



Promise Health Plan

2025

Quality Improvement and Health Equity Transformation Program Description Medi-Cal Product

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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.

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



Figure 1. California Department of Health Care Services Bold Goals

and stratification, workforce diversity and cultural responsiveness, and disparity reduction efforts (DHCS, 2022; Reference figure 1).

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. 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.

E. Diversity, Equity, and Inclusion Training Program Requirements.

The newly released DHCS APL 24-016 Diversity, Equity, and Inclusion (DEI) Training Program Requirements are a core part of increasing capacity to deliver culturally competent care. The DEI training program will support creating better relationships and connectivity with diverse members across populations who have been disadvantaged by the system. The training program will create an inclusive environment within the 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.

F. The California Department of Managed Health Care (DMHC) 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 23-029. 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 DMHC established the HEQMS and initial measure stratification requirements, which were shared with health plans in APL 22-028 Health Equity and Quality Measure Set and Reporting Process.

The HEQMS became 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 codifying the measures and benchmarks by January 1, 2027.

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 has adopted the NCQA health equity methodology for stratifying its HEQMS.

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

BSCPHP has obtained 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 helps 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 has adopted an actionable framework for improving health equity and prioritizing health equity for our members and the communities we serve.

H. 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 has been integrating health equity throughout the organization. The health plan has adopted by 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 informs the development of quality improvement programs, helps 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 who holds Health Plan Accreditation and most recently received Health Equity Accreditation for its Medicaid product line from the National Committee for Quality Assurance (NCQA).

The Health Equity Office (HEO) serves 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. 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).

Blue Shield Promise's HEART Program is designed to eliminate disparities.
Built on the following tenets:

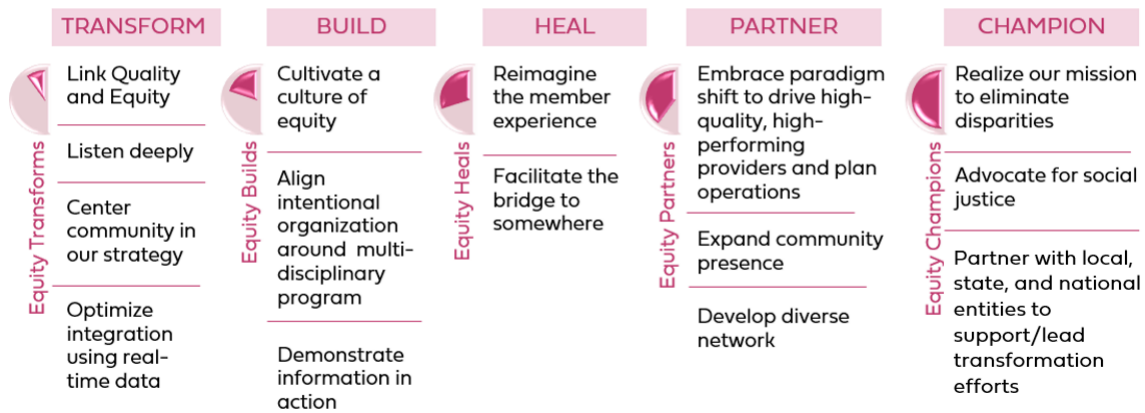


Figure 2 Health Equity Transformation Program Tenets

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

- A. **Transform.** Transforming equity includes the necessary link between quality and equity, and listening deeply to our members, providers, 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 HEO will then develop interventions to address these health disparities.
- B. **Build.** BSCPHP's HEO has developed a comprehensive Health Equity program that both meets regulatory requirements and supports BSCPHP's commitment to addressing health disparities. In addition, BSCPHP's HEO has developed 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 is 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 confirms 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 continue to be integrated into this Health Equity program. BSCPHP is fully committed to support disparity work as needs is 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 member. BSCPHP will continue to work to diversify our provider network, supporting cultural competency, health equity training, attempting to dismantle systemic racism and teach skills to reduce implicit bias, all leading 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 achieve 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, 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 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 of 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 a common language and shared understanding to achieve the transformation our members deserve. To facilitate this common language, health-equity related terms are defined in BSCPHP's *Advancing Health Equity* training and 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 responsible for the Quality Improvement and Health Equity Transformation Program. The Board approves the Quality Improvement and Health Equity Transformation Program Strategy, and is presented with related goals, metrics, and recommendations for BSCPHP. The Board provides oversight of performance against quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of all quality and health equity activities to the Medi-Cal Committee .

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 QIHETP planning.
2. 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.
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 and Health Equity Transformation Program governance structure (Reference figure 3).

