Quality Improvement Health Equity Transformation Program
Annual Evaluation
Medi-Cal Product

Report Year 2025

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Executive Summary

The Quality Improvement Health Equity Transformation Program (QIHETP) Annual Evaluation Report Year (RY) 2025 documents the annual review and formal assessment of Blue Shield Promise Health Plan's (Blue Shield Promise) Health Equity Advancements Resulting in Transformation, also known as the HEART program. This evaluation serves as the ongoing QIHETP activities described in the 2024 Quality Improvement Equity Committee Work Plan and conforms to the 2024-2025 Quality Improvement Health Equity Transformation Program Description.

Our 2024-2025 QIHET program goals and objectives support the QIHETP program principles that will seek to implement the Health Equity Office (HEO) milestones.

Quality Improvement Health Equity Transformation Program Goals and Objectives are built on the following program principles:

- Advance Information in action by integrating data and analytics platforms to generate valid, actionable, and meaningful information to increase quality and health equity.
- Build Sound Infrastructure and operations by building the infrastructure to support QIHETP. Integrate feedback provided by members, families and Network Providers, and community partners in the design, planning, and implementation of the QIHETP.
- Embed equity in everything we do by establishing a process and multi-disciplinary framework for solidifying a culture and a practice of equity across the organization.
- Design Interventions that matter by embedding equity-focused initiatives across the enterprise to consistently prioritize addressing health disparities and in accordance with regulatory requirements and strategies. Blue Shield Promise will utilize a health-equity lens to drive continual refinement of meaningful interventions, meeting members where they are. Blue Shield Promise will work to identify disparities, develop data-driven, scalable, customized interventions that sustainably address health inequities.

2024 QIHET Program Outcomes and Accomplishments:

- Launched internal *Advancing Health Equity* training with 99% completion and highest satisfaction rate
- HEART Advocate program pilot with 97% of participants who reported value add to role
- 200+ contractual requirements met, 100% audit ready
- Leading the required Health Equity training program and requirements

- Launched health equity integration plan model
- Added Network Providers to the Blue Shield Promise Health Equity Committee
- Developed an infrastructure for sharing updates
- Launched Health Equity dashboard
- Designed Provider Profile reports and disparity analysis reports
- Received NCQA Health Equity Accreditation with 100% score
- Influential market leader with Promise's Chief Health Equity Officer appointed to the Department of Healthcare Services Health Equity Think Tank and presenting at several statewide conferences

Table of Contents

I. Overview

The Blue Shield of California Promise Health Plan (Blue Shield Promise, or Plan) is a managed care organization, wholly owned by Blue Shield of California, offering Medi-Cal in Los Angeles and San Diego. It is led by healthcare professionals with a "members first" philosophy and is committed to eliminating disparities within the organization as well as the counties served.

Blue Shield Promise operates under a geographic managed care (GMC) model in San Diego County and operates as a delegated health plan in Los Angeles County. The Quality Improvement Health Equity Transformation Program (QIHETP), also known as the Health Equity Advancements Resulting in Transformation (HEART) program and activities are directly overseen by the Plan's Chief Health Equity Officer (CHEO).

Blue Shield Promise' HEART 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 QIHETP Annual Evaluation Report will address the Plan's initial Action Plan Goals and Objectives as outlined in the 2024-2025 QIHET Program Description including:

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

Table 1. QIHET Program Goals and Objectives

Blue Shield Promise will use multiple reliable data sources, methodologies, techniques, and tools to conduct the annual evaluation. These will include, but are not limited to, the data set and surveys below:

Data Sources/Sets

1. Appeals data.
2. Beneficiary demographics.
3. Case management/care coordination data.
4. Customer Experience call data.
5. Encounter and claims data.
6. Enrollment and disenrollment data.
7. Healthcare Effectiveness Data and Information Set (HEDIS®) member level data.
8. Member and provider complaint data.
9. Pharmacy data.
10. Statistical, epidemiological, and demographic member information.
11. Race, Ethnicity, Gender, Age, and Language (REGAL) data.
12. Sexual Orientation and Gender Identity (SOGI) data.
13. Vendor performance data.

Surveys and Studies

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data.
2. Community Advisory Committee (CAC).
3. Provider Advisory Committee (PAC).
4. Joint Operations Meeting (JOM).

The scope of the QIHETP Annual Evaluation Report covers services provided to Blue Shield Promise Medi-Cal members.

II. Data Sources

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

Quality improvement and health equity is a data-driven process. Blue Shield Promise uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives.

Blue Shield of California Promise Health Plan will use multiple reliable data sources, methodologies, techniques, and tools to conduct the QIHETP annual evaluation. These will include the following data sets and surveys defined.

Data Sources/Sets

1. Appeals data: Cultural, linguistics, or discrimination related appeals suggestive of disparity from the measurement year.
2. Beneficiary Demographics: California Department of Health Care Services 834 enrollment data.
3. Case management/care coordination data: data and procedures for resolving cases to identify morbidity and mortality data.
4. Consumer Assessment of Healthcare Providers and Systems (CAHPS®): CAHPS® 5.0H survey
conducted during the measurement year.
5. 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.
6. Encounter and claims data: ICD-10 codes received via member encounter and claims data.
7. Enrollment and disenrollment data: enrollment and disenrollment data within the measurement year.
8. Healthcare Effectiveness Data and Information Set (HEDIS®): HEDIS® report as submitted to NCQA for the reporting year.
9. Member and provider complaint data: Cultural, linguistics, or discrimination related complaints data suggestive of disparity from the measurement year.
10. Pharmacy data: data collection and compilation of data for various drug codes received.
11. Statistical, epidemiological, and demographic member information: validated individual member data as of measurement year and/or year end.
12. Race, Ethnicity, Gender, Age, and Language (REGAL) data: data collection on a member's race, ethnicity age, and language preferences.
13. Sexual Orientation and Gender Identity (SOGI) data: data collection on a member's sexual orientation and gender identity preferences.
14. Vendor performance data: competency assessment results for language assistance, and behavioral health data

Surveys and Studies

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data: CAHPS® survey conducted during the measurement year.
2. Community Advisory Committee (CAC), held in calendar year 2024.

3. Provider Advisory Committee (PAC), held in calendar year 2024.
4. Joint Operations Meetings (JOM), held in calendar year 2024.
5. Quality Improvement and Health Equity Committee (QIHEC), held in calendar year 2024.

III. Quality Improvement Health Equity Transformation Program Activities

Blue Shield of California seeks to advance health equity by implementing activities supporting the health plan mission to transform its health care delivery system into one that is worthy of families and friends and sustainably affordable. As aforementioned, Blue Shield Promise HEO operationalized program activities to meet the four program goals and objectives. These goals focus on the critical need to establish a strong foundation of governance and organizational infrastructure necessary for moving Promise along the continuum to become an organization that centers health equity in operations and strategic planning.

a. Goal #1: Sound Infrastructure and Operations

1. Objective #1: Blue Shield Promise will facilitate the QIHEC meeting with external partners by 3/21/2024.

The Blue Shield Promise HEO is comprised of the Chief Health Equity Officer, two (2) Health Equity Principal Program Managers, Health Equity Business Analyst, Chief Executive Officer, Chief Medical Officer, Vice President, Clinical Quality, and Director of Quality. Further, the HEO established the operational governance and framework in accordance with Blue Shield Promise current operating model and alignment with regulatory requirements.

Governance

Blue Shield Promise softly launched the QIHEC in 2023. The QIHEC included membership from Interdepartmental participants across multiple cross-functional areas such as Marketing, Grievances, Utilization Management, Quality Improvement, Community Engagement, Health Education and Cultural and Linguistics, Behavioral Health, and other medical health services. In 2024, the HEO focused efforts on recruiting external partners for committee membership and onboarded members hosting orientation prior to the first QIHEC meeting. QIHEC external partners represent twelve (12) voting members, and their back-up point person, totaling eighteen (17) individuals from eleven (11) diverse organizations across our Medi-Cal service Areas in Los Angeles and San Diego counties. The organizations include Federally Quality Health Centers, Individual Physician

Associations and/or Medical Groups, physicians, and county partners. The QIHEC inaugural meeting with internal and external partnership launched on 3/21/2024 and meets quarterly.

Blue Shield Promise has established committees, such as the 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.

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

The Blue Shield Promise QIHEC is responsible for Quality Improvement and Health Equity activities. The QIHEC is charged with reviewing and approving health equity activities including but not limited to the Culturally and Linguistically Appropriate Services (CLAS), Population Needs Assessment (PNA), Consumer Assessment of Healthcare Providers & Systems (CAHPS®), Healthcare Effectiveness Data and Information Set (HEDIS®) results as related to health equity, results of the Health Equity Advancements Resulting in Transformation (HEART) Measure Set, and the review, feedback, and approval of the annual written evaluation of the QIHETP.

The QIHEC leverages member and community feedback to have an equity-centered approach to program management, planning, policies, and procedures.

The responsibilities of the QIHEC include the following:

1. Review and approve annual QI and Health Equity (HE) plan. The Annual QIHETP workplan was reviewed and approved on March 20, 2025.
2. Develop, implement, maintain, and periodically update policies and procedures to ensure compliance with health equity requirements. The QIHEC reviewed and approved policies and procedures for the QIHETP including Policy # HEQ-001 QIHETP, HEQ-002 QIHEC, and HEQ-003 Diversity, Equity, and Inclusion (DEI) Training Program Requirements.
3. Analyze and evaluate the results of 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 CAHPS®, and the findings and

activities of other Blue Shield Promise committees such as the CAC and incorporated. Results into the design of QI and HE activities were reviewed in 2024 and incorporated as findings in this report.

4. Institute actions to address performance deficiencies, including policy recommendations as identified by committee members.
5. Ensure appropriate follow-up of identified performance deficiencies.
6. Implement and maintain a charter including the role, structure, and function of the QIHEC.
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 Blue Shield Promise Health Equity Accreditation activities, reports, and policies.

The Blue Shield Promise HEO identified an opportunity to enhance the governance structure. The Medi-Cal Committee of the Board convened in 2024. For the remainder of 2024, the QIHEC reported to the Medi-Cal Committee. The Medi-Cal Committee reports to the Blue Shield of California Board of Directors via consent agenda. In 2025, the QIHEC reports to the Medi-Cal Committee.

The Medi-Cal Committee is responsible for reviewing and approving the QIHETP and annual work plan. The Committee also directs modifications to the plan and program. The HEO prepares written progress reports that include a summary of findings and recommendations, actions taken, progress in objectives and improvements made.

Additionally, although the governance structure for Blue Shield Promise has been enhanced, the Blue Shield Promise HEO continues to participate in the HEOC and partner with Blue Shield of California and Blue Shield of California Life & Health Insurance Company. The HEOC is responsible for oversight of all health equity related activities conducted by Blue Shield of California, Blue Shield of California Life & Health Insurance Company, and Blue Shield of California Promise Health Plan lines of businesses. This includes all Commercial HMO and PPO, Exchange HMO and PPO, Medicare HMO and PPO, Medi-Cal, and Life & Health insurance products.

The HEOC is an accountability body for health equity enterprise-wide strategies and opportunities to expand/scale between lines of business and is co-chaired by Blue Shield of California's Vice President, Health Transformation and Blue Shield of California Promise Health Plan's Chief Health Equity Officer, or other designated personnel on an ad hoc basis.

Reporting

Blue Shield Promise defined regular reporting and information flow and/or data analysis expectations throughout the measurement year. The following are contractual reporting requirements listed and accomplished:

1. The Blue Shield Promise CHEO or designee provided a written summary of QIHEC activities, findings, recommendations, and actions following each meeting to BQIC and to DHCS upon request. On behalf of the CHEO, the HEO's designated staff submitted the first written summary due to the state DHCS on March 31, 2024.
2. The Blue Shield Promise CHEO or designee provided a written summary of the QIHEC activities and made these available publicly on the Plan's website post QIHEC meeting. The summary was made available in April 2024. On behalf of the CHEO, the HEO's designated staff continue to post the written summary at least on a quarterly basis following each QIHEC meeting.
3. The Blue Shield Promise CHEO or designee produced an annual Promise Health Equity report to the QIHEC on June 20, 2024, and formally submitted it to the DHCS on March 24, 2025.
4. The HEO tracked designated staff to provide annual copies of all final reports of independent accrediting agencies to DHCS in Quarter 1, 2025.
5. The HEO posted the annual Quality Improvement and Health Equity Plan to the Blue Shield Promise public website following the QIHEC meeting on June 20, 2024.

Membership Composition

Further, the Blue Shield Promise QIHEC membership includes:

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

iv. Seniors and Persons with Disabilities (SPD).
v. Persons with chronic conditions.

The HEO currently meets the contractual requirements and is representative of the outline of membership composition. Blue Shield Promise continues to recruit diverse internal and external membership representations to the QIHEC. The QIHEC meets quarterly and conducts off-cycle meetings as needed. Formal minutes are maintained for all QIHEC meetings by HEO designated staff.

NCQA Health Equity Accreditation

The Blue Shield Promise HEO works closely with the Blue Shield of California Quality Accreditation Department to plan, develop, and implement NCQA Health Equity Accreditation (HEA) guidelines and activities per DHCS contract requirements to obtain formal accreditation.

In 2024, in collaboration with Blue Shield of California Quality Accreditation Department, the HEO partnered with internal cross-functional departments to ensure all activities and documentation were completed in a timely manner, reviewed by existing committees for formal approval and submitted to NCQA Survey in November 2024. Blue Shield Promise received NCQA HEA in January 2025 with a 100% score, in accordance with DHCS contractual requirements and reported on NCQA HEA status to QIHEC.

2. Objective #2: Blue Shield Promise QIHET program documents will be reviewed and approved by the governance process by 9/30/2024.

a. QIHET Program Description

As part of building a sound infrastructure and operations *Blue Shield Promise QIHET program documents were reviewed and approved by the governance process by 9/30/2024*. Blue Shield Promise submitted the QIHET Program Description to the QIHEC for formal review and approval by March 21, 2024, and subsequently amended by the Medi-Cal Committee and presented to the QIHEC on September 19, 2024 (Reference Appendix 2. 2024-2025 QIHET Program Description).

The document was submitted to the QIHEC meeting for formal review and approval by the committee. The document outlines the QIHETP, defines the strategy and framework needed to advance health equity efforts across the organization in

accordance with the requirements set forth by the California Department of Health Care Services (DHCS).

Blue Shield Promise included an introduction of the QIHETP program levers Transform, Heal, Build, Partner, and Champion activities to support the drive to eliminate disparities among populations served are detailed in the document. It summarizes the health equity lens that has been applied to the health equity guiding principles to create a unique set of Health Equity Strategies.

The QIHETP structure is introduced in the document and includes the composition of the HEO, committee structure, and governance structure.

The QIHET Program Description establishes the four QIHETP program goals to:

1. Advance Information in Action,
2. Build Sound Infrastructure and Operations,
3. Embed Equity, and
4. Design Interventions that Matter.

Also highlighted in the document is the Health Equity Integration and adoption of the California Health Care Foundation (CHCF) and NCQA recommended measurement framework for accountability in Medicaid to advance health equity and the six domains listed:

1. Equitable Social Interventions,
2. Equitable Access to Care,
3. Equitable High-Quality Clinical Care,
4. Equitable Experiences of Care,
5. Equitable Structures of Care, and
6. Overall Well-Being.

The document outlines how the HEO will conduct QIHETP oversight and monitoring using a Quality Improvement Process, the development of a QIHETP Workplan, and annual health equity assessment of the effectiveness of the QIHETP through a formal evaluation process and prepare an annual QIHETP Evaluation such as this one.

The HEO maintains the QIHET Program Description on an annual basis. The document is tracked by way of the QIHETP Workplan.

b. QIHETP Work Plan

Blue Shield Promise established the 2024 QIHETP Work Plan at the QIHEC Quarter 1 2024 meeting held on March 21, 2024, and brought forward to committee members for formal review and approval quarterly thereafter.

The HEO developed the QIHETP Work Plan which 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 committee governance structure (Reference Appendix 1. 2024 QIHEC Work Plan).
The QIHETP Work Plan is a fluid document, updated as needed throughout the program year and referenced for comprehensive assessment of QIHETP activities. The scope of the annual work plan includes the following:

1. Goals and objective descriptions.
2. Planned equity-focused interventions and activities.
3. Performance target or measurable goals.
4. Time frame for all yearly planned activities including initiation and completion.
5. The person(s) responsible for each activity.
6. Root cause and corrective action if an activity is at risk.
7. Examples of monitoring previously identified issues.
8. Reporting requirements and frequency.
9. Status updates.
10. Summary of Population Health Management (PHM) interventions to address Social Drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity. BSCPHP will incorporate PHM findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management and Coordination of Care).
11. Assessment of quality performance measure results with a plan to address deficiencies as related to health equity that include Blue Shield Promise 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 at least quarterly to meet changing priorities, regulatory requirements, and identified areas for improvement. And submitted for review and approval by QIHEC voting members. The status of QIHETP Work Plan items is reported as appropriate to the BQIC and Medi-Cal Committee.

A written summary of the QIHETP and QIHEC activities, findings, recommendations, and actions are prepared after each QIHEC meeting and submitted to the BQIC, Medi-Cal Committee and DHCS upon request. Blue Shield Promise makes the written summary of the QIHEC and QIHETP activities publicly available on the Blue Shield Promise website at least on a quarterly basis.

The Blue Shield Promise CHEO coordinates the submission of QIHETP and QIHEC documents to DHCS. The CHEO ensures QIHETP reports are publicly available on Blue Shield Promise website and annually.

c. Policies and Procedures

Blue Shield Promise QIHETP policy and procedures are designed to integrate and promote health equity, addressing inequities, 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
6. Grievance and Appeals
7. Utilization Management

Blue Shield Promise 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 Blue Shield Promise website. Policies and procedures are reviewed and approved by the QIHEC.

Blue Shield Promise 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, partner and collaborating 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.

As part of building a sound infrastructure and operations, Blue Shield Promise QIHETP documents were reviewed and approved by the governance process prior to 9/30/2024 as mentioned in the objective. Blue Shield Promise reviews and approves all QIHET Program policies and procedures at least annually. In 2024, policies and procedures were reviewed at the QIHEC meeting held on September 19, 2024. The HEO office will continue to follow the established process for health plan policies and procedures.

d. Reports

In partnership and collaboration with cross-functional departments, the HEO conducted the following program reports:

1. **Health Equity Assessment an Introduction to Equity and the Redetermination Process t**he report highlights Blue Shield Promise's redetermination retention rate among Spanish speaking members of 81%, generalized to the Latino population; and Blue Shield Promise's redetermination retention rate among children and families of 83%. With Blue Shield Promise ending with a total of 48,000 members favorable to the Plan (Reference Appendix 3. Health Equity Assessment - Redeterminations Report).

2. **Health Equity Recommendations Report the Member Journey: Assessing Health Equity Opportunities** summarizes the member journey to identify our members' needs and understand opportunities to improve member experiences. The intent of the report's findings is to improve our ability to support members through their journey navigating the healthcare system,

allowing us to better facilitate coordination of care to address social drivers of health, and confirm members are obtaining needed care, placing additional emphasis on members in most need (Reference Appendix 4. Health Equity Recommendations Report the Member Journey: Assessing Health Equity Opportunities)

3. **Annual Culturally and Linguistically Appropriate Services (CLAS) Program and Program Evaluation Report** assesses the provider network to determine if the members' needs and preferences are being met for the measurement areas race, ethnicity, language, sexual orientation, gender identity, cultural and linguistic grievances, and plan CLAS training(s) and resources offered to providers (Reference Appendix 5. Annual Culturally and Linguistically Appropriate Services (CLAS) Program and Program Evaluation Report).

4. **The Medi-Cal Annual Health Disparities Report** identifies and address disparities in healthcare outcomes among different population groups by analyzing member race, ethnicity, language, sexual orientation and gender identity data (Reference Appendix 6. Medi-Cal Annual Health Disparities Report).

b. Goal #2: Equity embedded in everything we do

1. Objective #1: Prepare health equity integration plans, formal assessments, frameworks, and recommendation reports by 12/31/2024.

To embed equity in everything we do, Blue Shield Promise HEO continued to build and deepen our partnership and collaboration efforts. These activities began the previous year, in 2023, as we worked together to develop the HEART measure set with several cross-functional departments.

These efforts lead to developing a Health Equity Integration Plan (HEIP) documenting planned activities and outcomes to integrate health equity across the following functional areas: Health Education and Cultural and Linguistics, Growth, Community Engagement, and Marketing, Network, Population Health Management, Grievances and Appeals, Utilization Management, and Medical Services: Case management; Population Health Management Maternal Management, and Quality.

The purpose of the HEIP is to ensure that contract requirements to integrate health equity into functional areas are met. The process includes 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.

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

Blue Shield Promise HEO prepared and successfully finalized at least 7 health equity integration plans in calendar year 2024. The health equity integration plans included formal assessments, frameworks, and recommendation reports by department. The scope and timeline for the integration plans began in 2024, meeting with impacted teams to discuss the contract requirement and plan for this requirement. The HEO worked with teams to finalize integration plans by the end of 2024. Beginning in 2025, activities will begin to be implemented across the functional areas and progress will be reported. This work will continue to focus on interventions and identifying opportunities.

The HEO and designated departments are on track to the current timeline, operationalizing to implement activities and report progress while focusing on interventions. Integration plan activities span across the health plan and align with Health Equity program tenets.

To highlight a few key operations, the HEO will support disparity analysis, research, continuous quality improvement cycle, monitoring; draft narrative reports. The HEO will maintain entire Integration Plan across all teams, packaging one complete program summary and Present quarterly reports internally and to Promise's Health Equity Committee, Medi-Cal Committee (Board) and submission to DHCS.
There are a total of 37 activities across the health equity integration plans and categorized per each of the health equity tenets. These are the activities reflected in each integration plan that aligns with the contract requirements. There is an emphasis on staff training as an activity, focusing on preventive care, population health, provider network, and community engagement. By the end of Quarter 1, 2025, the teams are progressing well with 10 activities or 27% completed.

Next steps during calendar year 2025 include a health equity dashboard demonstration and kick off meeting in partnership with IT and future meetings with teams for integration plan work that will include a disparity data review to help drive activities. Teams will send monthly updates to the HEO, and leaders will present their results at our internal Performance Operations Drivers (POD) meeting. The

CHEO will present to the QIHEC, and a summary report will be provided to the Medi-Cal Committee June 2025.

2. Objective #2: Assess the Health Equity Advancements Resulting in Transformation (HEART) Advocate Program and determine opportunities for the next cohort by 7/1/2024.

The HEART Advocate Program was developed and championed by Blue Shield Promise's CHEO. Recognizing that health equity support staff is lean and an observed rising interest in equity amongst team members, the CHEO identified an opportunity to design a team of Advocates who could support equity in their personal and professional lives. The CHEO procured a team of volunteers with a vested interest in contributing to equitable solutions and created a forum for people to gather, learn, and share lived experiences.

The HEART Advocate Program was built based on Blue Shield Promise' HEART program goals and 5 tenets to transform, build, heal, partner, and champion health equity. The Advocate program helped support listening deeply, centering community in our strategy, cultivating a culture of equity, aligning intentional organization around multi-disciplinary programing, reimagining the member experience, expanding community presence, and realizing our mission to eliminating disparities.

Program participants were comprised of a vertical and horizontal staff spread leading all the way up to Senior Director and staff across the health plan from Call Center, Provider Network, and Quality teams. The program is a great opportunity to get together, build subject matter expertise, and continual use of a health equity lens approach.

The CHEO met with each Advocate individually to connect, understand professional roles and goals; and assessed how the program could be designed to maximize learnings and potential value to be gained with an equity-focused program. Once the team was finalized, the Advocates participated in a kick-off meeting where they shared their deeply personal stories about what participation means to them. It was clear that the Advocates were ambitious, seeking deep connections with peers, willing to assume leadership roles to lead equity initiatives, and had a vested interest in making a difference in the lives of our members.

The I Have HEART Advocate team launched with leadership support, and a team of energized, inspired Advocates who created a workplan of activities to implement over the course of the 6-month program. The workplan detailed activities aimed at

increasing knowledge, awareness, networking, and exposure to real-life scenarios. This document allows Advocates to proactively sign up for activities, which support personal interests and professional goals and leverage expertise and skillsets amongst the team. Advocates volunteered to Lead, Contribute, or Participate. Leaders planned meetings, led teams, facilitated collaboration across functional areas, and served as Project Manager of a given activity. Contributors supported the Leader, contributing ideas or helping execute tasks. Participants attended training and events hosted by the various Leaders.

The Advocates completed the following activities as a team, and for the team:

1. Advocates completed a series of health equity-related trainings within a safe space to discuss sensitive topics such as systemic racism, implicit bias, and health disparities. A training on Bias and Gender Affirming Care was prepared by one of our Advocate.
2. Drafted a Charter, describing goals, responsibilities, and other logistical details outlining participation for Advocates. The Charter clearly details frequently asked questions and serves as a tool for Advocates when describing the I Have HEART Advocate program.
3. Planned and facilitated a tour and focus group for Advocates at the Pomona Community Resource Center. The focus group assessed community and member needs. This resulted in a partnership with a Consulting firm who prepared a document outlining the Member Journey with identified pain points and opportunities to improve the member experience.
4. Procurement of a team of industry experts in the field of Artificial Intelligence and facilitated a panel discussion with the Advocates talking about AI and the Future of Healthcare.
5. Spearheaded a coffee chat with peers to provide a forum for sharing memorable member stories that have deeply impacted our roles and ignite our desire to serve. This information will be used to maximize member engagement, increase member satisfaction, and support planning value-added benefits.
6. Hosted a virtual, interactive Cost of Poverty Experience (COPE) event with over 40 participants in attendance. This event is designed to deepen understanding of the social determinants of health, impacting healthcare delivery and outcomes, and provide learning from communities that are most affected by inequities in health and social conditions, Participating in COPE created novel ways of thinking about what it takes to lift individuals and families out of poverty. This simulation allowed participants to explore the lived experiences and impact of poverty, firsthand, through the eyes of people in their personal journey.

7. Many Advocates expressed interest in gaining exposure to teams and roles in which they would not typically interact with in their daily role. Advocates were invited to attend the quarterly Promise Quality Improvement and Health Equity Committee. Each quarter, a representative presents a summary of the I Have HEART Advocate program. This affords opportunities to interact with Promise Leaders, learn about Committee operations, and learn updates and outcomes on Promise's HEART program.
8. The development of a Framework and presented the Framework to Promise's Quality Improvement and Health Equity Committee. This will be used to codify planning and operations for subsequent cohorts.

This voluntary, peer-led, and equity-focused collaborative is new and requires HR and Executive support recognizing the importance of centering an equity lens in our daily roles and operations. Second, because this program was new, there was no structure, resulting in the team designing a formal structure, from finalizing a program Charter, to preparing a framework for continuation into subsequent cohorts. The HEO worked to overcome challenges with lean resources, inspiring others to lead activities, use their time judiciously, and hold individual meetings to make vital connections. The planning was especially organic as Advocates' skills and interests emerged. Advocates went above and beyond the expectations of their current role, raising their hand, leaning in, with a cooperative mindset and member-centered approach.

This program was intentionally designed to empower our Advocates to lead health equity, become subject matter experts, build their skills set, while elevating their innovation and creativity; all in alignment of our North Star embodying courageousness. A HEART Advocate remarked, "*The HEART program gave me the courage and creativity to engage with other individuals across the organization to increase my knowledge of health equity and critical thinking skills to improve health outcomes and to advance health equity for the members and communities we serve*." Most notably, the HEO recruited from the Advocate team and filled an open position within the HEO.

A total of 45 participants completed the program; 93% of participants reported the program helped increase health equity for practical application of health equity concepts within own teams and departments; 100% reported value in the information shared; content was helpful; and there is potential to scale internally and externally. Overall, Cohort 1 participants indicated knowledge increase, program satisfaction, and the opportunity to continue and expand externally to Provider staff.

In 2024, the HEO assessed the success of the program and because of much success in the first cohort, a second cohort has launched and will run for 6 months. A total of 62 participants have already signed up for the program. The Advocates will support our HEART program leading activities to integrate health equity. And eventually, becoming subject matter experts championing equity in their work and among their departments.

c. Goal #3: Information in Action

1. Objective #1: Blue Shield Promise will develop a mandated Diversity, Equity, and Inclusion and Health Equity training by 12/31/2024.

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, reducing health disparities, and overall better quality of care.

To reduce any duplicative efforts across Blue Shield of California and Blue Shield Promise, in partnership with key stakeholders, the HEO conducted a thorough QIHETP training assessment of all regulations that expanded to other regulatory requirements including the Department of Health Care Services (DMHC), NCQA Health Plan Accreditation and Health Equity Accreditation standards, Senate Bill 923, and Centers for Medicare and Medicaid Services (CMS).

This extensive assessment led to creating a single comprehensive curriculum that would align across regulatory requirements and different timelines for launching the training. Most importantly to ensure that as an enterprise, we met the NCQA Health Plan Accreditation and Health Equity Accreditation requirement and timeline to provide at least one training to all employees on cultural and linguistically appropriate practices, reducing bias or promoting inclusion. This training curriculum would also be modified and adopted as our external facing training. As a result, the Blue Shield Promise was able to align APL 24-016 requirements with the expanded regulatory bodies.

A training curriculum was developed in partnership with at least 10+ subject matter experts representing cross functional departments such as Blue Shield of California Classic Health Equity Office, Provider Education, Blue Shield Promise Cultural and Linguistics, Medi-Cal Program Supports, Diversity, Equity, and Inclusion department and Learning Management System developers and instructors, and NCQA Health Equity Accreditation Quality and Assurance department.

The cohesive approach and development of the curriculum led to intentionally soft-launching and pilot testing for purposes of APL 24-016, the Blue Shield of California and Blue Shield Promise *2024 Advancing Health Equity: Training to Support Member Interactions* training to staff on May 3, 2024. The training required to be completed by all enterprise member-facing staff to complete by June 24, 2024. The training has also been made available as optional to all other staff members.

A full year prior to its intended release in calendar year 2025 and with successful results. Preliminary results have been outstanding with an overall positive response of a 92% score based on formal survey feedback. With staff feedback stating the following:

- *"I've been a nurse for 25 years, this was THE BEST diversity training. Thank you."*
- *Appreciate the multi-faceted ways this training uplift race/ethnicity/gender/sexual orientation inequity in health care. It did a great job capturing the complexities of identities and break down what health equity mean from the institutional, structural, and individual level. Love this training.*
- *A good reminder on how to address patients with respect concerning their gender / gender identity. How to remain neutral on how they are to be treated*
- *This course provided great information on how to help members feel seen with giving advice on how to communicate better so they feel heard*

Blue Shield Promise continued to track staff training completion and by the end of 2024, reached a 99% training completion rate.

In Quarter 2, 2024, key stakeholders regrouped to review the curriculum per annual cyclical review, to make training enhancements to the 2025 *Advancing Health Equity: Training to Support Member Interactions* and the external facing

Advancing Health Equity training for formal state DHCS submission, approval and official launch to all Blue Shield Promise staff planned for March 3, 2025, and external training on the new Blue Shield of California Provider Learning Center platform launched on April 28, 2025. External partners were notified of the training for completion.

Blue Shield Promise HEO received preliminary feedback regarding operational considerations from the Joint Operations Meetings (JOMs) prior to releasing the Advancing Health Equity training on the Provider Learning Center, specifically feedback noted regarding self-attestation versus group attestation for visibility. Blue Shield Promise HEO worked with the Provider Education team to build this attestation process prior to training implementation. As a result of this information, Blue Shield Promise built this and now accepts both self-attestation and/or group attestations via a spreadsheet that can be downloaded, filled out, and returned to the MCP per instructions listed on the Provider website. Blue Shield Promise will then import the data into the Provider Learning Center to mark those providers complete and share the data with regional managed care plans (MCPs).

