health (Reference: National Collaborating Centre for Determinants of Health). |
| **Oppression** | The systematic subjugation of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group (Reference: Racial Equity Tools). |
| **Privilege** | Unearned social power accorded by the formal and informal institutions of society to all members of a dominant group (e.g. white privilege, male privilege, etc.) (Reference: Racial Equity Tools). |
| **People of Color** | People who identify as one or more of the following racial and ethnic groups: American Indian or Alaska Native, Asian, Black, or African American, Hispanic, or Latino, and Native Hawaiian or Other Pacific Islander. |
| **Power** | Our ability, as individuals and as communities, to produce an intended effect. Power manifests in both positive and negative ways and shows up formally and informally (ccdconline.org).<br>Advancing equity, therefore, requires attention to power (as a determinant) and empowerment, or building power (as a process).<br>Reference: Power: The Most Fundamental Cause of Health Inequity? \| Health Affairs |
| **Race** | A socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific bases. This social construct was created and used to justify social and economic oppression of people of color by white people. An important thing to note is that while race is a social construct with no genetic or scientific bases, it has real social meaning (Reference: Boston Public Health Commission).<br><br>At Blue Shield California, we adhere to the minimum standards set by the federal Office of Management and Budget (OMB). The five OMB minimum standard categories for race are: American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or Other Pacific Islander, and white (Reference: census.gov). |
| **Race and Ethnicity – OMB categories** | The federal Office of Management and Budget (OMB) has set minimum standards for basic racial and ethnic categories that "are social-political constructs and should not be interpreted as being scientific or anthropological in nature."<br><br>The five OMB minimum standard categories for race are: American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or Other Pacific Islander, and white. The two OMB |

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| | minimum standard ethnicity categories are: Hispanic or Latino and Not Hispanic or Latino. (Reference: census.gov). |
| **Social Determinants of Health** | The interrelated social, political, and economic factors that create the conditions in which people live, learn, work and play. Examples: education, income, housing, employment (Reference: National Collaborating Centre for Determinants of Health). Addressing the social determinants of health alone will not sufficiently support our goal of advancing health equity (Reference: Health Affairs). |
| **Structural/ Systemic Racism** | When our institutions, such as housing, education, and transportation, collectively create systems and policies that work better for white people than for people of color (Reference: ccdconline.org). |
| **Targeted Universalism** | Approach to providing programs and services that make them available to all (universal) and reaches to vulnerable and marginalized populations so that they get supports and services that meet their needs (targeted) (Reference: National Collaborating Centre for Determinants of Health). Targeted universalism rejects a blanket universal approach, which is likely to be indifferent to the reality that different groups are situated differently relative to the institutions and resources of society. It also rejects the claim of formal equality that would treat all people the same as a way of denying difference. (Reference: National Equity Project) |
| **Vulnerable Population** | Groups and communities at a higher risk for poor health because of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability (Reference: National Collaborating Centre for Determinants of Health). |

# HEART Measure Set

| No. | Measure Description | Measure Definition | Measure Acronym | Measure Steward | Health Equity Framework Domain | Responsible Functional Area(s) | Responsible Owner(s) | Report Source | Reporting Status | Reporting Frequency | Baseline | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | IHA Completion | IHA completion rate stratified by REGAL during the measurement period | IHA | DHCS | Equitable Access to Care | Clinical Access Programs | Jesse Brennan-Cooke | Encounter Data | Validation Complete | Quarterly | TBD | TBD |
| 2 | Physical Accessibility | Percent of providers passing Physical Accessibility Review Survey with score >90% during the measurement period | PARS | DHCS | Equitable Access to Care | Clinical Access Programs | Jesse Brennan-Cooke | Heathy Data Systems | Validation Complete | Semi Annual | TBD | TBD |
| 3 | Redetermination Rate by REGAL | Redetermination rate of members reinstated by REGAL during the measurement period | REDET REGAL | DHCS | Equitable Access to Care | Community Engagement | Sandra Rose | 834 File | Pending Validation | Quarterly | TBD | TBD |
| 4 | Disnerollment by REGAL | Voluntary disenrollment by REGAL during the measurement period | DISENR REGAL | DHCS | Equitable Access to Care | Community Engagement | Sandra Rose | MARA Dashboard | Validation Complete | Quarterly | TBD | TBD |
| 5 | Interpreter service utilization | Number of Language line interpreter service requests by language during the measurement period | INT SVC UTIL | DHCS, DMHC Language Assistance; existing measure; Threshold Language APL | Equitable Access to Care | Cultural and Linguistics | Linda Fleischman | Language Line | Validation Complete | Quarterly | TBD | TBD |
| 6 | Translated documents | Number of translated documents by language or alternative format during the measurement period | TRNSLTD DOCS | DHCS, DMHC Language Assistance; existing measure; Threshold Language APL | Equitable Access to Care | Cultural and Linguistics | Linda Fleischman | Manual Report (ISI vendor) | Validation Complete | Quarterly | TBD | TBD |
| 7 | DPP Enrollment by REGAL | DPP enrollment by REGAL during the measurement period | DPP REGAL | DHCS | Equitable Access to Care | Health Education and Cultural and Linguistics | Linda Fleischman | Solera Health | Validation Complete | Quarterly | TBD | TBD |
| 8 | Members Utilizing Emergency Department Care More than Primary Care | The total number of members who had more emergency department (ED) visits than primary care visits within a 12-month period. | PHM KPI 1 | DMHC, DHCS CalAIM, NCQA | Equitable Access to Care | Population Health Management | Ayesha Sharma | Claims NCQA Data Sets | Validation Complete | Quarterly | TBD | TBD |
| 9 | Members Not Engaged in Ambulatory Care | The number of members with no ambulatory or preventive visit within a 12-month period. | PHM KPI 3 | DMHC, DHCS CalAIM, NCQA | Equitable Access to Care | Population Health Management | Ayesha Sharma | Claims NCQA Data Sets | Validation Complete | Quarterly | TBD | TBD |
| 10 | Members Engaged in Primary Care | The number of members who had at least one primary care visit within a 12-month period. | PHM KPI 2 | DMHC, DHCS CalAIM, NCQA | Equitable Access to Care | Population Health Management | Ayesha Sharma | Claims NCQA Data Sets Provider Data | Validation Complete | Quarterly | TBD | TBD |
| 11 | Getting Needed Care | Getting Needed Care by REGAL during the measurement period | GNC REGAL | NCQA | Equitable Access to Care | Quality | Alyson Spencer Christine Nguyen | CAHPS | Validation Complete | Annual Every Quarter 3 (mid-October) | TBD | TBD |
| 12 | Getting Care Quickly by (REGAL) | Getting Care Quickly by REGAL during the measurement period | GCQ REGAL | NCQA | Equitable Access to Care | Quality | Alyson Spencer Christine Nguyen | CAHPS | Validation Complete | Annual Every Quarter 3 (mid-October) | TBD | TBD |
| 13 | Grievances stratified by race and ethnicity | Grievance category stratified by race and ethnicity for all grievances received during the measurement period | GRV-RE | NCQA | Equitable Experiences of Care | Appeals and Grievances | Lorraine Greywitt | 834 file + Grievance universe file | Not Started | Quarterly | TBD | TBD |
| 14 | Discrimination-related grievances | Percentage of Discrimination grievances based on all grievances received during the measurement period | DISC GRV | NCQA | Equitable Experiences of Care | Appeals and Grievances | Lorraine Greywitt | 834 file + Grievance universe file | Pending Validation | Quarterly | TBD | TBD |
| 15 | C&L grievances | Percent of C&L grievances (interpreter services, translation-related) filed by members (based on all received quarterly) during the measurement period** | C&L GRV | DMHC, DHCS | Equitable Experiences of Care | Health Education and Cultural and Linguistics | Linda Fleischman | 834 file + Grievance universe file | Validation Complete | Quarterly | TBD | TBD |
| 16 | Overturned appeals stratified by race and ethnicity | Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period | APP-RE | NCQA | Equitable High Quality Clinical Care | Appeals and Grievances | Lorraine Greywitt | 834 file + Appeals universe file | Not Started | Quarterly | TBD | TBD |
| 17 | EPSDT Preventive Utilization Gap | Percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period stratified by REGAL | EPSDT UTIL GAP | DMHC, DHCS CalAIM, EPSDT | Equitable High Quality Clinical Care | Clinical Access Programs | Jesse Brennan-Cooke | CMS-416 | Validation Complete | Quarterly | TBD | TBD |
| 18 | Perinatal Immunization Status - Flu | Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date; or Deliveries where members had an influenza virus vaccine adverse reaction any time during or before the Measurement Period. | PERINATAL IZ FLU | NCQA | Equitable High Quality Clinical Care | Quality | Alyson Spencer Christine Nguyen Dr. Manisha Sharma | Inovalon | Pending Validation | Quarterly | TBD | TBD |