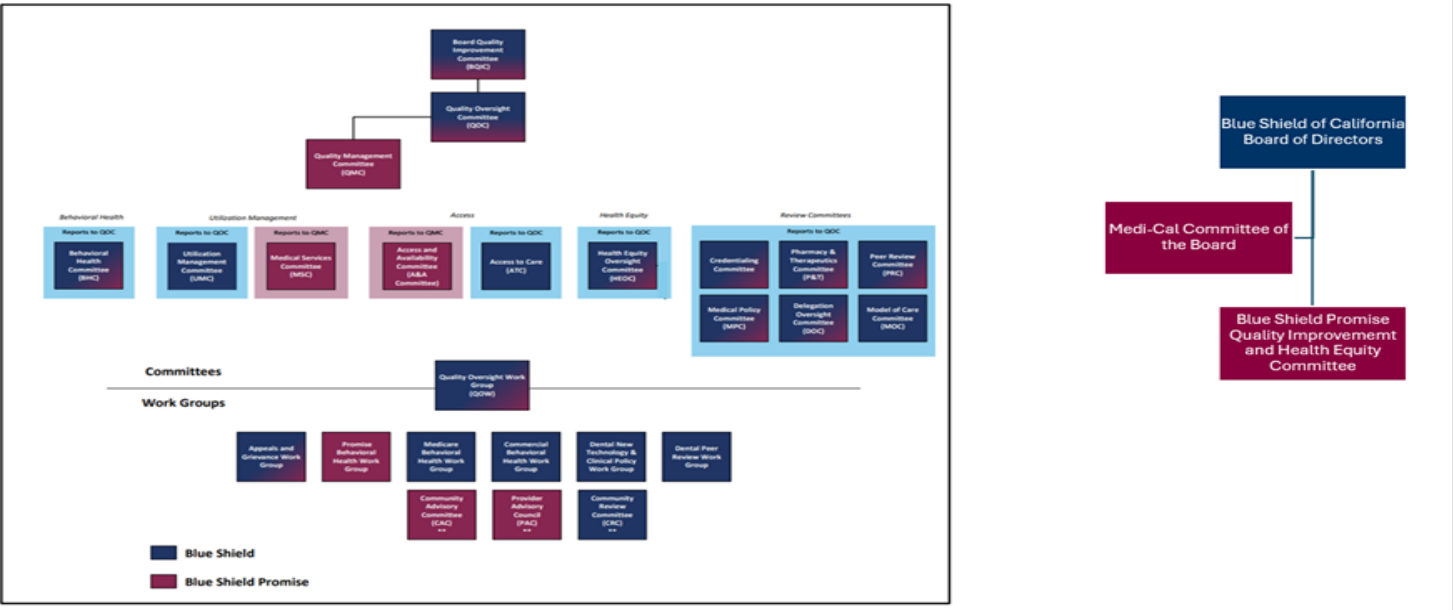


Figure 3. Quality Improvement Health Equity Transformation Program Governance Structure

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 Medi-Cal Committee. The Medi-Cal Committee reports to the Blue Shield of California Board of Directors via consent agenda.

The Blue Shield of California Board of Directors delegates the authority to review and approve the Health Equity related activities, including the annual Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation and associated documents and/or reports to the Medi-Cal Committee. The Medi-Cal Committee reviews information from internal and external stakeholders including but not limited to data, reporting, and feedback from the Community Advisory Committee (CAC).

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 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 members 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 and 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 are maintained for all meetings of the BSCPHP QIHEC.

IX. EXECUTIVE LEADERSHIP

BSCPHP's 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 Executive Vice President (EVP) and Chief Growth Officer of Blue Shield of California 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 (CMO), BSCPHP: The BSCPHP CMO reports to the BSCPHP President and CEO, and the Senior Vice President (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 (CHEO), BSCPHP: The CHEO will report directly to the BSCPHP President and CEO and will work cross functionally across the entire organization. The CHEO works 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 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 also plays 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 and monitor 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 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 • Capture and validate health equity related demographic data • Enable a simplified reporting and analytics platform that drives the delivery of equitable, whole-person care	• Maintain compliance with operational governance framework in accordance with BSCPHP's current operating model and in alignment with regulatory requirements • Define regular reporting and information flow/data analysis expectations • Maintain NCQA Health Equity Accreditation	• Establish organization-wide expectations that achieving health equity is everyone's responsibility • Incorporate health equity information sharing across BSCPHP	• Adopt a robust health equity intervention development process • 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. Having established a HEO that champions integration and transformation that drives Quality and Health Equity in Medi-Cal. The HEO will maintain and/or enhance 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 continue to 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 Drivers 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. Defining 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 drivers 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 drivers 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. Vice President, Clinical Quality, Blue Shield of California
- e. Director of Clinical Quality
- f. Health Equity Principal Program Manager
- g. Health Equity Principal Program Manager
- h. Health Equity Business Analyst

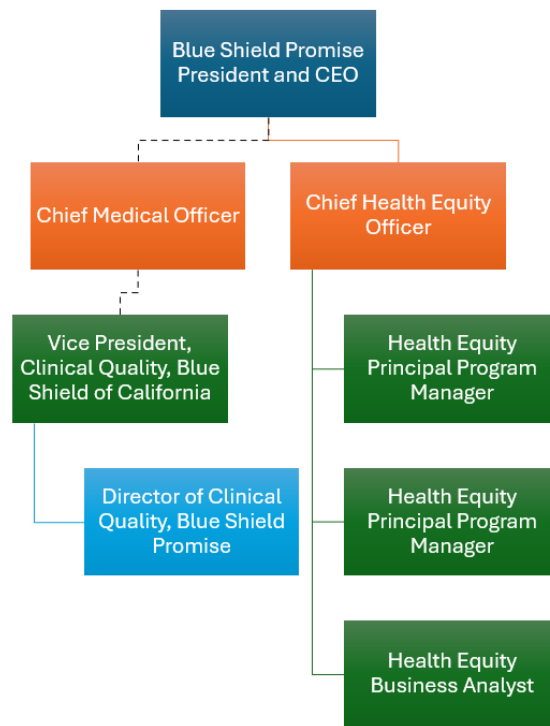


Figure 5. BSCPHP Health Plan Health Equity Office Organizational Chart

The President and CEO of BSCPHP reports to the EVP and Chief Growth Officer of Blue Shield of California 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 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 BSCPHP CHEO 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 VP 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 HEO staff are responsible for the execution and oversight of QIHETP daily 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 Advisory committee, Provider Advisory Committee, and other committees as identified by leadership and the community.

Policies and Procedures

BSCPHP's QIHETP 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 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 and/or initiatives such as the Annual QIHETP, meeting minutes from the quarterly QIHEC, Utilization management policies and procedures, Community 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 HEO, under the leadership of the CHEO and 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 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 captures 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 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

As of January 2025, BCPHP has acquired NCQA Health Equity Accreditation (HEA) per DHCS contract requirements. To maintain NCQA HEA accreditation, BSCPHP will monitor required reporting and activities and report appropriate updates to the QIHEC.