In 2025, Blue Shield Promise will continue to focus on successful training implementation and to track internal staff, subcontractors, downstream contractors and Network Providers to ensure compliance that all training will be completed by 12/31/2025.

d. Goal #4: Interventions that Matter

1. Objective #1: Conduct quarterly HEART Measure Set monitoring and analysis to identify health disparities and trends for interventions by 12/31/2024.

Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid

To integrate health equity in everything we do at Blue Sheild Promise and in collaboration with cross-functional Departments, the HEO developed a HEART Measure set adapted from the CHCF and NCQA recommended measurement framework for accountability in Medicaid to advance health equity. Specifically, the measurement framework supports a robust, comprehensive approach to monitoring disparities that may exist when assessing various health plan operations and data sources (CHCF and NCQA, 2022). The framework incorporates regulatory reporting requirements that stretches us to consider health equity in our oversight of metrics and outcomes.

The CHCF and NCQA framework represents an effort that centralizes 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 provides 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. Each impacted functional area met with the HEO in an introductory roadshow series experience to collaboratively develop a health equity measure set. 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 processes 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 1. 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 identified measures as recommended in the CHCF and NCQA framework, to meet state regulatory compliance.

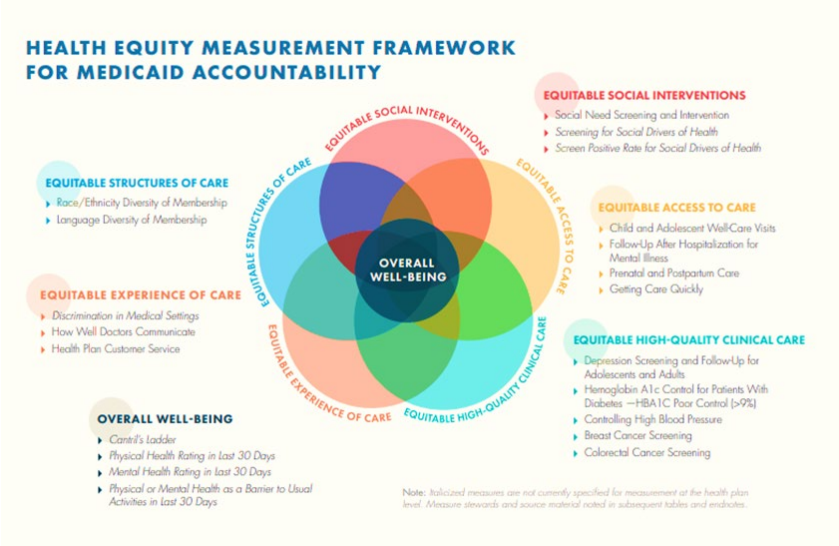

Figure 2. Health Equity Measurement Framework for Medicaid Accountability Summarized

Health Equity is integrated across the organization, and disparities transcend Departments impacting multiple cross-functional areas. Blue Shield Promise applies to a health equity lens to program oversight across each functional area. As figure 2 demonstrates, data and analytic sets extend beyond HEDIS® measures. The six domains extend across cross functional Departments throughout Blue Shield Promise.

Select measures outlined in the HEART Measure Set are stratified and analyzed for health disparities. When possible, metrics are 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 were selected by the HEO in collaboration with each functional area. Reporting has 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.

Blue Shield Promise 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:

1. Quality HEDIS® measures
2. Grievances and Appeals, Behavioral Health
3. Provider Relations and Contracting
4. Health Education
5. Cultural and Linguistics
6. CalAIM and subsidiary population health management functional area
7. Customer Experience
8. Clinical Access Programs
9. Maternal Health
10. 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. Blue Shield Promise 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 are following 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 is monitored at least quarterly and reported to the QIHEC. Reference Appendix 7 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 including tracking Blue Shield Promise 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. If identified, the Customer Experience team notes any notable operational challenges that impact health equitable structures and access to care.

B. Appeals and Grievances

Blue Shield Promise 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 shared with Blue Shield Promise 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 measures that meet both regulatory and health equity intent and purposes. Measures include the percentage of grievances related to cultural competency (interpreter services, language, alternative format, provider preferences) based on all grievances received during the measurement period, and percentage of Discrimination grievances based on all grievances received during the measurement period.

C. 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 Department have collaborated to report and monitor metrics required for monitoring. These metrics are a mix of guided CalAIM program measures, population health management program metrics, behavioral health program metrics and select Quality MCAS priority measures that link back to DHCS' bold goals. In collaboration with the HEO, all functional area leaders stratify the select health equity set by REGAL to identify any disparate populations within our membership for select measures.

D. Quality

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

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

E. Behavioral Health

The scope of the Health Equity Transformation Program extends into the delivery of behavioral health services. The HEO and Behavioral Health Department have monitored the recently released CalAIM metrics related to behavioral health and DHCS bold goals required for monitoring. These metrics are stratified by the REGAL dataset. Additionally, the Behavioral Health Department tracks the total number of prenatal and postpartum depression screenings. This will help us to identify any disparate populations within our prenatal and/or postpartum membership and identify any other populations that may be impacted by mental illness specifically among our most vulnerable populations including adolescents, homeless, and lesbian, gay, bisexual, transgender and queer, (LGBTQ+) members for select measures. Reference Appendix 7 for the complete HEART Measure Set as it relates to behavioral health.

F. 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 reflects 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, Blue Shield Promise will ensure Network Providers complete the new Diversity, Equity, Inclusion (DEI) Training Program that includes topics such as 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) Diversity, Equity, Inclusion Training Program Requirements APL 24-016 (supersedes APL 23-025).

The CHEO will collaborate with Blue Shield 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 DEI 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) and APL 24-016.

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

Finally, the Provider Contracting and Relations Department 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.

G. Health Education and Cultural and Linguistics

The Health Education and Cultural and Linguistics (HE / CL) team support member education activities, staff, and provider training. They also ensure materials and programs are culturally competent, advising recommendations to support health literacy, alternative formats, and interpreter services. The HE / CL team supports the development and implementation of health equity provider training. The HEO and Health Education and Cultural and Linguistics (HE/CL) teams selected relevant health equity measures including, tracking of cultural competency training is completed by member facing staff, tracking health education materials available in all threshold languages within service areas, total number of trainings completed track the utilization of interpreter services in partnership with Customer Experience, tracking the rate of bilingual member-facing health plan staff to ensure enough coverage is representative entire membership, tracking cultural and linguistic grievances filed by members, and stratified Diabetes Prevention Program enrollment outcome metrics by REGAL.

H. Maternal Health

The Maternal Health Department supports the delivery of perinatal services. In 2024, the HEO and Maternal Health team monitored 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, and c-section rates stratified by REGAL where possible to identify any disparate trend within our population. In partnership with the Behavioral Health Department, the Maternal Health functional area also tracks 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. The Maternal Health Equity team structured under the Office of the Chief Medical Officer finalized a comprehensive strategic plan for implementation in 2024-2028. The plan was presented to QIHEC in Quarter 3, 2024 as a Health Equity Spotlight Report.

I. Clinical Access Programs

The Clinical Access Programs Department supports the delivery of clinical programs including the Facility Site Review program, Initial Health Assessments, and the Early, Preventive, Screening and Development Treatment (EPSDT) program. The HEO and Clinical Access Programs selected specific metrics across various areas managed by

the Department. The HEART measure set for this functional area supports identification of any health disparities among the EPSDT population and provider network through the medical record review and facility site review audits.

The Clinical Access Programs functional area stratify outcomes measures specific to the percentage of members ages 0-20 with no ambulatory or preventive visit within a 12-month period, track compliance rate for FSRs and ensures providers are completing "Site personnel receive training on member rights" to meet minimally language assistance program requirements, track initial health assessment 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.

It is important to note that the HEART Measure Set is fluid and may change over time, the HEO is also working collaboratively with Medical Data Analytics and IT to automate measure reporting and development of a formal health equity dashboard that highlights and identifies disparities and inequities over time.

HEART Measure Set Monitoring Data Report Results

The HEO identified initial observations and emerging trends by HEART measure domain over the course of monitoring the HEART Measure Set from Quarter 2, 2023 into Quarter 1, 2024. The following are results by HEART measure domain.

Some initial observations were found under the Equitable Structures of Care. The call center number of internal bilingual calls by member's preferred language metric, we noted a high call volume in Spanish calls, totaling (10,939); while Language Line utilization was a total of 78 requests.

Call Center Number of Internal Bilingual Calls by Member's Preferred Language			
LA & San Diego	Q2 2023	Q3 2023	Q4 2023
Total Calls	31,286	46,759	64,721
English	81.11% (25,384)	81.00% (37,875)	81.60% (52,810)
Spanish	17.59% (5,502)	17.56% (8,212)	16.9% (10,939)

Table 2. Call Center Number of Internal Bilingual Calls by Member's Preferred Language

Under the Overall Well-Being domain, Depression Screening Follow-Up (DSF) measure we noted a geographical variance, and potential trend in race/ethnicity data. Notably among the Native Hawaiian/ Pacific Islander population.

Depression Screening Follow-Up				
	SD Q2 2023	SD Q3 2023	LA Q4 2023	SD Q4 2023
Follow up by Race	79.31%	78.26%	45.45%	77.66%
Native Hawaiian/ Pacific Islander	75.00% (16)	78.57% (14)	0.00% (2)	75.86% (29)
Other Race	68.55% (159)	67.1% (155)	42.86% (84)	100.00% (1)
Asian	80% (5)	75.00% (4)	100.00% (4)	90.00% (10)
Black or African American	82.61% (23)	81.82% (22)	66.67% (6)	84.38% (32)
White	89.53% (86)	89.87% (79)	57.14% (7)	84.24% (165)
Native	100.00% (1)	100.00% (1)	0% (1)	100.00% (2)

Table 3. Depression Screening Follow-Up Measure

Under Equitable Access to Care, again Language Line utilization metric we noted ASL to be the highest utilization of onsite interpreter service compared to other languages.

Interpreter Service Utilization			
LA & San Diego	Q2 2023	Q3 2023	Q4 2023
Total	1,122	620	477
American Sign Language	19.20% (216)	30.16% (187)	38.99% (186)
Spanish	24.59% (276)	21.94% (136)	16.35% (78)
Russian	13.72% (154)	15.81% (98)	16.14% (77)

Table 4. Interpreter Service Utilization

Under the Equitable High-Quality Clinical Care domain, we noted low childhood immunizations among African American (24.00%) children and White children (26.10%).

Childhood Immunizations					
	SD Q2 2023	LA Q3 2023	SD Q3 2023	LA Q4 2023	SD Q4 2023
Screening by Race	28.64%	20.97%	29.60%	22.05%	31.33%
Black or African American	22.2% (54)	7.92% (202)	23.08% (52)	9.47% (190)	24.00% (50)
White	23.64% (330)	10.40% (173)	24.76% (319)	10.92% (174)	26.10% (318)
Native Hawaiian or Pacific Islander	36.17% (47)	21.43% (14)	36.965 (46)	35.71% (14)	39.53% (43)
Asian	43.75% (32)	31.87% (91)	43.75% (32)	31.25% (96)	43.75% (32)

Table 5. Childhood Immunization Measure

Under Equitable Social Interventions, 1% of members have at least one Social Determinant of Health report. This rate was not expected as this has continuously been an area of improvement for the last couple of years. The HEO recognized an opportunity to further train Providers for z code submissions, or to implement a provider incentive to improve the rates. Based on the findings, the Quality team is leading an SDOH incentives Program for Providers. The program has been officially submitted to the DHCS and is under desk review for formal approval.

The HEO did not identify a trend in the Equitable Experience of Care domain but will continue to monitor rates for each metric in this domain.

The HEO's initial observations have led to recommendations per metric, including planned or current activities. For example, the SDOH reporting metric, the Quality team is leading SDOH incentives for Providers. The program has been officially submitted to the DHCS and is under desk review for approval.

For Childhood Immunization Status, we need to assess the root causes for why our measures are low among African American and White populations, could it be vaccine hesitancy vs. access issues. For the DSF measure, we would like to continue to track the next 6 months' worth of data to confirm the geographical variance trend we're seeing now.

Regarding the bilingual calls managed by call center, our initial observation is to ensure call center agents can meet the need of our Spanish-speaking members. We did reach out to Call Center leadership who confirmed they are prioritizing recruitment of bilingual Call Center staff; 21 of 29 recent hires are bilingual. For interpreter service utilization, we saw a higher request service for ASL utilization when compared to other languages. We have requested membership data to identify people with disabilities, and ASL category across all HEART measures to assess health outcomes for people with disabilities, specifically among our hard of hearing members.

Domain	Metric	Observation	Recommendation
Equitable Social Interventions	SDOH Reporting	1% of members with Social Determinants of Health reported	SDOH Incentives for Providers pending DHCS approval
Equitable High-Quality Clinical Care	Childhood Immunization Status	Low Childhood Immunizations among African American (24%) and White (26%)	Assess root causes (vaccine hesitancy vs. access)
Overall Well-Being	Depression Screening follow-up	Geographical variance	Track next 6 months to confirm trend
Equitable Structures of Care	Bilingual calls managed by Call Center	Assess if Call Center agents can meet need of Spanish-speaking members	Call Center Leadership to prioritize recruitment of bilingual Call Center staff 21 of 29 recent hires are bilingual
Equitable Access to Care	Interpreter service utilization	American Sign Language highest utilization of onsite interpreter service	1. Request membership data to identify hard of hearing members 2. ASL category across all HEART measures to assess health outcomes for hard of hearing members

Table 6. Opportunities and/or Next Steps

Health Equity Dashboard

In 2024, the HEO, in partnership with IT, Data Analytics, and AArete Consulting teams worked to enhance reporting, automation, and build a health equity dashboard to improve tracking and trending of data over time. The health equity dashboard and automation project were initiated in August 2024, with a goal of automating all measures on the HEART Measure Set by December 2024.

In partnership with IT, Data Analytics, and AArete Consulting, the health equity dashboard was built and finalized by the end of March 2025. The health equity dashboard features validated measures, statistical analysis, tracking and trending for efficient disparity analysis, interactive geo-mapping, and customizable filters by measure, REGAL stratification and region. HEO designated staff reconciles quarterly monitoring reports and brings forward the analysis to all internal cross-functional teams as part of the health equity integration plan for review. A comprehensive annual assessment is planned for Quarter 2, 2025.

There are additional refinements underway in 2025, including the development of a member-level detail self-service feature, at this time, member-level detail data reports are accessible on an ad-hoc basis and requested by the partnering department to the HEO; top card insights; new disparity logic enhancements that compares the highest and lowest performing groups within race and ethnicity measures; internal race and ethnicity variable that uses historical and supplementary data sources to improve accuracy of internal planning. There are also planned future state enhancements that would include Experience Cube data migration, scalability to other lines of business, expansion of measures, provider report enhancements, and grievances enhancements.

As a result of using the dashboard, data has already been proven and enabled the HEO to apply the continuous quality improvement cycle to increase social drivers of health (SDOH) reporting. Baseline data indicated that Provider rates reporting SDOH remains low, 1.6% of all members have 1+ SDOH reported via z-code. SDOHs impact 80%-90% of health status. Understanding SDOH needs like housing, food security, and transportation is crucial for an individual's holistic care. The current screening rate significantly limits our ability to address these fundamental needs and coordinate care for our members.

The HEO conducted a brief root cause analysis to understand why rates remain low. Including taking a look at operations and system barriers, and identified that there is 1) a lack of standard process and/or tools to screen for SDOH in various practices; 2) variable processes to document z-codes in encounter form; 3) a lack of referral resources hinder provider readiness to document SDOH codes; and 4) data challenges to intake codes and translate into reporting.

As a result of this insight, the HEO will conduct a health equity quality improvement effort with the goal to increase SDOH reporting by 5% by December 31, 2025. The interventions planned span from pilot testing innovative data sharing partnering with Family Health Centers of San Diego (FHCSD) to exchange critical SDOH data, improving coordination of care; provider incentives for impact, encouraging healthcare providers to actively screen for SDOH needs and address disparities through performance-based incentives; and streamlining z-code documentation to connect patients with targeted community resources, ensuring unmet social needs translate into real-time interventions.

Health Equity Spotlight Interventions

In partnership with cross-functional departments, the HEO spotlighted five (5) interventions during the 2024 QIHEC quarterly meetings. The following interventions below include findings, interventions, and outcomes presented by each department.

Redetermination Process

The Department of Health Care Services (DHCS) announced that due to the COVID-19 public health emergency (PHE) ending, the continuous coverage requirement would also end on March 30, 2023. This would impact about 15 million Medi-Cal members who will need to renew their Medi-Cal coverage over the next year. Redetermination of Medi-Cal coverage was previously on hold due to the Consolidated Appropriations Act, which established continuous Medi-Cal coverage requirements for beneficiaries during the state public health emergency.

Beneficiaries had active coverage regardless of any changes in circumstances while this act was in place. The Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan was updated in March 2023 to include policy changes and resumption of redetermination operations for Medi-Cal coverage.

Due to the significant impact this will have on the Medi-Cal program, DHCS provided a timeline on the unwinding activities. While the continuous coverage requirements end, annual renewals for all beneficiaries will occur on their next normally scheduled annual renewal date. Renewal activities began on April 1, 2023, for beneficiaries with a July 2023 renewal date and will continue for each respective month following. This will continue an annual basis, and the redetermination process generally takes up to three months to determine eligibility.

Beneficiaries were notified via mail regarding their Medi-Cal eligibility and requirements to submit a renewal form by mail, phone, in person, or online to avoid losing coverage, which can result in potential gaps in care. Beneficiaries also had the option to create or check BenefitsCal to get alerts about their eligibility status.

The following criteria are included in the renewal form to establish basic eligibility requirements:

- Income, expenses, deductions
- Address
- Review and update household information
- Supporting documents

To support continuity of coverage and access to care, Blue Shield Promise launched a variety of redetermination activities through various outreach channels to support members and raise awareness about the steps needed to renew their Medi-Cal coverage.

The Blue Shield Promise Community and Provider Engagement Department developed and piloted an innovative algorithm to prioritize outreach for populations at disproportionate risk for disenrollment based on criteria such as:

- Housing insecurity and homelessness
- Members with a senior and People with Disabilities (SPD's) aid code.
- Households with a child under 17 years of age
- Spanish speaking members
- Households with 3 or more people
- Households within 3 miles of a Community Resource Center

The Blue Shield Promise ended 2023 with 48,000 members favorable to plan and nearly 290,000 (55%) of members completed the redetermination process. The plan achieved an 80% redetermination rate, compared to:

- 79% State
- 74% LA Care
- 77.7% LA County
- 77.1% San Diego County

County	Retention Rate 2023 (Promise Book of Business Assumption)	Retention Rate (Mbrs w/June 2023 renewal)	Retention Rate (Mbrs w/July 2023 renewal)	Retention Rate (Mbrs w/Aug 2023 renewal)	Retention Rate (Mbrs w/Sept 2023 renewal)
Los Angeles- Spanish	80%	83%	79%	79%	81%
San Diego- Spanish	76%	79%	80%	81%	84%

Table 7. Blue Shield Promise Retention Rate by County

Per the Los Angeles (LA) Times, it was reported that over 50% of people disenrolled from Medi-Cal from June through October 2023 were Latino. Disenrollments were primarily for procedural reasons. Further, results indicate that Blue Shield Promise's redetermination retention rate among Spanish speaking members is 81%; and the redetermination retention rate among children and families is 83%.

With the LA times article and over 40% of Promise population in LA are Spanish speaking members, this is a highlight for Promise from health equity lens for redetermination retentions.

Clinical Access Programs: Emergency Response in San Diego County

Blue Shield Promise, Office of the CMO, provided a Health Equity Spotlight Report highlighting Blue Shield of California Promise Health Plan's Emergency Response during the historic rainfall and flooding in San Diego County on January 22, 2024.

More than a month's worth of rain fell, causing widespread, dangerous flooding in the city's urban core. It was San Diego's wettest January day on record and ranked in the top five wettest days for any time of year since 1850. Meteorologist Alex Tardy, with the National Weather Service in San Diego said, "This is significant rainfall anywhere, but 2-3 inches in three hours is going to rank up there with probably a 50- to 100- year type flood." On January 23, 2024, Governor Gavin Newsom declared a

State of Emergency in San Diego. On February 2, 2024, DHCS provided tools and resources for MCPs to conduct *Winter Wellness Checks*.

The Clinical Access Programs team conducted 3,000 outreach calls to Seniors and Persons with Disabilities members to conduct *Winter Wellness Checks*. These calls were all completed in the first and second week of February 2024. The team was able to leave messages for 60% of the members; 10% of the members were reached with live calls; 30 members required assistance with Durable Medical Equipment (DME), medications or doctor visits; and 1 member required assistance with housing. All voicemails left during the outbound call campaign included contact information on how to access the Plan for assistance. Members who requested or required assistance from the outbound call campaign were engaged with Case Management through our Population Health Management Program and offered continued support.

Blue Shield Promise also donated $70,000 to community organizations who were directly supporting those affected by the flooding.

Member Journey

The Blue Shield Promise, HEO, provided an overview of the Health Equity Recommendations Report the Member Journey: Assessing Health Equity Opportunities to the QIHEC Quarter 3, 2024 meeting. Conducting this report allows us to center the member's voice, integrate health equity across Blue Shield Promise, employing a data driven strategy, inform resources and initiatives to reduce disparities.

The report summarizes the member journey to identify our member's needs and understand opportunities to improve member experiences. The intent of the report findings is to improve our ability to support members through their journey navigating the healthcare system, allowing us to better facilitate coordination of care to address social drivers of health, and confirm members are obtaining needed care, placing additional emphasis on members in most need.

Blue Shield Promise' Health Equity Office partnered with AArete, a healthcare consulting firm, to prepare an assessment of the member journey. This includes eligibility and enrollment, understanding benefits, accessing and utilizing care, and health outcomes. The Intent of this report was to better understand opportunities to improve member experiences with health care and the health plan from an equitable perspective, leveraging a human-centered design approach.

The Methodology used to create the member journey was from stakeholder interviews and data review including surveys such as the Net Promoter Score (NPS) survey findings and member responses and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Some examples of questions asked during stakeholder interviews include "what are impactful barriers to members" and "how does your area ensure members have equal access to care."

AArete designed a model outlining the stages of the member journey for children and adults. Each stage was assessed to understand emotions, touchpoints, bright spots and pain points that members may encounter (Reference Figure 3).

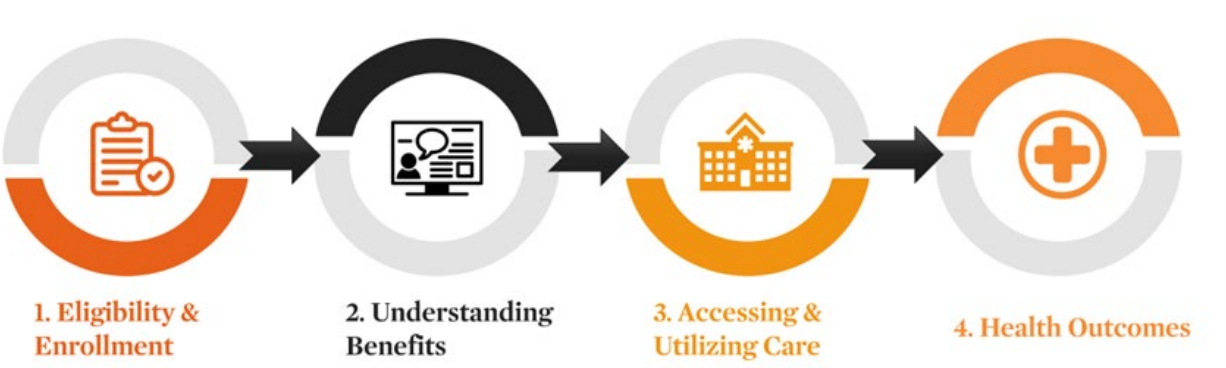

Figure 3. Stages of the Member Journey for Children and Adults

The report highlighted adult and child member journey successes, or bright spots, as summarized in Figure 4. These include in-person support provided at the Blue Shield Promise Community Resource Centers (CRCs) in Los Angeles County, the availability of member materials in multiple languages, and a well-trained and diverse Care Management and Social Services team.

Bright Spots	
Adult	**Child**
• Reliable non-emergency medical transportation (NEMT) • Timely translation services • A responsive and helpful Member services team • In-person support at community resource centers (CRCs) • Well-trained and diverse Care Management and Social Services teams • Increased Member Satisfaction from non-mandated/value-added benefits provided by Blue Shield Promise • Member materials available in multiple languages • Members can select providers based on name, gender, and language in the "Find-A-Doctor" portal, allowing Members to align with their provider on these identities	• Access to programs like Children's Health Services and Department of Developmental Services • Medi-Cal benefits for Kids and Teens • Increased care coordination • Support from regional centers • Community Resources Centers and Regional Centers provide vital face-to-face support for Members under 21 and their parents/guardians • Access to regional centers can help Members and their families understand their coverage and have their questions answered • CRCs provide many resources for Members with children including new parent classes and free diaper giveaways

Figure 4. Member Journey Report Findings: Identified Bright Spots

The report also highlighted adult and child members' journey opportunities for improvement, or pain points, as summarized in Figure 5. These included member data often being inaccurate which makes it difficult for members to receive materials and welcome calls to better understand their benefits, long wait times, and provider shortages in rural areas, such as a shortage of Speech Therapists presenting a challenge to member access to care.

Pain Points	
Adult	**Child**
• Individuals' immigration status causes hesitancy to share demographic information out of fear that their immigration status may be affected • Some Members must rely on a P.O. box for mail adding difficulty to receiving member materials • Member data is often inaccurate, delaying enrollment and correspondence for those without a phone number or mailing address • Members without a phone number or with limited minutes cannot receive a Welcome Call from Member Services, preventing these Members from understanding their coverage and having the opportunity to ask questions • Members that rely on FQHCs likely see different clinicians each visit, making it difficult to develop trust	• The BSP website is difficult for Members to navigate and understand, preventing them from finding their needed support • Medi-Cal Members may lack reliable access to internet • Navigating healthcare system can be 0verwhelming for parents • Unawareness surrounding NEMT • Inability to use NEMT to travel to CRCs • Lack of CRCs in San Diego • Lack of provider data synchronization • Long wait times to see a provider • Provider shortages in rural areas • General lack of understanding around Medi-Cal coverage • Overwhelming and confusing involvement of Children's Health Services and Department of Developmental Services • Inconsistent regional center capabilities • Speech therapist shortages • Lack of coordination when aging out of Children's Health Services

Figure 5. Member Journey report Findings: Identified Pain Points

These findings can be generalized to the larger Medi-Cal population served by Blue Shield Promise. An enhanced Health Equity lens could be added to the information included within this Member Journey Report by further drilling down into the experiences of members in specific sub-populations that may be more prone to experience health issues and inequities. For example, the adult member journey

map included in this report examines the general adult member experience. However, this experience may differ largely for those Blue Shield Promise members who may belong to certain ethnic/racial groups and those who have chronic conditions.

For future journey mapping efforts, AArete, recommends focusing on certain sub-populations for further exploration of their specific member journey. In addition to ethnic/racial groups and those members with chronic conditions, these populations may also include maternal health, justice-involved, those experiencing unsheltered homelessness, serious mental illness, LGBTQIA+ population, members requiring long-term care, etc.

Future recommendations for the adult member journey include, 1) Strategies to improve member contact and demographic information, 2) Assessment of community resources and member outreach, 3) Enhanced member education and value-added benefits, and 4) Leverage diverse data for meaningful insights. For the Child member journey, recommendations include 1) Utilizing texting campaigns and communications to replace phone communications, 2) Restructure care management delegation, and 3) Reassess provider networks with a health equity focus.

As the next steps, this report will be shared with all stakeholders internally and the Health Equity Office will work closely to identify opportunities with respective teams to address these findings in calendar year (CY) 2025.

Potential opportunities to address findings include partnering with vendor Violet Health who offers a Provider platform to collect Sexual Orientation and Gender Identify (SOGI) data and provide cultural competency trainings, a common theme highlighted as a bright spot of CRCs in Los Angeles County, this might be a potential opportunity to consider comparable services in San Diego County. Another opportunity is to establish strategic goals to increase member demographic data collection.

As we begin to track and address these findings, the Health Equity Office will report the outcomes to the committee in 2025.

Maternal Health Equity Strategy

Maternal Health Equity finalized a comprehensive strategic plan for implementation in 2024-2028. The plan was presented to QIHEC in Quarter 3, 2024 as a Health Equity Spotlight Report.

Statistics were shared indicating the worsening maternal and infant health crisis. The United States is facing a worsening maternal and infant health crisis. In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. The Population Reference Bureau states that more than 80% of pregnancy-related deaths could have been avoided. There are alarming racial disparities in maternal health for American Indian/Alaska Native women, the rate is about 2x the rate of non-Hispanic white women. Black women are dying at a rate nearly 3x higher than non-Hispanic white women.

Improving health equity requires focus in these 3 areas to develop strategies and design clinical interventions that close care gaps: 1) Removal of the barriers; 2) Culturally rigorous data collection; and 3) Bi-directional cultural humility

The intent is for all Blue Shield Promise birthing members to have access to high-quality equitable health care. Initiatives such as a Breastfeeding Resource Guide and Learning Collaborative were shared during the committee meeting.

The Maternal & Infant Health Equity Goals and Milestones Roadmap from 2024-2028 details the work completed to date, ongoing work, and future work.

+++ Complete ++ Ongoing + Not Started

GOALS	MILESTONES	2024	2025	2026	2027	2028
Launch predictive analytic capabilities to design data-driven interventions to reduce disparities and mortality*	1. Launch maternity analytics vendor (Lucina) – approved, anticipated launch April 2025 ++					
	2. Build phased implementation plan with Lucina, IT, and key BSC stakeholders, including Maternity Care Management +					
	3. Capture baseline and benchmarks for HEART measures and set improvement targets (stratify by REAL, Geography & Facility) +					
Build and sustain a holistic, end-to-end maternal & infant health infrastructure focused on continuous improvement	1. Implement value-based contracts specific to maternal health+					
	2. Partner with Provider Contracting to build a comprehensive perinatal network, including nurse-midwives, community health workers, and birthing centers++					
	3. Collaborate with Medi-Cal Quality & Maternal Infant Health Equity workgroup to support the DHCS Bold Goals initiative – meeting series to begin 9/16++					
	4. Align on 2024-2028 goals & priorities across the enterprise to align with the Blue Shield of California Maternal Child Health Equity roadmap++					
Promote equitable member & family-centered care across prenatal & postpartum continuum	1. Review baseline data & advise on interventions to close gaps in care for 2 new maternal behavioral health HEDIS measures++					
	2. Perform a current state evaluation leveraging Lucina baseline reporting to measure effectiveness of current interventions, quality gaps & plan targeted interventions+					
	3. Launch 3 UserZoom surveys to engage the voice of Medi-Cal birthing people and their families and integrate perspectives into strategy and program design • (1) Pregnancy Loss (Jan 2024)+++ (2) Doulas Services + • (3) Topic TBD +					
	4. Streamline & stabilize doula benefit operations and increase enrollment by 15%++					
Form provider and community partnerships to address root causes of disparities and mortality	1. Execute doula contracts to build an equity-centered network with community-based doulas++					
	2. Launch First 5 LA home visiting quality incentive contract, funding approved for MSA. Community Investment Agreement in process for 2024–2025++					
	3. Develop Antelope Valley maternal health current state assessment and develop at least one pilot and/or community partnership to address gap(s)+					
	4. Evaluate the feasibility of providing tailored meals to postpartum members (Sunterra Food Boxes)++					
Become a trusted Maternal & Infant Health Equity partner of regulators, local government, and community leaders	1. Actively participate in key Maternal & Infant Health Equity forums to advance knowledge of trending areas of focus, create partner driven solutions and to strengthen mutual areas of focus to improve member health outcomes++					
	2. Collaborate with CAHP on doula benefit recommendations to DHCS to improve member and doula experience++					
	3. Represent Promise as subcommittee SME for LA County Health Plans (MCP's) Community Partnership SMART Goal Workgroup++					
	4. Provided CalAIM IPP funding for 3 doula organizations (Reach Healthcare, For the Village, Birth Workers of Color Collective)+++					
Develop interventions to support the achievement of Bold Goals	1. Drive Maternal Health Bold Goals workgroup in partnership with Quality, Health Equity & Maternal Mental Health++					
	2. Develop targeted interventions to reduce disparities in prenatal and postpartum care+					
	3. Partner with the Behavioral Health team to increase maternal depression screenings++					
	4. Align quality measurement with national standard-setting organizations and tie back to provider quality programs+					

Figure 6. 2024–2025: Maternal & Infant Health Equity Goals & Milestones Roadmap

Sexual Orientation and Gender Identity (SOGI) Data Collection Focus Group

On October 2024, the Blue Shield Promise HEO formed a SOGI Data collection focus group with QIHEC committee member participation from AltaMed Health Services, Family Health Centers, and San Ysidro Health.