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| 19 | Perinatal Immunization Status - Tdap | Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or Deliveries where members had any of the following: • Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period. • Encephalopathy due to Td or Tdap vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis) any time during or before the Measurement Period. | PERINATAL IZ Tdap | NCQA | Equitable High Quality Clinical Care | Quality | Alyson Spencer<br>Christine Nguyen<br>Dr. Manisha Sharma | Inovalon | Pending Validation | Quarterly | TBD | TBD |
| 20 | C-section rates by REGAL | C-section rates by REGAL during the measurement period | CSCTN | DMHC, DHCS | Equitable High Quality Clinical Care | Maternal Health | Dr. Manisha Sharma Nicole Evans | Tableau | Validation Complete | Quarterly | TBD | TBD |
| 21 | Pharmacotherapy for Opioid Use Disorder by REGAL | Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period | POD REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 22 | Follow-Up after ED Visits for Substance Use – 30 day by REGAL | Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period | FUA REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 23 | Colorectal Cancer Screening by REGAL | Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified | COL REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 24 | Hemoglobin A1c Control for Patients with Diabetes by REGAL | The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year | HBD REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 25 | Controlling High Blood Pressure by REGAL | Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL | CBP REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 26 | Child and Adolescent Well Care Visits by REGAL | Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL | WCV REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 27 | Childhood Immunization Status by REGAL | Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); | CIS REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 28 | Immunizations for Adolescents by REGAL | The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and | IMA REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 29 | Prenatal and Postpartum Care: Postpartum Care by (REGAL) | The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL | PPC POST REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 30 | Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL) | The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL | PPC TIME REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 31 | Well-Child Visits in the First 30 Months of Life by REGAL | Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their firs 15 months of life stratified by REGAL | W30 REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 32 | Follow-Up After ED Visit for Mental Illness – 30 days by REGAL | Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period | FUM REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 33 | Breast Cancer Screening by REGAL | Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL | BCS REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |
| 34 | Asthma Medication Ratio by REGAL | Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL | AMR REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |

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| 35 | Potentially Preventable 30-day Post-Discharge Readmission by (REGAL) | Percentage of readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable during measurement period stratified by REGAL | PPR REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Not Started | Quarterly | TBD | TBD |
| 36 | Care Management for High-Risk Members after Discharge | The total number of transitions for high-risk members during the Intake Period within a 12-month period. | PHM KPI 5 | DMHC, DHCS CalAIM, NCQA | Equitable Social Interventions | Population Health Management | Ayesha Sharma | Claims<br>Care Connect<br>Risk Stratification<br>ECM | Validation Complete | Quarterly | TBD | TBD |
| 37 | Populations of Focus | Percent of members stratified into each populations of focus | POF | DHCS | Equitable Social Interventions | Social Services | Jennifer Miyamoto-Echeverria<br>Raine Arndt-Couch | Claims | Pending Validation | Quarterly | TBD | TBD |
| 38 | Community Support utilization | Community support utilization by category | CS UTIL | DHCS | Equitable Social Interventions | Social Services | Jennifer Miyamoto-Echeverria<br>Raine Arndt-Couch | Claims | Pending Validation | Quarterly | TBD | TBD |
| 39 | SDOH reporting | Rate of network providers reporting SDOH codes | SDOH | DHCS | Equitable Social Interventions | Social Services | Jennifer Miyamoto-Echeverria<br>Raine Arndt-Couch | Tableau | Pending Validation | Quarterly | TBD | TBD |
| 40 | SDOH reporting by REGAL | Total number of members screened for SDOH by REGAL during the measurement period | SDOH REGAL | DHCS | Equitable Social Interventions | Social Services | Jennifer Miyamoto-Echeverria<br>Raine Arndt-Couch | Claims,<br>Care Connect | Not Started | Quarterly | TBD | TBD |
| 41 | PCP Staff Training | Compliance rate for all FSRs completed assessing FSR section "Site personnel receive training on member rights" performed during measurement period | PCP TRNG | DHCS | Equitable Structures of Care | Clinical Access Programs | Jesse Brennan-Cooke | Heathy Data Systems | Validation Complete | Semi<br>Annual | TBD | TBD |
| 42 | Enrollment Growth by REGAL | Enrollment growth stratified by REGAL during the measurement period | ENR REGAL | DHCS | Equitable Structures of Care | Community Engagement | Sandra Rose | MARA Dashboard | Pending Validation | Quarterly | TBD | TBD |
| 43 | Multi-lingual staff | Total number of multi-lingual staff during the measurement period | MUL STAFF | DHCS, DMHC Language Assistance; existing measure; Threshold Language APL | Equitable Structures of Care | Customer Experience | Vivian Phillips Husband Robert<br>Chor | Manual Report | Validation Complete | Semi<br>Annual | TBD | TBD |
| 44 | Bilingual calls managed by Call Center | Call center number of internal bilingual calls by member's preferred language during the measurement period | CALL CTR BLNGL | DHCS, DMHC Language Assistance; existing measure; Threshold Language APL | Equitable Structures of Care | Customer Experience | Vivian Phillips Husband Robert<br>Chor | Tableau | Validation Complete | Quarterly | TBD | TBD |
| 45 | Cultural Competency Training | Cultural competency training – internal completion rate by member-facing staff | CULT COMP TRNG | DMHC, DHCS | Equitable Structures of Care | Health Education and Cultural and Linguistics | Linda Fleischman | LMS | Validation Complete | Annual<br>Every Quarter 3 | TBD | TBD |
| 46 | Member-facing staff representative of membership | Rate of bilingual member-facing health plan staff by language is representative o membership during the measurement period | BLNGL STF | DMHC, DHCS | Equitable Structures of Care | Health Education and Cultural and Linguistics | Linda Fleischman | Manual Report | Validation Complete | Semi<br>Annual | TBD | TBD |
| 47 | Health Education Materials | Health Education materials available in all threshold languages during the measurement period; and Percent of health ed materials | HEALTH ED | DHCS | Equitable Structures of Care | Health Education and Cultural and Linguistics | Linda Fleischman | Manual Report<br>(Healthwise vendor) | Validation Complete | Annual<br>Every Quarter 4 | TBD | TBD |
| 48 | Complex Care Management (CCM) Enrollment Among all Eligible Members | The number of members eligible for CCM for 1 or more days within a 90-day period. | PHM KPI 4 Rate A | DMHC, DHCS CalAIM, NCQA | Equitable Structures of Care | Population Health Management | Ayesha Sharma | Claims<br>Care Connect<br>Risk Stratification | Validation Complete | Quarterly | TBD | TBD |
| 49 | CCM Enrollment Among all Eligible Members Who Were Not Already Enrolled During the Previous Measurement Period | The number of members eligible for CCM for 1 or more days within a 90-day period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period. | PHM KPI 4 Rate B | DMHC, DHCS CalAIM, NCQA | Equitable Structures of Care | Population Health Management | Ayesha Sharma | Claims<br>Care Connect<br>Risk Stratification | Validation Complete | Quarterly | TBD | TBD |
| 50 | Provider Network by Threshold Language | Percent of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area – i.e. X% speak threshold languages (per geographic area) | PROV NTWK LANG | DHCS | Equitable Structures of Care | Provider Contracting | Melinda Kjer | PIMS or CACTUS | Not Started | Quarterly | TBD | TBD |
| 51 | Positive maternal mental health screening | Positive maternal mental health screening results by REGAL during the measurement period | MMH POS | DMHC, DHCS | Overall Well-Being | Behavioral Health | David Bond | Manual Report | Not Started | Quarterly | TBD | TBD |
| 52 | Perinatal Depression Screening | Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period | PND | DHCS; DMHC Maternal Mental Health Program | Overall Well-Being | Behavioral Health | David Bond | Inovalon | Not Started | Quarterly | TBD | TBD |
| 53 | Postpartum Depression Screening and follow-up | Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care during the measurement period. | PDS | DHCS; DMHC Maternal Mental Health Program | Overall Well-Being | Behavioral Health | David Bond | Inovalon | Not Started | Quarterly | TBD | TBD |
| 54 | Depression Screening and Follow up for Adolescents and Adults by REGAL | Percentage of Depression Screening and Follow up for Adolescents and Adults by race, ethnicity, gender, age, and/or language (REGAL) during the measurement period | DSF REGAL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Overall Well-Being | Behavioral Health<br>Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Inovalon | Validation Complete | Quarterly | TBD | TBD |

***Definitions:**
Not Available (NA)
Nothing to Report (NR) due to reporting frequency date.
Report Pending indicates deferred for a specified timeframe; dependent on report source
To be determined (TBD)