3. Equity Embedded

BSCPCP is seeking to embed Health Equity into everything we do. BSCPHP has established 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 Diversity, Equity and Inclusion staff training, Advancing Health Equity, which encompasses sensitivity, diversity, cultural competency, cultural humility, and health equity topics. BSCPHP seeks to recruit and retain a diverse workforce with varying cultural backgrounds, spoken languages, 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 continue to 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 prioritized based on importance and feasibility, defining multiple levels of

influence to target such as patient, provider, community, and various delivery modes of communication such as print, social media, in-person. 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 by the established governance structure.

2025 QIHET Program Objectives	
Goal	Objective
Sound Infrastructure and Operations	Complete 100% of all Health Equity Accreditation activities as required by 12/31/2025
	100% of health equity related contract deliverables will be compliant by 12/31/2025
Information in Action	Operationalize 100% of requirements to launch Diversity, Equity and Inclusion training program by 12/31/2025
	At least 30% of network providers complete Diversity, Equity, and Inclusion training by 12/31/2025
Equity embedded in everything we do	90% of finalized Health Equity Integration Plan activities will be completed by 12/31/2025
	HEART advocate program survey yields >90% participant report of value added upon program completion
Interventions that Matter	Member social drivers of health data collection increases by 5% by 12/31/2025

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 such as but not limited to Grievances and Appeals, Utilization Management, and Behavioral Health within BSCPHP to identify and address disparities. Applying a health equity lens to program oversight across each functional area are 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 conducted in calendar year 2024, was an experience between the Health Equity Office and functional area leaders which 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 roadshow was 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 initiated monitoring of the data for the selected measures to identify disparities and/or trends over time. Integrated data results and outcomes are shared at the QIHEC meetings 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, we 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 Cultural and Linguistics (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 Community 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 the 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 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 roadshow 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.

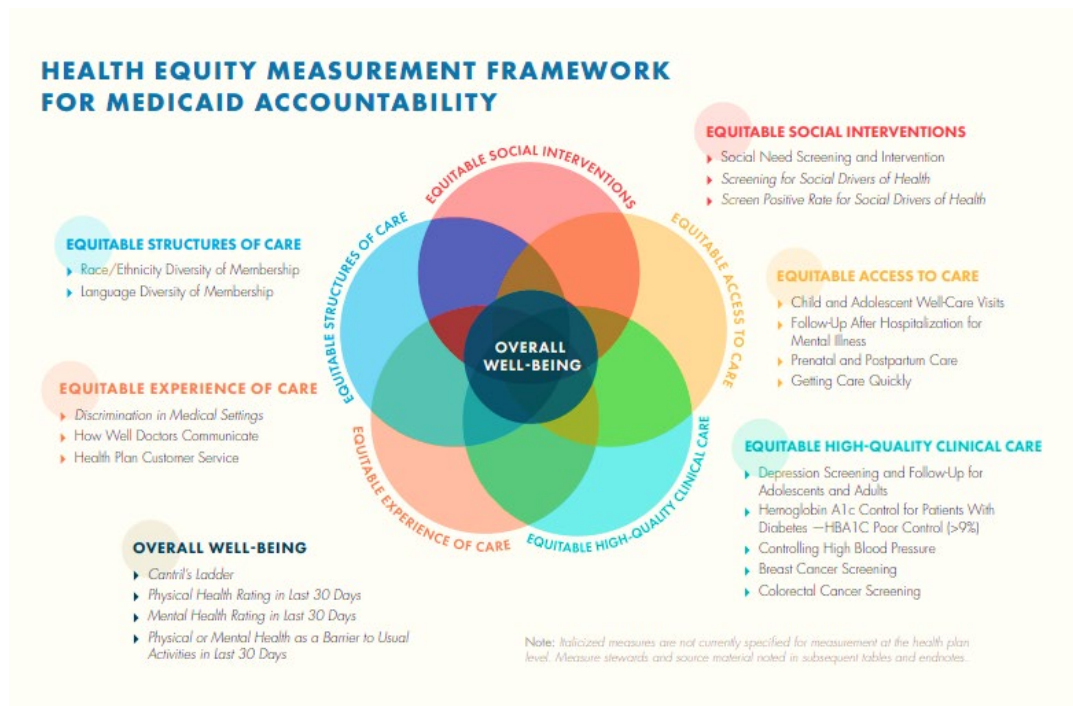


Figure 7. Health Equity Measurement Framework for Medicaid Accountability Summarized

Health Equity is integrated across the organization and disparities transcend departments impacting multiple cross-functional areas. 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 spoken language (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 have been 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
- Managed Care Accountability Set (MCAS) 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 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 has defined 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

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 on 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:

- Grievance category stratified by race and ethnicity for all grievances received during the measurement period.
- Percentage of Discrimination grievances based on all grievances received during the measurement period.
- Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period.

D. CalAIM

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 the 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 Managed Care Accountability Set (MCAS) comprised of metrics assessing utilization, preventive care screening, and management of chronic health conditions. Quality and health equity intersect when 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), and All Plan Letter (APL) 24-016: Diversity, Equity, and Inclusion Training Program Requirements.

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, 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 HEO and 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 cultural competency 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 the 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 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 (FSR) program and Initial Health Appointments. 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 provider network through the medical record review and facility site review audits. The Clinical Access Programs functional area will:

- 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 appointment rate completion and stratify by REGAL to determine if there is 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 the 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

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 helps 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.

BSCPHP has recently been awarded the NCQA Health Equity Accreditation (HEA) 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. BSCPHP will maintain NCQA HEA and monitor required reports and planned activities. Updates will be reported to the QIHEC and other committees as appropriate.