During the focus group, we discussed through the problem statement and challenges of collecting SOGI data. The focus group discussion centered on exploring solutions for how we can increase SOGI data collection, increase staff comfortability for asking patients for this information, and discussed possible interventions.

Some of the common themes we garnered about was the frequency of missing data across clinic and health plan systems. And challenges with collecting the information because of the sensitivity of the questions, back-logs in data entry due to paper format questionnaires and delays in digitizing the responses into internal systems. Challenges with Staff and Provider hesitancy to ask SOGI questions and vice versa patient hesitancy to provide SOGI responses environmental factors that can also play a role in data collection, and lack of administrative buy-in.

We also discussed best practices and potential interventions, including offering patients access to answer these sensitive questions via an iPad at check in, in the waiting room, bi-directional data sharing between medical groups and health plan systems, development of an incentive program encouraging members to update their SOGI information using trusted messaging, and partnering with patient facing campaigns.

The Blue Shield Promise HEO shared tools and resources with the workgroup, gender affirming care training that's available on our public training website and exploring solutions for bi-directional data sharing. Moreover, we were able to meet with Family Health Centers and our internal IT partners to discuss some potential solutions for bi-directional and supplemental data sharing pilot testing opportunities.

Health Equity Spotlight Intervention Summary Outcomes

Blue Shield Promise will continue to spotlight health equity interventions, monitor the HEART Measure Set to 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 the DHCS Bold Goals: 50x2025

initiative, a strategy introduced in the DHCS Comprehensive Quality Strategy (DHCS, 2022).

The table below summarizes some key outcomes for each Health Equity Spotlight intervention presented throughout the calendar year 2024:

Table 8. Health Equity Spotlight Interventions

Health Equity Spotlight Interventions: Summary Outcomes				
Spotlight	**Finding**	**Source**	**Intervention**	**Outcome**
Redetermination Outreach Activities	Redetermination Rate favorable to plan.	Report	Algorithm to prioritize multi-channel outreach to populations at disproportionate risk for disenrollment based on select criteria developed by the Provider and Community Engagement Department.	48,000 members favorable to plan, and nearly 290,0000 (55%) of members completed redetermination process. Plan achieved 80% redetermination rate, higher rate compared to State, Los Angeles County, San Diego County and LA Care. Redetermination rate among Spanish Speaking members is 81%; and among children and families 83% compared to only 50% of people who disenrolled from Medi-Cal among the Latino population as reported by the Los Angeles Times.
Member Journey	Member data often being inaccurate. Difficult for members to receive materials and welcome calls to better understand their benefits. Member experience long wait times. Provider shortages in rural areas, such as a shortage of Speech Therapists. Challenges to member access to care.	Report	Health Equity assessment report to identify member's needs and understand opportunities to improve member experiences.	Future recommendations for the adult member journey include: 1) Strategies to improve member contact and demographic information, 2) Assessment of community resources and member outreach, 3) Enhanced member education and value-added benefits, and 4) Leverage diverse data for meaningful insights. For the Child member journey, recommendations include: 1) Utilizing texting campaigns and communications to replace phone communications, 2) Restructure care management delegation, and 3) Reassess provider networks with a health equity focus. Partner with vendor Violet Health who offers a Provider platform to collect Sexual Orientation and Gender Identify (SOGI) data and provide cultural competency trainings. Potential opportunity to consider comparable services in San Diego County. Establish strategic goals to increase member demographic data collection.
Clinical Access Programs: Emergency Response in San Diego County	State of Emergency in San Diego due to flooding.	QIHEC Summary Report	Outreach Calls	3,000 outreach calls to Seniors and Persons with Disabilities members to conduct Winter Wellness Checks. • Left messages for 60% of the members; • 10% of the members were reached with live calls; • 30 members required assistance with Durable Medical Equipment (DME), medications or doctor visits; and • 1 member required assistance with housing. Blue Shield Promise also donated $70,000 to community organizations who were directly supporting those affected by the flooding.
Maternal Health Equity Strategy	In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. More than 80% of pregnancy-related deaths could have been avoided.	QIHEC Summary Report	Developed Maternal & Infant Health Equity Goals and Milestones Roadmap from 2024-2028	Launch maternity analytics vendor (Lucina) – approved, anticipated launch April 2025. Partner with Provider Contracting to build a comprehensive perinatal network, including nurse-midwives, community health workers, and birthing centers. Collaborate with Medi-Cal Quality & Maternal Infant Health Equity workgroup to support the DHCS Bold Goals initiative – meeting series to begin 9/16.

	Racial disparities in maternal health for American Indian/Alaska Native women, the rate is about 2x the rate of non-Hispanic white women. Black women are dying at a rate nearly 3x higher than non-Hispanic white women. Improving health equity requires focus in these 3 areas to develop strategies and design clinical interventions that close care gaps: 1) Removal of the barriers; 2) Culturally rigorous data collection; and 3) Bi-directional cultural humility			Align on 2024-2028 goals & priorities across the enterprise to align with the Blue Shield of California Maternal Child Health Equity roadmap. Review baseline data & advise on interventions to close gaps in care for 2 new maternal behavioral health HEDIS measures. Launch UserZoom surveys to engage the voice of Medi-Cal birthing people and their families and integrate perspectives into strategy and program design regarding Pregnancy Loss (Jan 2024). Streamline & stabilize doula benefit operations and increase enrollment by 15%. Execute doula contracts to build an equity-centered network with community-based doulas. Launch First 5 LA home visiting quality incentive contract, funding approved for MSA. Community Investment Agreement in process for 2024–2025. Evaluate the feasibility of providing tailored meals to postpartum members (Sunterra Food Boxes). Actively participate in key Maternal & Infant Health Equity forums to advance knowledge of trending areas of focus, create partner driven solutions and to strengthen mutual areas of focus to improve member health outcomes. Collaborate with CAHP on doula benefit recommendations to DHCS to improve member and doula experience. Represent Promise as subcommittee SME for LA County Health Plans (MCP's) Community Partnership SMART Goal Workgroup. Provided CalAIM IPP funding for 3 doula organizations (Reach Healthcare, For the Village, Birth Workers of Color Collective). Drive Maternal Health Bold Goals workgroup in partnership with Quality, Health Equity & Maternal Mental Health. Partner with the Behavioral Health team to increase maternal depression screenings.
Sexual Orientation and Gender Identity (SOGI) Data Collection Focus Group	Frequency of missing data across clinic and health plan systems. Challenges with collecting the information because of the sensitivity of the questions. Back-logs in data entry due to paper format questionnaires and delays in digitizing the responses into internal systems. Challenges with Staff and Provider hesitancy to ask SOGI questions. Patient hesitancy to provide SOGI responses. Environmental factors that can also play a role in data collection. Lack of administrative buy-in.	Qualitative Feedback	Focus Group	Discussed best practices and potential interventions, including: 1) Offering patients access to answer sensitive questions via an iPad at check in, in the waiting room; 2) Bi-directional data sharing between medical groups and health plan systems; 3) Development of an incentive program encouraging members to update their SOGI information using trusted messaging; and 4) Partnering with patient facing campaigns. Blue Shield Promise HEO shared tools and resources: 1) Gender affirming care training that's available on our public training website; 2) Exploring solutions for bi-directional data sharing; and 3) Meet with Family Health Centers and our internal IT partners to discuss some potential solutions for bi-directional and supplemental data sharing pilot testing opportunities.

Blue Shield Promise will continue to develop customized interventions that target equitable, whole-person care in marginalized populations and/or communities. Blue Shield Promise 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.

Blue Shield Promise 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, etc., and delivery modes of communication such as print, social media, in-person, etc. Blue Shield Promise will also define outcome and process measures and identify keys to sustainability.

NCQA Health Equity Accreditation Reports

The HEO is also tracking NCQA Health Equity Accreditation reports as part of the Quality Improvement and Health Equity Committee Workplan, including report findings, interventions, outcomes, and bringing quarterly updates forward to committee members.

The CLAS report assesses the provider network to determine if the members' needs and preferences are being met for the measurement areas race/ethnicity, language, sexual orientation, gender identity, cultural & linguistic grievances, and Plan CLAS training and resources offered to providers.

The table below describes CLAS report findings, interventions, and outcomes:

Table 9. Culturally and Linguistically Appropriate Services (CLAS) Report Findings, Interventions and Outcomes

Report	Finding	Intervention(s)	Outcomes	Status
Culturally and Linguistically Appropriate Services (CLAS) Report	Member self-reported race and ethnicity data captured: 95.5% Los Angeles; 82.8% San Diego Goal: 80%	1) Sent reminders to all members regarding privacy and protections of their race, ethnicity, and language, sexual orientation, and gender identify data and shared the process for how to update member profiles (COMPLETED) 2) Focus on data integration from external sources to increase the amount of self-reported member demographic data available to us (ONGOING)	Will report 2025 CLAS report	Item #1: Completed as of NCQA submission- November 2024. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report. Item #2: In process. Current status: • Completed initial assessment of data sources and inclusion of data. • Assessing internal data streams and ability to integrate. • Based on assessment, we will design a plan on data integration.
Culturally and Linguistically	NCQA requires health plans to	1) Leverage addition al provider sources to encourage providers to self-identify race, ethnicity and language data.	Will report 2025 CLAS report	Item #1, 4: In progress. Assessment, including intervention outcomes, will

Appropriate Services (CLAS) Report	develop race and ethnicity ratio and assess the provider network against those thresholds. All targeted threshold ratios were met except for *Some Other Race* for Promise San Diego. 97% of providers do not self-report race and ethnicity data.	Promise to partner with Violet Health and leverage their Health Equity provider training and other resources (Q1 2025). 2) Send reminders to all providers about the importance of updating their provider profile, which includes, but not limited to race, ethnicity, and spoke4n languages including office staff (COMPLETED) 3) Develop cross-department workgroup to review provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline. Additionally, this team will examine our internal process for collecting and displaying English and develop an action plan based on their findings (COMPLETED) 4) Violet Health pilot (IN PROGRESS)		occur in Q4 2025 and will be included in the CLAS Report. Current status: • Outreach efforts to identified facilities/providers have been completed. Additional follow-up to continue, especially among providers who have expressed interest. Item #2: Completed as of NCQA submission- November 2024. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report. Item #3: Completed as of NCQA submission- November 2024. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report.
Culturally and Linguistically Appropriate Services (CLAS) Report	Examined cultural and linguistic grievances to assess how the network meets the members' cultural needs and preferences Total grievances received: 53 (Los Angeles; 51 (San Diego). No threshold as cultural grievances are reviewed	1) Obtain feedback from Consumer Advisory Committee for preferred communication of language assistance resources (COMPLETED) 2) Released member notification with instructions to access language assistance services (COMPLETED) 3) Develop provider letter noting resources and language assistance services available (IN PROGRESS) 4) Grievance case review (PLANNED) 5) Facilitate training to transportation vendor given high volume cases (PLANNED)	Will report 2025 CLAS report	Item #1: Completed. Presented to CAC on September 10, 2024. A summary of the committee is included below. This feedback will be incorporated into the program design. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report. •The committee expressed strong interest in received physical materials (i.e., mailers) that highlight interpreter and translation services provided by Promise in a clear concise manner, including providers. •Committee recommends Promise work with providers on ways to improve appointment scheduling when an interpreter is required or having follow up calls in member's preferred languages. Item #2: Completed as of NCQA submission – November 2024. Item #3: Completed as of NCQA submission – November 2024. Items #4 and 5: In progress. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report. In reviewing grievances, we identified opportunities to work with Customer Service and transportation vendor teams to improve interpreter utilization. Current status: •Review internal desk level procedures when requesting transportation services and leveraging interpreter services. •Meeting scheduled with internal team to review grievances related to transportation vendor & review oversight process related to interpreter services utilization.
Culturally and Linguistically Appropriate Services (CLAS) Report	Blue Shield has low response rates (1%) for sexual orientation and gender identity data Goal: 20% by 2028	1) Socialize process for updating member profile 2) Training performed to improve staff comfort in broaching topic with members (COMPLETED) 3) Focus group with Federally Qualified Health Centers to understand barriers for collection (COMPLETED) 4) Explore process for data sharing with Federally Quality Health Center (IN PROGRESS)	Will report 2025 CLAS report	Item #1: Completed as of NCQA submission – November 2024. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report. Item #2: Completed as of NCQA submission – November 2024. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the CLAS Report. Item # 3: Completed as of NCQA submission – November 2024. Results of focus groups indicate barriers. Based on this, shared best practices toolkit for collecting SOGI from patients.

				Item #4: In progress. Current summary: •Awaiting provider profile report from Health Equity Dashboard, including member-level data and work with providers to reconcile with existing members/patients. •Explore a bidirectional data feed once provider finalize reconciliation.

Health Disparities Report

The Health Disparity Report identifies and address disparities in healthcare outcomes among different population groups by analyzing member race, ethnicity, language, sexual orientation and gender identity data

The table below describes Health Disparities report findings, interventions, and outcomes:

Table 10. Health Disparities Report Findings, Interventions and Outcomes

Report	Finding	Intervention(s)	Outcomes	Status
Health Disparities Report	Inequities by race/ethnicity for poor diabetes control for members in Los Angeles County Hispanic/Latino members in Los Angeles County accounted for a large proportion of the denominator and had the highest number of members demonstrating HbA1c Poor Control (>9.0%)	1) Partner with our Health Education department to host a parallel Spanish speaking class series at the same time as the English-speaking class in August 2) Employ heat maps to identify Hispanic or Latino members who reside near the Community Resource Centers to encourage attendance through mailed letters 3) Among Hispanic/Latino members who are assigned to a provider group with Health Navigators, encourage attendance through live calls. Members can also bring family members or care givers	Will report 2025 Health Disparities Report Quarterly analysis using Health Equity Dashboard	Items #1-3: In progress. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the Disparities Report
Health Disparities Report	Inequities by race/ethnicity for Child and Adolescent Well Care Visits among Promise members in both San Diego and Los Angeles County Target goals for both counties were not achieved when stratifying performance by race	Intervention strategy will focus on reducing inequities for Black/African American, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and white members as these groups showed the highest preventive care visit gaps among Promise members. 1) Increase access to well-care visits, by offering the service in the members' community and offering flexibility for scheduling and attending the visit (PLANNED) 2) Connect members to a usual source of care as well clinic days can help members identify their primary care provider and connect them to other Blue Shield Promise resources (PLANNED) 3) Share results from the well-care visit with the members' assigned provider and connect members to Blue Shield Promise resources (PLANNED)	Will report 2025 Health Disparities Report Quarterly analysis using Health Equity Dashboard	Items #1-3: In progress. Assessment, including intervention outcomes, will occur in Q4 2025 and will be included in the Disparities Report. Current summary: •Heat map was employed in December 2024 to identify the Community Resource Centers (CRC's) in Los Angeles and areas in San Diego that serve a large proportion of Black/African American, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and white members, to identify locations and community resource centers for 2025 clinic days. •The corresponding CRC's in Los Angeles and locations in SD were prioritized for hosting well-child clinic days in 2025. Additional clinic dates were also implemented to increase access to well-care visits, offering flexibility for scheduling and attending the visit. •A distinct outreach list was created for the vendor to prioritize outreach to this population. The initial outreach was to support increased access and flexibility for scheduling appointments. •Routine components of the well child visit at the clinic day remain the same including connecting members to a

				usual source of care by helping members identify their primary care provider, connecting members to other Blue Shield Promise resources, and sharing results of the visit with the member's assigned primary care provider. •Promise is also testing out the promotion of Blue Shield Promise resources by partnering with Health Education and providing Health Education teammates a space to promote health education and Blue Shield Promise resources.

Blue Shield Promise will continue to track progress over time and conduct an annual report evaluating program effectiveness for each CLAS and Health Disparities Reports. Quarterly updates will be presented to the committee.

IV. Key Findings

The following list highlights key findings the HEO has identified throughout the calendar year 2024.

- Strive to meet 100% Medi-Cal contractual requirements.
- The Blue Shield Promise HEO will continue to participate in the HEOC and partner with Blue Shield of California and Blue Shield of California Life & Health Insurance Company, bringing forward health equity activity updates and strive to align across the enterprise where possible.
- Blue Shield Promise will continue to work toward maintaining NCQA HEA, monitor activities, and report updates to quarterly QIHEC meetings.
- Blue Shield Promise will continue to fully operationalize the Diversity, Equity, and Inclusion Training Program Requirements per Medi-Cal contractual requirements and APL 24-016 and ensure high completion and satisfaction rate for both internal staff and external trainings.
- The HEO will act on key findings and recommendations that resulted from the Member Journey Health Equity Assessment report. Future recommendations and the potential opportunities to address findings include partnering with vendor Violet Health who offers a Provider platform to collect Sexual Orientation and Gender Identify (SOGI) data and provide cultural competency trainings, a potential opportunity to consider comparable services in San Diego County, and an opportunity to establish strategic goals to increase member demographic data collection (Reference Appendix 4. Health Equity Recommendations Report the Member Journey: Assessing Health Equity Opportunities).
- Continual monitoring of the HEART Measure set over time is needed. Initial observations drew limited data inferences.

- The HEO to confirm data variance trend across the metrics, while concurrently, working in partnership with the IT and Data Analytics teams to enhance the health equity dashboard to improve tracking and trending of data.
- Design Provider Profile reports and disparity analysis reports with an opportunity to partner with internal and external stakeholders to enhance reporting.
- The need to increase member SDOH data collection.
- Blue Shield Promise HEO will continue to implement the HEART Advocate program pilot with cohort 2 and strive highest participant satisfaction rates.
- Successfully implement the health equity integration plan model and continue to partner with cross-functional departments to embed health equity in everything we do.

V. Action Plan

In 2025, the HEO will seek 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 11. QIHET Program Goals and Objectives

Furthermore, the QIHETP Action Plan lists all actions and milestones needed to formally build and implement Blue Shield Promise QIHETP. The Action Plan is managed by the HEO (Reference Appendix 8. 2024-2025 QIHETP Action Plan).

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, Medi-Cal Committee and Blue Shield of California Board of Directors via consent agenda.

VI. Stakeholder Engagement

Blue Shield Promise utilizes Stakeholder Engagement to impact the QIHETP Annual Evaluation. Groups such as the Community Advisory Committee, Provider Advisory Committee and Joint Operations Meetings are engaged and provide valuable feedback from a member and/or provider perspective.

a. Community Advisory Committee

Blue Shield Promise provides the Community Advisory Committee (CAC) with an opportunity to provide input on various health plan activities that may impact the QIHETP. Blue Shield Promise provides health equity program updates to the CAC, solicits input, discusses opportunities for improvement for health plan activities and progress made toward QIHETP goals and objectives.

In 2024, Blue Shield Promise CAC meetings were engaged to learn about the new health equity website when presented during Quarter 3, 2024 meetings in both Los Angeles and San Diego counties. The HEO asked the committee for feedback and input. Blue Shield Promise makes a written summary of QIHEC activities, findings, recommendations, and actions. These are prepared after each meeting and publicly available on our website at least on a quarterly basis. The CAC members did not have any feedback.

The HEO will continue to publish QIHETP and QIHEC updates on the website ensuring we remain compliant of our Medi-Cal contractual requirements. Further, the HEO will continue to bring forward pertinent QIHETP topics to upcoming meetings to garner feedback toward the development and/or enhancement of health plan programs.

b. Provider Advisory Council

Blue Shield Promise ensures contracted health care providers, practitioners, and allied health care personnel receive pertinent information regarding the QIHETP. The HEO

participated in the Provider Advisory Council meetings, including Quarter 3, 2024 Los Angeles and San Diego County meetings to.

The HEO asked the committee for feedback and input. Blue Shield Promise makes a written summary of QIHEC activities, findings, recommendations, and actions. These are prepared after each meeting and publicly available on our website at least on a quarterly basis. The PAC members did not have any feedback.

The HEO will continue to publish QIHETP and QIHEC updates on the website ensuring we remain compliant of our Medi-Cal contractual requirements. The HEO will continue to bring forward pertinent QIHETP topics to upcoming meetings to garner feedback toward the development and/or enhancement of health plan programs.

c. Joint Operations Meeting

The Blue Shield Promise HEO also participated in 2024 Joint Operations Meetings and met with several individual provider associations (IPAs) and medical groups. The HEO had the opportunity to present on the topic of health equity at 50 JOM meetings over the calendar year.

The HEO introduced the newly released DHCS All Plan Letter (APL) 23-025 Diversity, Equity, Inclusion (DEI) Training Program Requirements (updated APL 24-016), and provided the audience with implementation timeline and updates. Including the phased in approach to training development, cross collaboration with partnering with regional Managed Care Health Plans (MCPs), development of the DEI training program, submission and approval of new training content, and piloting the DEI program and training completion. The HEO informed IPAs and medical groups that beginning January 1, 2026, all internal Promise health plan staff, as well as our Subcontractors, Downstream Subcontractors and Network Providers will need to have completed the new DEI Training Program which encompasses sensitivity, diversity, cultural competency, cultural humility, and health equity topics.

The JOM participants had some great initial feedback regarding the training, including one IPA who requested more information on what the expectations are for IPA's and medical groups, and how they will get visibility if Network Providers have to self-attest. The IPA would like to be able to attest on behalf of all Providers in their network, share a detailed list of all Providers who have completed the training, and return the detailed list of training completions to the MCP to relieve some of the administrative burden on the Provider. The HEO representative took this feedback into consideration as we continued to build up the attestation process. Additional clarification was requested from the IPA regarding the training cadence, whether this is an annual requirement or only required for

new hires and during times of credentialing and recredentialing cycles. The HEO representative confirmed cadence as written in the APL. The IPA expressed they would like to weigh in on regional workgroup discussions.

The HEO noted this feedback and worked with the Provider Education team to build this attestation process prior to training implementation planned for April 28, 2025. Blue Shield Promise accepts both self-attestation and/or group attestations via a spreadsheet that can be downloaded, filled out, and returned to the MCP per instructions listed on the Provider website. Blue Shield Promise will then import the data into the Provider Learning Center to mark those providers complete and share the data with regional MCPs.

During the 2024 JOM presentations, the HEO representative also provided updates regarding Senate Bill (SB) 923 Gender Affirming Care and health plan requirements to complete cultural competency training for providing trans-inclusive health care for individuals who identify as transgender, gender divers, or intersex (TGI). The Bill also requires that Plan's Provider directory identify all providers that offer and have provided gender-affirming services and post this in the Provider directories, as well as ensuring this remains current and up to date.

The HEO representative confirmed Blue Shield Promise currently has the capabilities for providers to self-attest offering gender affirming care services and are available on the Provider Connection Platforms. This information is live for members to access via Find a doctor feature on Blue Shield Promise website. Commentary provided by JOM attendees regarding SB 923 Gender Affirming Care were regarding the training topics and requirements that were outlined in the impending release of the new APL 24-017: Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements at the time of the presentations. The HEO representative confirmed they will bring updates back to the JOM as policy is released.

In 2025, the HEO plans to continue to bring forward pertinent QIHETP topics and updates to upcoming meetings to garner feedback toward the development and/or enhancement of health plan programs.

VII. Annual Evaluation Reporting and Oversight

Results and key findings of the QIHETP Annual Evaluation will be presented to QIHEC in Quarter 2, 2025. The Health Equity Principal Program Manager will manage the 2025 QIHETP Action Plan updating outcomes as they become available. An executive summary will be presented to the QIHEC, Medi-Cal Committee, Blue Shield of California Board of

Directors via consent agenda, and various committee meetings 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. The HEO will incorporate recommendations as received from functional area leaders, committees, members, and Network Providers to enhance the delivery of health equitable programs. Blue Shield Promise HEO will incorporate feedback into the QIHETP Annual Evaluation RY 2025, as applicable. The QIHETP Annual Evaluation will be posted on the Plan's public website. Notification of the website and program updates will be transmitted via the member newsletter, Member Handbook (Evidence of Coverage), and Provider Manual.

VIII. References

1. Blue Shield of California Health Equity Oversight Committee Charter.
2. Blue Shield of California Promise Health Plan Quality Improvement Health Equity Committee Charter.
3. Blue Shield of California Promise Health Plan HEQ-001: Quality Improvement Health Equity Transformation Program Policy.
4. Blue Shield of California Promise Health Plan HEQ-002: Quality Improvement Health Equity Committee Policy.
5. Blue Shield of California Promise Health Plan HEQ-003: Diversity, Equity, and Inclusion Training Program Requirements Policy.
6. California Health Care Foundation (CHCF) and National Committee for Quality Assurance (NCQA) (2022). White Paper. Advancing Health Equity: A Recommended Measurement Framework for Accountability in Medicaid. Retrieved from https://www.ncqa.org/wp-content/uploads/2022/10/NCQA-CHCF-EquityFrmwrkMedicaid-Sep22_FINAL.pdf.
7. California Department of Health Care Services Medi-Cal Managed Care Boilerplate Contracts from https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
8. National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards retrieved from https://www.ncqa.org/programs/health-equity-accreditation/.

VIII. Appendices

Appendix 1. 2024 QIHEC Work Plan

Appendix 2. 2024-2025 QIHET Program Description

Appendix 3. Health Equity Assessment - Redeterminations Report

Appendix 4. Health Equity Recommendations Report the Member Journey: Assessing Health Equity Opportunities

Appendix 5. Annual Culturally and Linguistically Appropriate Services (CLAS) Program and Program Evaluation Report

Appendix 6. Medi-Cal Annual Health Disparities Report

Appendix 7. HEART Measure Set

Appendix 8. 2024-2025 QIHETP Action Plan

blue of california | Promise Health Plan

Quality Improvement and Health Equity Committee Workplan

Item No.	Regulatory Standard (e.g., CMS, DMHC, DHCS and NCQA, Office of Affordability)	Planned Activity	Responsible Person/Owner(s)	Reporting Frequency	Goal	Objective	Action Item e.g., performance measure, measurable(s)	Initiation Date	Completion Date	Q1	Q2	Q3	Q4	Reporting Date(s)	Status	Risk	If an activity is at risk, what is the root cause and/or corrective action	Comments
1	DHCS	Health Equity Office Policies and Procedures: - Quality Improvement and Health Equity Transformation Program (QIHETP) Policy - Quality Improvement Health Equity Committee (QIHEC) Policy - Diversity, Equity, Inclusion (DEI) Training Program Policy	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Submit Policies and Procedures for annual review and approval by 3/21/2024.	Annual Review and Approval	1/1/2024	3/21/2024	X		X		3/21/2024 9/19/2024	Closed	Low		
2	DHCS	Quality Improvement and Health Equity Committee Charter	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Submit the QIHEC Charter to QIHEC for review and approval by 3/21/2024.	Annual Review and Approval	1/1/2024	3/21/2024	X		X		3/21/2024 9/19/2024	Closed	Low		9/19/2024 amended and revised according to updated governance structure for the remainder of calendar year (CY) 2024.
3	DHCS	Quality Improvement and Health Equity Transformation (QIHET) Program Description	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Develop the written QIHET Program Description and submit to QIHEC for review and approval by 3/21/2024.	Annual Review and Approval	1/1/2024	3/21/2024	X		X		3/21/2024 9/19/2024	Closed	Low		9/19/2024 amended and revised according to updated governance structure for the remainder of calendar year (CY) 2024.
4	DHCS	Quality Improvement and Health Equity Transformation Program Evaluation	Valerie Martinez	Annual	Build Sound Infrastructure and Operations	Assess the QIHET Program Evaluation and submit to QIHEC for review and approval by 6/20/2024.	Annual Review and Approval	3/21/2024	6/20/2024		X			6/20/2024	Closed	Low		
5	DHCS, NCQA	Health Equity Advancement Resulting in Transformation (HEART) Measure Set Monitoring Report	Valerie Martinez	Quarterly	Embed Equity and Advance Information in Action	Submit the HEART Measure Set monitoring report to track and trend notable health disparities to QIHEC by 3/21/2024 and quarterly thereafter.	Analysis of quarterly reports to identify HE disparities.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
6	DHCS	Health Equity Spotlight Report	Various Functional Leads	Quarterly	Embed Equity	Submit a Health Equity Spotlight Report to demonstrate health equity integration in everything we do by 3/21/2024 and quarterly thereafter.	Spotlight and report a health equity initiative.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
7	DHCS	I have HEART Advocate Program and Updates	Valerie Martinez	Quarterly	Build Sound Infrastructure and Operations Cultivate a culture of Equity	Introduce the I have HEART Advocate Program to QIHEC by 3/21/2024, and updates quarterly thereafter.	Informational and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
8	DHCS, NCQA	APL 23-025: Diversity, Equity, and Inclusion Training Program Requirements and compliance per implementation timeline	Valerie Martinez Linda Fleischman Angelica Matsuno Melinda Kjer	Quarterly	Embed Equity Build Sound Infrastructure and Operations Cultivate a Culture of Equity	Development of DEI training, implementation and monitoring by 1/1/2025.	DEI training development updates for informational purposes and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
9	DHCS, NCQA	Senate Bill (SB) 923 Gender Affirming Care Training Requirements and Updates	Various Functional Leads	Quarterly	Embed Equity Build Sound Infrastructure and Operations Cultivate a Culture of Equity	Provide general updates to QIHEC by 3/21/2024, and quarterly thereafter.	Informational and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
10	DHCS, NCQA	Assembly Bill (AB) 133 REAL/SOGI data collection Requirements and Updates	Danika Cunningham Valerie Martinez	Quarterly	Embed Equity Build Sound Infrastructure and Operations Cultivate a Culture of Equity	Provide general updates to QIHEC by 3/21/2024, and quarterly thereafter.	Informational and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
11	NCQA	NCQA Health Equity Accreditation Updates	Danika Cunningham Valerie Martinez	Quarterly	Embed Equity Build Sound Infrastructure and Operations Cultivate a Culture of Equity	Provide general updates to QIHEC by 3/21/2024, and quarterly thereafter.	Informational and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
12	DHCS	BSP Bold Goals Strategic Plan Updates	Valerie Martinez	Semiannual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Develop Quality Improvement Studies for Subpopulation(s) with disparities identified in Bold Goals (2) to reduce health disparities in given subpopulations.	Informational report out to QIHEC for discussion.	3/21/2024	12/12/2024		X		X	6/20/2024 12/12/2024	Planned	Low		
13	DHCS	Health Equity Assessment Report (2)	Valerie Martinez	Semiannual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Prepare Health Equity Assessment Reports that will include an in-depth assessment to understand specific areas looking at utilizations, services offered, member experience, outcomes, barriers and opportunities to improve.	Informational report out to QIHEC for discussion.	3/21/2024	12/31/2024			X		9/19/2024 3/20/2025	Planned	Low		
14	DHCS	Health Equity Assessment Quality MCAS Report	Valerie Martinez Christine Nguyen	Annual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Submit a Health Equity Assessment Quality MCAS Report to demonstrate how the HEO is tracking and trending notable health disparities and advancing information in action.	Informational and report out to QIHEC.	6/20/2024	12/31/2024					3/20/2025	Planned	Low		
15	DHCS	Health Equity Recommendation Report (2)	Valerie Martinez	Semiannual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Prepare Health Equity Recommendation Reports from an equity lens. A formal analysis for teams to incorporate health equity. The reports will contain analysis of the problem or need statement, review of best practices or competitive landscape, regulatory requirements, and impact of recommendations.	Informational report out to QIHEC for discussion.	3/21/2024	12/12/2024			X	X	9/19/2024 12/12/2024	Planned	Low		

16	DHCS	Health Equity Framework (2)	Valerie Martinez	Semiannual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Prepare Health Equity Frameworks as a tactical guide for business unit leaders integrating health equity into operations.	Informational report out to QIHEC for discussion.	3/21/2024	12/12/2024			X	X	9/19/2024 12/12/2024	Planned	Low		
17	NCQA	Annual Health Disparities Report	Christine Nguyen	Annual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Complete Report by July 12, 2024. Submit NCQA Health Disparities Report to demonstrate how the HEO is tracking and trending notable health disparities and advancing information in action by 9/19/2024.	Annual Review and Approval	4/1/2024	7/12/2024				X	12/12/2024	Planned	Low		
18	DHCS	**Health Equity Integration Plan** Updates per functional area: - Health Education and Cultural and Linguistics - Growth, Community Engagement, and Marketing Network - Grievances and Appeals - Utilization Management - Medical Services: Case management; Population Health Management, Maternal Management, Health Education, and Quality	Various Functional Leads	Quarterly	Embed Equity Build Sound Infrastructure and Operations Cultivate a Culture of Equity	Develop Health Equity Integration Plans and provide updates on each functional area to QIHEC by 6/20/2024, and quarterly thereafter.	Informational report out to QIHEC for discussion.	1/1/2024	12/12/2024		X	X	X	6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
19	DHCS	Health Equity Internal Engagement	Valerie Martinez	Quarterly	Embed Equity	Provide general updates to QIHEC by 3/21/2024, and quarterly thereafter.	Informational and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
20	DHCS	Health Equity External Engagement	Valerie Martinez	Quarterly	Embed Equity	Provide general updates to QIHEC by 3/21/2024, and quarterly thereafter.	Informational and report out to QIHEC.	1/1/2024	12/12/2024	X	X	X	X	3/21/2024 6/20/2024 9/19/2024 12/12/2024	Ongoing	Low		
21	DHCS, DMHC, NCQA	Culturally and Linguistically Appropriate Services (CLAS) Report	Danika Cunningham Valerie Martinez Linda Fleischman	Annual	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Submit a CLAS Report to demonstrate how the organization continually improves its services to meet the needs of multicultural populations.	Informational report out to QIHEC for discussion.	1/1/2024	12/12/2024				X	12/12/2024	Planned	Low		
22	DHCS	Member and Family Engagement Strategy	Sandra Rose	Quarterly	Embed Equity Advance Information in Action Build Sound Infrastructure and Operations	Provide general updates to QIHEC by 12/12/2024, and quarterly thereafter.	Informational report out to QIHEC for discussion.	1/1/2024	12/12/2024				X	12/12/2024	Planned	Low		

Legend	
Status	**Definition**
Complete	Presented and Approved by Committee
Planned	Future Activity
Ongoing	Ongoing Monitoring (daily, monthly, annually)

Summary of Changes	
Status	**Definition**
MM/DD/YYYY	*Briefly explains item changes*
3/21/2024	Establishment of original document
6/20/2024	Added activities, updated responsible owners and quarterly activities completed.
9/19/2024	Added activities, updated responsible owners and quarterly activities completed.
12/12/2024	Updated workplan template, activities and status. Added tabs to monitor NCQA HEA Health Disparities and CLAS written reports and activities.