** This is a subset of DISC GRV

| Equitable Structures of Care | | | |
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| | **Measure Description** | **Measure Definition** | **Measure Acronym** |
| 1 | Complex Care Management (CCM) Enrollment Among all Eligible Members | The number of members eligible for CCM for 1 or more days within a 90-day period. | PHM KPI 4 Rate A |
| 2 | CCM Enrollment Among all Eligible Members Who Were Not Already Enrolled During the Previous Measurement Period | The number of members eligible for CCM for 1 or more days within a 90-day period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period. | PHM KPI 4 Rate B |
| 3 | Enrollment Growth by REGAL | Enrollment growth stratified by REGAL during the measurement period | ENR REGAL |
| 4 | Bilingual calls managed by Call Center | Call center number of internal bilingual calls by member's preferred language during the measurement period | CALL CTR BLNGL |
| 5 | Multi-lingual staff | Total number of multi-lingual staff during the measurement period | MUL STAFF |
| 6 | PCP Staff Training | Compliance rate for all FSRs completed assessing FSR section "Site personnel receive training on member rights" performed during measurement period | PCP TRNG |
| 7 | Cultural Competency Training | Cultural competency training – internal completion rate by member-facing staff | CULT COMP TRNG |
| 8 | Health Education Materials | Health Education materials available in all threshold languages during the measurement period; and Percent of health ed materials | HEALTH ED |
| 9 | Member-facing staff representative of membership | Rate of bilingual member-facing health plan staff by language is representative of membership during the measurement period | BLNGL STF |
| 10 | Provider Network by Threshold Language | Percent of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area – i.e. X% speak threshold languages (per geographic area) | PROV NTWK LANG |
| **Overall Well-Being** | | | |
| | **Measure Description** | **Measure Definition** | **Measure Acronym** |
| 11 | Depression Screening and Follow up for Adolescents and Adults by REGAL | Percentage of Depression Screening and Follow up for Adolescents and Adults by race, ethnicity, gender, age, and/or language (REGAL) during the measurement period | DSF REGAL |
| 12 | Perinatal Depression Screening | Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period | PND |
| 13 | Postpartum Depression Screening and follow-up | Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. during the measurement period | PDS |
| 14 | Positive maternal mental health screening | Positive maternal mental health screening results by REGAL during the measurement period | MMH POS |
| **Equitable Access to Care** | | | |
| | **Measure Description** | **Measure Definition** | **Measure Acronym** |
| 15 | Members Utilizing Emergency Department Care More than Primary Care | The total number of members who had more emergency department (ED) visits than primary care visits within a 12-month period. | PHM KPI 1 |
| 16 | Members Engaged in Primary Care | The number of members who had at least one primary care visit within a 12-month period. | PHM KPI 2 |
| 17 | Members Not Engaged in Ambulatory Care | The number of members with no ambulatory or preventive visit within a 12-month period. | PHM KPI 3 |
| 18 | Disnerollment by REGAL | Voluntary disenrollment by REGAL during the measurement period | DISENR REGAL |
| 19 | Redetermination Rate by REGAL | Redetermination rate of members reinstated by REGAL during the measurement period | REDET REGAL |
| 20 | Interpreter service utilization | Number of Language line interpreter service requests by language during the measurement period | INT SVC UTIL |
| 21 | Translated documents | Number of translated documents by language or alternative format during the measurement period | TRNSLTD DOCS |
| 22 | Physical Accessibility | Percent of providers passing Physical Accessibility Review Survey with score >90% during the measurement period | PARS |
| 23 | IHA Completion | IHA completion rate stratified by REGAL during the measurement period | IHA |
| 24 | DPP Enrollment by REGAL | DPP enrollment by REGAL during the measurement period | DPP REGAL |
| 25 | Getting Needed Care | Getting Needed Care by REGAL during the measurement period | GNC REGAL |
| 26 | Getting Care Quickly by (REGAL) | Getting Care Quickly by REGAL during the measurement period | GCQ REGAL |
| **Equitable Social Interventions** | | | |
| | **Measure Description** | **Measure Definition** | **Measure Acronym** |
| 27 | Care Management for High-Risk Members after Discharge | The total number of transitions for high-risk members during the Intake Period within a 12-month period. | PHM KPI 5 |
| 28 | SDOH reporting | Rate of network providers reporting SDOH codes | SDOH |
| 29 | SDOH reporting by REGAL | Total number of members screened for SDOH by REGAL during the measurement period | SDOH REGAL |
| 30 | Populations of Focus | Percent of members stratified into each populations of focus | POF |
| 31 | Community Support utilization | Community support utilization by category | CS UTIL |
| **Equitable High-Quality Clinical Care** | | | |
| | **Measure Description** | **Measure Definition** | **Measure Acronym** |
| 32 | Overturned appeals stratified by race and ethnicity | Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period | APP-RE |
| 33 | Follow-Up After ED Visit for Mental Illness – 30 days by REGAL | Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period | FUM REGAL |
| 34 | Pharmacotherapy for Opioid Use Disorder by REGAL | Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period | POD REGAL |
| 35 | Follow-Up after ED Visits for Substance Use – 30 day by REGAL | Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period | FUA REGAL |
| 36 | Well-Child Visits in the First 30 Months of Life by REGAL | Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life stratified by REGAL | W30 REGAL |
| 37 | Breast Cancer Screening by REGAL | Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL | BCS REGAL |

| | | | |
|---|---|---|---|
| 38 | Colorectal Cancer Screening by REGAL | Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified by REGAL | COL REGAL |
| 39 | Hemoglobin A1c Control for Patients with Diabetes by REGAL | The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year | HBD REGAL |
| 40 | Controlling High Blood Pressure by REGAL | Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL | CBP REGAL |
| 41 | Asthma Medication Ratio by REGAL | Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL | AMR REGAL |
| 42 | Child and Adolescent Well Care Visits by REGAL | Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL | WCV REGAL |
| 43 | Childhood Immunization Status by REGAL | Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday during the measurement period stratifed by REGAL | CIS REGAL |
| 44 | Immunizations for Adolescents by REGAL | The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates during the measurement period stratified by REGAL | IMA REGAL |
| 45 | Potentially Preventable 30-day Post-Discharge Readmission by (REGAL) | Percentage of readmission rates for patients who are readmitted to a hospital for a reason that is considered unplanned and potentially preventable during measurement period stratified by REGAL | PPR REGAL |
| 46 | Prenatal and Postpartum Care: Postpartum Care by (REGAL) | The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL | PPC POST REGAL |
| 47 | Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL) | The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL | PPC TIME REGAL |
| 48 | EPSDT Preventive Utilization Gap | Percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period stratified by REGAL | EPSDT UTIL GAP |
| 49 | C-section rates by REGAL | C-section rates by REGAL during the measurement period | CSCTN |
| 50 | Perinatal Immunization Status - Flu | Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date; or Deliveries where members had an influenza virus vaccine adverse reaction any time during or before the Measurement Period. | PERINATAL IZ FLU |
| 51 | Perinatal Immunization Status - Tdap | Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), or Deliveries where members had any of the following: • Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period. • Encephalopathy due to Td or Tdap vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis) any time during or before the Measurement Period. | PERINATAL IZ Tdap |
| **Equitable Experiences of Care** | | | |
| **Measure Description** | | **Measure Definition** | **Measure Acronym** |
| 52 | Grievances stratified by race and ethnicity | Grievance category stratified by race and ethnicity for all grievances received during the measurement period | GRV-RE |
| 53 | Discrimination-related grievances | Percentage of Discrimination grievances based on all grievances received during the measurement period | DISC GRV |
| 54 | C&L grievances | Percent of C&L grievances (discrimination-related, interpreter services, translation-related) filed by members (based on all received quarterly) during the measurement period | C&L GRV |