XIV. MONITORING AND OVERSIGHT

Ongoing monitoring is a key mechanism to evaluate the progress of quality activities, as outlined in the Work Plan, and are submitted to the Medi-Cal 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 Medi-Cal Committee will review and monitor all QIHETP and QIHEC-related policies and procedures. The Medi-Cal Committee directs necessary modifications of QIHETP and QIHEC policies and procedures to ensure compliance with health equity regulatory requirements.

BSCPHP's Medi-Cal Committee coordinates with the QIHEC to approve the overall QIHETP and the annual plan of the QIHETP. 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 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 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 conducted in calendar year 2024 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 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 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).

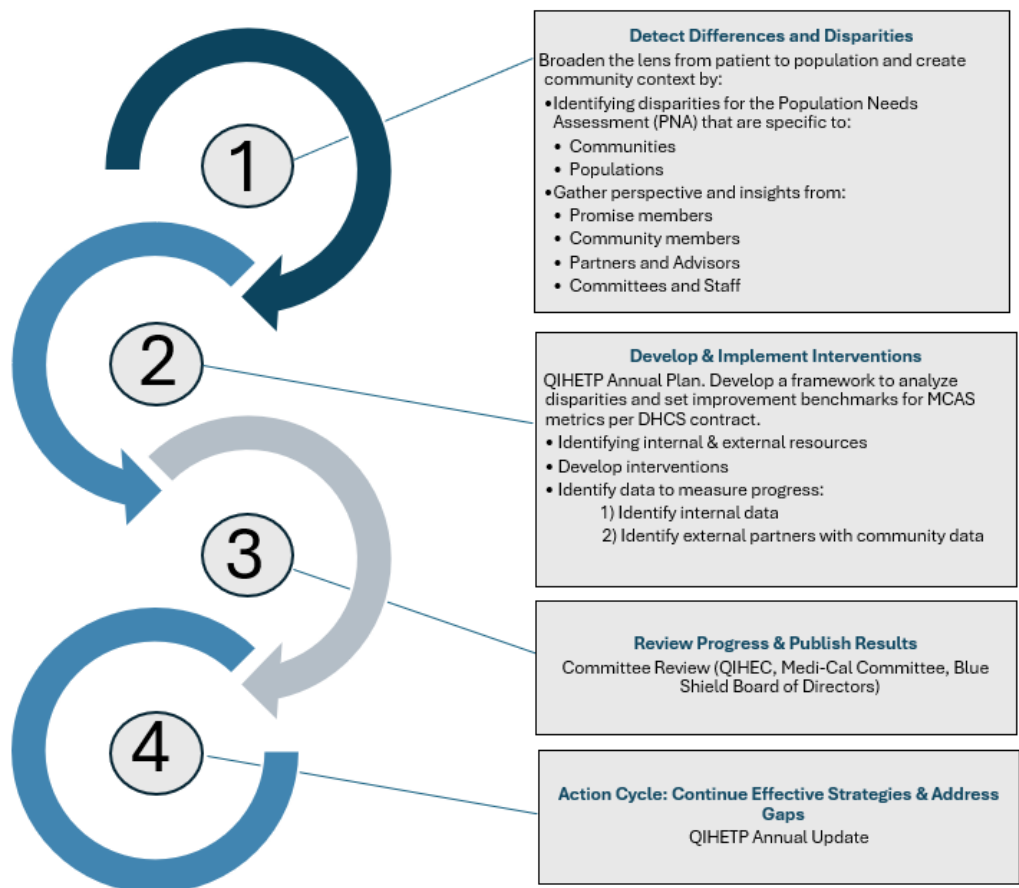


Figure 8. Principles of Continuous Quality Improvement in Action

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 as assessing 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 race, ethnicity, age, gender, 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 23-001, 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 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 work groups. 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 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 goal for the QIHETP is to at minimum meet all state requirements and maintain compliance. 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 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. 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 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 members 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 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 Medi-Cal Committee, and DHCS upon request. BSCPHP shall make a written summary of the QIHEC and QIHETP activities publicly available on the BSCPHP website at least on a quarterly basis.

BSCPHP's CHEO coordinates the 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 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 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 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 are 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 individuals 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 individuals 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 individuals 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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XXII. APPENDICES