Health Disparities Report (MY2023/RY2024)

Owner: Christine Nguyen and Valerie Martinez
Driver: Amie Eng

No.	Category	Findings	Recommendations	Action/Planned Intervention(s)	Date of Implementation	Progress/Status	Responsible Departments	Goal	Improvements
1	Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c poor control (>9.0%)	When reviewing performance rates by race or ethnicity, the population in Los Angeles County, overall, met the DHCS MPL (37.96%). The total population, after stratifying by race, showed that 36.96% of members were diagnosed with diabetes had poorly controlled HbA1c levels, which was 1.0 percentage points lower than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that the 37.64% of corresponding members demonstrated poorly controlled HbA1c levels, which was 0.32 percentage points lower than the MY2023 DHCS MPL, except for members who identified as “Hispanic or Latino” and the group “Unknown Ethnicity”. After stratifying by ethnicity, members who identified as Hispanic or Latino (38.08%, n=3,952) is an opportunity in Los Angeles because this category did not meet the goal of the DHCS MPL (37.96%).	Increase the number and percentage of members diagnosed with Diabetes who have controlled HbA1c levels (by decreasing the number of members with poor controlled HbA1c levels) to improve the health of our members, with an emphasis on members who identified as Hispanic or Latino in Los Angeles County	Employing tailored and culturally appropriate Diabetes management courses, offering a parallel Spanish speaking course. Offering the courses in person at Blue Shield Promise Community Resource Centers. Using heat maps to identify Hispanic or Latino members who reside in Los Angeles County to encourage attendance through mailed letters. Among Hispanic or Latino members who are assigned to a provider group with Health Navigators, encourage attendance through live calls.	7/1/2024	In Process	Quality Improvement Health Education and Cultural and Linguistics	DHCS MPL 37.96%	
2	Child and Adolescent Well Care Visits (WCV)	The lowest group that did not meet goal were Not Hispanic or Latino (42.40%) with denominator of 19,753. The group “Asked but No Answer” had a compliance rate of 40.00%, but the denominator was 5, which is lower than the reporting population requirement of 30. Similar to San Diego County observations, in Los Angeles, the group Hispanic or Latino had the greatest impact because they represent a much larger proportion of the overall denominator, highlighting the opportunity to address WCV compliance among lower scoring groups mentioned above, including White members and Black/African American members, and Native Hawaiian or Pacific Islander members.	Increase overall performance for child and adolescent well care visits, with an emphasis on Black or African American, Native Hawaiian or Other Pacific Islander members.	Well Child Clinic Days: Partnering with vendor to increase access to timely well-child visits through live calls to members who have not yet had a well-care visit, offering scheduling assistance, and hosting well child clinic days. We will also employ heat maps to identify areas/regions where a large volume of Black or African, and Native Hawaiian or Other Pacific Islander members and families live to identify new community sites for well child clinic days that are familiar to and trusted by our target population. We will also partner with our vendor to match the practitioner’s race/ethnicity to our target group’s race/ethnicity. In addition to completing the visit during the well child clinic day, the vendor will also help members complete a social driver of health (SDOH) assessment to address social needs.	11/1/2024	In Process	Quality Improvement	DHCS MPL 48.07%	
3	Child and Adolescent Well Care Visits (WCV)	The lowest scoring groups that did not meet the goal of the DHCS MPL (48.07%) included English (46.31%, n=64,967), Russian (42.75%, n=255), Vietnamese (42.43%, n=304), and Korean (35.29%, n=102). For Los Angeles County there may be opportunities to address lower WCV compliance rates among members whose preferred language are English, Russian, Vietnamese, or Korean.	Increase overall performance for child and adolescent well care visits, with an emphasis on members whose preferred language includes Vietnamese, Russian, or Korean.	Well Child Clinic Days: Partnering with a vendor to conduct tailored outreach to members who speak Vietnamese, Korean, and Spanish, helping members with limited English proficiency get appointments scheduled. Intervention includes matching members with these language preferences to customer service representatives who speak the corresponding languages. The customer service representatives will contact the member in their preferred language to help offer scheduling assistance and book appointments during the clinic days.	11/1/2024	In Process	Quality Improvement Customer Experience	DHCS MPL 48.07%	

Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation Report

Owner: Linda Fleischman and Valerie Martinez
Driver(s): Jennifer Mazariegos, Rosa Hernandez

No.	Category	Findings	Recommendations	Action/Planned Intervention(s)	Date of Implementation	Progress/Status	Responsible Departments	Goal	Improvements
1	Provider Network	When assessing the Medi-Cal networks by threshold languages, Blue Shield Promise did not meet the thresholds for the following specialty types in Los Angeles: cardiology (English and Spanish) and gastroenterology (English, Spanish and Cantonese). In San Diego, the threshold languages were not met for the following specialty types and languages: cardiology (English, Spanish and Tagalog) and gastroenterology for English and Spanish.	1.Increase the number of Spanish speaking cardiologist in Los Angeles and San Diego Counties and Spanish, and Tagalog (San Diego only) speaking gastroenterologists in Los Angeles and San Diego counties. Increasing the number of specialty providers that speak these languages will ensure our members network preferences are met and potentially will result in higher overall satisfaction. 2. Examine our internal process of how we collect and display English speaking cardiologist and gastroenterologists in Los Angeles and San Diego Counties to ensure our network language data is accurate.	Administrative Facing: 1, 2: Cross-department workgroup to be formed to review all provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline. Additionally, this team will examine our internal process for collecting and displaying English and develop a action plan based on their findings.	Quarter 1 2025	Not Started	Health Equity Quality Provider Network Provider Outreach IT Provider Contracting	8% of practitioner office staff speak at least one threshold language	
2	Grievances related to Culturally Appropriate Care for Members	Interpreter Services Results In 2023, the top-ranking languages requested for telephonic interpretation were Spanish 67%, Mandarin 8.3%, Russian 4.0%, and Vietnamese 3.0%. The use of interpretation services increased in 2023 by 36% compared to 2022.	Increase member and provider awareness of: 1. How to request an interpreter and the pre-planning timeline requirements to book this service. 2. How to request written materials be translated into the members preferred written languages. These two improvements will support our members overall satisfaction.	Member-Facing: 1. Ask members of the Community Review Committee to share their feedback on the best method of communication with them on language assistance resources.	9/1/2024	Completed	Health Equity Quality Customer Service Provider Relations	Meet 100% of interpreter requests for all languages (over the phone and in-person)	
3	Grievances related to Culturally Appropriate Care for Members	Translation Services Results From January 2023 through December 2023 there was a total of 19,632 requests for written translation services including alternative formats and 100% of those requests for translation were completed and returned to the relevant members. results show the top three requested written translation requests were Spanish (n=1,342), Russian (n=216), followed by Traditional Chinese (n=158).	Increase member and provider awareness of: 1. How to request an interpreter and the pre-planning timeline requirements to book this service. 2. How to request written materials be translated into the members preferred written languages. These two improvements will support our members overall satisfaction.	Member-Facing: 1. Ask members of the Community Review Committee to share their feedback on the best method of communication with them on language assistance resources.	9/1/2024	Completed	Health Equity Quality Customer Service Provider Relations	Meet 100% of written translation requests for all threshold languages	
3	Grievances related to Culturally Appropriate Care for Members	Blue Shield Promise had a total of 159 linguistically related grievances in 2023 through Q1 2024 and a total of 192 culturally related grievances. Most linguistically related grievances were related to the member's experience using an interpreter.	Increase member and provider awareness of: 1. How to request an interpreter and the pre-planning timeline requirements to book this service. 2. How to request written materials be translated into the members preferred written languages. These two improvements will support our members overall satisfaction.	Member-Facing: 2. Develop and disseminate a member notification on how to access language assistance services, including interpreter and translation information.	9/1/2024	Completed	Health Equity Quality Customer Service Provider Relations	Review all cultural and linguistically related grievances.	

4	Grievances related to Culturally Appropriate Care for Members	Blue Shield Promise had a total of 159 linguistically related grievances in 2023 through Q1 2024 and a total of 192 culturally related grievances. Most linguistically related grievances were related to the member's experience using an interpreter.	Increase member and provider awareness of: 1. How to request an interpreter and the pre-planning timeline requirements to book this service. 2. How to request written materials be translated into the members preferred written languages. These two improvements will support our members overall satisfaction.	Member-Facing: 3. Develop and disseminate a provider letter and online provider announcement notification including cultural awareness and linguistic resources, language assistance services, including interpreter and translations and Cultural Competency training.	10/1/2024	Completed	Health Equity Quality Customer Service Provider Relations	Review all cultural and linguistically related grievances.	
5	Grievances related to Culturally Appropriate Care for Members	Blue Shield Promise had a total of 159 linguistically related grievances in 2023 through Q1 2024 and a total of 192 culturally related grievances. Most linguistically related grievances were related to the member's experience using an interpreter.	Increase member and provider awareness of: 1. How to request an interpreter and the pre-planning timeline requirements to book this service. 2. How to request written materials be translated into the members preferred written languages. These two improvements will support our members overall satisfaction.	Administrative-Facing: 4. Setup a working session meeting to review grievance results and the current Customer Service process for asking and confirming the members preferred written language to receive material in. Based on findings a action plan will be developed and implemented.	Quarter 4 2024	Not Started	Health Equity Quality Customer Service Provider Relations	Review all cultural and linguistically related grievances.	
6	Member and Provider Race, Ethnicity, and Language Data Member Sexual Orientation and Gender Identity Data.	Lack of member and provider race, ethnicity, and language data; root cause of this insufficient data is that race and ethnicity is optional for providers to share. For both members and providers, there is a potential lack of understanding of how the Plan will utilize their data and our privacy and protection may be the underlining reasons for not sharing this information. These same potential root causes apply to why members are not sharing their sexual orientation and gender identity information.	Increase data capture for member and providers' race, ethnicity, and language information to allow for accurate network analysis and comparison to support member needs and preferences Increase data capture of member sexual orientation and gender identity data.	Member-Facing: 1.Partner with Violet (Vendor) and leverage their Health Equity provider training and other resources to encourage providers to self-identity race, ethnicity, language data.	Quarter 1 2025	In progress	Health Transformation Network Analytics Health Equity Provider Communication/Network Compliance	Achieve 80% of self-report race and ethnicity	
7	Member and Provider Race, Ethnicity, and Language Data Member Sexual Orientation and Gender Identity Data.	Lack of member and provider race, ethnicity, and language data; root cause of this insufficient data is that race and ethnicity is optional for providers to share. For both members and providers, there is a potential lack of understanding of how the Plan will utilize their data and our privacy and protection may be the underlining reasons for not sharing this information. These same potential root causes apply to why members are not sharing their sexual orientation and gender identity information.	Increase data capture for member and providers' race, ethnicity, and language information to allow for accurate network analysis and comparison to support member needs and preferences Increase data capture of member sexual orientation and gender identity data.	Member-Facing: 2.Send reminders to all providers about the importance of updating their provider profile, which includes, but not limited to race, ethnicity, and spoken languages including office staff.	Quarter 3 2024	Completed	Health Transformation Network Analytics Health Equity Provider Communication/Network Compliance	Achieve 80% of self-report race and ethnicity	

8	Member and Provider Race, Ethnicity, and Language Data Member Sexual Orientation and Gender Identity Data.	Lack of member and provider race, ethnicity, and language data; root cause of this insufficient data is that race and ethnicity is optional for providers to share. For both members and providers, there is a potential lack of understanding of how the Plan will utilize their data and our privacy and protection may be the underlining reasons for not sharing this information. These same potential root causes apply to why members are not sharing their sexual orientation and gender identity information.	Increase data capture for member and providers' race, ethnicity, and language information to allow for accurate network analysis and comparison to support member needs and preferences Increase data capture of member sexual orientation and gender identity data.	Member-Facing: 3.Send out reminders to all members regarding the privacy and protections of their race, ethnicity, and language, sexual orientation, and gender identity data and share the process for how to update their profiles.	Quarter 3 2024	Completed	Health Transformation Network Analytics Health Equity Provider Communication/Network Compliance	Achieve 80% of self-report race and ethnicity	
9	CLAS Provider Training	Lack of current web system ability quantify the number of providers that take CLAS trainings per year. The root cause is the system is configured to count based off the start date of training going live.	Improve web system ability to count the number of providers that take trainings by year instead of an accumulative total. This shift would support the Plans ability trend data and see yearly training participation rates.	Administrative-Facing: Establish meeting with IT/web team to examine system abilities to shift from accumulative to a year rate of providers who take CLAS training. The result of this meeting will include timeline for implementing the change.	Quarter 1 2025	Not Started	Quality Health Equity IT/Web	100 providers complete CLAS trainings and receive CEU units	

blue california

Promise Health Plan

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

Responsible Health Equity Office Staff

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Contents

I. Introduction and Background

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

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

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

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

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

Figure 1. California Department of Health Care Services Bold Goals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. Quality Improvement Health Equity Transformation Program Tenets

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

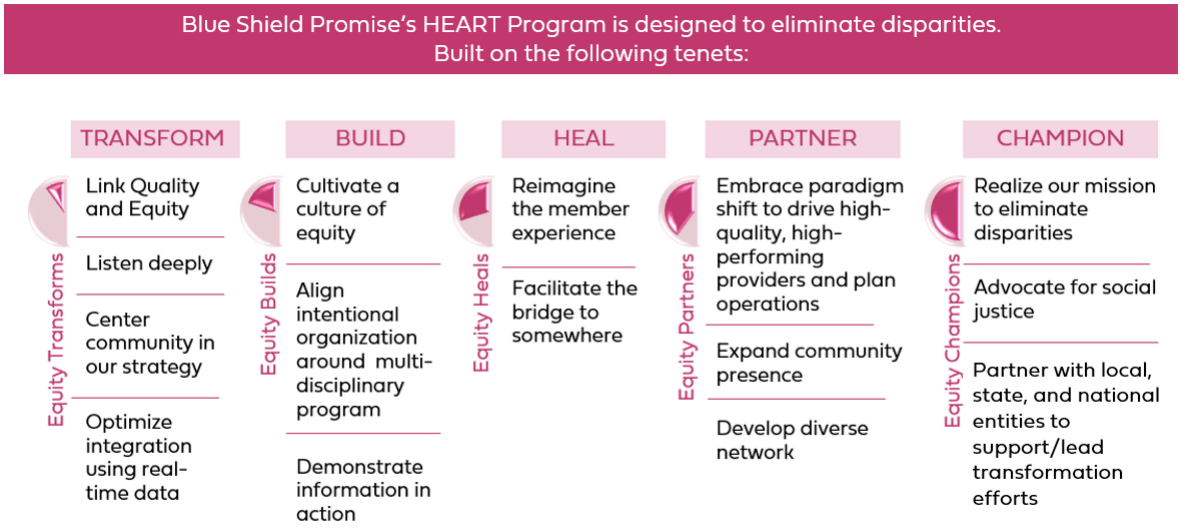

Figure 2 Health Equity Transformation Program Tenets

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

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

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

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

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

V. Activities

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

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

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

Table 1. Health Equity Strategies and Activities

VI. Health Equity Keywords

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

VII. Quality Improvement Health Equity Transformation Program Structure

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

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

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

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

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

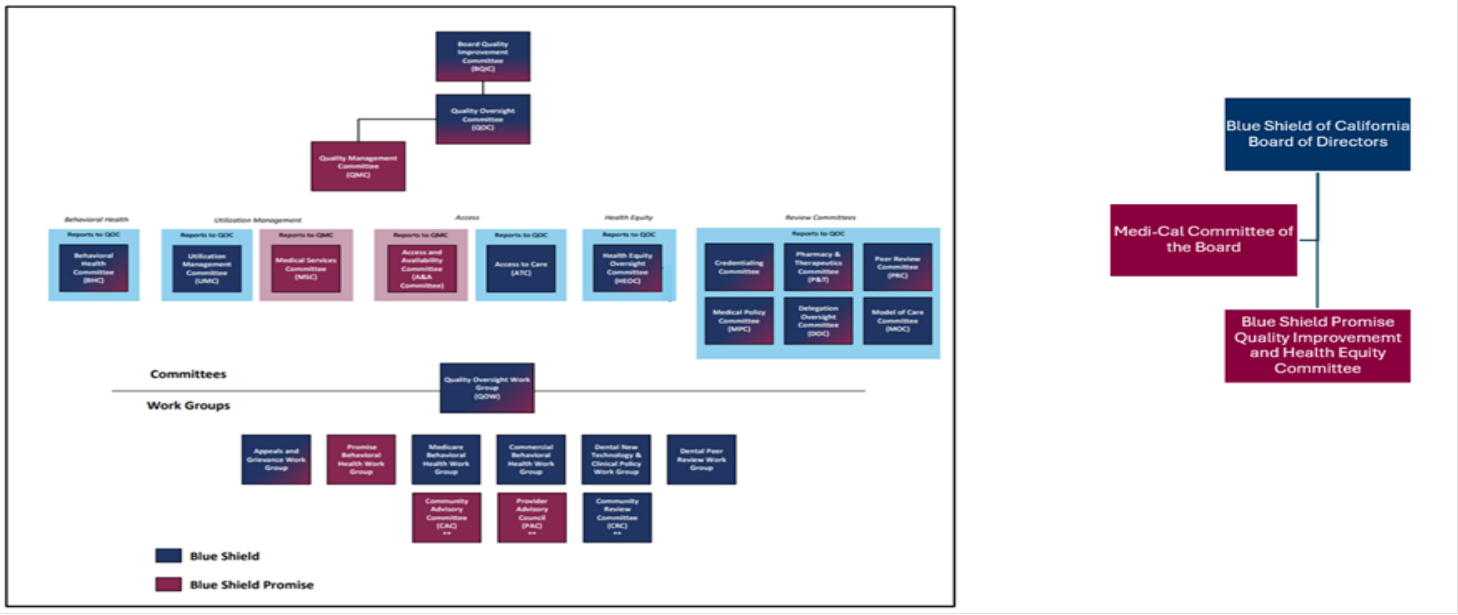

Figure 3. Quality Improvement Health Equity Transformation Program Governance Structure

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

VIII. Quality Improvement Health Equity Committee

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

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

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

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

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

Reporting

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

Membership Composition

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

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

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

IX. Executive Leadership

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

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

The HEO is comprised of the following BSCPHP leaders:

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

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

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

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

X. Quality Improvement Health Equity Transformation Program Goals and Objectives

A. Quality Improvement Health Equity Transformation Program Goals

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

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

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

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

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

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

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

Information in Action	Sound Infrastructure and Operations	Equity Embedded	Interventions that Matter
• Develop a comprehensive data strategy for stratification and analysis of health disparities • Capture and validate health equity related demographic data • Enable a simplified reporting and analytics platform that drives the delivery of equitable, whole-person care	• Formulate Health Equity Office • Establish the Office of Health Equity's 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 • Obtain NCQA Health Equity Accreditation	• Establish organiation-wide expectations that achieving health equity is everyone's responsibility • Incorporate health equity informaiton 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. Establishing a HEO that champions integration and transformation that drives Quality and Health Equity in Medi-Cal. The HEO will establish regular reporting and information

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

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

1. Advance Information in Action

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

   BSCPHP has committed to the following Information in Action strategies:

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

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

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

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

2. Sound Infrastructure and Operations

Integration

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

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

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

Health Equity Office

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

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

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

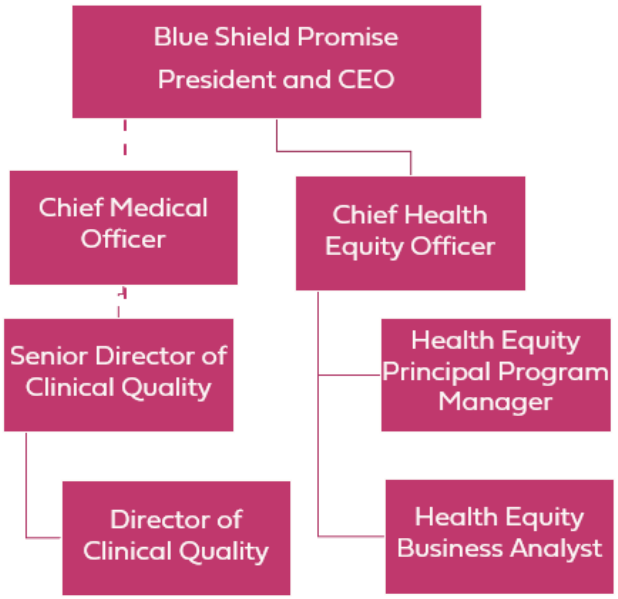

Figure 5. BSCPHP Health Plan Health Equity Office Organizational Chart

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

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

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

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

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

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

Governance

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

Policies and Procedures

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

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

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

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

Monitoring and Oversight

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

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

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

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

Accreditation

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

3. Equity Embedded

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

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

4. Interventions that Matter

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

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

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

B. QIHETP Objectives

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

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

Table 2. QIHET Program Goals and Objectives

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

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

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

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

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

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

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

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

XII. Health Equity Integration

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

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

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

The framework six domains are as follows:

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

Figure 6. Health Equity Measurement Framework for Medicaid Accountability Domains

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

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

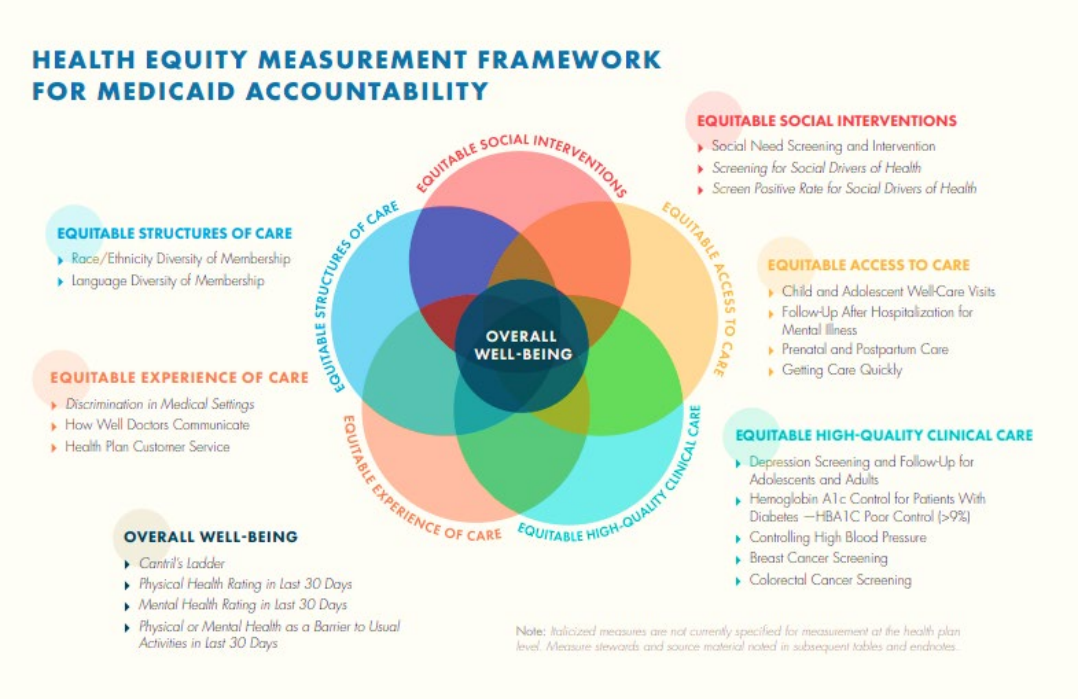

Figure 7. Health Equity Measurement Framework for Medicaid Accountability Summarized

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

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

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

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

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

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

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

A. Customer Experience

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

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

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

C. Appeals and Grievances

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

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

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

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

D. Cal Aim

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

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

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

E. Quality

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

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

F. Behavioral Health

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

G. Provider Contracting and Relations

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

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

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

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

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

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

H. Health Education and Cultural and Linguistics

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

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

I. Maternal Health

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

J. Clinical Access Programs

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

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

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

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

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

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

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

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

XIII. National Committee for Quality Assurance Health Equity Accreditation

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

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

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

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

XIV. Monitoring and Oversight

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

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

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

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

A. Priority Populations and Focus Areas

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

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

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

B. HEART Measure Set

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

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

XV. Quality Improvement Process

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

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

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

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

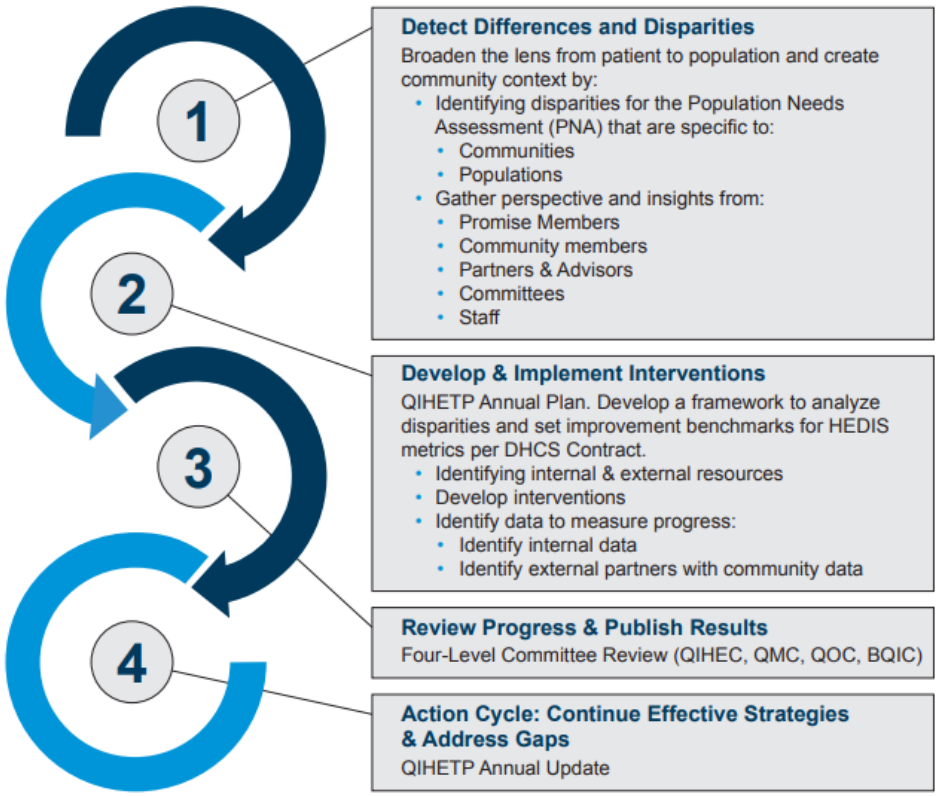

Figure 8. Principles of Continuous Quality Improvement in Action

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

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

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

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

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

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

XVI. Annual Review of the Health Equity Transformation Program Description

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

XVII. Quality Improvement and Health Equity Work Plan

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

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

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

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

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

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

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

XVIII. Annual Evaluation

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

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

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

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

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

XIX. Data Sources

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

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

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

XX. Confidentiality and Information Security

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

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

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

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

XXI. Resources

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5. California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-011: Population Needs Assessment retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
6. California Department of Managed Health Care (DMHC) APL 22-028 Health Equity and Quality Measure Set and Reporting Process retrieved from https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx
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16. Medicaid and CHIP Payment and Access Commission (MACPAC) (2022). Access in Brief: Experiences of Lesbian, Gay, Bisexual, and Transgender Medicaid Beneficiaries with

Accessing Medical and Behavioral Health Care. Retrieved from https://www.macpac.gov/wp-content/uploads/2022/06/Access-in-Brief-Experiences-in-Lesbian-Gay-Bisexual-and-Transgender-Medicaid-Beneficiaries-with-Accessing-Medical-and-Behavioral-Health-Care.pdf