## HEART Measure Set

| No. | Measure Description | Measure Definition | Measure Acronym | Measure Steward | Health Equity Framework Domain | Responsible Functional Area | Responsible Owner(s) | Subject Matter Expert (SME) | Responsible Person for Data Report Pull/Submission to | Report Source | Reporting Frequency | Baseline | Target | Data Link | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | ED Utilization | Members who had more ED visits than primary care visits within a 12-month period by REGAL during the measurement period | ED UTIL | DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA | Equitable Access to Care | Cal AIM | Paige Brogan | Natalie Johnstone | Paige Brogan | | Quarterly | TBD | TBD | | REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5 |
| 2 | PCP Utilization | Members who had a primary care visit within a 12-month period by REGAL during the measurement period | PCP UTIL | DMHC, DHCS CalAIM, EPSDT, NCQA | Equitable Access to Care | Cal AIM | Paige Brogan | Natalie Johnstone | Paige Brogan | | Quarterly | TBD | TBD | | REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5 |
| 3 | Preventive Care Access | Percentage of members with no ambulatory or preventive visit within a 12-month period | PREV UTIL | DMHC, DHCS CalAIM, NCQA | Equitable Access to Care | Cal AIM | Paige Brogan | Natalie Johnstone | Paige Brogan | | Quarterly | TBD | TBD | | REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5 |
| 4 | Transitions and Care Manager Interaction | Transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge. by REGAL during the measurement period | TOC | DMHC, DHCS CalAIM, NCQA | Equitable Social Interventions | Cal AIM | Paige Brogan | Natalie Johnstone | Paige Brogan | | Quarterly | TBD | TBD | | REMOVED MEASURE TO REPLACE WITH PHM KPI 1-5 |
| 5 | CCM Enrollment | Members eligible for CCM who are successfully enrolled in the CCM program by REGAL during the measurement period | CCM ENR | DMHC, DHCS CalAIM, NCQA | Equitable Structures of Care | Cal AIM | Paige Brogan | Natalie Johnstone | Paige Brogan | | Quarterly | TBD | TBD | | |
| 6 | EPSDT PCP Utilization | Members ages 0-20 who had a primary care visit within a 12-month period by REGAL during the measurement period | EPSDT UTIL | DMHC, DHCS CalAIM, EPSDT | Equitable High-Quality Clinical Care | Clinical Access Programs | Jesse Brennan-Cooke | Sherri Callahan | Brigitte Lamberson | CMS-416 | Quarterly | TBD | TBD | | |
| 7 | Cultural competency-related grievances | Percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period | CULT COMP GRV | NCQA | Equitable Experiences of Care | Appeals and Grievances | Lorraine Greywitt | Allan Shin | Allan Shin | 834 file + Grievance universe file | Quarterly | TBD | TBD | | A&G do not track this measure; no code to distinguish this. HECL team confirm they track similar metric. Need to confirm this is duplicative to Linda Fleischman's measure. |
| 8 | Maternal Mental Health Screening Referral | Rate of members with positive maternal mental health screening referred to behavioral health services during the measurement period | MMH REF | DMHC, DHCS | Equitable Social Interventions | Behavioral Health | David Bond | David Bond | Gi Villavicencio | Manual Report | Quarterly | TBD | TBD | | Suggestion to pend until reporting is resolved; BH confirmed limited referral data, members can call BH number on member card without a referral. Can only track Code and Screening encounters (90- |
| 9 | Plan All-Cause Readmissions by (REGAL) | For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission during the measurement period stratified by REGAL | PCR REGAL | DMHC, DHCS CalAIM, NCQA | Equitable High Quality Clinical Care | Quality<br>CalAIM | Alyson Spencer<br>Christine Nguyen | Alyson Spencer<br>Christine Nguyen<br>Paige Brogan<br>Ayesha Sharma | Christine Nguyen | Inovolon | Quarterly | TBD | TBD | | |
| 10 | Breast feeding rates | Rate of breastfeeding at least 6 months following birth from all deliveries occuring during the measurement period | BRFDNG | New Measure | Equitable High Quality Clinical Care | Maternal Health | Katie Abbott<br>Nicole Evans | Katie Abbott<br>Nicole Evans | Katie Abbott<br>Nicole Evans | Claims | Quarterly | TBD | TBD | | |
| 11 | NICU Admits | Rate of newborns of babies born during the measurement period to prenatal care patients aditted to the Neonatal Intensive Care Unit upon birth | NICU ADMITS | New Measure | Equitable High Quality Clinical Care | Maternal Health | Dr. Manisha Sharma<br>Ysobel Smith<br>Dana Harden | Dr. Manisha Sharma<br>Ysobel Smith<br>Dana Harden | TBD | Claims | Quarterly | TBD | TBD | | |
| 12 | Pre term birth | Pre term birth before 37 weeks of pregnancy of babies born during the measurement period | PRETERM BIRTH | New Measure | Equitable High Quality Clinical Care | Maternal Health | Dr. Manisha Sharma Nicole Evans | Dr. Manisha Sharma Nicole Evans | TBD | Claims | Quarterly | TBD | TBD | | |
| 13 | Low birth weight | Birthweight of babies born during the measurement period (<1,00 grams; 1,500-2,499 grams; >2,500 grams) | LBW | New Measure | Equitable High Quality Clinical Care | Maternal Health | Dr. Manisha Sharma Nicole Evans | Dr. Manisha Sharma Nicole Evans | TBD | Claims | Quarterly | TBD | TBD | | |
| 14 | Maternal Morbidity | Rate of Maternal morbidity by REGAL during the measurement period | MAT MORB | DHCS | Equitable High Quality Clinical Care | Maternal Health | Dr. Manisha Sharma Nicole Evans | Dr. Manisha Sharma Nicole Evans | Brigitte Lamberson | Tableau | Quarterly | TBD | TBD | | |
| 15 | Pregnancy Mortality Surveillance System (PMSS) Post 1-year | Pregnancy Mortality Surveillance System (PMSS) definition: A pregnancy-related death as a death while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy. | PMSS REGAL | New Measure | Equitable High Quality Clinical Care | Maternal Health | Dr. Manisha Sharma Nicole Evans | Dr. Manisha Sharma Nicole Evans | TBD | Claims | Quarterly | TBD | TBD | | |
| 16 | CRC Reach by REGAL | Number of Blue Shield members served Community Resource Centers during the measurement period | CRC REGAL | NEW | Equitable Access to Care | Community Engagement | Sandra Rose | Sandra Rose | Yuwei Weinberg | Inovolon | Quarterly | TBD | TBD | | |

Blue Shield Promise's

Health Equity Advancements Resulting in Transformation (HEART) Program

# Health Equity Integration Strategy

## Executive Summary

This document outlines a process to ensure the Health Equity contract requirement to integrate health equity into functional areas is met. The proposed process includes planning, implementation, and actions needed to maintain a set of health equity activities for each functional area. Each area will be able to successfully demonstrate they are integrating and prioritizing health equity into program plans and operations. Identified activities will be rooted in evidence-based best practices and BSCPHP's Health Equity Guiding Principles.

Prepared By: Valerie Martinez, Promise Chief Health Equity Officer

January 1, 2024

## Introduction

BSCPHP's Health Equity Office (HEO) is comprised of Promise's Chief Executive Officer and President (CEO), Chief Medical Officer (CMO), Chief Health Equity Officer (CHEO), Senior Director of Quality, Director of Quality, Health Equity Principal Program Manager, and Health Equity Business Analyst. The CHEO is responsible for oversight of the HETP, or Promise's HEART program activities and contract requirements.

As a contractor of the Department of Healthcare Services (DHCS) Medi-Cal contract, Blue Shield of California Promise Health Plan (BSCPHP) is required to maintain a Health Equity Transformation Program (HETP) which includes the following, at a minimum – **integration of health equity activities across a wide range of functional areas** such as utilization management, marketing, network, health education, grievances and appeals, and case management.

In response, **BSCPHP's HEO will maintain a Health Equity Integration Plan documenting planned activities and outcomes to integrate health equity across a wide range of functional areas.**

BSCPHP functional areas in scope include Health Education and Cultural and Linguistics, Growth and Engagement (Marketing), Network, Population Health Management, Grievances and Appeals, Utilization Management, and Quality.