Appendix 1. 2025 Advancing Health Equity Terms and Definitions List

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

Appendix 3. Health Equity Integration Plan

Appendix 4. Quality Improvement Health Equity Transformation Program Action Plan

2025 Advancing Health Equity Term List 47 total terms in list for 2025 Advancing Health Equity 40 of 47 terms are defined within the content 7 of 47 terms are race/ethnicity terms used but not defined within the content				
Notes	Terminology	Definition	Definition Source	Source Link
Aligned with SMEs	American Indian or Alaska Native in content with statistics	Individuals with origins in any of the original peoples of North, Central, and South America, including, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya.	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-178
Aligned with SMEs	Asian in content with statistics	Individuals with origins in any of the original peoples of Central or East Asia, Southeast Asia, or South Asia, including, for example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, and Japanese.	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-179
Aligned with SMEs	Bias Header 7, scene 2	Bias describes the positive or negative associations, attitudes, preferences, or stereotypes that influence behavior and decisions. Bias may be implicit (unconscious) or explicit (conscious) and requires awareness, acknowledgement, and conscious effort to overcome.	National Committee for Quality Assurance (NCQA)	Confirmed by Marilyn Milano
Aligned with SMEs	Black or African American in content with statistics	Individuals with origins in any of the Black racial groups of Africa, including, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-180
Aligned with business driver	Cultural Competency Header 8, scene 4, example 1	Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities.	Senate Bill 923: Gender affirming care	https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB923
Aligned with business driver	Cultural Humility Header 8, scene 4, example 5	Cultural humility is the ability of organizations, systems, and health care professionals to value, respect, and respond to diverse cultural health beliefs, behaviors, and needs (e.g., social, cultural, linguistics) when providing health care services.	National Committee for Quality Assurance (NCQA)	Confirmed by Marilyn Milano
Aligned with business driver	Cultural and Linguistically Appropriate Practices Header 8, scene 4, example 4	Cultural and linguistically appropriate practices seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing services.	National Committee for Quality Assurance (NCQA)	Confirmed by Marilyn Milano
Aligned with business driver	Cultural Sensitivity Header 8, scene 4, example 2	Awareness and appreciation of the values, norms, and beliefs characteristic of a cultural, ethnic, racial, or other group that is not one's own, accompanied by a willingness to adapt one's behavior accordingly.	American Psychological Association	https://dictionary.apa.org/cultural-sensitivity
Aligned with business driver	Culture Header 12, scene 2	A set of shared attitudes, values, goals and practices that characterize an institution, organization or group. Culture is transmitted and reinforced through tradition, art, language and ritual, among other practices.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Disability Header 8, scene 6	A disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.	Disability and Health Overview Disability and Health Promotion Center for Disease Prevention	https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html#:~:text=A%20disability%20is%20any%20condition,around%20them%20(participation%20restrictions)
Aligned with business driver	Discrimination Header 4, scene 2	The unjust and differential treatment of the members of different age, gender, racial, ethnic, religious, national, ability identity, sexual orientation, socioeconomic, and other groups at the individual level (e.g., behavioral manifestation of prejudice involving negative, hostile, and injurious treatment of the members of targeted groups) and the institutional/structural level (e.g., operating procedures, laws, and policies) that favor certain groups over others and has the effect of restricting opportunities for other groups.	American Psychological Association	https://dictionary.apa.org/discrimination
Aligned with business driver	Diversity Header 8, scene 2	The characteristics and experiences, both seen and unseen, that make everyone unique.	Diversity, Equity, and Inclusion Centers for Medicare & Medicaid Services	https://www.cms.gov/about-cms/work-with-us/careers/diversity-equity-and-inclusion
Aligned with SMEs	Equality Header 3, scene 8	equality means providing the same to all	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms page 33 (with Equity) - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Equity Header 8, scene 2	Ensuring fair access to opportunities and resources, while taking into consideration individual's barriers or privileges and eliminating systemic barriers and privileges.	Diversity, Equity, and Inclusion Centers for Medicare & Medicaid Services	https://www.cms.gov/about-cms/work-with-us/careers/diversity-equity-and-inclusion
Aligned with business driver	Gender-Affirming Care Header 10, scene 2	Gender-affirming care is a supportive form of healthcare. It involves an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people.	Gender-Affirming Care and Young People Health and Human Services, Office of Population Affairs	https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf
Aligned with SMEs	Gender expansive Header 10, scene 3	A person with a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Gender Expression Header 10, scene 3	A person's gender-related appearance or behavior, or the perception of such appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.	California Civil Rights	https://calcivilrights.ca.gov/wp-content/uploads/sites/32/2017/06/FinalTextRegTransgenderIdExpression.pdf
Aligned with business driver	Gender Identity Header 10, scene 3	Each person's internal understanding of their gender, or the perception of a person's gender identity, which may include male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.	California Civil Rights	https://calcivilrights.ca.gov/wp-content/uploads/sites/32/2017/06/FinalTextRegTransgenderIdExpression.pdf
Aligned with SMEs	Health Disparities Header 4, scene 1	Refer to a higher burden of illness, injury, disability, or mortality experienced by one group compared to another.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	Health Equity Header 3, scene 7	Health equity is the condition in which everyone has a fair and just opportunity to attain their highest level of health.	Centers for Disease Control and Prevention	https://www.cdc.gov/healthequity/index.html#:~:text=Health%20equity%20is%20the%20state,their%20highest%20level%20of%20health.
Aligned with SMEs	Health Inequities Header 5, scene 1	Differences in health outcomes that are systematic, avoidable, unnecessary, unfair, and unjust.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf

Aligned with SMEs	Health Literacy Header 11, scene 1	Is used to describe the ability of individuals to locate, understand, interpret, and apply health information to guide their decisions and behavior.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	Hispanic or Latino <i>in content with statistics</i>	Includes individuals of Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and other Central or South American or Spanish culture or origin.	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-181
Aligned with business driver	Implicit Bias Header 7, scene 3	Unconscious mental process that stimulates negative attitudes about people outside one's own "in group" and positive attitude or beliefs about people recognized inside one's own "in group." Implicit racial bias leads to discrimination against people not of one's own group.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Inclusion Header 8, scene 2	The actions taken to understand, embrace, and leverage the unique identities and perspectives of all individuals so that all feel welcomed, valued, and supported.	Diversity, Equity, and Inclusion Centers for Medicare & Medicaid Services	https://www.cms.gov/about-cms/work-with-us/careers/diversity-equity-and-inclusion
Aligned with SMEs	Institutional Racism Header 4, scene 2	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race. Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Intersectionality Header 5, scene 4	Is the continued overlapping systems of oppression and discrimination that communities face based on race, gender, ethnicity, ability, etc.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	Intersex Header 10, scene 3	"Intersex" is an umbrella term used to describe natural bodily variations, which can include external genitalia, internal sex organs, chromosomes, or hormonal differences that transcend typical ideas of male and female.	Senate Bill 179: Gender recognition	https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB179
Aligned with business driver	Limited English Proficiency Header 9, scene 1	Limited English Proficiency (LEP) Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand the English language.	USA - Federal Election Commission	https://www.fec.gov/about/equal-employment-opportunity/limited-english-proficiency/#::~:~:text=In%20general%2C%20such%20individuals%20are,read%2C%20write%20or%20understand%20English.
Aligned with business driver	Marginalization Header 3, scene 7	Marginalized is commonly used as a verb meaning "to relegate to an unimportant or powerless position within society or group." Marginalization, or to marginalize describes the casting aside of groups as unimportant or powerless within society. Examples of marginalized groups include those based on social economic status, race, gender identity, sexual orientation, age, physical ability, or language.	Deconstructing Bias: Marginalization - NICHD Connection - Science@NICHD National Institutes of Health	https://science.nichd.nih.gov/confluence/pages/viewpage.action?pageId=242975243#:~:text=Today%2C%20examples%20of%20marginalized%20populations,of%20social%20determinants%20of%20health.
Aligned with SMEs	Middle Eastern or North African* <i>in content with statistics</i>	Individuals with origins in any of the original peoples of the Middle East or North Africa, including, for example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli. <i>Note: This is a new category added to the Census race and ethnicity data effective March 28, 2024, in preparation for the 2030 Census. Historically, Middle Eastern or North African were included in the White race and ethnicity data.</i>	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-182
Aligned with SMEs	Native Hawaiian or Pacific Islander <i>in content with statistics</i>	Individuals with origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands, including, for example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese.	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-183
Aligned with business driver	Non-Binary Header 10, scene 3	Is an adjective describing a person who does not identify exclusively or at all as a man or a woman. Nonbinary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all nonbinary people do. Nonbinary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Older Adults Header 8, scene 9	Older adults are generally defined as individuals aged 65 or older.	Age National Institutes of Health, Health and Human Services	https://www.nih.gov/nih-style-guide/age
Aligned with business driver	Oppression Header 5, scene 2	Unjust or cruel exercise of power or authority; the product of injustice.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	People of Color Header 4, scene 3	Term used mostly, but not exclusively, in the U.S. to describe people not considered "white."	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Privilege Header 5, scene 4	A set of advantages systemically conferred on a particular person or group of people.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	Racism Header 5, scene 3, effect 2	Racism is a system of structuring opportunity and assigning value based on phenotype ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Sex at Birth Header 10, scene 3	Infants are assigned a sex at birth, "male" or "female," based on the appearance of their external anatomy, and an M or an F is written on the birth certificate.	Gay & Lesbian Alliance Against Defamation (GLAAD)	https://glaad.org/reference/trans-terms
Aligned with business driver	Sexual Orientation Header 10, scene 3	Sexual orientation describes a person's enduring physical, romantic, and/or emotional attraction to another person.	Gay & Lesbian Alliance Against Defamation (GLAAD)	https://glaad.org/reference/trans-terms
Aligned with SMEs	Social Drivers of Health Header 6, scene 1	Refer to the underlying community-wide social, economic, and physical conditions in which people are born, grow, live, work, and age.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	Social Exclusion Header 5, scene 2	Is a relational process of denying groups of people access to economic, social, political, and cultural resources, based on unequal power relations.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Stereotype Header 8, scene 4, example 3	Assignment of assumed characteristics or attributes to the members of a given group (e.g., by ethnicity, nationality, class, or other status/identities). It occurs in a variety of historical representations or expressions that can cause trauma and racial injury by "othering" groups and denying people their individuality, culture and humanity.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	Stigma Header 6, scene 3, stigma 1	Elements of labeling, stereotyping, separating, status loss and discrimination co-occurring in a power situation that allows these processes to unfold.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf

Aligned with SMEs	Structural Racism Header 4, scene 2	Refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with business driver	Transgender Header 10, scene 3	Denotes a person whose sense of personal identity and gender expression does not correspond with their assigned sex at birth.	Advancing Health Equity: A Guide to language, narrative and concepts - Glossary of key terms - American Medical Association	https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
Aligned with SMEs	White in content with statistics	Individuals with origins in any of the original peoples of Europe, including, for example, English, German, Irish, Italian, Polish, and Scottish. <i>Note: This is a new definition added to the Census race and ethnicity data effective March 28, 2024, in preparation for the 2030 Census. Historically, the White race and ethnicity data included Middle Eastern or North African.</i>	Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity	https://www.federalregister.gov/d/2024-06469/p-184

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 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	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	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	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	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	Rosa Hernandez	Language Line	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	Rosa Hernandez	Manual Report (ISI vendor)	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	Rosa Hernandez	Solera Health	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 CaAIM, NCQA	Equitable Access to Care	Population Health Management	Neil Putman	Claims NCQA Data Sets	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 CaAIM, NCQA	Equitable Access to Care	Population Health Management	Neil Putman	Claims NCQA Data Sets	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 CaAIM, NCQA	Equitable Access to Care	Population Health Management	Neil Putman	Claims NCQA Data Sets Provider Data	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	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	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	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	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	Rosa Hernandez	834 file + Grievance universe file	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	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 CaAIM, EPSDT	Equitable High Quality Clinical Care	Population Health Management	Ysobel Smith	CMS-416	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	Inovalon	Quarterly	TBD	TBD

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 Christine Nguyen	Inovalon	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	Nicole Evans	Tableau	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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	COL REGAL	DMHC, DHCS CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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	CIS REGAL	DMHC, DHCS Bold Goal, DHCS CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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	IMA REGAL	DMHC, DHCS Bold Goal, DHCS CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 first 15 months of life stratified by REGAL	W30 REGAL	DMHC, DHCS Bold Goal, DHCS CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	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 CaIAIM, NCQA	Equitable High Quality Clinical Care	Quality CaIAIM	Alyson Spencer Christine Nguyen	Inovalon	Quarterly	TBD	TBD