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XXII. Appendices

Appendix 1. Health Equity Keywords

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

Appendix 3. Health Equity Integration Plan

Appendix 4. Quality Improvement Health Equity Transformation Program Action Plan

Appendix 1: Health Equity Keywords

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

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

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

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

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

HEART Measure Set

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

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 Dr. Manisha Sharma	Inovalon	Pending Validation	Quarterly	TBD	TBD
20	C-section rates by REGAL	C-section rates by REGAL during the measurement period	CSCTN	DMHC, DHCS	Equitable High Quality Clinical Care	Maternal Health	Dr. Manisha Sharma Nicole Evans	Tableau	Validation Complete	Quarterly	TBD	TBD
21	Pharmacotherapy for Opioid Use Disorder by REGAL	Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period	POD REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
22	Follow-Up after ED Visits for Substance Use – 30 day by REGAL	Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period	FUA REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
23	Colorectal Cancer Screening by REGAL	Percentage of adults 50–75 who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 years stratified	COL REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
24	Hemoglobin A1c Control for Patients with Diabetes by REGAL	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was <8.0% during the measurement year	HBD REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
25	Controlling High Blood Pressure by REGAL	Percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year stratified by REGAL	CBP REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
26	Child and Adolescent Well Care Visits by REGAL	Percentage of members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period stratified by REGAL	WCV REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
27	Childhood Immunization Status by REGAL	Percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA);	CIS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
28	Immunizations for Adolescents by REGAL	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and	IMA REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
29	Prenatal and Postpartum Care: Postpartum Care by (REGAL)	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery during the measurement period stratified by REGAL	PPC POST REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
30	Prenatal and Postpartum Care: Timeliness of Prenatal Care by (REGAL)	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization during the measurement period stratified by REGAL	PPC TIME REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
31	Well-Child Visits in the First 30 Months of Life by REGAL	Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their firs 15 months of life stratified by REGAL	W30 REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
32	Follow-Up After ED Visit for Mental Illness – 30 days by REGAL	Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period	FUM REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
33	Breast Cancer Screening by REGAL	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL	BCS REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD
34	Asthma Medication Ratio by REGAL	Percentage of adults and children 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year stratified by REGAL	AMR REGAL	DMHC, DHCS CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	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	Not Started	Quarterly	TBD	TBD
36	Care Management for High-Risk Members after Discharge	The total number of transitions for high-risk members during the Intake Period within a 12-month period.	PHM KPI 5	DMHC, DHCS CalAIM, NCQA	Equitable Social Interventions	Population Health Management	Ayesha Sharma	Claims Care Connect Risk Stratification ECM	Validation Complete	Quarterly	TBD	TBD
37	Populations of Focus	Percent of members stratified into each populations of focus	POF	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Claims	Pending Validation	Quarterly	TBD	TBD
38	Community Support utilization	Community support utilization by category	CS UTIL	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Claims	Pending Validation	Quarterly	TBD	TBD
39	SDOH reporting	Rate of network providers reporting SDOH codes	SDOH	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Tableau	Pending Validation	Quarterly	TBD	TBD
40	SDOH reporting by REGAL	Total number of members screened for SDOH by REGAL during the measurement period	SDOH REGAL	DHCS	Equitable Social Interventions	Social Services	Jennifer Miyamoto-Echeverria Raine Arndt-Couch	Claims, Care Connect	Not Started	Quarterly	TBD	TBD
41	PCP Staff Training	Compliance rate for all FSRs completed assessing FSR section "Site personnel receive training on member rights" performed during measurement period	PCP TRNG	DHCS	Equitable Structures of Care	Clinical Access Programs	Jesse Brennan-Cooke	Heathy Data Systems	Validation Complete	Semi Annual	TBD	TBD
42	Enrollment Growth by REGAL	Enrollment growth stratified by REGAL during the measurement period	ENR REGAL	DHCS	Equitable Structures of Care	Community Engagement	Sandra Rose	MARA Dashboard	Pending Validation	Quarterly	TBD	TBD
43	Multi-lingual staff	Total number of multi-lingual staff during the measurement period	MUL STAFF	DHCS, DMHC Language Assistance; existing measure; Threshold Language APL	Equitable Structures of Care	Customer Experience	Vivian Phillips Husband Robert Chor	Manual Report	Validation Complete	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	Validation Complete	Quarterly	TBD	TBD
45	Cultural Competency Training	Cultural competency training – internal completion rate by member-facing staff	CULT COMP TRNG	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman	LMS	Validation Complete	Annual Every Quarter 3	TBD	TBD
46	Member-facing staff representative of membership	Rate of bilingual member-facing health plan staff by language is representative o membership during the measurement period	BLNGL STF	DMHC, DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman	Manual Report	Validation Complete	Semi Annual	TBD	TBD
47	Health Education Materials	Health Education materials available in all threshold languages during the measurement period; and Percent of health ed materials	HEALTH ED	DHCS	Equitable Structures of Care	Health Education and Cultural and Linguistics	Linda Fleischman	Manual Report (Healthwise vendor)	Validation Complete	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	Ayesha Sharma	Claims Care Connect Risk Stratification	Validation Complete	Quarterly	TBD	TBD
49	CCM Enrollment Among all Eligible Members Who Were Not Already Enrolled During the Previous Measurement Period	The number of members eligible for CCM for 1 or more days within a 90-day period, excluding those members who were enrolled in CCM for 1 or more days during the previous Measurement Period.	PHM KPI 4 Rate B	DMHC, DHCS CalAIM, NCQA	Equitable Structures of Care	Population Health Management	Ayesha Sharma	Claims Care Connect Risk Stratification	Validation Complete	Quarterly	TBD	TBD
50	Provider Network by Threshold Language	Percent of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area – i.e. X% speak threshold languages (per geographic area)	PROV NTWK LANG	DHCS	Equitable Structures of Care	Provider Contracting	Melinda Kjer	PIMS or CACTUS	Not Started	Quarterly	TBD	TBD
51	Positive maternal mental health screening	Positive maternal mental health screening results by REGAL during the measurement period	MMH POS	DMHC, DHCS	Overall Well-Being	Behavioral Health	David Bond	Manual Report	Not Started	Quarterly	TBD	TBD
52	Perinatal Depression Screening	Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period	PND	DHCS; DMHC Maternal Mental Health Program	Overall Well-Being	Behavioral Health	David Bond	Inovalon	Not Started	Quarterly	TBD	TBD
53	Postpartum Depression Screening and follow-up	Percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care during the measurement period.	PDS	DHCS; DMHC Maternal Mental Health Program	Overall Well-Being	Behavioral Health	David Bond	Inovalon	Not Started	Quarterly	TBD	TBD
54	Depression Screening and Follow up for Adolescents and Adults by REGAL	Percentage of Depression Screening and Follow up for Adolescents and Adults by race, ethnicity, gender, age, and/or language (REGAL) during the measurement period	DSF REGAL	DMHC, DHCS Bold Goal, DHCS CalAIM, NCQA	Overall Well-Being	Behavioral Health Quality CalAIM	Alyson Spencer Christine Nguyen	Inovalon	Validation Complete	Quarterly	TBD	TBD

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

** This is a subset of DISC GRV

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

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

HEART Measure Set

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

Blue Shield Promise's

Health Equity Advancements Resulting in Transformation (HEART) Program

Health Equity Integration Strategy

Executive Summary

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

Prepared By: Valerie Martinez, Promise Chief Health Equity Officer

January 1, 2024

Introduction

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

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

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

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

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

Operations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

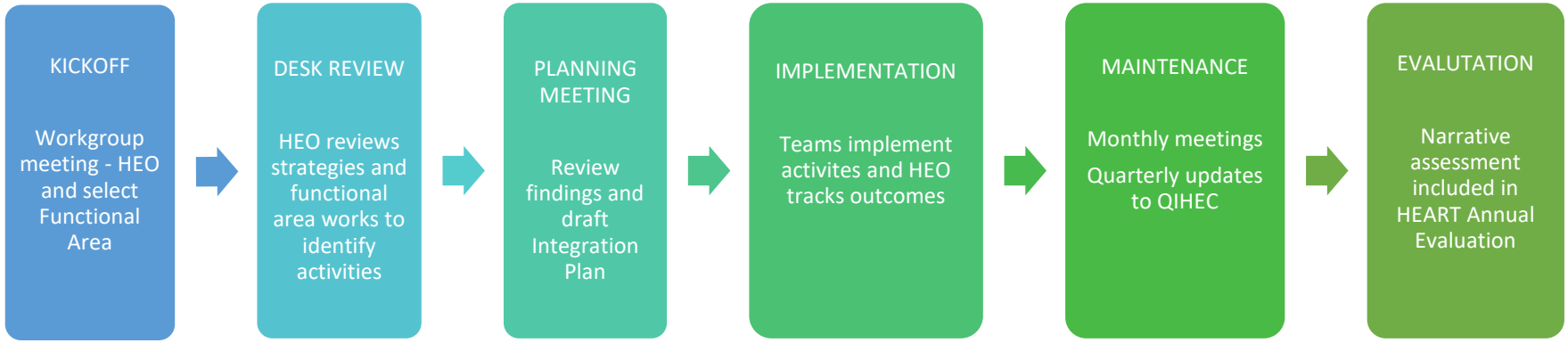
10) The Health Equity Office will provide quarterly updates at the Quality Improvement and Health Equity Committee meetings.

Review Process

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

Appendix

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



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

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

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

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

3. BSCPHP's Health Equity Guiding Principles

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

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

4. Health Equity Integration Plan

Health Equity Integration Plan (SAMPLE)										
Department: Health Education										
Key stakeholders: Insert name and title										
No.	**Health Equity Tenet Cat.**	**Health Equity Tenet**	**Activity**	**Objective**	**Actions Needed to Accomplish Activity**	**Accountable Owner**	**Key Driver**	**Due Date**	**Completion Date**	**Outcomes**
1	*Build*	*Cultivate a culture of equity*	*Staff training*	*100% of staff will complete DEI Training by 12/31/2024*	*1) Socialize requirement to staff* *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:										

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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									

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

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

Appendix 4: Quality Improvement Health Equity Transformation Program Action Plan

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

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

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

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

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

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

Health Equity Assessment: Equity and the Redetermination Process

Responsible Health Equity Office Staff

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

Name: Brigitte Lamberson, MPH
Title: Health Equity Principal Program Manager
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Contents

I. Introduction and Background

The Department of Health Care Services (DHCS) announced that due to the COVID-19 public health emergency (PHE) ending, the continuous coverage requirement would also end on March 30, 2023. This would impact about 15 million Medi-Cal members who will need to renew their Medi-Cal coverage over the next year. Redetermination of Medi-Cal coverage was previously on hold due to the Consolidated Appropriations Act, which established continuous Medi-Cal coverage requirements for beneficiaries during the public health emergency. Beneficiaries had active coverage regardless of any changes in circumstances while this act was in place. The Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan was updated in March 2023 to include policy changes and resumption of redetermination operations for Medi-Cal coverage.

Due to the significant impacts this will bring to the Medi-Cal program, DHCS provided a timeline on the unwinding activities. While the continuous coverage requirements end, annual renewals for all beneficiaries will occur on their next normally scheduled annual renewal date. Renewal activities began on April 1, 2023, for beneficiaries with a July 2023 renewal date and will continue for each respective month following. This will continue on an annual basis and the redetermination process generally takes up to three months to determine eligibility.

Beneficiaries were notified via mail regarding their Medi-Cal eligibility and requirements to submit a renewal form by mail, phone, in person, or online to avoid losing coverage, which can result in potential gaps in care. Beneficiaries also had the option to create or check BenfitsCal to get alerts about their eligibility status.

The following criteria is included on the renewal form to establish basic eligibility requirements:

- Income, expenses, deductions
- Address
- Review and update household information
- Supporting documents

To support continuity of coverage and access to care, Blue Shield Promise launched a variety of redetermination activities through various outreach channels to support members and raise awareness about the steps needed to renew their Medi-Cal coverage.

II. Key Findings

Blue Shield Promise ended 2023 with 48,000 members favorable to plan and nearly 290,000 (55%) of members completed the redetermination process. The plan achieved a 80% redetermination rate, compared to:

- 79% State
- 74% LA Care
- 77.7% LA County
- 77.1% San Diego County

County	Retention Rate 2023 (Promise Book of Business Assumption)	Retention Rate (Mbrs w/June 2023 renewal)	Retention Rate (Mbrs w/July 2023 renewal)	Retention Rate (Mbrs w/Aug 2023 renewal)	Retention Rate (Mbrs w/Sept 2023 renewal)
Los Angeles- Spanish	80%	**83%**	**79%**	**79%**	**81%**
San Diego- Spanish	76%	**79%**	**80%**	**81%**	**84%**

Per LA Times, it was reported that over 50% of people disenrolled from Medi-Cal from June through October 2023 were Latino. Disenrollments were primarily for procedural reasons.

Promise's redetermination retention rate among Spanish speaking members is 81%.

Promise's redetermination retention rate among children and families is 83%.

With the LA times article and over 40% of Promise population in LA are Spanish speaking members, this is a highlight for Promise from health equity lens for redetermination retentions.

III. Redetermination Process

Review of Process

The Blue Shield Promise Community and Provider Engagement Department developed and piloted an innovative algorithm to prioritize outreach for populations at disproportionate risk for disenrollment based on criteria such as;

- Housing insecurity and homelessness
- Members with a senior and People with Disabilities (SPD's) aid code.
- Household's with a child under 17 years of age
- Spanish speaking members
- Households with 3 or more people
- Households within 3 miles of a Community Resource Center

Results

Ethnicity

Line of Business	Measure	Average monthly Promise members going through redetermination	Redetermination retention rate (%)
MEDI-CAL LA	HISPANIC/LATINO	6487	78.8%
MEDI-CAL LA	NOT HISPANIC/LATINO	5418	78.4%
MEDI-CAL LA	UNKNOWN	18489	79.8%
MEDI-CAL SD	HISPANIC/LATINO	2811	83.2%
MEDI-CAL SD	NOT HISPANIC/LATINO	2903	79.0%
MEDI-CAL SD	UNKNOWN	4565	78.1%

Race

Line of Business	Measure	Average monthly Promise members going through redetermination	Redetermination retention rate (%)
MEDI-CAL LA	BLACK (AFRICAN AMERICAN)	2115	83.2%
MEDI-CAL LA	HISPANIC/LATINO	6482	78.8%
MEDI-CAL LA	NOT ASSIGNED	3741	74.5%
MEDI-CAL LA	OTHER (SPECIFY)	13903	81.4%
MEDI-CAL LA	WHITE (CAUCASIAN)	1635	74.2%
MEDI-CAL SD	BLACK (AFRICAN AMERICAN)	456	81.9%
MEDI-CAL SD	HISPANIC/LATINO	2808	83.2%
MEDI-CAL SD	NOT ASSIGNED	1752	74.8%
MEDI-CAL SD	OTHER (SPECIFY)	2395	78.6%
MEDI-CAL SD	WHITE (CAUCASIAN)	1789	78.3%

Language

Line of Business	Measure	Average monthly Promise members going through redetermination	Redetermination retention rate (%)
MEDI-CAL LA	ENGLISH	15121	79.1%
MEDI-CAL LA	NOT ASSIGNED	2057	74.5%
MEDI-CAL LA	RUSSIAN	105	78.4%
MEDI-CAL LA	SPANISH	12303	80.5%
MEDI-CAL LA	VIETNAMESE	152	80.7%
MEDI-CAL SD	ENGLISH	6410	79.9%
MEDI-CAL SD	NOT ASSIGNED	1619	76.2%
MEDI-CAL SD	RUSSIAN	37	84.3%
MEDI-CAL SD	SPANISH	1939	81.7%
MEDI-CAL SD	VIETNAMESE	55	83.5%

Age

Line of Business	Measure	Average monthly Promise members going through redetermination	Redetermination retention rate (%)
MEDI-CAL LA	0-18	14011	85.4%
MEDI-CAL LA	19-34	7745	72.6%
MEDI-CAL LA	35-44	2395	73.6%
MEDI-CAL LA	45-54	2447	76.5%
MEDI-CAL LA	55+	3795	76.0%
MEDI-CAL SD	0-18	2610	88.1%
MEDI-CAL SD	19-34	2892	75.5%
MEDI-CAL SD	35-44	1323	76.4%
MEDI-CAL SD	45-54	1011	79.4%
MEDI-CAL SD	55+	2443	77.8%

Conclusion

These results will be presented to Blue Shield Promise's Quality Improvement and Health Equity Committee (QIHEC). Additionally, quarterly monitoring reports of stratified HEDIS® measures will be presented to the QIHEC for continued monitoring and oversight of disparities. Actions will be taken as advised by the QIHEC. Actions may include presenting results to the Provider Advisory Committee and Member Advisory Committee to gather feedback and recommendations. Subsequent detailed analysis of final HEDIS® rates will be performed in 2024 and presented to the QIHEC.

IV. References

1. LA Times Article - Opinion: California's great strides in Medi-Cal expansion are threatened by system inefficiencies - Los Angeles Times (latimes.com)

Health Equity Assessment Report

The Member Journey:
Assessing Health Equity Opportunities.

An Adaptation from the Health Equity Recommendations Report-Member Journey as prepared by Aarete Management and Technology Consulting Firm

Date: September 11, 2024

Prepared By:
Valerie Martinez, Promise Chief Health Equity Officer
Alexis Duke, Health Equity Business Analyst

Table of Contents

Executive Summary

BSCPHP's Health Equity Office seeks to better understand opportunities to improve member experiences with health care and the health plan from an equitable perspective. Blue Shield Promise Health Plan's (BSCPHP) Health Equity Office partnered with AArete, a consulting firm, to assess bright spots and pain points members may experience as they navigate their healthcare journey.

The AArete team conducted interviews with leaders across Blue Shield Promise. The interviews provided a variety of insights into the member experience. Findings will be used to identify opportunities to integrate a health equity lens into program design, policy development, and operations.

Key findings.

Bright spots for the adult population include:

- Reliable non-emergency medical transportation (NEMT)
- Timely translation services
- A responsive and helpful Member services team
- In-person support at community resource centers (CRCs)
- Well-trained and diverse Care Management and Social Services teams
- Increased Member Satisfaction from non-mandated/value-added benefits provided by Blue Shield Promise

Bright spots for members under age 21 include:

- Access to programs like CCS, DDS, and
- Medi-Cal for Kids and Teens,
- Increased care coordination
- Support from regional centers

Key pain points include:

- Unawareness surrounding NEMT
- Inability to use NEMT to travel to CRCs
- Lack of CRCs in San Diego,
- Inconsistent CRC capabilities,
- Lack of provider data synchronization (leading to scheduling errors)
- long wait times to see a provider
- Provider shortages in rural areas
- General lack of understanding around Medi-Cal coverage
- Overwhelming and confusing involvement of CCS and DDS

- Inconsistent regional center capabilities,
- Speech therapist shortages,
- Lack of coordination when aging out of CCS.

The following narrative is an extract from AArete's final report.

Methodology

Limitations & Caveats

While describing the insights gained from leadership within BSCPHP, this report also attempts to highlight the limitations and assumptions connected to these findings. Supporting data drawn from cited sources reinforce the findings gathered from stakeholder interviews.

Interview Methodology

The Aarete team interviewed staff from the following business areas. Citations are noted throughout the report to indicate feedback from the various business areas.

Citation	Business Area
1	Community Resource Centers (LA)
2	Eligibility & Enrollment
3	Member Services/Customer Care
4	Member Experience (Product Strategy)
5	Case Management
6	Children's Services
7	Social Services
8	Clinical Access Programs
9	Member Advisory Committee

Below are questions the AArete team asked the stakeholders during the interviews.
Note: not all questions listed below were asked of every stakeholder and follow-up questions and/or discussions may have differed from what's listed below.

1. What are common pain points in Member's experience? What are some challenges for Members as they engage with the Plan, their providers, or as they accessing services?
2. What are the most impactful barriers to accessing services for members in your functional area?
3. How does your area ensure Members have equal access? (consider language, location, Member's cultural needs, etc.) Are we working to remove barriers or do our policies impede access/utilization? For example, hours of operation can impact someone who works 9-5 and cannot make a call or visit a provider during those times
4. How does your area make business decisions to account for changing Member needs (cultural, linguistic, etc.)?
5. How does your area learn of common member needs in any interactions? For example, hearing reports of transportation needs, food, or housing.

Cited Sources

1. The Medi-Cal Maze: Why Many Eligible Californians Don't Enroll by California Health Care Foundation
2. Net Promotor Score Survey Findings and Member Responses
3. 2023 HEART Measure Data
4. CAHPS Reporting Year 2023 results

The goal of developing the Member journey maps was to leverage a human-centered design approach. AArete conducted internal stakeholder interviews with approximately 20 different business unit leaders and staff at Blue Shield Promise to develop the Member journey maps outlined in this report. Member interviews were not conducted at this time.

While all findings described below relate primarily to the Member experience, some have a plan-centric bias because of the methodology utilized. Interviewing plan leaders about the Member's perspective naturally slants findings towards what these leaders have line of sight into.

The Member journey maps were developed utilizing a "hypothesis-first" approach. Development of member journey maps was based on the existing knowledge of AArete's garnered experience with Blue Shield Promise and history of working with Medicaid plans. In addition, the maps were based on the existing knowledge and assumptions gathered during the stakeholder interviews with Blue Shield Promise leaders.

The qualitative methodologies utilized to develop these Member journey maps seek to develop insight and direction. These Member journey maps can be enhanced by leveraging additional internal and external data sources and conducting more interviews with Blue Shield Promise stakeholders and Members. Due to the methods used, these Member journey maps are exploratory in nature.

Assessing Stages of the Medi-Cal Member Journey

The Aarete team designed a model depicting the stages of the member journey for children and adults. Each stage was assessed to understand emotions, touchpoints, bright spots and pain points members may encounter. The following graphic depicts the four stages of the member journey.

1. **Eligibility and Enrollment.** During the eligibility and enrollment stage, members complete an application and the process to enroll may take up to 45 days before a health plan is assigned. This process is a critical source of demographic data.
2. **Understanding Benefits**. Once enrolled, members are provided with a member handbook, or Explanation of Benefits, to explain Medi-Cal benefits.

3. **Accessing and Utilizing Care.** Members access care including preventive, urgent, emergency care.
4. **Health Outcomes.** Health plans report health outcomes via various quality metrics. These measures are assigned by regulatory and/or accreditation agencies.

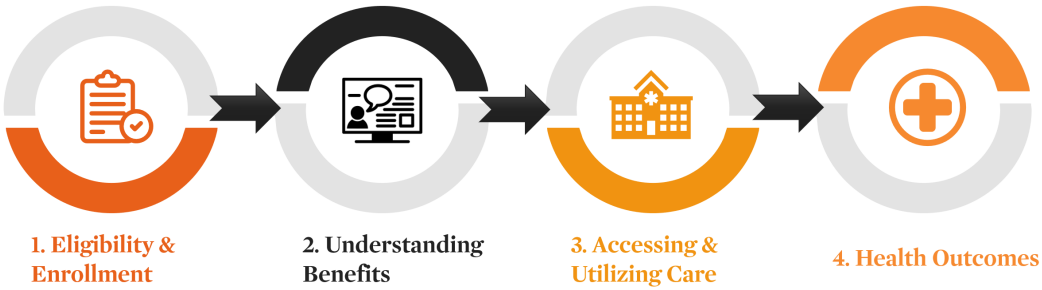

Figure 1. Stages of the Member Journey

Equity and stages of the member journey

Demographic data is collected during the enrollment process. This is a critical step to collecting member information such as race, ethnicity, age, address or geographic region, and gender. Data completeness supports disparity analysis to identify inequities. Members experience challenges understanding their Medi-Cal benefits. Health equity gaps such as literacy and/or linguistic needs compound this understanding. Access to care is impacted by members experiencing health inequities. Population health efforts will create an infrastructure to facilitate improved health outcomes. Recent requirements to stratify quality metrics employ an equity approach to assessing and addressing disparities and inequities.

Findings

The following findings are separated into the adult and members under age 21 journey map.

Adult Member Journey Details by Journey Stage

1. Eligibility & Enrollment: Adult Member Journey

Emotions

Members currently have a confusing eligibility and enrollment experience and are not fully aware of the information they must provide during the process. This results in Blue Shield Promise (BSP) obtaining inaccurate Member data (e.g., phone numbers, addresses) which contributes to unequal access and connection to the plan. There are flexible enrollment modalities for Medi-Cal. However, a lengthy enrollment process (traditional process takes up to 45 days) and resources provided to Members (e.g., Welcome Materials) may leave Members with unanswered questions. Lastly, Members prefer to have access to in-person enrollment assistance. However, that may not always be readily available for Members.

Member Actions

- Eligible Members enroll in Medi-Cal through preferred modality (online, in-person, phone, or mail)

- Members select or are assigned to Blue Shield Promise
- Members receive Welcome Kit and Medi-Cal Member ID in the mail [2]
- Members receive Welcome Call from BSP Member Services [3]

Touchpoints

- Los Angeles Members enroll with the County Department of Public Services
- San Diego Members enroll with the County Health and Human Services Agency
- New Blue Shield Promise Members receive a Welcome Call and Welcome Kit that explains their coverage and connects them to the plan [2, 3]

Bright Spots

- A variety of modalities are available for enrollment for Members in both counties
- Members are sent their Welcome Kit and Medi-Cal ID within 7 days of Blue Shield Promise receiving their data from the Department of Health Care Services (DHCS) and LA Care [2]
- The timely enrollment process once data is received enables BSP to quickly connect Members to services [2]
- The Welcome Call Members receive allows them to interact with a real person, ask questions, and understand their coverage [3]

Pain Points

- Some Members (e.g., unsheltered Members experiencing homelessness) must rely on a P.O. box for mail. This adds difficulty to receiving Welcome Materials and Member ID cards and creates barriers for Members who do not have a permanent address [2]
- Member data is often inaccurate, delaying enrollment for those without a phone number or mailing address [2, 3, 5]
- Members without a phone number or with limited minutes cannot receive a Welcome Call from Member Services, preventing these Members from understanding their coverage and having the opportunity to ask questions [3, 5]
- The enrollment portal creates administrative burden for community-based organizations, disincentivizing enrollment for Members that utilize these locations [9]
- PCP auto assignment often results in Members receiving a provider they did not ask for or a provider that refuses to see the Member upon arrival [4]
- Individuals without satisfactory immigration status may feel hesitant to share data with Blue Shield Promise or otherwise engage with the plan out of fear that their immigration status may be affected [10]

Supporting Data

- See the Net Promotor Score Survey Member responses. Many Members feel dissatisfied with the provider they have been assigned to and have trouble switching to a provider they prefer

Assumptions

- The findings above describe the enrollment process once Blue Shield Promise is involved. As source 10 describes, there are many other problems with the enrollment process that occur prior to Blue Shield Promise involvement including confusing application instructions, difficulty providing eligibility, hesitation to apply, and long delays in eligibility determinations. Please see source 10 for additional details
- Member enrollment is processed quickly once Member data is received, but this process is dependent upon the receipt of data in a timely manner. LA Care often has more delays than DHCS in getting data to Blue Shield Promise, and Members may attribute delays outside of Promise's control to the plan. The findings above that Member data are processed quickly therefore only hold from the Member perspective if LA Care and DHCS are timely in sending new Member data [2]

2. Understanding Benefits: Adult Member Journey

Emotions

Members have a neutral experience understanding their coverage. This experience varies by the Member's location, access to a CRC, and access to reliable transportation. Those with a CRC nearby feel well supported, but those without access to a CRC may remain confused about their benefits and unable to navigate the Blue Shield Promise website to learn more.

Member Actions

- Members can call Member Services with questions about coverage [2, 3]
- Members can visit a local CRC or FQHC (if available) for in-person guidance and support, building trusted relationships with healthcare representatives, Community Health Advocates, or Community Health Workers in the community [1, 9]
- Members can visit the Blue Shield Promise website for additional information and resources
- Members participate in initial health screenings (such as their Initial Health Appointment or a Health Information Form) that help inform their health needs, leading to discussions about the care they will receive

Touchpoints

- Calling Member Services, as needed [2, 3]
- Visiting a Community Resource Center (CRC) [1, 9]
- Visiting a Federally Qualified Health Center (FQHC) or another Community Based Organization (CBO)
- Visiting the Blue Shield Promise Website
- Asking questions with their assigned care management (ECM, CCM, CHW, etc.), if applicable

Bright Spots

- CRCs allow Members to develop a relationship with someone (usually bilingual staff) who lives in the community and can answer questions about their coverage. These trusted relationships make the Member feel they have direct access to Blue Shield Promise [1, 4, 9]
- The language translation vendor through BSP Member Services is typically fast and reliable and resolves issues quickly. This ensures that Members who are not fluent in English can easily access Member Services in their native language [3]
- The Member Services line is fast and responsive with little to no wait time to be connected to a real person, even during peak hours [3]
- Welcome Materials are available in multiple languages, ensuring equitable access by language

Pain Points

- The BSP website is difficult for Members to navigate and understand, preventing them from finding their needed support [4]
- Medi-Cal Members may lack reliable access to internet creating a barrier to learning more about plan coverage on their own
- Members can access the internet at nearby CRCs to access BSP resources. However, Members without transportation cannot use NEMT to travel to CRCs, making these resources more inaccessible for these Members [1]
- San Diego does not have CRCs, creating a gap between counties in the level of support Members can directly receive from BSP [1, 4]
- Not all CRCs have the same capabilities (e.g., bilingual staff, connections in the community, classes/resources, etc.) [1]
- Many Members do not understand the importance of preventive care and avoid seeing their PCP or any doctor until they are very ill [8]
- Members that rely on FQHCs (Members in San Diego) likely see different doctors each visit, making it difficult to develop trust [4]
- Members do not always understand their benefits, even with the support described above. [1, 3, 8, 9] Some Members, for example, feel the need to schedule appointments with their doctor to request over-the-counter drugs further leading to inefficiencies and access issues. [4] Welcome Materials are sometimes seen as overwhelming [4]

Supporting Data

- Promotor scores are higher around a three-mile radius of CRCs, indicating CRCs improve Member satisfaction [4]
- San Diego sees slightly lower satisfaction scores than Los Angeles, but the Member Experience team attributes this to more parents in LA filling out the form on behalf of children. This care is more meaningful to Members [4]

- Members click off a Blue Shield Promise page after an average of two minutes. This means Members likely feel overwhelmed and give up on searching the website [4]
- HEART Measure 6 – Interpreter services were used by Members 1,122 times in Q3 2023 and 620 times in Q4 2023 for 26 different languages, demonstrating Member's equal access to Blue Shield Promise resources regardless of language
- HEART Measure 7 – 178 documents were translated into 30 different languages in Q4 of 2023
- HEART Measure 16 – Q3 2023 saw only 7 grievances related to interpreter services and 20 related to discrimination
- HEART Measure 49 – Blue Shield Promise has 54 bilingual customer service staff members
- HEART Measure 50 – The Call Center handled ~68,000 bilingual calls in the Member's preferred language in Q3 2023
- HEART Measure 53 – 46.48% of all Blue Shield Promise health education materials have been translated into all threshold languages as of Q2 2023
- CAHPS Reporting Year 2023 – 'Customer Service' is one of Blue Shield Promise's top three performing measures in both Los Angeles and San Diego, for the adult population

Assumptions

Many of the findings in this section are contingent upon the Member having access to a CRC. This requires Members to have a CRC nearby, CRC resources in their language, and reliable access to transportation. Members that do not have all three of these conditions cannot utilize the CRCs as easily

Access & Utilizing Care: Adult Member Journey

Emotions

Members have a negative experience accessing care. Many Members have long wait times between completing enrollment and seeing a doctor. This is amplified for Members in rural areas or "provider deserts." Members that have an appointment scheduled run into issues with transpiration and/or scheduling conflicts resulting from inaccurate provider data. As a result, Members may feel impatient and feel like they are not a priority.