The Integration Plan will be designed to intentionally align with industry standards and best practices and BCSPHP's Health Equity Guiding Principles and Program Tenets (Appendix 1) to ensure activities are rooted in BSCPHP's Health Equity program goals and evidence-based recommendations. These industry standards and best practices will be documented in the Health Equity Framework (Appendix 2) to be prepared by the HEO.

## Operations

BSCPHP's Health Equity Office will maintain the following process (Appendix 3) to ensure health equity is strategically integrated across functional areas to address disparities and inequities.

1) BSCPHP's Health Equity Office will convene a workgroup with leaders for each of the required areas. Leaders are encouraged to include additional support staff to support planning, implementation, and evaluation.

Contract Except: *Provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed; Ensure all Contractor policy and procedures consider Health Inequities and are designed to promote Health Equity where possible, including but not limited to:*
*1) Marketing strategy;*
*2) Medical and other health services policies;*
*3) Member and provider outreach;*
*4) Community Advisory Committee;*

*5) Quality Improvement activities, including delivery system reforms;*
*6) Grievance and Appeals; and*
*7) Utilization Management*

2) Functional Area Leaders include:
    - Health Education and Cultural and Linguistics: Linda Fleischman
    - Community and Provider Engagement (**Marketing**); Sandra Rose; Dre
        - Community Advisory Committee
    - Network: Melinda Kjer
    - Population Health Management: Susan Mahonga
    - Grievances and Appeals: Lorraine Greywitt
    - Utilization Management: Manisha Sharma
    - Quality: Christine Nguyen
    - Medical and other Health Services

3) At this time, the process, Health Equity framework, and template Integration Plan will be reviewed.
    a. HEO to define scope – specific areas that must incorporate equity. For example, Discrimination grievances, or Community Advisory Committee
    b. The functional area will be asked to provide strategic plans or work plans detailing initiatives in flight to assess if existing processes can be leveraged.
    c. The HEO will then assess those plans and identify opportunities to integrate a health equity approach to reduce disparities.
    d. Simultaneously, the functional area will review the Framework and begin drafting activities to integrate health equity.

4) The HEO will coordinate a follow up working meeting where the Health Equity Integration Plan will be drafted by the workgroup.

    Note: BSCPHP's CHEO recommends a pilot starting with one identified functional area, followed by a staggered implementation concluding with all 7 areas having implemented an Integration Plan by 12/31/2024. This will allow the HEO to assess resources needed to maintain operations and oversight.

5) The Health Equity Business Analyst will maintain an Integration Plan (Appendix 4) for each area, updating progress and outcomes.

6) The workgroup will prepare a set of planned activities to integrate health equity into policy, programs, and planning. Operationally, the HEO advises functional areas, the workgroup collaboratively identifies activities, and the functional area completes the work, and reports back to HEO.

7) The HEO will facilitate monthly meetings. Agenda to include:

a. Review the status of the planned activities, updating the Integration Plan as needed.
b. The Health Equity Office will prepare data analysis on HEART measures, identifying trends and recommendations to address identified disparities and opportunities.

8) Outcomes with supporting narrative will be incorporated into the Health Equity Annual Evaluation

9) Functional areas to cascade updates within teams and share at appropriate forums

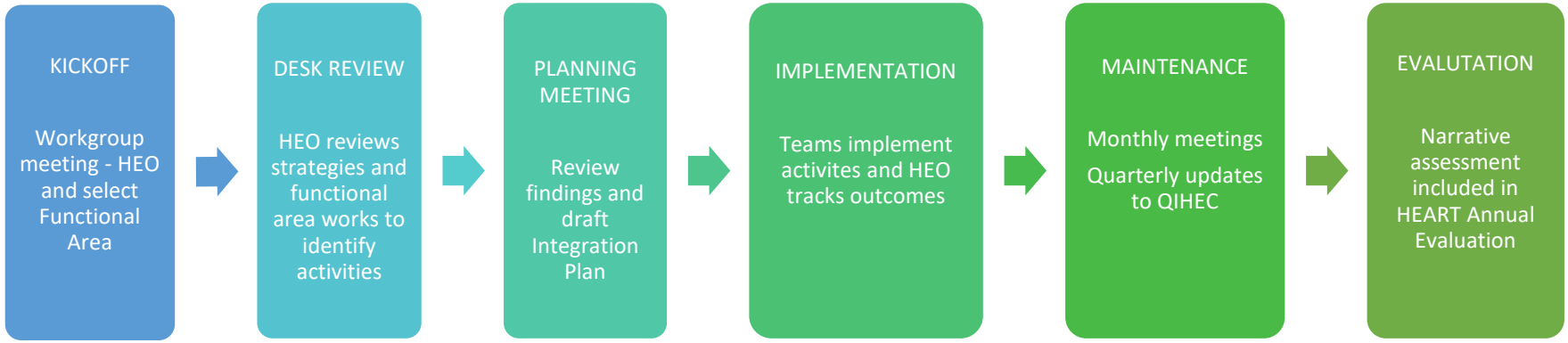
10) The Health Equity Office will provide quarterly updates at the Quality Improvement and Health Equity Committee meetings.

## Review Process

BSCPHP's CHEO will present this proposed operation to the Senior Leadership Team, requesting feedback for implementation. Once approved, the CHEO will work to implement this program plan. Senior Leaders will support program implementation, advising leaders and informing activities, as needed. Updates will be presented to BSCPHP's Performance and Operations Drivers Meeting and the Quality Improvement and Health Equity Committee.

# Appendix

1. **Operational Flow.** The following process details the steps to implement and maintain the Health Equity Integration Plans




2. **Health Equity Framework.** The HEO will prepare a model framework for functional areas to reference when designing activities to integrate a health equity approach. Reference to the Framework will demonstrate that BSCPHP's HEART program is aligned with industry best practices, and annual goals and activities are designed to deliver a best-in-class, model equity program.

   The Health Equity Framework will detail industry best practices, recommendations for health equity program planning, and examples of activities to apply the health equity lens to program and policy planning. The Framework will include:

   - Literature review demonstrating why health equity is important, and the impact to members, operations, cost of healthcare, health outcomes.
   - Contract requirements as related to equity.

- Industry best practices at the enterprise level and per functional area. Competitior analysis and assessment of market leaders.
- Commitments – policies and procedures submitted to DHCS as part of readiness and bid submission.
- Recommendations and impact analysis as related to the Health Equity Maturity Model. Recommendations will be rated on the maturity model as will a readiness assessment to embrace these concepts or work. Impact analysis will include expected outcomes if recommendations are implemented (i.e., reduced cost, increase member satisfaction, HEDIS rates improve, increased provider satisfaction, etc.).