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 CalAIM	Alyson Spencer Christine Nguyen	Inovalon	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	Neil Putman	Claims Care Connect Risk Stratification ECM	Quarterly	TBD	TBD
37	Populations of Focus	Percent of members stratified into each populations of focus	POF	DHCS	Equitable Social Interventions	Population Health Management	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Claims	Quarterly	TBD	TBD
38	Community Support utilization	Community support utilization by category	CS UTIL	DHCS	Equitable Social Interventions	Population Health Management	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Claims	Quarterly	TBD	TBD
39	SDOH reporting	Rate of network providers reporting SDOH codes	SDOH	DHCS	Equitable Social Interventions	Population Health Management	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Tableau	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	Population Health Management	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Claims, Care Connect	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	Semi 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	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 Chor	Manual Report	Semi 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 Chor	Tableau	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	Rosa Hernandez	LMS	Annual Every Quarter 3	TBD	TBD
46	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	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Rosa Hernandez	Manual Report	Semi 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	Rosa Hernandez	Manual Report (Healthwise vendor)	Annual 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	Neil Putman	Claims Care Connect Risk Stratification	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	Neil Putman	Claims Care Connect Risk Stratification	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	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	Jesse Brennan-Cooke	Manual Report	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	Jesse Brennan-Cooke	Inovalon	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	Jesse Brennan-Cooke	Inovalon	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 Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	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			
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	Disenrollment 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	Overtured appeals stratified by race and ethnicity	Overtured 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 stratified 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

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 BSCPHP'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:

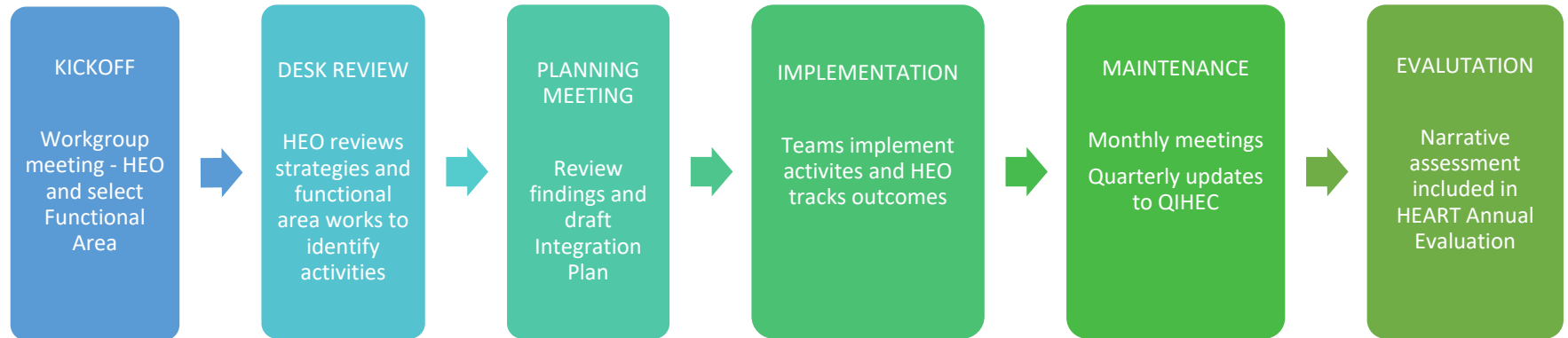
- a. Review the status of the planned activities, updating the Integration Plan as needed.
 - b. The Health Equity Office will prepare data analysis on HEART measures, identifying trends and recommendations to address identified disparities and opportunities.
- 8) Outcomes with supporting narrative will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

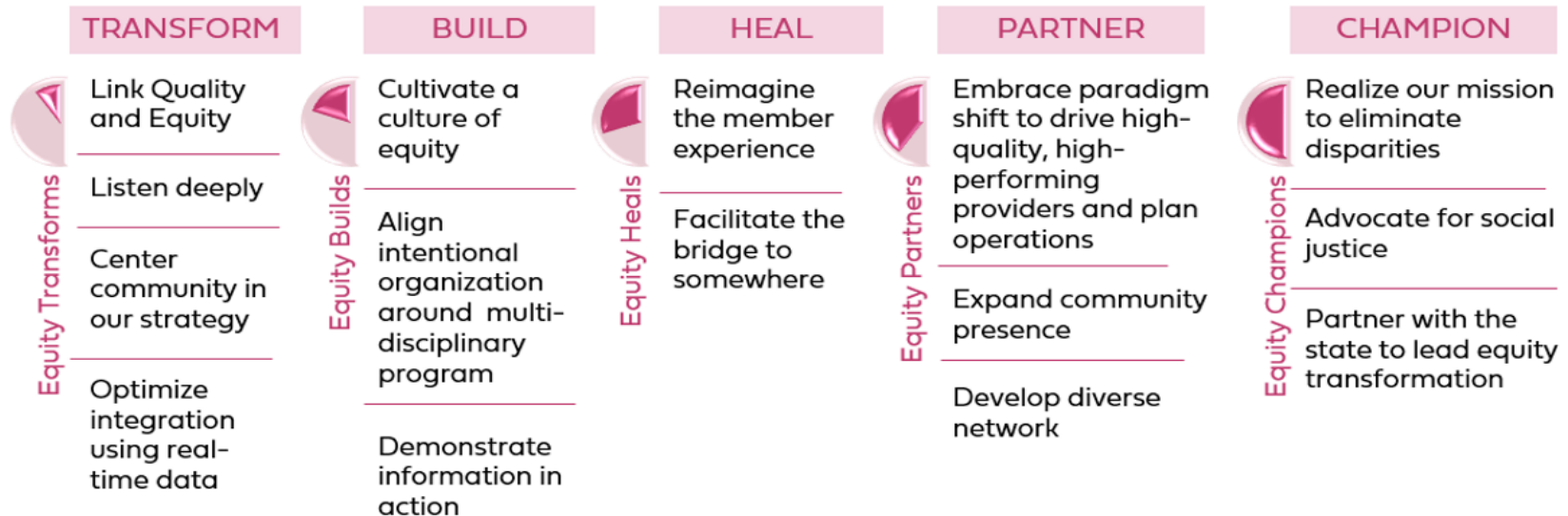
The Health Equity Framework will detail industry best practices, recommendations for health equity program planning, and examples of activities to apply the health equity lens to program and policy planning. The Framework will include:

- 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. Competitor 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:



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 2) Set due date 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:										

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

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 maintain the BSCPHP QIHETP. The Action Plan will be managed by the HEO. The goal for QIHETP is to at minimum meet all state requirements and achieve DHCS compliance. The QIHETP workplan will document intended activities.