Member Actions

- Members are assigned a Primary Care Provider (PCP) near their place of residence and attend their first appointment
- Members may be referred to necessary specialists to seek additional care if needed
- Members are connected to an appropriate level of care management (Enhanced Care Management, Complex Case Management, Community Health Worker, etc.), if needed and desired
- Members may receive higher level of care (e.g., hospital admission), if needed

Touchpoints

- Their initial PCP appointment
- Their annual PCP visits
- Support from their Care Manager (as applicable)
- Specialty Provider Visits (as applicable)
- Non-Emergency Medical Transportation (NEMT)

Bright Spots

- Members can select providers based on name, gender, and language in the "Find-A-Doctor" portal, allowing Members to align with their provider on these identities [5]
- NEMT provider is reliable for Members that are aware of the benefit [3, 8]
- The Care Management and Social Services teams are diverse, knowledgeable about their communities, and well trained in cultural sensitivity, making Members feel that BSP appreciates their cultural background and can connect with their identity and personal needs [7]

Pain Points

- Provider data is not always synchronized, leading to scheduling errors or Members being denied care upon arrival [3, 8]
- Members are not always aware of NEMT when transportation barriers may exist for these Members [5, 8]
- Members wait a long time to be connected to a provider [1, 3, 5]
- Members schedule appointments with providers but upon arrival are told the provider is not in-network resulting in a surprise out-of-network bill for the Member [3, 4]
- Members in rural areas are often connected to providers far away and face shortages of providers (specialists in particular), creating large barriers to access for these Members [1, 4, 5, 8]
- Members cannot select providers of similar race or ethnicity (information often left omitted on the "Find-A-Doctor" portal), causing Members to feel they cannot connect with their care managers or providers appropriately [5]
- Members with jobs that lack flexibility (e.g., time off/PTO) are often unable to attend available appointments [8]
- Medi-Cal Members move residences often and have difficulty switching providers, creating a barrier to access for those with unstable housing or employment [3]

Supporting Data

- The Member Experience team found no large disconnect between a Member's demographics and who they were assigned to for care [4]
- Member satisfaction is lower in rural areas because of the lack of providers [4]
- HEART Measure 13 – 69% of adults in Los Angeles and 72% of Adults in San Deigo feel they are getting care quickly

- HEART Measure 51 – 92% of Member-facing staff completed the "Cultural Competence and Humility" and "Providing Language Assistance" trainings as of Q3 2023
- CAHPS Reporting Year 2023 – 'Getting Care Quickly' is one of Blue Shield Promise's bottom three performing measures in both Los Angeles and San Diego, for both the child and adult populations
- See the Net Promotor Score Survey Member responses in the Appendix. Some Members describe waiting a long time to see a provider, getting assigned a provider far away, or getting assigned to a provider who said they would not accept them as a patient

3. Member Health Outcomes & Satisfaction: Adult Member Journey

Emotions

Members feel positive overall about improving their health with Blue Shield Promise. Overall plan satisfaction is high, and it increases for Members utilizing the extra benefits Blue Shield Promise offers. Strong care coordination can ensure Members feel supported, even when third party providers lack empathy or cultural sensitivity. With this support, Members feel appreciated.

Member Actions

- Members see improved health outcomes and better health literacy
- Members have more autonomy over their health and feel empowered to take control of their care and seek additional resources
- Members continue seeking care on a consistent/regular basis

Touchpoints

- Assigned PCP/Providers
- Member Services
- Appeals and Grievances
- Lifestyle Medicine, as needed (e.g., Health Education, Disease Management)

Bright Spots

- Members' satisfaction increases with the more benefits they are aware of. This effect is especially prevalent when Members learn of non-mandated/value-added benefits, such as Blue Shield Promise's GED Works program [4]
- Members using care the most are the most satisfied, and typically have the best health outcomes [4]
- Blue Shield Promise scores well in overall satisfaction [4]
- Care Management guides Members through their care and ensure they feel supported, even when Members must access benefits that are carved out of the plan [6]

Pain Points

- Providers that lack empathy or cultural sensitivity can make Members feel unheard [4, 6]

- If a provider fails to collect the Members' Medi-Cal IDs, these Members may incorrectly receive a bill for the services rendered, creating unforeseen financial stress for Members [3]
- Providers lacking cultural competency may contribute to lack of trust and motivation among Members to utilize their benefits
- Some Members are confused about their coverage and worry they will receive a bill if they seek care. [10] This hesitation prevents these Members from seeking the care they need when they need it [8]
- Dissatisfaction with carved-out benefits is often attributed to Blue Shield Promise [4]
- Members with worse health outcomes drive negative plan perception [4]

Supporting Data

- CAHPS Reporting Year 2023 – Member satisfaction with the plan is directly correlated with their overall health
- There is a perception among potential Members that Medi-Cal provides poorer coverage and less respectful treatment that other types of insurance [10]

Assumptions

- The finding that Members lose trust and motivation when their providers lack cultural competency is based on anecdotal evidence

Children & Adolescents Member Journey Details by Journey Stage

1. Eligibility & Enrollment: Children & Adolescents Member Journey

Member Emotions

Members under 21 currently have a confusing enrollment experience. In addition to the challenges faced by adult Members, Members under 21 face an added layer of complexity with the involvement of CCS and DDS. This does result in additional benefits available to these Members (which improves satisfaction), but the complexity may make the enrollment process feel long and confusing

Member Actions

- Eligible Members are enrolled in Medi-Cal through preferred modality
- Members select or are assigned to Blue Shield Promise (BSP)
- Members receive Welcome Kit and Medi-Cal Member ID in the mail [2]
- Members and their parents/guardians receive Welcome Call from BSP Member Services [3]
- Eligible Members are enrolled in California Children's Services (CCS) or the Department of Developmental Services (DDS), as applicable and dependent on Members' diagnoses

Touchpoints

- Los Angeles Members enroll with the County Department of Public Services
- San Diego Members enroll with the County Health and Human Services Agency

- New Blue Shield Promise Members receive a Welcome Call and Welcome Kit that explains their coverage and connects them to the plan [2, 3]
- Members eligible for CCS are connected to their CCS Care Manager who explains CCS's role in supporting their care [6]
- Members eligible for DDS are connected to the necessary Early Intervention or Early Start (EI/ES) program at their nearest regional center

Bright Spots

- Members under 21 have access to many additional programs tailored to providing them with the best care possible. Members that require CCS and DDS are connected to these state programs, but all Members under 21 have additional benefits with Blue Shield Promise under Medi-Cal for Kids and Teens (e.g., Child Health and Disability Prevention Program (CHDP), Early Periodic Screening, Diagnostic, and Treatment (EPSDT), etc.)

Pain Points

- Members under 21 often have inaccurate or missing phone number and address data, delaying their enrollment and reducing their access to and support from Blue Shield Promise. [2, 3, 5, 6] This data gap may be particularly large with Members under 21 due to hesitation from parents and guardians in sharing their child's data
- Members under 21 may feel that the enrollment process is particularly long since they may be enrolled in another program (CCS or DDS) after completing their enrollment with Promise. This added complexity contributes to Members under 21 feeling overwhelmed or confused about their coverage

Supporting Data

- HEART Measure 18 – The EPSDT utilization gap is 61% in Los Angeles and 62% in San Diego as of Q3 2023

Assumptions

- AArete is assuming parents and guardians are more protective of their children's data
- These finding also assume Members are aware of additional programs like CCS and DDS and that Medi-Cal for Kids and Teens educational efforts have been successful. Members that have not heard of these programs could not take advantage of the benefits
- AArete is assuming Members feel the enrollment process feels longer for Members under 21. This is based on the findings that Members under 21 and their parents/guardians feel overwhelmed by the involvement of CCS and DDS and other additional programs. The added complexity can make Members feel their enrollment process is not actually over when they become a Member

2. Understanding Benefits: Children & Adolescents Member Journey

Emotions

Members under 21 have a neutral experience understanding their coverage. This experience varies greatly by the Members location, access to a CRC, access to a regional center, and access to reliable transportation. How well a Member feels supported may vary by the quality of resource center or access to a CRC

Member Actions

- Members and their parents/guardians can call Member Services with questions about coverage [2, 3]
- Members can visit CRC or FQHC (if available) for in-person guidance and support, building trusted relationships with healthcare representatives Community Health Advocates, or Community Health Workers in the community [1, 9]
- Members can visit the Blue Shield Promise website for additional resources
- Members under 21 participate in the standard initial health screenings (e.g., Initial Health Appointment, Health Information Form) but also have access to all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or Medi-Cal for Kids and Teens services. These additional screenings help inform the Member of available services and benefits.

Touchpoints

- Calling Member Services, as needed [2, 3]
- Visiting a Regional Center for potential Developmental Disability Services, as applicable [6]
- Visiting a Community Resource Center (CRC) [1, 9]
- Visiting a Federally Qualified Health Center (FQHC)
- Visiting the Blue Shield Promise Website
  Receiving Medi-Cal for Kids and Teens educational materials from Blue Shield Promise
-

Bright Spots

- Members in CCS or DDS have access to care management services, enhancing their coordination of care [6]
- Members under 21 have access to more screenings and diagnostic tests, allowing them to better inform their treatment
- Community Resources Centers and Regional Centers provide vital face-to-face support for Members under 21 and their parents/guardians. [1, 6, 9] Access to these locations can help Members and their families understand their coverage and have their questions answered. CRCs provide many resources for Members with children including new parent classes and free diaper giveaways [1, 4]

Pain Points

- Members under 21 and their parents/guardians may feel overwhelmed. For Members enrolled in CCS and DDS, they will receive additional phone calls and other contact from the state, in addition to contact from Blue Shield Promise. With more entities

participating in the care of these Members, some Members may feel overwhelmed and disengage with the plan and any attempts to contact them [6]

- San Diego does not have CRCs, preventing Members under 21 and their parents/guardians from accessing this important support. [1, 4] This can be particularly harmful given the complexity of care for Members under 21
- Regional centers, much like CRCs, have inconsistent capabilities. Specifically, Regional Centers vary greatly in their ability to make appropriate referrals. Which Regional Center a Member is accessing can therefore determine how effective their support is [6]

Supporting Data

- Because of inaccurate or missing contact information and Member abrasion, Promise has roughly 3,400 Members under the age of 21 that cannot be reached, and the plan is only able to engage with 826 of the 6,199 Members enrolled in CCS or a regional center [6]

Assumptions

- Members without a nearby CRC or regional center cannot utilize these facilities. Additionally, Members cannot benefit from these locations without resources in their preferred language or reliable access to transportation
- AArete is assuming the care coordination facilitated by CCS is high quality and helpful to the Member. While interview findings support this finding, it is dependent on the quality-of-care management available

3. Access & Utilizing Care: Children & Adolescents Member Journey

Emotions

Members under 21 may have negative experiences accessing care. Although Medi-Cal for Kids and Teens makes it significantly easier to access the necessary treatment, Members under 21 are particularly sensitive to delays in care given the time-sensitive nature of early intervention and developmental needs. Delays in connecting to care and shortages of providers (speech therapists in particular) create disproportionate stress for Members under 21. Coordination of care with IPA care management or CCS sometimes creates care delays or worsens the Member experience. In the end, this leaves many Members feeling impatient.

Member Actions

- Members under 21 are connected to an appropriate level of care management (e.g., Enhanced Care Management) if desired. Members enrolled in CCS have a CCS Care Manager assigned to them who may coordinate with a Blue Shield Promise care manager, if needed [6]
- Members are assigned a Primary Care Provider (PCP) near their place of residence and attend their first appointment
- Members are referred to necessary specialists to seek additional care, as needed
- Members receive higher level of care (e.g., hospital admission), if needed

Touchpoints

- Their initial PCP appointment
- Their annual PCP visits
- Support from their Care Manager (as applicable)
- Specialty Provider Visits (as applicable)
- Non-Emergency Medical Transportation (NEMT)
- Services covered under Medi-Cal for Kids and Teens (EPSDT) create more touchpoints with Members

Bright Spots

- Members with access to CCS or DDS have additional coordination of care that can assist them in effectively accessing their care [6]
  Medi-Cal for Kids and Teens allows Members under 21 to access all medically necessary Early and Periodic Screening, Diagnostic, and Treatment services free of charge, even for services not typically covered the plan

Pain Points

- Members under 21 may experience long wait times to be connected to a provider. [1, 3, 5]
  This can be especially problematic as early intervention often makes timeliness of care vital for these Members [6]
- Many Members under 21 require access to a speech therapist, but a large shortage exists for these providers, preventing these Members from getting the important and time-sensitive care that they require [6]
- Some health conditions for Members under 21 have a very small window for effective treatment, so delays in care can have life-long impacts on these Members and make timely access to care important for Members under 21 [6]
- Variances within Medical Group or Independent Practice Association Care Management can lead to worse communication and care coordination for delegated Members. This may contribute to the feeling that they are not properly cared for [6]
- Some providers refer Members to CCS and begin denying care before the Members is officially enrolled in CCS, instead of waiting for CCS to begin covering their care. This creates frustration for Members and their caregivers, and delays important treatment [6]

Supporting Data

- CAHPS Reporting Year 2023 – 'Getting Care Quickly' is one of Blue Shield Promise's bottom three performing measures in both Los Angeles and San Diego, for both the child and adult populations

Assumptions

- None

4. Member Health Outcomes & Satisfaction: Member Journey

Emotions

Members under 21 feel positive overall about improving their health with Blue Shield Promise. Members under 21 have access to many additional programs and services like Medi-Cal for Kids and Teens, CHDP, CCS, and DDS, making them feel supported by the plan. Members under 21 are met with a wider array of services for reduced cost, leading to higher satisfaction. While there are added complexities including aging out of this category, Members generally appreciate the added support

Member Actions

- Members see improved health outcomes and better health literacy
- Members have more autonomy over their health and feel empowered to take control of their care and seek additional resources
- Members continue seeking regular care
- Members enrolled in CCS age out of the program and return to BSP for care management, if needed

Touchpoints

- Member Services
- Appeals and Grievances
- Lifestyle Medicine (e.g., Health Education, Disease Management)
- Assigned PCP/Providers

Bright Spots

- Member satisfaction increases for Members with children being supported by Blue Shield Promise. This care often means more to Members than their own care, improving the Members of families enrolled with Blue Shield Promise [4]
- Extra value-added benefits that are not mandated are also appreciated more by Members under 21 and their parents/guardians. The care for these Members has an amplified effect on Member satisfaction [4]

Pain Points

- The amplified impact on Member satisfaction for those with children enrolled with Blue Shield Promise works in reverse; if there is any dissatisfaction with coordination of care of the services received, this dissatisfaction is amplified for Members under 21 and their parents/guardians
- Cultural sensitivity and empathy are particularly important for parents who are advocating on behalf of their children. Providers that lack empathy or cultural sensitivity can make these Members feel unheard [4, 6]
- Dissatisfaction with carved-out benefits is attributed to Blue Shield Promise. Vision services, for example, are extremely important to Members under 21 and their parents/guardians. For example, children who lose their glasses may not be supported by vision providers, creating dissatisfaction with Blue Shield Promise, despite these services being carved out [4]

- Members that age out of CCS rely on Blue Shield Promise for care coordination when they turn 21. Blue Shield Promise has no way of anticipating these Members and often has a difficult time beginning care management as a result. From the Member's perspective, this process can be frustrating and lead to feeling unappreciated by the Plan [6]

Supporting Data

- Member satisfaction is higher in Los Angeles because of parents responding on behalf of their children. Care for a Member's children means more to them [4]

Assumptions

- AArete is assuming the amplified importance of care for children on Member satisfaction works in both directions
- If a member has some form of care manager, this provider can clarify which benefits are carved out. [6] Members attributing dissatisfaction with carved-out benefits to Blue Shield Promise therefore only applies if the Member does not have a care manager or connection to a live person at the plan who can clarify these concerns

Conclusion and Recommendations

As referenced in the 'Limitations & Caveats' section of the Member Journey Mapping Approach, the main takeaways included in the Member Journey Maps within this narrative report can be enhanced in several ways. Many of the takeaways included within this report can be generalized to the larger Medi-Cal population being served by Blue Shield Promise once confirmed through additional information gathering, research, data analysis, and interviews conducted with Members and additional stakeholders. In addition, an enhanced Health Equity lens could be added to the information included within this Member Journey report by further drilling down into the experiences of Members in specific sub-populations that may be more prone to experience health issues and inequities. For example, the adult Member journey map included in this report examines the general adult Member experience. However, this experience may differ largely for those Blue Shield Promise Members who may belong to certain ethnic/racial groups and those who have chronic conditions. For future journey mapping efforts, AArete recommends focusing on certain sub-populations for further exploration of their specific Member journey. In addition to ethnic/racial groups and those Members with chronic conditions, these populations may also include maternal health, justice-involved, those experiencing unsheltered homelessness, serious mental illness, LGBTQIA+ population, Members requiring long-term care, etc. Listed below are AArete's future recommendations for the Member journey maps included in this narrative report and the supporting themes and opportunities identified throughout.

AArete is available to continue enhancing these findings by conducting additional market research, leveraging additional internal Blue Shield Promise and publicly available data sources, and conducting Member interviews to incorporate the direct Member perspective.

Recommendations

The Aarete team prepared the following recommendations based on findings.

Adult Member Journey

1. **Strategies to Improve Member Contact and Demographic Information** – Blue Shield Promise should stay apprised of the status of the Department of Health Care Services' (DHCS) Member Contact and Demographic Information Initiative Strategy (MCDI) [linked] and incorporate these preliminary draft strategies into any relevant internal Blue Shield Promise operational processes to improve the gathering of Member's demographic and contact information. Blue Shield Promise should also focus on the improvement of Medi-Cal Redetermination efforts to ensure Members are outreached to and updating their information accurately and timely. Increased outreach efforts should be focused on those Members found more likely to be averse to providing their information to Medi-Cal/Blue Shield Promise. For example, many Hispanic/Latino or other immigrants in the Blue Shield Promise service area may be less inclined to share their information with Medi-Cal/the plan in fear of affecting their immigration status.

2. **Assessment of Community Resources and Member Outreach –** The entry points of Members interacting with the plan across Blue Shield Promise service areas should be assessed to ensure Members have equal access to the plan. Community Resource Centers only being available in Los Angeles County may result in additional outreach and services needed for Blue Shield Promise Members in San Diego County. Subsequently, larger reliance on community-based organizations and Federally Qualified Health Centers (FQHCs) in San Diego County exists for these Members. This presents an opportunity for Blue Shield Promise to assess the areas in which Members can be outreached to in the community and the plan can leverage improved relationships and partnerships with CBOs and FQHCs in these areas (e.g., through community or outreach co-branded events). These improved partnerships could lead to improved plan perception among the Members in areas where CRC resources do not exist or are not readily available.

3. **Enhanced Member Education and Value-added Benefits** – Medi-Cal Members, especially those with diverse backgrounds (i.e., English not their first language), may lack the health literacy needed to navigate and understand their health plan benefits. In addition, Net Promotor Score survey data exemplifies that positive plan perception can be largely attributed to value-added (i.e., not mandated) benefits that Members are often not aware of. One example includes Blue Shield Promise's new GED Works programs. The Blue Shield Promise Health Equity Office should continue to partner with their Blue Shield Promise Marketing and Product Strategy partners to continue improvement efforts that focus on enhancements to Member education, Member health literacy, and value-added benefits. In addition, carved-out benefits may also contribute to Member's negative perception or dissatisfaction with the plan (page 18) further exemplifying that Member education around their plan benefits is imperative.

4. **Leverage Diverse Data for Meaningful Insights** – The Health Equity Office should continue to leverage additional data gathered among the HEART Measures to gain meaningful insights into health equity gaps that may persist among certain populations (e.g. maternal health, justice-involved individuals). In addition, the Health Equity Office should continue to partner with the Population Health Management (PHM) team and leverage PHM data as the PHM program continues to grow. For example, data from Risk Stratification and Segmentation (RSS), Transitional Care Services, Closed Loop Referrals, etc. can be examined through a health equity lens to gain meaningful insights and identify areas for improvement.

Supporting Themes & Opportunities

- Difficulties exist gathering Members accurate demographic data and contact information leading to delays and issues in the enrollment process (page 9)
    - This may disproportionately affect those Members who do not have easy access to a cell phone or those without a mailing address such as Members experiencing unsheltered homelessness or justice-involved Members
- Members may be hesitant to provide information to Blue Shield Promise, especially among the immigrant population for fear their immigration status may be affected (page 9)
- Many Medi-Cal Members may not have easy access to the internet to navigate Blue Shield Promise information on the website to understand their plan benefits (page 12)
    - Members can access Community Resource Centers (CRCs) to gain access to the internet to access Blue Shield Promise resources. However, Members without easy access to transportation cannot use Non-Emergency Medical Transportation (NEMT) to travel to CRCs, making these resources inaccessible to Members (reference DHCS's Frequently Asked Questions on NEMT/NMT and APL 22-008)
- CRCs only exist in Los Angeles County and resources/capabilities provided may not be provided equally across CRCs. In addition, CRCs not existing in San Diego may contribute to the lack of community resources and connections that Members can have to Blue Shield Promise (page 12)
- Members being made more aware of their benefits including non-mandated/value-added benefits is correlated with increased satisfaction in Member's perception of the plan (page 17). Carved-out benefits may also contribute to Member's dissatisfaction with the plan (page 18)
- Members with worse health outcomes drive negative plan perception (page 18)

Children & Adolescents Member Journey

Recommendations

1. **Texting Campaigns and Communication** – There is an opportunity for Blue Shield Promise to develop texting campaigns to replace certain phone communications with Members. This could increase effective communication with Members and improve

engagement with the plan. Many Blue Shield Promise Members feel overwhelmed with the level of communication they receive, but Members under 21 and their families feel particularly overwhelmed given the involvement of additional programs. Too many phone calls and communications can cause these Members to give up on understanding their coverage and disengage with the plan altogether which may lead to worse health outcomes. Texting information to Members during the enrollment and education process will allow Members to process information at their speed and engage with the plan in a convenient way and pace that suits their lifestyle. The effect of these improvements on Member communication could be most noticeable for Members under 21 and their families.

2. **Restructure Care Management Delegation** – Care management is especially of value for Members under 21 and their families. Variances in delegated Medical Group (MG)/Independent Practice Association (IPA) care management efforts and effectiveness can exist. As a business unit clinical leader described, it appears IPA care management in select environments is run like a business and does not take the human-centered, member-focused approach required for effective support of Members, especially those under the age of 21. Blue Shield Promise should lead an effort to audit MG/IPA care management (CM) periodically to evaluate their CM documentation. Effectiveness in the MG/IPA CM delegates would be confirmed by review of CM notes to reflect meeting minimal standards for interviewing and developing a reasonable treatment plan. This audit and the member/parent feedback when engaged in CM for Members under 21 would improve communication and member understanding of choices and options to support their goals. This recommendation would require CM audits and shared results with the IPA while carefully coaching IPAs to develop a high-quality system of care management. By relying primarily on internal care management and assigning Members only to IPA care managers units who fulfill Audit requirements, Blue Shield Promise can increase the quality-of-care management provided to all Members. This can help make getting care feel easier, clarify dissatisfaction with carved-out benefits, and support parents/guardians advocating for their children when experiencing provider access issues or delays in important early interventions.

3. **Reassess Provider Networks with a Health Equity Focus** – Blue Shield Promise may consider assessing the exponential value of combined DHCS Provider Adequacy Report, DHCS Health Equity Report and the Member grievances specific to Level 2, and subsequently adding in Level one. The adult map highlighted that there are shortages of providers (particularly specialists) in rural areas, especially where significant health inequities are prevalent. Members under 21 face the same sub-specialty shortages and are negatively impacted by a shortage of speech therapists in the network. Members can sometimes wait six months to receive time-sensitive care which is a significant health equity gap in provider adequacy that exists in Blue Shield Promise's provider

network, most critically felt in regions with a low Healthy Places Index (HPI) score. By assessing the DHCS and DMHC adequacy reporting by sub-specialty and licensed professionals specific to pediatrics and adults, a macro report can be generated quarterly for prioritization and collaboration with multi-plans through CAHP to enhance provider group recruitment, collaboration with residency programs and physician recruitment incentives. The same inadequate resources are seen in other non-physician ancillary clinical licensed staff. In addition to strengthening its provider network, Blue Shield Promise could otherwise enhance Member access to providers by adding the ability to select providers based on similar race/ethnicity, language spoken, and additional characteristics of providers in the provider portal. This will allow Members to select providers that they feel can relate to their lived experience enhancing the member-focused approach as part of the Blue Shield Promise commitment.

Supporting Themes & Opportunities

- Children's Services has especially low engagement from their Members due to inaccurate data and Member abrasion (page 23)
    - Members under 21 and their families feel overwhelmed and often disengage from the plan because of the number of phone calls they get from Blue Shield Promise, CCS, DDS, and other parties involved in their care (page 23)
- There may be more substantial variances in Care Management in under resourced IPAs. A CM annual audit may permit a fair and equitable means of assessing CM capabilities often negatively impacted by lack of access to Electronic Health Records (EHR) or other physical and resource barriers within the IPA. These barriers can prevent the Member from getting the increased coordination or communication that a MG with shared EHR, UM and Claims module or Blue Shield Promise care manager could provide (page 26).
- Members under 21 often lack clarity about their coverage because of the involvement of CCS or DDS and other programs available to them (like Medi-Cal for Kids and Teens) (page 21)
    - Dissatisfaction with carved-out benefits is often attributed to Blue Shield Promise (page 28)
- Members under 21 may wait a long time to get care, a fact that is especially problematic since early intervention makes this care extremely important (page 26)
    - There is a severe shortage of speech therapist providers, delaying time-sensitive treatment for many Members under 21 (page 26)
    - Blue Shield Promise Members in rural areas face shortages of specialists (page 15) (this applies to both Members under 21 and adults)
    - Members are unable to select providers of similar race or ethnicity due to information often left omitted on the Blue Shield Promise provider directory making Members feel as if they cannot connect with a provider with a similar background or lived experience (page 15) (this applies to both Members under 21 and adults)

Note: Pain Points and Bright Spots on the Members under 21 Member Journey have an inherent health equity focus as they relate to differences in the Member experience due to age and the unique experiences this age group experiences

Conclusion

This report contains an assessment and recommendations to ensure the provider network meets the cultural needs of members and BSP is recruiting and retaining a diverse provider network. The report does not contain an assessment of related Network Adequacy requirements. The HEO recommends accountable owners assess requirements for all lines of business and prepare recommendations that can be integrated across the health plan, not just specific to BSP. The HEO recommends all involved parties form a collaborative workgroup to review related work and prepare a strategic plan to meet DHCS requirements. The HEO also recommends the workgroup prepare an action plan that considers these recommendations as these will help meet and exceed Regulator expectations. The strategic plan should be presented to the BSP Quality improvement and Health Equity Committee.

Appendix A: Net Promotor Score Survey Responses

Below are verbatim responses from the Net Promotor Score Survey Responses and includes Member responses to the question "Would you recommend BSP to friends and family?" In addition to leaving a score, Members can leave a comment explaining why they rated Blue Shield Promise the way they did. This subset of responses relates mostly to PCP auto assignment. [4]

- "The doctor's office I've been assigned to. Long wait time, long appointment, I called and said they were short staffed, and no one informed me. Not so good an experience."
- "Sometimes they don't want you as patient, the doctors specifically, they assign you to another doctor you don't know. It's also hard to find a good dental clinic and optometrist as well."
- "As of right now the health care providers that are assigned to us aren't fully doing their job."
- "For example, I recently had to change my primary care physician and they assigned me to a physician that was very far from my house for the new physician. That is about it."
- "I was assigned a doctor I was not thrilled with. They made it difficult to find and switch doctors. I think there is a big difference in the things that are covered, and the list of doctors compared to nonmedical plans."
- "Well, because I didn't choose the doctor for my daughter, it was assigned. Because I went to the doctor and he wants to give me an appointment until March of this year, so. No, that's it."
- "I have this plan because of my financial situation. I am new to this plan, and I am trying to navigate through this plan. Finding a provider is so hard. You have a list, but it is so hard. Some are not taking new patients. Some of these are not doing face-to-face appointments. Also, you can only see a physician's assistant of the provider. Some need the doctor because they have a higher level of problems. It is hard to navigate through the system. I found a provider I have only seen once. They do rehab as well as primary care. They also assigned me to a primary care doctor who was thirty miles away. Then they did not let me change."
- "The doctors I get assigned, I guess. The doctors where I live aren't great, I guess. At the end of the day, its health insurance, and it gets the job done."
- "So, the doctor I was closest to me or assigned to when I received my health plan card in the mail. I went to the doctor, and they told me they don't take that insurance. Even though I was sent that card by the insurance company."

Blue Shield of California Promise Health Plan
Annual Culturally and Linguistically Appropriate Services (CLAS) Program and Program Evaluation Report
August 2024

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Table of Contents

Appendices

Addendums

Introduction

Blue Shield of California Promise Health Plan (inclusive of Medicaid products in Los Angeles and San Diego Counties) for the remainder of this report will be referred to as Blue Shield Promise (BSP), dedicated to advancing health equity, improving quality, and eliminating health care disparities. As such, Blue Shield Promise aligns with the U.S. Department of Health and Human Services (HHS) National Culturally and Linguistically Appropriate Services (CLAS) 15 Standards[1] by continuously evaluating its members' cultural, ethnic, racial, and linguistic preferences and needs, including our provider network, to ensure services are being provided. These fundamental elements are used to develop strategic decisions for intervention activities for the next year and a retrospective evaluation of the overall program. Additionally, based on HHS 2015 Presentation entitled "Exploring Culture in CLAS: Sexual Orientation and Gender Identity" by Dacri L. Graves, Blue Shield Promise has included member sexual orientation and gender identity data to start to build a baseline of our members cultural needs and preferences.

Blue Shield Promise has two committees, the Community Advisory Committee (CAC) and the Health Equity Oversight Committee (HEOC). The CAC comprises of Blue Shield Promise members and local community groups. The CAC will review, provide feedback, and support the identification and prioritization of opportunities for improvement in this report and each year going forward. The Health Equity Oversight Committee is responsible for monitoring and approving all Health Equity Accreditation related activities and reports.

Methodology

Blue Shield Promise uses various methods to collect members and providers data to assess needs and preferences. Those data methods and systems include but are not limited to the State of California Census data, demographic information sent to Blue Shield Promise via the EDI 834 Enrollment files which are stored within Facets (an internal claims management data system), provider information stored within the Provider Informatics Management System (PIMS), and member grievance data, which is stored in AuthAccel (also known as MHK). Members and providers can provide and update their information via secure member and provider portals, respectively. All questions are voluntary and were developed to not stigmatize members nor providers. Members can also update their information when speaking with a Customer Service representative. Race and ethnicity data is rolled up into a one-question format Office of Management and Budget (OMB) format.

[1] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf

Table A details the categories and respective goals that have been established by Blue Shield and are included in the evaluation of CLAS and the Health Equity program. This assessment will ultimately support our ability to serve our members with the highest level of quality and services.

Table A: Blue Shield Promise Categories and Goals for Evaluation

Category	Goal
Interpreter Request (Over the Phone and In-Person)	Requirement: meet 100% of interpreter requests for all languages (over the phone and in-person)
Written Translation Request	Requirement: meet 100% of written translation requests for all threshold languages
Practitioner Office Staff	8% of practitioner office staff speak at least one threshold language
Provider Training	100 providers complete CLAS training and receive CEU units
Language Needs	1 PCP (Family Medicine (GP & FP), Internal Medicine, and Pediatrics) to 2,000 members
	1 SCP to 1,200 members
Race and Ethnicity for Providers	1 PCP speaking a threshold language to 1,200 members speaking a threshold language.

	1 American Indian/Alaska Native practitioner to 600 American Indian/Alaska Native members
	1 Asian practitioner to 700 Asian members
	1 Black/African American practitioner to 900 Black/African American members
	1 Hispanic/Latino practitioner to 3,400 Hispanic/Latino members
	1 Middle Eastern/North African practitioner to 700 Middle Eastern/North African members
	1 Native Hawaiian/Pacific Islander practitioner to 900 Native Hawaiian/Pacific Islander members
	1 white practitioner to 700 white members
	1 other race practitioner to 700 other race members
Member Cultural and Linguistic Grievances	Blue Shield has no threshold for grievances related to cultural and linguistic grievances. Requirement: review all cultural and linguistically related grievances.