3. BSCPHP's Health Equity Guiding Principles

**Blue Shield Promise Health Equity program is designed to eliminate disparities*.**
**Built on the following tenets:**

| TRANSFORM | BUILD | HEAL | PARTNER | CHAMPION |
|---|---|---|---|---|
| Equity Transforms | Equity Builds | Equity Heals | Equity Partners | Equity Champions |
| Link Quality and Equity | Cultivate a culture of equity | Reimagine the member experience | Embrace paradigm shift to drive high-quality, high-performing providers and plan operations | Realize our mission to eliminate disparities |
| Listen deeply | Align intentional organization around multi-disciplinary program | Facilitate the bridge to somewhere | Expand community presence | Advocate for social justice |
| Center community in our strategy | Demonstrate information in action | | Develop diverse network | Partner with the state to lead equity transformation |
| Optimize integration using real-time data | | | | |

4. Health Equity Integration Plan

| Health Equity Integration Plan (SAMPLE) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Department: Health Education** | | | | | | | | | | |
| **Key stakeholders:** Insert name and title | | | | | | | | | | |
| | | | | | | | | | | |
| **No.** | **Health Equity Tenet Cat.** | **Health Equity Tenet** | **Activity** | **Objective** | **Actions Needed to Accomplish Activity** | **Accountable Owner** | **Key Driver** | **Due Date** | **Completion Date** | **Outcomes** |
| 1 | *Build* | *Cultivate a culture of equity* | *Staff training* | *100% of staff will complete DEI Training by 12/31/2024* | *1) Socialize requirement to staff*<br>*2) Set due date*<br>*3) Send reminder email* | *Linda Fleischman* | *Rosa Hernandez* | *6/1/24* | | |
| 2 | *Build* | *Optimize integration using real-time data* | *Health Education classes offered in multiple languages leveraging member data* | *At least 3 classes will be offered in Mandarin by 12/31/2024* | | | | | | |
| **NOTES:** | | | | | | | | | | |

blue california | Promise Health Plan

| Workgroup Notes | |
|---|---|
| **Meeting Date:** | **Attendees:** |
| **Agenda:** | |
| **Notes:** | |

| HEART Measure Set - Health Education Metrics | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **No.** | **Metric** | **Definition** | **Q3 2023** | **Q4 2023** | **Q1 2024** | **Q2 2024** | **Q3 2024** | **Q3 2024** | **Q4 2024** |
| 1 | DPP Enrollment by REGAL | DPP enrollment by REGAL during the measurement period | | | | | | | |
| 2 | C&L Grievances | Percent of C&L grievances (discrimination-related, interpreter services, translation-related) filed by members (based on all received quarterly) during the measurement period | | | | | | | |
| 3 | Cultural Competency Training | Cultural competency training – internal completion rate by member-facing staff | | | | | | | |
| 4 | Member-facing Staff Representative of Membership | Rate of bilingual member-facing health plan staff by language is representative of membership during the measurement period | | | | | | | |
| 5 | Health Education Materials | Health Education materials available in all threshold languages during the measurement period; and Percent of health ed materials | | | | | | | |
| **Analysis**: Trends, findings, disparities identified, opportunities | | | | | | | | | |

blue california | Promise Health Plan

| HEART Measure Set – Population Health Management Metrics | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **No.** | **Metric** | **Definition** | **Q3 2023** | **Q4 2023** | **Q1 2024** | **Q2 2024** | **Q3 2024** | **Q3 2024** | **Q4 2024** |
| 1 | Members Utilizing Emergency Department Care More than Primary Care | The total number of members who had more emergency department (ED) visits than primary care visits within a 12-month period | | | | | | | |
| 2 | Members Not Engaged in Ambulatory Care | The number of members with no ambulatory or preventive visit within a 12-month period | | | | | | | |
| 3 | Members Engaged in Primary Care | The number of members who had at least one primary care visit within a 12-month period | | | | | | | |
| 4 | Care Management for High-Risk Members after Discharge | The total number of transitions for high-risk members during the Intake Period within a 12-month period | | | | | | | |
| 5 | Complex Care Management (CCM) Enrollment Among all Eligible Members | The number of members eligible for CCM for 1 or more days within a 90-day period | | | | | | | |
| 6 | CCM Enrollment Among all Eligible Members Who Were Not Already Enrolled During the Previous Measurement Period | The number of members eligible for CCM for 1 or more days within a 90-day period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period | | | | | | | |
| **Analysis**: Trends, findings, disparities identified, opportunities | | | | | | | | | |

| HEART Measure Set – Community Engagement Metrics | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **No.** | **Metric** | **Definition** | **Q3 2023** | **Q4 2023** | **Q1 2024** | **Q2 2024** | **Q3 2024** | **Q3 2024** | **Q4 2024** |
| 1 | Enrollment Growth by REGAL | Enrollment growth stratified by REGAL during the measurement period | | | | | | | |
| 2 | Disenrollment by REGAL | Voluntary disenrollment by REGAL during the measurement period | | | | | | | |
| 3 | CRC Reach by REGAL | Number of Blue Shield members served Community Resource Centers during the measurement period | | | | | | | |
| 4 | Redetermination Rate by REGAL | Redetermination rate of members reinstated by REGAL during the measurement period | | | | | | | |
| **Analysis**: Trends, findings, disparities identified, opportunities | | | | | | | | | |

## Appendix 4: Quality Improvement Health Equity Transformation Program Action Plan

The QIHETP Action Plan lists all actions and milestones needed to formally build and implement the BSCPHP QIHETP. The Action Plan will be managed by the HEO.

The initial goal for the QIHETP is to at minimum meet all state requirements and achieve DHCS Request for Proposal (RFP) content for implementation readiness. The QIHETP workplan will document intended activities.