Task	Comments	Contract Requirement	Due Date	Collaboration	Status
Health Equity Organizational Chart	Maintain chart at a minimum annually by 1/1/2025	Yes	1/1/2025	HEO	Closed
Health Equity Office Structure	Maintain HEO structure and chart at a minimum annually by 1/1/2025	Yes	1/1/2025	HEO	Closed
5-year strategic plan and Maturation Model	Complete and present to executive leadership	No	3/31/2025	HEO	Open
QIHET Program Description	Annual draft in progress due to QIHEC Q1 meeting	Yes	3/20/2025	HEO	Open
QIHETP Policy	Annual policy review and formal submission to the state	Yes	6/26/2025	HEO Compliance Medi-Cal Growth Office	Open
QIHEC Policy	Annual policy review and formal submission to the state	Yes	6/26/2025	HEO Compliance Medi-Cal Growth Office	Open
Diversity, Equity and Inclusion (DEI) Training Program Requirements Policy	Annual policy review and formal submission to the state	Yes	3/20/2025	HEO Compliance Medi-Cal Growth Office	Open
QIHEC Charter	Draft annual QIHEC Charter and submit to QIHEC Q1 for review and approval	Yes	3/20/2025	HEO	Open
HEOC Charter	Review HEOC Charter for submission to HEOC approval	Yes	2/13/2025	BSC- HEO BSP- HEO	Closed
QIHETP Workplan	In progress for submission to QIHEC Q1 for committee review and approval	Yes	3/20/2025	HEO	Open
Health Equity Workgroup	Ongoing workgroups to address open gaps enterprise-wide.	Yes	2/21/2025, Ongoing	BSC- HEO BSP- HEO Quality NCQA Accreditation Medi-Cal Growth Office Strategic and Performance	Open

QIHEC (committee member consent, agenda, slide deck, meeting minutes)	QIHEC Q1 completed; QIHEC Q2, Q3 and Q4 are scheduled	Yes	3/20/2025 6/26/2025 9/18/2025 12/11/2025	HEO	Open
Medi-Cal Committee	Submit QIHETP regulatory reports (QIHEC Charter, summaries, meeting minutes, work plan, QIHETP Program Description, QIHETP Annual Evaluation, NCQA CLAS Report) ; Q1 completed; QIHEC Q2, Q3 and Q4 are scheduled	Yes	2/17/2025 4/29/2025 10/20/2025 11/17/2025	HEO	Open
Health Equity Oversight Committee (agenda, slide deck, meeting minutes)	HEOC Q1 completed; QIHEC Q2, Q3 and Q4 are scheduled	Yes	2/13/2025 4/14/2025 8/28/2025 10/7/2025	BSC- HEO BSP- HEO	Open
DEI training for BSP staff	Launch 2025 Advancing Health Equity training	Yes	3/3/2025	BSP-HEO HE/CL Medi-Cal Program Support BSC-HEO BSC-DEI NCQA Health Equity Accreditation, Quality Assurance	Open
DEI training for Providers, Subcontractors and Downstream Subcontractors	Launch 2025 Advancing Health Equity training	Yes	3/25/2025	BSP-HEO BSC-HEO HE/CL Medi-Cal Program Support BSC-DEI NCQA Health Equity Accreditation, Quality Assurance	Open
Promise Health Equity Dashboard	Finalize development of the Promise Health Equity Dashboard	Yes	3/15/2025	HEO IT Medical Data and Analytics	Open
Promise Health Equity Dashboard Training	Facilitate a demonstration of the navigation, experience, and use of the dashboard	No	3/28/2025	HEO IT Medical Data and Analytics	Open
Monitor HEART Measure Set	Identify low performing measures, health disparities and inequities across HEART measure set	Yes	6/15/2025	HEO	Open
QIHETP Annual Evaluation Report	Need to draft QIHETP Annual Evaluation Report	Yes	6/26/2025	HEO	Open
Review Marketing Plan and identify HE activities	CHEO to review Marketing Plan and identify HE activities in collaboration	Yes	TBD	Community Engagement HEO	Open

	with Community Engagement Department				
Population Needs Assessment and Population Health Management Strategy	Support draft and use findings to guide program activities	Yes	7/1/2025	HEO PHM	Open
BSP Population Needs Assessment	Support draft and use findings to guide program activities None	Yes	TBD	HE/CL PHM HEO	Open
Health Equity Integration Plan	Integrate and promote health equity, addressing inequities	Yes	12/31/2025	HEO CMO Medical Services A&G HE/CL Marketing Provider Network PHM Quality UM	Open
Committee involvement (QIHEC, MAC, PAC, PPC)	CHEO representation in committee involvement. Co-chairing QIHEC with CMO CHEO provide updates such as CAC, PAC, JOM Member and Provider feedback needed to enhance QIHETP for required written reports	Yes	Varies	HEO Community Engagement Provider Relations	Open
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 – HEO BSP- HEO Quality	Open
Maintain NCQA Health Equity Accreditation	Mitigate known gaps, monitor written report activities, maintain policies and procedures, written annual reports	Yes	12/31/2025	HEO NCQA HEA, Quality Assurance HE/CL Quality IT	Open