Member Self-Reported Race and Ethnicity	Goal: Achieve 80% of self-report race and ethnicity

California Census Data on Race, Ethnicity, and Language:

Blue Shield Promise assesses the population's language profile at least every three years to determine the languages spoken in its service area and assesses and reports on the language profile of the community, to anticipate and plan for changes in the language services it provides. According to California's 2020 Census, the total population is 39,583,223. The top five counties with the highest number of residents are Los Angeles, San Diego, Orange, Riverside, and San Bernardino. Based on the U.S. Census Bureau, the difference in the overall racial distribution is mainly due to improvements in the design of the two separate questions (using the OMB standards format) for race data collection and processing some demographic enhancements for the past ten years. The upgrades and changes enabled a more thorough and accurate depiction of how people self-identify, yielding a more precise portrait of how people report their Hispanic origin and race within the context of a two-question format[2].

Table 1. California Census Data: Race and Ethnicity

Total:	**39,538,223**
The population of one race:	**23,958,571**
White alone	13,714,587
Black or African American alone	2,119,286
American Indian and Alaska Native alone	156,085
Asian alone	5,978,795
Native Hawaiian and Other Pacific Islanders alone	138,167
Some Other Race alone	223,929
Hispanic or Latino	15,579,652
Not Hispanic or Latino:	23,958,571
The population of two or more races:	**1,627,722**
The population of two races:	1,500,424
White; Black or African American	220,162
White; American Indian and Alaska Native	270,349

[2] P1: RACE - Census Bureau Table

White; Asian	563,222
White; Native Hawaiian and Other Pacific Islander	37,904
White; Some Other Race	223,468
Black or African American; American Indian and Alaska Native	29,533
Black or African American; Asian	46,247
Black or African American; Native Hawaiian and Other Pacific Islander	7,531
Black or African American; Some Other Race	28,389
American Indian and Alaska Native; Asian	7,321
American Indian and Alaska Native; Native Hawaiian and Other Pacific Islander	1,376
American Indian and Alaska Native; Some Other Race	1,867
Asian; Native Hawaiian and Other Pacific Islander	45,831
Asian; Some Other Race	13,281
Native Hawaiian and Other Pacific Islander; Some Other Race	3,943

Data Source: United States Decennial Census Bureau – California
Report: P2 HISPANIC OR LATINO, AND NOT HISPANIC OR LATINO BY RACE

Table 2. California Census Data: Spoken Languages

Languages	Estimate	Percent
English	20,540,480	55.6%
Speak a language other than English	16,370,476	44.4%
Spanish	10,461,392	28.3%
Asian and Pacific Island Languages	3,682,707	10.0%
Other Indo-European languages	1,797,310	4.9%
Other languages	429,067	1.2%

Data Source: United States Decennial Census Bureau – California
Report: American Community Survey. S1601 LANGUAGE SPOKEN AT HOME (2022)

Based on the 2022 American Community Survey estimates, English, Spanish, and Asian Pacific Islander languages were the primary languages spoken at home in almost all of California. In addition to inquiring about the language spoken at home, the Census asked about the household's ability to speak English. In California, 55.6% speak English, 28.3% speak Spanish, and 10.0% speak Asian and Pacific Islander languages.

Blue Shield Promise Member and Provider Race and Ethnicity

Blue Shield Promise captures race and ethnicity data for its members and it compares its membership demographics to its network providers. Evaluating this data allows Blue Shield Promise to determine if members' cultural, linguistic needs, and preferences are met and identify opportunities for improvement within our provider network. Providers can voluntarily provide race and ethnicity data to Blue Shield Promise, as it is not required for submission in the State of California. Blue Shield Promise actively requests providers to self-report their demographic information to analyze the needs of our members better. Improving data collection methods will promote prosperous and robust data in the future, which will help Blue Shield Promise better assess the needs of our member-to-provider population. In alignment with the updated March 2024 OMB Statistical Policy Directive (SPD) Number 15 regulation, Blue Shield Promise added the race option, Middle Eastern/North African in both the member and provider portal. The tables below show the current race and ethnicity data for Blue Shield Promise members and providers.

Table 3. 2024 Blue Shield Promise Member and Provider Race/Ethnicity Comparison

Race/Ethnicity	Los Angeles			San Diego			Total		
	Count	Percent	Provider to Member Ratio	Count	Percent	Provider to Member Ratio	Count	Percent	Provider to Member Ratio
Member: Hispanic or Latino	251,042	67.06%	1:1,163	66,966	36.05%	1:1,099	318,008	56.77%	1:1,224
Provider: Hispanic or Latino	216	0.88%		61	0.43%		260	0.79%	
Member: Black or African American	31,499	8.41%	1:316	9,310	5.01%	1:424	40,809	7.29%	1:356
Provider: Black or African American	100	0.41%		22	0.15%		115	0.35%	

Member: Native Hawaiian or Other Pacific Islander	3,493	0.93%	1:874	1,734	0.93%		5,227	0.93%	1:1,308
Provider: Native Hawaiian or Other Pacific Islander	4	0.02%		0	0.00%		4	0.01%	
Member: White	30,339	8.10%	1:74	35,624	19.18%	1:224	65,963	11.78%	1:127
Provider: White	413	1.68%		160	1.12%		522	1.58%	
Member: Asian	20,333	5.43%	1:92	11,028	5.94%	1:231	31,361	5.60%	1:126
Provider: Asian	223	0.91%		48	0.34%		251	0.76%	
Member: American Indian or Alaska Native	387	0.10%		490	0.26%		877	0.16%	
Provider: American Indian or Alaska Native	0	0.00%		0	0.00%		0	0.00%	
Members: Middle Eastern or North African	3	0.08%		5	0.27%		8	0.14%	
Provider: Middle Eastern or North African	0	0.00%		0	0.00%		0	0.00%	
Member: Some other race	6,583	1.76%	1:92	9,163	4.93%	1:917	15,746	2.81%	1:205
Provider: Some other race	72	0.29%		10	0.07%		77	0.23%	
Member: Sum of all self-reported	343,679	91.80%		134,320	72.31%		477,999	85.34%	

Race/Ethnicity Categories									
Provider: Sum of all self-reported Race/Ethnicity Categories	812	3.31%		240	1.68%		969	2.93%	
Member: Unknown	13,747	3.67%		44,037	23.71%		57,784	10.32%	
Provider: Unknown	548	2.24%		115	0.81%		610	1.85%	
Member: Choose not to disclose "Decline"	34	0.01%		36	0.02%		70	0.01%	
Provider: Choose not to disclose "Decline"	0	0.00%		0	0.00%		0	0.00%	
Member: Who did NOT RESPOND "No Response"	16,917	4.52%		7,360	3.96%		24,277	4.33%	
Provider: Who did NOT RESPOND "No Response"	22,938	93.57%		13,843	97.08%		31,187	94.43%	
Member: Sum of "Unknown" and "Decline"	13,781	3.68%		44,073	23.73%		57,854	10.33%	
Provider: Sum of "Unknown" and "Decline"	548	2.24%		115	0.81%		610	1.85%	
Total Membership	374,377	66.84%		185,753	33.16%		560,130	100.00%	
Total Providers	24,514	74.23%		14,259	43.18%		33,026	100.00%	

- *Data as of August 2024*
- *Providers participating in the Commercial and Exchange networks are represented as a single value.*

- *"Other Race" is race or ethnicity that is not listed or members who self-report more than one (1) race and ethnicity. "Unknown" represents the number and percent of data that is unavailable.*

As of August 2024, 85% of Blue Shield Promise members self-report a race and ethnicity, therefore meeting the 80% Blue Shield Promise goal. At least 4% of BSP members (24,277 members) responded with "no response." There is a total of 13,781 Los Angeles members and 44,073 San Diego members who have reported race/ethnicity as "Uknown or Choose not to Disclose." Of note 6,583 Los Angeles members do report "Other" as a race option, and in San Diego 9,136 members reported "Other" as a race option. Members who also reported more than one race and ethnicity option are also identified in the "Other race" option. The BSP members self-reported race and ethnicity rates for White, Asian and Hispanic Latino members are aligned to those to the U.S. Census. A total of 31,361 members identified as Asian and 318,008 members identified as Hispanic/Latino. Hispanic/and Latino members make up over 57% of the BSP membership.

When evaluating Blue Shield Promise's practitioner demographics, over 94% of practitioners do not report a race and ethnicity. A total of 969 practitioners report race and ethnicity, with most practitioners self-identified as white 2% (522). When comparing the Los Angeles and San Diego membership with our practitioner data, Blue Shield Promise currently meets the preferences of our members and ethnicities except for Middle Eastern/North African and some other race. Middle Eastern/North African was a new addition to both member and provider race and ethnicity options. However, with 94% of BSP Los Angeles County and 97% of San Diego County providers not reporting their race and ethnicity, there is a disadvantage to our analysis as Blue Shield Promise cannot appropriately assess the provider network. It is important to note that both member and provider race and ethnicity information are optional to self-report.

Blue Shield Promise Member Languages Compared to Practitioner and Practitioner Office Staff Language Capacity

To evaluate the language services offered to our members and determine if their language needs and preferences are being met, Blue Shield Promise analyzed our members preferred spoken and written languages by at least one percent of the population or two-hundred eligible individual, whichever is less followed by identifying our members threshold language (refer to Table 6 below). Blue Shield Promise defines threshold languages as all languages other than English spoken by five percent of the population or by one thousand individuals, whichever is less (refer to Table 6). This analysis will expand and assess our practitioners' languages and their office staff language capabilities to determine if the languages services offered meet the needs of our members

Blue Shield Promise collects, stores, and retrieves members preferred spoken and written language to ensure our members have access to appropriate services and support throughout their healthcare journey. This data is stored in the enrollment system, Facets and Radiant One, and is securely maintained and accessed by approved personnel in compliance with their job duties. Member preferred language information is collected in a variety of ways including enrollment forms, the member portal, and when speaking with our customer service agents. Members and providers are informed of the free interpreter and translation services available to them and how to access these services provided by Blue Shield Promise.

Additionally, Knox-Keene regulatory requirements in the state of California require Medicaid health plans to send members the Notice of Language Assistance disclaimers with any vital documents. This notice is translated into seventeen (17) languages, based on California census data (see Appendix A for details). Below is a breakdown of members' spoken and written preferences with comparison to our providers and the practitioner office staff.

Table 4: Member Preferred Spoken and Written Languages

Language	Los Angeles				San Diego			
	Preferred Spoken Languages Member Count	Preferred Spoken Languages Percent of Members	Preferred Written Languages Member Count	Preferred Written Languages Percent of Members	Preferred Spoken Languages Member Count	Preferred Spoken Languages Percent of Members	Preferred Written Languages Member Count	Preferred Written Languages Percent of Members
English	199,826	53.91%	200,012	53.96%	141,165	76.37%	141,348	76.47%
Spanish	156,396	42.19%	156,312	42.17%	37,361	20.21%	37,323	20.19%
Russian	2,480	0.67%	2,474	0.67%	1,171	0.63%	1,151	0.62%
Vietnamese	2,144	0.58%	2,134	0.58%	1,267	0.69%	1,259	0.68%
Armenian	2,469	0.67%	2,456	0.66%	20	0.01%	19	0.01%
Mandarin	3,470	0.94%	10	0.00%	552	0.30%	2	0.00%
Tagalog	603	0.16%	580	0.16%	1,405	0.76%	1,342	0.73%
Arabic	618	0.17%	613	0.17%	803	0.43%	798	0.43%
Korean	1,071	0.29%	1,065	0.29%	309	0.17%	308	0.17%
Chinese (simplified)	8	0.00%	2,233	0.60%	0	0.00%	453	0.25%
Farsi	779	0.21%	769	0.21%	484	0.26%	477	0.26%
Chinese (traditional)	11	0.00%	2,259	0.61%	2	0.00%	178	0.10%
Cantonese	1,529	0.41%	4	0.00%	107	0.06%	1	0.00%
Khmer (Cambodian)	517	0.14%	513	0.14%	75	0.04%	73	0.04%
Thai	263	0.07%	261	0.07%	23	0.01%	24	0.01%
Portuguese	51	0.01%	51	0.01%	119	0.06%	119	0.06%
Lao	6	0.00%	6	0.00%	142	0.08%	139	0.08%
Samoan	98	0.03%	98	0.03%	23	0.01%	22	0.01%
Japanese	51	0.01%	51	0.01%	49	0.03%	49	0.03%
French	35	0.01%	35	0.01%	53	0.03%	52	0.03%
Turkish	29	0.01%	29	0.01%	39	0.02%	39	0.02%
Ukrainian	10	0.00%	10	0.00%	28	0.02%	27	0.01%

Production Date: August 2024

Hindi	24	0.01%	24	0.01%	10	0.01%	10	0.01%
Yue Chinese	29	0.01%	29	0.01%	NA	NA	NA	NA
Sign language	9	0.00%	0	0.00%	47	0.03%	1	0.00%
Hebrew	21	0.01%	22	0.01%	4	0.00%	3	0.00%
Bengali	22	0.01%	21	0.01%	NA	NA	NA	NA
Polish	7	0.00%	7	0.00%	14	0.01%	14	0.01%
Italian	4	0.00%	4	0.00%	14	0.01%	15	0.01%
Punjabi	15	0.00%	13	0.00%	2	0.00%	2	0.00%
Hmong	1	0.00%	1	0.00%	13	0.01%	13	0.01%
No data available	7	0.00%	9	0.00%	3	0.00%	6	0.00%
Ilocano	7	0.00%	7	0.00%	6	0.00%	3	0.00%
Urdu	10	0.00%	10	0.00%	NA	NA	NA	NA
Tamang	2	0.00%	2	0.00%	7	0.00%	7	0.00%
Pashto	2	0.00%	2	0.00%	6	0.00%	6	0.00%
Burmese	5	0.00%	3	0.00%	4	0.00%	2	0.00%
Ugoslavian	6	0.00%	6	0.00%	NA	NA	NA	NA
Haitian creole	NA	NA	NA	NA	6	0.00%	4	0.00%
Chinese	0	0.00%	1	0.00%	4	0.00%	5	0.00%
Swahili	2	0.00%	2	0.00%	2	0.00%	2	0.00%
Bulgarian	4	0.00%	4	0.00%	NA	NA	NA	NA
Romanian	3	0.00%	3	0.00%	NA	NA	NA	NA
Somali	NA	NA	NA	NA	2	0.00%	2	0.00%
Indonesian	2	0.00%	2	0.00%	NA	NA	NA	NA
Amharic	2	0.00%	2	0.00%	NA	NA	NA	NA
Gujarati	1	0.00%	1	0.00%	1	0.00%	0	0.00%
Abkhazian	NA	NA	NA	NA	1	0.00%	2	0.00%
Uyghur	NA	NA	NA	NA	1	0.00%	1	0.00%
Tigrinya	1	0.00%	1	0.00%	NA	NA	NA	NA
Serbian	1	0.00%	1	0.00%	NA	NA	NA	NA

Persian	1	0.00%	1	0.00%	NA	NA	NA	NA
Latin		NA	NA	NA	1	0.00%	1	0.00%
Hakka	2	0.00%	0	0.00%	NA	NA	NA	
German	NA	NA	NA	NA	1	0.00%	1	0.00%
Corsican	NA	NA	NA	NA	1	0.00%	1	0.00%
Assyrian	1	0.00%	1	0.00%	NA	NA	NA	NA
Wu Chinese	1	0.00%	0	0.00%	NA	NA	NA	NA
Min nan Chinese	1	0.00%	0	0.00%	NA	NA	NA	NA
Georgian	1	0.00%	0	0.00%	NA	NA	NA	NA
Fukienese	NA	NA	NA	NA	1	0.00%	0	0.00%
Albanian	NA	NA	NA	NA	1	0.00%	0	0.00%
Abkhaz	NA	NA	NA	NA	1	0.00%	0	0.00%
Total	370,653	100.00%	370,653	100.00%	184,851	100.00%	184,851	100.00%

Data as of August 29, 2024

The preferred member spoken languages up to 1% or 200 members, whichever is less, is highlighted in green in the table above. These include English, Spanish, Russian, Vietnamese, Armenian (Los Angeles only), Mandarin, Tagalog, Arabic, Korean, Farsi, Cantonese (Los Angeles only), Khmer (Los Angeles only), and Thai (Los Angeles only). The spoken languages threshold for Los Angeles County spoken by 5% or up to 1,000 members includes: English, Spanish, Russian, Vietnamese, Armenian, Mandarin, Korean and Cantonese. For San Diego County, the spoken languages threshold up to 5% or up to 1,000 members includes: English, Spanish, Tagalog, Vietnamese, and Russian. Based on the BSP members preferred language data, the data is in alignment with the top spoken languages for the state of California.

Table 5. Member Spoken Threshold Language Compared to Practitioner Languages

Language	Los Angeles					San Diego					Did we meet the standard of 1:1,200 (1 PCP:1,200 members)
	Count		Percent		Ratio	Count		Percent		Ratio	
	Member	Provider	Member	Provider		Member	Provider	Member	Provider		
English	199,826	8,815	54.20%	37.11%	1:24	141,165	4,875	76.84%	35.06%	1:30	Yes
Spanish	156,396	6,022	42.42%	25.35%	1:27	37,361	2,332	20.34%	16.77%	1:17	Yes
Mandarin	3,470	867	0.94%	3.65%	1:5	552	162	0.30%	1.17%	1:4	Yes
Russian	2,480	363	0.67%	1.53%	1:8	1,171	102	0.64%	0.73%	1:12	Yes
Vietnamese	2,144	529	0.58%	2.23%	1:5	1,267	157	0.69%	1.13%	1:9	Yes
Armenian	2,469	539	0.67%	2.27%	1:6	NA	NA	NA	NA	NA	Yes
Tagalog	NA	NA	NA	NA	NA	1,405	193	0.76%	1.39%	1:8	Yes
Korean	1,071	507	0.29%	2.13%	1:3	NA	NA	NA	NA	NA	Yes
Cantonese	1,529	202	0.41%	0.85%	1:9	NA	NA	NA	NA	NA	Yes
Total	370,653	24,351	100.00%	100.00%	1:16	184,851	14,186	100.00%	100.00%	1:14	Yes

Data as of August 29, 2024

NA: Not applicable for this county

The table above shows the members threshold languages along with the number of providers that speak that language in each of the designated counties. In 2023, The top languages spoken by members in Los Angeles County were English (54.2%), Spanish (42.4%); and Mandarin (0.94%). In San Diego County, the top spoken languages by members were English (76.85%), Spanish (20.34%) and Tagalog (0.76%). Upon examining the ratio of providers speaking the threshold languages BSP meets the thresholds for member to provider spoken languages.

Table 6. Language Services Available Through Practices

Practice Language	Los Angeles		San Diego		Grand Total	
	Count of Practices	% of Practices	Count of Practices	% of Practices	Count of Practices	% of Practices
Spanish	1,909	94.50%	713	97.27%	2,269	94.90%
Mandarin	633	31.34%	200	27.29%	703	29.40%
Vietnamese	576	28.51%	253	34.52%	683	28.57%
Russian	536	26.53%	206	28.10%	603	25.22%
Korean	529	26.19%	198	27.01%	590	24.68%
Tagalog	407	20.15%	195	26.60%	502	21.00%
Cantonese	448	22.18%	147	20.05%	497	20.79%
Farsi	416	20.59%	159	21.69%	492	20.58%
English	314	15.54%	137	18.69%	392	16.39%
Armenian	358	17.72%	65	8.87%	370	15.47%
Chinese	270	13.37%	99	13.51%	311	13.01%
Arabic	200	9.90%	146	19.92%	280	11.71%
French	204	10.10%	103	14.05%	252	10.54%
Hindi	184	9.11%	70	9.55%	234	9.79%
Yue Chinese	172	8.51%	24	3.27%	186	7.78%
Urdu	88	4.36%	71	9.69%	124	5.19%
Portuguese	58	2.87%	56	7.64%	101	4.22%

Practice Language	Los Angeles		San Diego		Grand Total	
	Count of Practices	% of Practices	Count of Practices	% of Practices	Count of Practices	% of Practices
Persian	89	4.41%	8	1.09%	93	3.89%
Hebrew	87	4.31%	18	2.46%	90	3.76%
German	60	2.97%	30	4.09%	83	3.47%
Thai	77	3.81%	37	5.05%	82	3.43%
Punjabi	64	3.17%	21	2.86%	78	3.26%
Japanese	59	2.92%	24	3.27%	74	3.09%
Gujarati	56	2.77%	8	1.09%	62	2.59%
Italian	48	2.38%	18	2.46%	56	2.34%
Telugu	33	1.63%	13	1.77%	42	1.76%
Turkish	41	2.03%	NA	NA	41	1.71%
Greek	19	0.94%	24	3.27%	34	1.42%
Lithuanian	12	0.59%	31	4.23%	32	1.34%
Khmer	29	1.44%	4	0.55%	31	1.30%
Taiwanese	31	1.53%	NA	NA	31	1.30%
Filipino	29	1.44%	6	0.82%	30	1.25%
Romanian	24	1.19%	6	0.82%	28	1.17%
Burmese	26	1.29%	NA	NA	26	1.09%

Practice Language	Los Angeles		San Diego		Grand Total	
	Count of Practices	% of Practices	Count of Practices	% of Practices	Count of Practices	% of Practices
Polish	16	0.79%	10	1.36%	24	1.00%
Sign language	10	0.50%	15	2.05%	24	1.00%
Lao	8	0.40%	17	2.32%	19	0.79%
Latin	7	0.35%	19	2.59%	19	0.79%
Tamil	16	0.79%	5	0.68%	17	0.71%
Kannada	12	0.59%	4	0.55%	16	0.67%
Bengali	14	0.69%	1	0.14%	15	0.63%
Kashmiri	15	0.74%	NA	NA	15	0.63%
Nepali	15	0.74%	NA	NA	15	0.63%
Marathi	10	0.50%	5	0.68%	14	0.59%
Swedish	8	0.40%	8	1.09%	13	0.54%
Hungarian	6	0.30%	5	0.68%	11	0.46%
Danish	6	0.30%	10	1.36%	10	0.42%
Hmong	5	0.25%	5	0.68%	8	0.33%
Ilocano	2	0.10%	6	0.82%	8	0.33%
Indonesian	7	0.35%	1	0.14%	8	0.33%
Ukrainian	8	0.40%	1	0.14%	8	0.33%

Practice Language	Los Angeles		San Diego		Grand Total	
	Count of Practices	% of Practices	Count of Practices	% of Practices	Count of Practices	% of Practices
Chinese (family)	7	0.35%	NA	NA	7	0.29%
Malay	6	0.30%	NA	NA	6	0.25%
Bulgarian	2	0.10%	5	0.68%	5	0.21%
Estonian	1	0.05%	5	0.68%	5	0.21%
Fataleka	5	0.25%	5	0.68%	5	0.21%
Kurdish	0	0.00%	5	0.68%	5	0.21%
Sindhi	5	0.25%	NA	NA	5	0.21%
Chamorro	3	0.15%	2	0.27%	3	0.13%
Dutch	3	0.15%	NA	NA	3	0.13%
Egyptian	1	0.05%	2	0.27%	3	0.13%
Hindustani	3	0.15%	NA	NA	3	0.13%
Samoan	3	0.15%	0	0.00%	3	0.13%
Sinhala	3	0.15%	NA	NA	3	0.13%
Croatian	2	0.10%	NA	NA	2	0.08%
Czech	2	0.10%	NA	NA	2	0.08%
Ibo	2	0.10%	NA	NA	2	0.08%
Malayalam	1	0.05%	1	0.14%	2	0.08%

Practice Language	Los Angeles		San Diego		Grand Total	
	Count of Practices	% of Practices	Count of Practices	% of Practices	Count of Practices	% of Practices
Norwegian	NA	NA	2	0.27%	2	0.08%
Shanghainese	2	0.10%	NA	NA	2	0.08%
Swahili	0	0.00%	2	0.27%	2	0.08%
Yiddish	1	0.05%	1	0.14%	2	0.08%
Afrikaans	1	0.05%	NA	NA	1	0.04%
Amharic	1	0.05%	NA	NA	1	0.04%
Assyrian	1	0.05%	NA	NA	1	0.04%
Flemish	1	0.05%	NA	NA	1	0.04%
Iloko	1	0.05%	NA	NA	1	0.04%
Mien	1	0.05%	NA	NA	1	0.04%
Serbian	1	0.05%	NA	NA	1	0.04%
Serbo-Croatian	1	0.05%	NA	NA	1	0.04%
Tongan	1	0.05%	NA	NA	1	0.04%
Wu Chinese	1	0.05%	0	0.00%	1	0.04%
Cebuano	NA	NA	0	0.00%	0	0.00%
Faroese	0	0.00%	0	0.00%	0	0.00%
Fukienese	0	0.00%	0	0.00%	0	0.00%

Practice Language	Los Angeles		San Diego		Grand Total	
	Count of Practices	% of Practices	Count of Practices	% of Practices	Count of Practices	% of Practices
Hakka	0	0.00%	NA	NA	0	0.00%
Hausa	0	0.00%	NA	NA	0	0.00%
Navajo	0	0.00%	NA	NA	0	0.00%
Toishanese	0	0.00%	NA	NA	0	0.00%
Grand total	2,020	100.00%	733	100.00%	2,391	100.00%

Data as of August 2024

Blue Shield Promise compared our provider network to the top five languages: Spanish, Mandarin, Vietnamese, Russian, and Korean. These results revealed that we are meeting and exceeding most of the network to meet the needs and preferences of our members. We included high-volume specialists to better assess and support the needs and preferences of our members.

There is a total of 2,391 practices in both LA and San Diego counties across the provider network. In both LA and SD counties the top spoken language for practitioner offices was Spanish; LA (95%) and SD (97%). The next top 4 spoken languages for practices were Mandarin, Vietnamese, Russian and Korean for both LA and SD counties. This aligns with the threshold languages for both counties.

Member and Practitioners Use of Interpreter Services for Medi-Cal

A key component to ensuring that members receive the services they need and prefer includes examining the utilization of interpreter services by members and providers. At a minimum, members are notified annually about the availability of interpreter services (refer to Appendix C) for an example of these notifications). Blue Shield Promise contracts with Language Line, a vendor who provides over-the-phone interpreter services for all lines of business. The tables below include an assessment of the utilization of interpreter services by members and providers. For the provider assessment, Language Line is unable to break out the assessment by line of business.

Table 7. 2023 Blue Shield Promise Member Utilization of Interpreter Services Requests

Language	Number of Calls	Percent of Languages
Spanish **	49,584	67%
Mandarin (Chinese)**	6,146	8.3%
Russian *	3,225	4.0%
Vietnamese **	2,219	3.0%
Korean *	1,837	2.5%
Arabic **	1,421	2.0%
Armenian *	1,316	1.8%
Tagalog **	1,278	1.7%
Cantonese (Chinese) **	1,154	1.6%
Haitian creole	1,081	1.5%
Farsi **	934	1.3%
Dari	656	<1.0%
Khmer *	565	<1.0%
Pashto	311	<1.0%
Thai	276	<1.0%
Laotian	203	<1.0%
Ukrainian	130	<1.0%
Japanese	123	<1.0%
Portuguese	122	<1.0%
Turkish	105	<1.0%
Somali	97	<1.0%
Hindi	81	<1.0%
Punjabi	81	<1.0%
Amharic	75	<1.0%
Bengali	71	<1.0%
Burmese	63	<1.0%
Swahili	55	<1.0%
Other languages less than 50 requests	476	<1%
Total Calls	**73,685**	

- *Data as of August 2024*
- *Per DHCS, there are 11 threshold languages in Los Angeles County and 7 threshold languages in San Diego County.*
- *LA County threshold language **Includes both LA and SD counties*

Over the Phone Interpreter Services

In 2023, the top-ranking languages requested for telephonic interpretation were Spanish 67%, Mandarin 8.3%, Russian 4.0%, and Vietnamese 3.0%. The use of interpretation services increased in 2023 by 36% compared to 2022. The increase in utilization demonstrates that our member engagement strategies are effective. Language services are provided to members through member newsletters which are in the member's preferred language, language assistance notice, Evidence of Coverage, Blue Shield Promise website, and Welcome Packets. Providers receive information on language assistance services through website, provider manual, provider contracts, IPA in-services, and annual mailing on requirements annually. We will continue to look for additional methods to promote language services to members and providers.

Interpreter Services – Provider Requested

There was a total of 998 interpreter services requested by all Blue Shield Promise providers in the calendar year 2023. Language Line is unable to produce reports by product type, therefore the counts included are cumulative for Blue Shield, including Blue Shield of California Promise Health Plan, our Medicaid product. The top 5 languages requested by providers for interpreters' services include: Spanish (660), Mandarin (184), Korean (22), Russian (21), and Pashto (16).

Table 8. Provider Requested Interpreter Services

Language Requested	Count	Percent of Requested Interpreter Services
Spanish	660	66.13%
Mandarin	184	18.44%
Korean	22	2.20%
Russian	21	2.10%
Pashto	16	1.60%
Vietnamese	10	1.00%
Cantonese	9	0.90%
Dari	9	0.90%
Farsi	9	0.90%
Amharic	8	0.80%
Punjabi	7	0.70%
Japanese	5	0.50%
Arabic	4	0.40%
Tagalog	4	0.40%
Hindi	3	0.30%
Khmer	3	0.30%
Somali	3	0.30%
Thai	3	0.30%
Armenian	2	0.20%
Danish	2	0.20%
French	2	0.20%

Haitian creole	2	0.20%
Portuguese	2	0.20%
Bengali	1	0.10%
Burmese	1	0.10%
Dutch	1	0.10%
Finnish	1	0.10%
Hmong	1	0.10%
Laotian	1	0.10%
Ukrainian	1	0.10%
Yiddish	1	0.10%
Total	**998**	**100.00%**

Data as of August 2024

Utilization of Written Translation Services

Blue Shield Promise offers health education and member materials free of charge to our members in multiple languages. Members are informed of this free service immediately upon enrollment, reminders on our website and annual member communications. Our members can additionally request written translations of materials in another language or format, such as Braille, electronic text file, audio, or in larger print. Blue Shield Promise's written translation of materials is supported by our vendor ISI. The data listed below shows an annual cumulative total of all written translation requests and if the written translation was completed.

Table 9. 2023 Member Translation Requests and Completion Results

Language Requested	# of Documents	% of Documents Requests Completed
Spanish	1,342	100%
Traditional Chinese	158	100%
Simplified Chinese	70	100%
Russian	216	100%
Vietnamese	173	100%
Korean	119	100%
Arabic	170	100%
Armenian	123	100%
Tagalog	141	100%
Haitian Creole	1	100%
Farsi	146	100%
Dari	0	100%
Khmer	100	100%

Overall Total	2,759	100%

From January 2023 through December 2023 there was a total of 19,632 requests for written translation services including alternative formats and 100% of those requests for translation were completed and returned to the relevant members. Blue Shield Promise has met its membership needs and preferences for this service. To better understand the data and our members' language service requests, we analyzed the number of requests per language type. The results show the top three requested written translation requests were Spanish, Russian, followed by Traditional Chinese. As this is our baseline report we will continue to monitor and looks for trends to ensure our members needs are continually being met. BSP met the goal of completing 100% of written translations requests for all threshold languages.

Provider Network

Blue Shield Promise examined our network for providers who speak member threshold languages to determine if there is a need to expand our provider network offerings to members to increase the quality of services offered. Furthermore, Blue Shield analyzed the network by specialty type to ensure our providers are meeting the needs and preferences of our membership to determine if network improvements can be made. The following specialties were assessed by threshold languages: pediatrics, family practice, cardiology, gastroenterology, and obstetrics/gynecology (OB/GYN). Full spatial analysis availability monitoring and appropriate provider to member ratios are addressed in Blue Shields *Availability and Medical Ratio Guidelines* section of our *Accessibility and Availability Policy and Procedures,* see table 10. below.

Table 10. Availability and Medical Ratio Guidelines

Provider to Member Ratio Guidelines	Standard	Goal
Total SCP (Specialty or Specialist Care Practitioner) to Member Availability Ratio: Specialists	1 SCP to 1,200 members	100%
Ethnic/Cultural and Language Needs	1 PCP speaking a threshold language to 1,200 members speaking a threshold language.	100%

Note: We are using the Ethnic / Cultural and Language Needs Standard to access if met goal for PCP's. PCPs are defined as (Family Medicine (GP & FP), Internal Medicine, and Pediatrics). We are using the strictest standard for PCP's. For Specialties we are using the High-Volume Specialty Standard and applying ethnic/cultural and language standard for PCP.