| Task | Comments | Contract Requirement | Due Date | Collaboration | Status |
|---|---|---|---|---|---|
| Chief Health Equity Officer position | CHEO started 9/26/2022 | Yes | 10/1/2022 | HEO | Closed |
| Health Equity Organizational Chart | Submitted and approved by the DHCS on 04/11/2023 | Yes | 3/14/2023 | HEO | Closed |
| Health Equity Office Structure | Submitted and approved by the DHCS on 04/11/2023 | Yes | 3/14/2023 | HEO | Closed |
| Medi-Cal Readiness Deliverable: 2.2. QIHETP | Submitted on 3/30/2023 to the DHCS; pending approval by the DHCS | Yes | 3/30/2023 | HEO | Closed |
| Identify DHCS Health Equity contractual requirements | Will need to review Medi-Cal Managed Care Health Plan Contract and develop a gap analysis; will also need to include any NCQA and/or DMHCS requirements cross walk | No | 5/31/2023 | HEO<br>Compliance<br>Medi-Cal Growth Office | Closed |
| 5-year strategic plan, Maturation Model | Completed and presented to executive leadership | No | 3/1/2023 | HEO | Closed |
| QIHETP Description | Draft in progress due to QIHEC Q2 meeting | Yes | 6/5/2023 | HEO | Closed |
| QIHETP Policy | Submitted and approved by the DHCS on 03/09/2023 | Yes | 2/10/2023 | HEO<br>Compliance<br>Medi-Cal Growth Office | Closed |
| QIHEC Policy | Submitted on 3/30/2023 to the DHCS; pending approval by the DHCS | Yes | 2/10/2023 | HEO<br>Compliance<br>Medi-Cal Growth Office | Closed |
| QIHEC Charter | Completed and submitted to QIHEC Q1 for review and approval; Approved by committee on 3/6/2023 | Yes | 3/6/2023 | HEO | Closed |
| HEOC Charter | In progress for submission to HEOC for committee review and approval | Yes | 3/31/2024 | BSC Health Transformation Lab<br>BSP- HEO | Closed |
| QIHETP Workplan | In progress for submission to QIHEC Q2 for committee review and approval | Yes | 6/5/2023 | HEO | Closed |

| | | | | | |
|---|---|---|---|---|---|
| HEOC Workplan | In progress for submission to HEOC for committee review and approval | Yes | 3/31/2024 | BSC Health Transformation Lab<br>BSP- HEO | Open |
| Health Equity Workgroup | Ongoing workgroups to address open gaps enterprise-wide.<br>NCQA gap analysis, owner identification BSC vs. BSP.<br>IT/Data system builds enhancements needed e.g., FACETS REAL/SOGI data available to first contact Customer Experience member facing staff | Yes | 3/31/2024 | BSC-<br>Health Transformation Lab<br><br>BSP-<br>HEO<br>Quality<br>NCQA Accreditation<br>Medi-Cal Growth Office<br>Strategic and Performance | Closed |
| QIHEC (introduction emails/committee member recruitment, agenda, slide deck, meeting minutes) | QIHEC Q1 completed; QIHEC Q2, Q3 and Q4 are scheduled | Yes | 3/21/2024<br>6/20/2024<br>9/19/2024<br>12/12/2024 | HEO | Open |
| Health Equity Oversight Committee (agenda, slide deck, meeting minutes) | HEOC inaugural committee meeting | Yes | 10/10/2024 | BSC-<br>Health Transformation Lab<br><br>BSP-<br>HEO | Closed |
| DEI training for BSP staff | Enhance current cultural competency training; exploring internal resources and/or external vendors for sourcing, as needed | Yes | 5/31/2024 | HEO<br>HE/CL | Closed |
| Develop HEART Measure Set | Identify all impacted departments, facilitate meetings | Yes | 5/15/2023 | | Closed |
| Health Equity Measure Set Roadshow Experience | Share strategic plan, facilitate collaboration, establish partnerships between HEO and functional area leaders | No | 4/30/2023 | | Closed |
| Stratified reporting of HEDIS®/ Health Equity Measure Set | Many data sets must be stratified and analyzed for disparities for the very first time- key measures will need to be selected for each data set. With this, development of a separate roadmap and strategy is needed to ensure that Promise can meet DHCS requirement timelines, but also operationalize high quality health equity work. | Yes | 9/13/2023 | HEO<br>A&G<br>BH<br>CalAim<br>PHM<br>Customer Experience<br>Clinical Services (FSR)<br>HE/CL<br>Maternal Health<br>Provider Contracting<br>Quality<br>Corporate Citizenship and Reputation | Closed |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Social Services Management<br>Community Engagement | |
| Update global policies and procedures with health equity lens | Need to review all policies and procedures with a health equity lens. Need to connect with Sylvona Boler for P&P operational process as presented in April 2023 MPOD meeting | Yes | 12/31/2042 | HEO<br>Compliance<br>Medi-Cal Growth Office | Open |
| QIHETP Annual Evaluation Report | Need to draft QIHETP Annual Evaluation Report | Yes | 4/30/2024 | HEO | Closed |
| Review Marketing Plan and identify HE activities | CHEO to review Marketing Plan and identify HE activities in collaboration with Community Engagement Department | Yes | TBD | Community Engagement<br>HEO | Open |
| Population Needs Assessment and Population Health Management Strategy | Support draft and use findings to guide program activities None | Yes | TBD | BSC-<br>Health Transformation Lab<br>HEO | Open |
| BSP Population Needs Assessment | Support draft and use findings to guide program activities None | Yes | 6/30/2023 | HE/CL<br>HEO | Closed |
| BSP Population Health Management Strategy | support draft and use findings to guide program activities | Yes | 5/15/2024 | PHM<br>HEO | Closed |
| Provider Health Equity training | No known training. Need to develop content and implement. Systems to track provider compliance unknown. | Yes | 12/31/2025 | HEO<br>Provider Relations<br>HE/CL | Open |
| Assess health equity pilots | Need to assess current health equity pilots, projects, programs – part of 5-year strategic planning and maturation model. | Yes | 12/31/2024 | HEO<br>A&G<br>BH<br>CalAim<br>PHM<br>Customer Experience<br>Clinical Services (FSR)<br>HE/CL<br>Maternal Health<br>Provider Contracting<br>Quality<br>Corporate Citizenship and Reputation<br>Social Services Management<br>Community Engagement | Open |
| Committee involvement (QIHEC, MAC, PAC, PPC) | CHEO representation in committee involvement.<br>Co-chairing QIHEC with CMO | Yes | TBD | HEO<br>Community Engagement | Open |

| | | | | | |
|---|---|---|---|---|---|
| | CHEO provide updates as MAC, PAC, PPC<br>Member and Provider feedback needed to build QIHETP for required written reports | | | | |
| Provider involvement in Health Equity – APM, VBC | No existing mechanisms to assess provider HE competence (possibly incorporated into z-code training). Roadmap and timeline needed for journey to HE related APMs and VBC after CHEO is hired. Unclear whether Salesforce (or any other platform) will have functionality to track or facilitate selection of partners for interventions. | Yes | TBD | BSC – Health Transformation Lab<br><br>BSP- HEO and Quality | Open |
| NCQA Health Equity Accreditation in 2025 | Need to Identify owners for all HEA standards and elements; IT policies need to be updated to include NCQA data; Data REAL/SOGI collection systems implementation needed; report writing needed | Yes | 12/31/2025 | HEO<br>NCQA Accreditation<br>HE/CL<br>IT<br>Other - TBD | Open |