The following tables are an analysis on provider to member ratios by specialty type and member threshold languages.

Table 11. Data on Provider to Member Ratio – Los Angeles County

Language	Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
English	1:81	1:280	1:165	1:1,632	1:3,065	1:534
Spanish	1:75	1:227	1:208	1:1,855	1:2,919	1:475
Mandarin	1:11	1:39	1:21	1:439	1:293	1:76
Russian	1:24	1:84	1:36	1:416	1:832	1:166
Vietnamese	1:8	1:30	1:27	1:430	1:430	1:77
Armenian	1:14	1:52	1:35	1:357	1:624	1:146
Tagalog	1:1	1:9	1:8	1:301	1:301	1:32
Cantonese	1:11	1:40	1:33	1:484	1:1,451	1:76
Korean	1:3	1:35	1:16	1:155	1:361	1:42
Grand Total	1:109	1:371	1:248	1:2,226	1:3,560	1:760

Data as of August 2024

Table 12. Provider to Member Ratio– San Diego County

Language	Provider to Member Ratio Pediatric (Pediatric Members <18)	Provider to Member Ratio Family Practice	Provider to Member Ratio Internal Medicine	Provider to Member Ratio Cardiology	Provider to Member Ratio Gastroenterology	Provider to Member Ratio OB/GYN
English	1:71	1:436	1:244	1:3,638	1:3,019	1:663
Spanish	1:42	1:120	1:156	1:1,568	1:1,881	1:263

Russian	1:40	1:108	1:70	1:1,178	1:1,178	1:196
Vietnamese	1:20	1:68	1:39	1:634	NA	1:127
Tagalog	1:8	1:65	1:45	1:1,417	NA	1:283
Grand Total	1:80	1:379	1:260	1:3,313	1:3,501	1:697

Data as of August 2024

When assessing the Medi-Cal networks by threshold languages, Blue Shield Promise did not meet the thresholds for the following specialty types in Los Angeles: cardiology (English and Spanish) and gastroenterology (English, Spanish and Cantonese). In San Diego, the threshold languages were not met for the following specialty types and languages: cardiology (English, Spanish and Tagalog) and gastroenterology for English and Spanish. We just met the threshold for Russian gastroenterology in San Diego County and we will continue to monitor. While this will serve as a baseline measurement for CLAS, Blue Shield Promise acknowledges that regional differences can exist and must be incorporated to identify improvement opportunities. One potential root cause is that specialty providers are not populating the language field with English.

Blue Shield Promise Member Promise Sexual and Gender Identity

Blue Shield Promise allows members to self-identify their sex-assigned at birth, gender identity, preferred pronouns and sexual orientation via the Blue Shield member portal. An in-depth assessment was completed to adequately identify the wording of questions and options made available for members to not stigmatize any individual wishing to self-disclose this voluntary information. Blue Shield explicitly shares that none of this information will be used for underwriting purposes or to determine benefit coverage, including a statement within the My Profile section of the portal "Blue Shield collects data that will be used to ensure equitable access to healthcare for all members. These questions are optional, and your self-reported information is confidential. It won't be used to decide what services you qualify for." Members, including those over the age of 12, can update their member profile. Below is a baseline as the plan continues to provide education to members on the importance of self-reporting this information.

Table 13. Member Sex Assigned at Birth

Sex Assigned at Birth	Los Angeles		San Diego		Grand Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Sex Assigned at Birth: Male	168,058	44.89%	90,045	48.47%	258,103	46.08%
Sex Assigned at Birth: Female	206,332	55.11%	95,712	51.52%	302,044	53.92%
Sex Assigned at Birth: Unknown	1	0.00%	1	0.00%	2	0.00%
Choose not to disclose (Decline)	3	0.00%	8	0.00%	11	0.00%
No Response	0	0.00%	0	0.00%	0	0.00%
Total Self-Reported Sex Assigned at Birth	374,391	100.00%	185,758	100.00%	560,149	100.00%
Response Rate: Number of Members Who Responded	374,394	100.00%	185,766	100.00%	560,160	100.00%
Total Membership	374,394	66.84%	185,766	33.16%	560,160	100.00%

Data as of August 29, 2024

Table 14. Member Gender Identity

Gender Identity	Los Angeles		San Diego		Grand Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Gender Identity: Male	1,082	0.29%	725	0.39%	1,807	0.32%
Gender Identity: Female	1,819	0.49%	950	0.51%	2,769	0.49%
Gender Identity: Non-Binary	29	0.01%	38	0.02%	67	0.01%
Gender Identity: Transgender male/trans man	12	0.00%	16	0.01%	28	0.00%
Gender Identity: Transgender female/trans woman	13	0.00%	28	0.02%	41	0.01%
Gender Identity: Genderqueer	6	0.00%	10	0.01%	16	0.00%
Gender Identity: Other	1	0.00%	5	0.00%	6	0.00%
Gender Identity: Choose not to disclose (Decline)	0	0.00%	0	0.00%	0	0.00%
Gender Identity: No Response	371,426	99.21%	183,987	99.04%	555,413	99.15%
Total Self-Reported Gender Identity (Sum of first 7 selections)	2,962	0.79%	1,772	0.95%	4,734	0.85%
Response Rate Number of Members Who Responded	2,962	0.79%	1,772	0.95%	4,734	0.85%
Total Membership	374,394	66.84%	185,766	33.16%	560,160	100.00%

Data as of August 29, 2024

Less than 1% of members provided a gender identity. There was a total of 555,413 members who declined to provide this information. There is still over 99% of members who have not provided this information on the portal. There are 1,807 members who identify as male 2,769 members who identify as female, 67 who identify as non-binary, 28 members who identify as transgender male, 41 who identify as transgender female, 16 members identify as genderqueer and 6 who identify as other.

Table 15. Member Preferred Pronouns

Preferred Pronouns	Los Angeles		San Diego		Grand Total	
	Count	Percentage	Count	Percentage	Count	Percentage
He/Him Pronouns	268	0.07%	332	0.18%	600	0.11%
She/Her Pronouns	465	0.12%	398	0.21%	863	0.15%
They/Them Pronouns	38	0.01%	65	0.03%	103	0.02%
Other Pronouns	4	0.00%	12	0.01%	16	0.00%
Choose not to disclose (Decline)	44	0.01%	36	0.02%	80	0.01%
No Response	373,601	99.79%	184,975	99.57%	558,576	99.72%
Total Self-Reported Pronouns	752	0.20%	758	0.41%	1,510	0.27%
Number of Members Who Responded	793	0.21%	791	0.43%	1,584	0.28%
Total Membership	374,394	66.84%	185,766	33.16%	560,160	100.00%

Data as of August 29, 2024

Table 16. Member Sexual Orientation

Preferred Pronouns	Los Angeles		San Diego		Grand Total	
	Count	Percentage	Count	Percentage	Count	Percentage
Lesbian	16	0.00%	23	0.01%	39	0.01%
Gay	42	0.01%	59	0.03%	101	0.02%
Homosexual (Gay + Lesbian)	58	0.02%	82	0.04%	140	0.02%
Heterosexual	531	0.14%	555	0.30%	1,086	0.19%
Bisexual	43	0.01%	66	0.04%	109	0.02%
Queer	29	0.01%	33	0.02%	62	0.01%
Other	49	0.01%	49	0.03%	98	0.02%
Don't Know	22	0.01%	25	0.01%	47	0.01%
Choose not to Disclose (Decline)	106	0.03%	58	0.03%	164	0.03%

Data as of August 2024

Blue Shield Promise gives the option for members to self-identify their sexual orientation and gender identity (SOGI), including preferred pronouns on the member portal or when speaking to Customer Service. Blue Shield has a very low self-identification rate across all SOGI questions. Blue Shield Promise members have low self-identification responses for gender identity among

sexual orientation and preferred pronouns. Low response rates may be attributed to members who are not fully aware that this information can be securely shared with Blue Shield or fully understand the need for collecting this information. The Center for American Progress published an article in 2018 that discrimination or the potential of discrimination in health care settings endanger lives of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) people's lives, experiencing delays or denials of medically necessary care.[3] This could potentially discourage people in reporting information to their health plan and providers.

Grievances Related to Linguistically and Culturally Appropriate Care for Members

Blue Shield Promise is committed to delivering the highest quality of services to our members. As such, analyzing member grievances is one of the pathways that is used to determine if our internal services are meeting members' needs and preferences Blue Shield Promise has integrated into our AuthAccel system, a way to quantify our grievances into CLAS types by lines of business to help us determine areas of improvement.

Note that we have no internal grievance threshold as we want to examine all Culturally and Linguistically Appropriate Services (CLAS) grievances. Thus, BSP has determined that each CLAS grievance needs to be reviewed to obtain the highest level of understanding of our members' needs and preferences.

We take additional steps to ensure that our network providers have access to resources to increase cultural awareness and provide culturally appropriate care for our members. Blue Shield does this through the development of training and access to educational resources on our website. We encourage providers to utilize these resources through our provider portal and communication campaigns (see Appendix B).

Table 17. Medi-Cal Los Angeles Grievances

	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Total
Linguistically related grievances	9	9	15	15	17	65
Culturally related grievances	19	18	21	21	36	115
Total # of grievances	28	27	36	36	53	180

[3] Discrimination Prevents LGBTQ People From Accessing Health Care - Center for American Progress

Table 18. Medi-Cal San Diego Grievances

	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Total
Linguistically related grievances	13	16	28	16	21	94
Culturally related grievances	7	9	16	15	30	77
Total # of grievances	20	25	44	31	51	171

Blue Shield Promise had a total of 159 linguistically related grievances in 2023 through Q1 2024 and a total of 192 culturally related grievances. Most linguistically related grievances were related to the member's experience using an interpreter. The common themes include, but are not limited to:

- Member feels interpreter did not interpreter correctly
- Member said Provider would not make appointment for interpreter.
- Interpreter not showing up to member appointment due to incorrect date or location.

A total of 192 culturally related grievances were reviewed for 2023 and Q1 2024 across both Los Angeles and San Diego Counties. The most common themes for these grievances are related to:

- Poor experiences with provider and their office staff due to their race, sexual orientation, gender identity or spoken language
- Negative experiences with Blue Shield Promise staff due to language needs during the telephone
- Discriminated against by the member's doctor due to religious beliefs and spoken language during provider visits.

Provider Education and Training Resources

To improve cultural responsiveness, Blue Shield offers providers free trainings and educational resources. This information is available on the provider website and in the provider portal (refer to Appendix B). Many of these trainings focus on health equity and cultural awareness and qualify for Continuing Medical Education (CME) credit. The table below outlines the available training courses, a report on the completion rate to date (if available) and the number of providers who received CME. The goal is to have 100 providers successfully complete any of the courses for CME credits. Since the completion rate is cumulative, the current goal has been met. However, the inability to quantify the number of providers that take CLAS training per year has been challenging as it has been configured to count based off the start date of training going live. There are two eLearnings, *Implicit Bias in Healthcare and What can you do about it* and *Improving Health Literacy with plain language* that we are unable to track the number of views of this training. We included traffic information from 2022 for insights. Beginning January 2025[4], all contracted providers will be required to complete training on advancing health equity and will cover a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. Once the training is finalized, a link to access the training will be made available to providers.

Table 18. Provider Education and Training Resources

Course Title and link	Description	Traffic as of (unique views)	# of providers who received CME
Care for Transgender/Nonbinary Patients-webinar to be held on 10/18/23 Recorded webinar (55 min) Presentation (PDF, 4 MB) To earn enduring Continuing Medical Education (CME) credit	Barry K. Eisenberg, M.D. and Ilana Sherer, M.D., FAAP from the Palo Alto Medical Foundation/Sutter Health discuss and answer questions about what we can do to help improve the healthcare experience of transgender and nonbinary youth, adolescents, and adults.	179 attendees; 155 views (recording)	61

[4] APL 23-025 (ca.gov)

Course Title and link	Description	Traffic as of (unique views)	# of providers who received CME
by viewing this webinar, visit Scripps Health.			
Addressing Cardiac Care Disparities for Better Patient Outcomes-webinar held 9/19/23. CME available Recorded webinar (51 min) Presentation (PDF, 7 MB)	Dr. Columbus Batiste, chief of cardiology at Kaiser Permanente Riverside and Moreno Valley Medical Centers, addresses key health disparities in cardiac care and how to reduce their occurrence.	17 attendees; 100 views (recording	19
Racism in American Medicine Webinar held on 9/20/22 CME available (recorded webinar available soon)	Dr. Tina Sacks, Assistant Professor at UC Berkeley School of Social Welfare, and Dr. Lily Lamboy, Director of Diversity, Equity, and Inclusion at Blue Shield, discuss the latest research in health inequities, share insights from patient grievances, and identify ways to avoid them.	86 attendees; 55 views (recording)	55
What your Lesbian, Gay, Bisexual, Transgender, and Questioning patients would like you to know (February 2020) Recorded webinar (1.5 hours) Presentation (PDF, 1.3 MB)	This webinar covers practical guidelines and considerations for providing inclusive health care to your LGBT/Q patients. Topics include creating a welcoming environment for LGBT/Q patients, using non-judgmental questions, and using language preferred by LGBT/Q patients.	2337	933 (not all were BSC providers)

Course Title and link	Description	Traffic as of (unique views)	# of providers who received CME
Implicit Bias in Healthcare and What You Can Do About It	eLearning: This interactive module is a quick way for clinicians and office staff to recognize and mitigate implicit bias.	As of 9/2022 was 94. Updated number available.	n/a
Addressing low health literacy - Improve patient outcomes without adding time (February 2021) Recorded webinar (59 min) Presentation (PDF, 885 KB)	Dr. Cliff Coleman, MD, MPH, a national expert in health literacy, presents communication best practices designed to improve patients' understanding while not adding time to healthcare professionals' busy workloads.		

2024 Barrier Analysis

We are in the early stages of developing the Blue Shield Promise CLAS Program. The focus is to streamline the processes and collection of data. However, member-facing barriers and opportunities have been identified. Listed below are the identified barriers for member-facing and administrative opportunities.

Item #	Category	Barriers
1	Provider Network	Member and Administrative Facing: Lack of English and Spanish speaking cardiologist in Los Angeles and San Diego Counties and limited English, Spanish, and Tagalog (San Diego only) speaking gastroenterologists in Los Angeles and San Diego counties have been identified. The potential root causes are English speaking specialty providers are not populating the language field with English and believing the system will auto default to English. Second, Spanish and Tagalog speaking specialty providers this may be due to under reporting of provider languages and a network need to increase specialty providers that speak these languages.
2	Grievances related to Culturally Appropriate Care for Members	Member and Administrative Facing: Lack of member and provider awareness regarding the process steps in how to request an interpreter be present during the members health care encounters. We believe the potential root cause is members and providers are not recalling the pre-planning timeline requirements to request an interpreter, which is affecting the member and providers healthcare visit.
3	Grievances related to Culturally Appropriate Care for Members	Member-Facing: Lack of members receiving health plan materials in their preferred written languages. This may be due to several factors including members not being aware of how to update the Plan on their written language preferences and the Customer Service department process for asking the members to confirm their written language preferences while on a call.
4	Member and Provider Race, Ethnicity, and Language Data	Member-Facing: Lack of member and provider race, ethnicity, and language data. We believe the root cause of this insufficient data is that race and ethnicity are optional for providers to share. We find this same reason to support *Some Other Race* the data results for San Diego County.

	Member Sexual Orientation and Gender Identity Data.	For both members and providers, we believe there is a potential lack of understanding of how the Plan will utilize their data and our privacy and protection may be the underlining reasons for not sharing this information. These same potential root causes apply to why we believe members are not sharing their sexual orientation and gender identity information.
5	CLAS Provider Training	Administrative Facing Lack of current web system ability quantify the number of providers that take CLAS trainings per year. The root cause is the system is configured to count based off the start date of training going live.

2024 Opportunity for Improvement and Intervention Plan for Blue Shield Promise

Opportunity for Improvement and Intervention Plan						
Item	**Opportunity for Improvement**	**New Intervention**	**Responsible Party**	**Informed Party**	**Implementation Date**	**Status**
1	1.Increase the number of Spanish speaking cardiologist in Los Angeles and San Diego Counties and Spanish, and Tagalog (San Diego only) speaking gastroenterologists in Los Angeles and San Diego counties. Increasing the number of specialty providers that speak these languages will ensure our members network preferences are met and potentially will result in	Administrative Facing 1, 2: Cross-department workgroup to be formed to review all provider network language data that did not meet goal, examine current outreach activities, determine best practices approach to increase the network in these areas, and develop a timeline. Additionally, this team will examine our internal process for collecting and displaying English and develop a action plan based on their findings.	Health Equity Quality Provider Network Provider Outreach IT Provider Contracting	Health Equity Oversight Committee Community Advisory Committee	1.Q1 2025	1.Not Started

Opportunity for Improvement and Intervention Plan						
Item	**Opportunity for Improvement**	**New Intervention**	**Responsible Party**	**Informed Party**	**Implementation Date**	**Status**
	higher overall satisfaction. 2. Examine our internal process of how we collect and display English speaking cardiologist and gastroenterologists in Los Angeles and San Diego Counties to ensure our network language data is accurate.					
2, 3	Increase member and provider awareness of: 1. How to request an interpreter and the pre-planning timeline requirements to book this service. 2. How to request written materials be translated into the members preferred written languages.	**Member-Facing:** 1. Ask members of the Community Advisory Committee to share their feedback on the best method of communication with them on language assistance resources. 2. Develop and disseminate a member notification on how to access language	Health Equity Quality Customer Service Provider Relations	Health Equity Oversight Committee Community Advisory Committee	1. September 2024 2. September 2024	1. Completed 2. Completed

Opportunity for Improvement and Intervention Plan						
Item	**Opportunity for Improvement**	**New Intervention**	**Responsible Party**	**Informed Party**	**Implementation Date**	**Status**
	These two improvements will support our members overall satisfaction.	assistance services, including interpreter and translation information. * *See Appendix C* 3. Develop and disseminate a provider letter and online provider announcement notification including cultural awareness and linguistic resources, language assistance services, including interpreter and translations and Cultural Competency training. **Administrative-Facing:** 1. Setup a working session meeting to review grievance results and the current Customer Service process for asking and confirming			3. October 2024 4. Q4 2024	3. In progress 4. To Start

Opportunity for Improvement and Intervention Plan						
Item	**Opportunity for Improvement**	**New Intervention**	**Responsible Party**	**Informed Party**	**Implementation Date**	**Status**
		the members preferred written language to receive material in. Based on findings a action plan will be developed and implemented.				
4	Increase data capture for member and providers' race, ethnicity, and language information to allow for accurate network analysis and comparison to support member needs and preferences Increase data capture of member sexual orientation and gender identity data.	**Member-Facing** 1. Partner with Violet (Vendor) and leverage their Health Equity provider training and other resources to encourage providers to self-identity race, ethnicity, language data. 2. Send reminders to all providers about the importance of updating their provider profile, which includes, but not limited to race, ethnicity, and spoken languages including office staff.	Health Transformation Network Analytics Health Equity Provider Communication /Network Compliance	Health Equity Oversight Committee Community Advisory Committee	1. Q1 2025 2. Q3 2024 3. Q3 2024	1.In progress 2.Completed 3.Completed

Opportunity for Improvement and Intervention Plan						
Item	**Opportunity for Improvement**	**New Intervention**	**Responsible Party**	**Informed Party**	**Implementation Date**	**Status**
		3. Send out reminders to all members regarding the privacy and protections of their race, ethnicity, and language, sexual orientation, and gender identity data and share the process for how to update their profiles.				
5	Improve web system ability to count the number of providers that take trainings by year instead of an accumulative total. This shift would support the Plans ability trend data and see yearly training participation rates.	Administrative-Facing Establish meeting with IT/web team to examine system abilities to shift from accumulative to a year rate of providers who take CLAS training. The result of this meeting will include timeline for implementing the change.	Quality Health Equity IT/Web	Health Equity Oversight Committee Community Advisory Committee	Q1 2025	To Start

Plan for Evaluation of Interventions

As this is the first year conducting the Annual Culturally and Linguistically Appropriate Services (CLAS) Report, the plan for the evaluation of the effectiveness of these interventions is to occur in September 2025 and will be reviewed and evaluated by the Community Advisory Committee (CAC) and the Health Equity Oversight Committee (HEOC).

Plan for Annual Evaluation of the CLAS Program

In 2024, the Blue Shield Promise CLAS program had several achievements and areas identified for continued improvement. As our CLAS Program is relatively new, many of our efforts were focused on the building of a CLAS infrastructure and conducting baseline reports for future analysis. Below is a breakdown of the successes and the overall evaluation of the program thus far. Our plan is to conduct a full annual evaluation of the overall effectiveness of the CLAS Program in September 2025 which will include trending of measures, analysis, identified barriers, opportunities for improvement and interventions. At that time, this report will be reviewed and evaluated by our members and community representatives at the CAC and HEOC. The 2024 achievements included, but are not limited to the development and implementation of the following:

- Integrated CLAS and Health Equity into our Quality Program Description and QI Work Plan.
- Developed and implemented a revised Health Equity Oversight Committee.
- Standardized the schedule for monitoring of interpreter services vendors so they can report to Blue Shield of California quarterly and/or annually on the competency testing and results of their interpreters to ensure continuous oversight and monitoring.
- Aligned organizational policies for data access and policies on permissible use and impermissible use.
- Completion of the first Annual CLAS, Disparities, and Utilization Reports
- Launched and completed 2024 Employee Experience with Language Services Survey
- Updated the race options available on the Blue Shield Promise member portal with questions

Overall, the CLAS program successfully launched and integrated numerous new CLAS initiatives. This resulted in increased awareness and visibility of CLAS needs and preferences of our members.

To have appropriate oversight and monitoring of activities by leadership all CLAS initiatives were listed/described in the Quality Work Plan. Leadership is actively involved and engaged in all CLAS initiatives via participation in committees and work groups. Additionally, they serve as a source of addressing any barriers requiring escalation.

Appendix A: Notice of Language Assistance

Blue Shield of California Promise Health Plan
Medi-Cal
Annual Health Disparities Report

MY 2023/RY 2024

Production Date: <Month Year>
Revision Date: <Month Year>

Table of Contents

Introduction

Blue Shield of California Promise Health Plan (inclusive of Medicaid also known as Medi-Cal products in San Diego and Los Angeles Counties) for the remainder of this report will be referred to as Blue Shield Promise (BSP), is dedicated to identifying and addressing health care disparities with the aim of improving our services and advancing health equity of our members. To support this goal, Blue Shield Promise annually uses race, ethnicity, language, and gender data to assess and identify the existence of health disparities and develops and implements interventions to reduce those identified disparities to improve health of our members. This report will serve as the initial baseline year for the Medi-Cal lines of business and all interventions will be evaluated for effectiveness in each forthcoming year.

Methodology

To identify and reduce health care disparities within the Blue Shield Promise population, Blue Shield Promise will leverage the Healthcare Effectiveness Data and Information Set (HEDIS) clinical performance measures and Consumer Assessment of Healthcare Provider and Systems (CAHPS) data and analyze specific measures by race, ethnicity, language, and gender, following the HEDIS® *Volume 2 Technical Specifications for Health Plans*[1]. Based on this assessment, Blue Shield will develop and implement interventions to address identified health care disparities in our Blue Shield Promise membership.

The selection of HEDIS® and CAHPS measures was determined in collaboration with our Medical Director(s), clinical quality, and data analytics teams. The selected HEDIS® measures along with the rationale for inclusion are listed below.

The selected HEDIS® measures were identified for quality improvement and concurrently monitored and tracked for the Medi-Cal population based on alignment with regulatory and contractual requirements, including the Department of Healthcare Services (DHCS) Managed Care Accountability Set (MCAS). The MY 2023 goal for each measure is to reach the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed.

In 2012, the National Quality Forum (NQF), an organization that promotes patient protections and healthcare quality through measurement, published criteria for the selection of disparities measures called the *Healthcare Disparities and Cultural Competency Consensus Standards: Disparities Sensitive Measure Assessment*[2]. These standards identify the following protocol indicators:

- Prevalence
- Quality Gap
- Impact
- High Degree of Discretion
- Communication- sensitive services
- Social determinants
- Category
- Measure Type
- Crosscutting

In alignment with these indicators and the clinical advisement, Blue Shield Promise has selected the measurements below. For our analysis Blue Shield Promise used HEDIS® Measurement Year (MY) 2023 data for services rendered in 2023. For the MY 2023 data, Blue Shield Promise used Inovalon as the HEDIS® measure data vendor. Blue Shield Promise chose to focus on "Controlling Blood Pressure," "Hemoglobin A1c Control for Patients With Diabetes," "Prenatal and Postpartum Care," and "Child and Adolescent Well Care Visits" to align with priority clinical areas included in the DHCS Managed Care Accountability Set.

1. **Clinical Performance Data: HEDIS® measures by race and ethnicity:**
    - **Controlling High Blood Pressure (CBP)**
        - The CBP measure assesses members 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.
    - **Hemoglobin A1c Control for Patients With Diabetes (HBD)**
        - The HBD measure assesses members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following level: HbA1c Poor Control (>9.0%).

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] https://www.qualityforum.org/Topics/Disparities.aspx

- **Prenatal and Postpartum Care (PPC)**
    - Timeliness of Prenatal Care. 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.
    - Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
- **Child and Adolescent Well Care Visits (WCV)**
    - The WCV measure assesses the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

2. **Clinical Performance Data: HEDIS® measure by preferred language:**
    - **Child and Adolescent Well Care Visits (WCV)**
        - The WCV measure assesses the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
3. **Clinical Performance Data: HEDIS® measure by Gender:**
    - **Child and Adolescent Well Care Visits (WCV)**
        - The WCV measure assesses the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

In 2023, Blue Shield Promise used Press Ganey, formerly known as Symphony Performance Health (SPH) Analytics, a Centers for Medicare and Medicaid Services (CMS) certified company, as our CAHPS vendor. The following data is based on the 2023 Medicaid Adult CAHPS survey. The survey was administered via mail and phone. Members eligible for the survey were Blue Shield Promise members who were continuously enrolled in the last 6 months of 2023 with no more than one gap in enrollment of up to 45 days. Blue Shield Promise used the top box ratings for each selected measure: "Rating of Health Care". This is represented by rates for respondents who selected a rating of 8, 9 or 10. These measures are included in the CAHPS survey measures for reporting. Race and Ethnicity data is voluntary for respondents.

4. **Individual Experience Data: CAHPS Measures by race and ethnicity:**
    - **Rating of Health Care (8,9,10)**

      Question: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?

Race and Ethnicity Data
For each measure, the organization used direct data sources to stratify the HEDIS® measures by race/ethnicity. In alignment with the HEDIS® technical specifications, direct data refers to data collected directly from members method and reflects members' self-identification. Directly collected data includes any source for which the member self-identified race or ethnicity. This includes data collected directly from members by the health plan, as well as third-party data collected directly from a member by another entity (e.g., the state or CMS). Direct sources may include, but are not limited to:

- Surveys.
- Health risk assessments.
- Disease management registries.
- Case management systems.
- EHRs.
- CMS/state databases.
- Enrollment information furnished by enrolling entities (e.g., state Medicaid agencies, employers).
- CCDs.

Consequently, the data will reflect the eligible population, numerator, and rate from direct data sources for the measures stratified by race and ethnicity. For language and gender, Blue Shield Promise selected "Child and Adolescent Well Care Visits," because this measure aligns with DHCS' focus on preventive children's health and is a population in which more language and gender data would be available. Blue Shield will use HEDIS® Measurement Year 2023 data for services rendered in 2023.

Section 1a. Blue Shield Promise Clinical Performance Data, HEDIS® by Race and Ethnicity: Controlling High Blood Pressure (CBP)

In 2024, scores for the HEDIS® measures were provided by Inovalon. Below is a breakdown of scores for the HEDIS® Measurement Year (MY) 2023 Controlling High Blood Pressure (CBP) measure for San Diego and Los Angeles County. In San Diego County, the tables reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

In MY 2024, the goal for Controlling High Blood Pressure (CBP) was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY 2023 DHCS MPL was 61.31%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories.
"Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".
"Asked But No Answer," is an option for members who decline to answer or provide a response.
"Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY 2023— Controlling High Blood Pressure (CBP) by Race:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
American Indian or Alaska Native	1	1	100%	61.31%	Yes	9	15	60%	61.31%	No
Asian	22	27	81.48%	61.31%	Yes	590	1,173	50.30%	61.31%	No
Black or African American	9	14	64.29%	61.31%	Yes	515	1,190	43.28%	61.31%	No
Native Hawaiian or Other Pacific Islander	2	2	100%	61.31%	Yes	48	83	57.83%	61.31%	No
Some Other Race	1	1	100%	61.31%	Yes	6	10	60%	61.31%	No
Two or More Races	0	0	N/A	N/A	N/A	0	1	0%	61.31%	No
Asked but No Answer	0	0	N/A	N/A	N/A	1	1	100%	61.31%	Yes
Unknown Race	0	0	N/A	N/A	N/A	0	5	0%	61.31%	No
White	46	67	68.66%	61.31%	Yes	365	781	46.74%	61.31%	No
Total	**81**	**112**	**72.32%**	61.31%	Yes	**1,534**	**3,259**	47.07%	61.31%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Medi-Cal HEDIS® MY 2023— Controlling High Blood Pressure (CBP) by Ethnicity:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Hispanic or Latino	64	94	68.09%	61.31%	Yes	1,717	3,022	56.82%	61.31%	No
Not Hispanic or Latino	78	109	71.56%	61.31%	Yes	1,515	3,208	47.23%	61.31%	No
Asked But No Answer	0	0	N/A	N/A	N/A	1	2	50 %	61.31%	No
Unknown Ethnicity	11	19	57.89%	61.31%	No	2,828	5,241	53.96%	61.31%	No
Total	153	222	68.92%	61.31%	Yes	6,061	11,473	52.83%	61.31%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Quantitative Analysis:

The eligible population for the Controlling Blood Pressure (CBP) measure are Blue Shield Promise members 18–85 years of age who had a diagnosis of hypertension. The measure assesses the percentage of the eligible population whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. In San Diego County, the tables above reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

As the tables above show, overall, when examining CBP rates by race and ethnicity, the population in San Diego County exceeded the goal, the DHCS MPL (61.31%). The total population, after stratifying by race, showed that 72.32% of members diagnosed with hypertension demonstrated controlled blood pressure levels, which was 11.01 percentage points above the MY2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that 68.92% of corresponding members demonstrated controlled blood pressure levels, which was 7.61 percentage points above the MPL. In San Diego County, almost all racial and ethnic groups met the DHCS MPL, except for members who identified as "Unknown Ethnicity."

On the other hand, when reviewing performance rates by race or ethnicity, the population in Los Angeles County, overall, did not meet the goal. The total population, after stratifying by race, showed that 47.07% of members diagnosed with hypertension demonstrated controlled blood pressure levels, which was 14.24 percentage points below the MPL of 61.31%. The total population, after stratifying by ethnicity, showed that 52.83% of corresponding members demonstrated controlled blood pressure levels, which was 8.48 percentage points lower than the MPL. In Los Angeles County, all racial and ethnic groups did not meet the DHCS MPL.

For San Diego County, most racial groups had denominators less than 30, accentuating differences in CBP compliance between groups and are not actionable. For example, the highest performing groups in San Diego County were American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and "Some Other Race." These groups demonstrated 100% compliance but were only represented by denominators of 1 or 2. The next highest scoring group were Asian members with a compliance rate of 81.48%. However, the denominator for this group was 27, which is less than the reporting population requirement of 30. While the lower scoring groups were White (68.66%) and Black or African American members (64.29%), these two groups exceeded the DHCS MPL of 61.31%. When examining CBP rates by ethnicity, the highest performing and the largest group in San Diego County was Not Hispanic or Latino (68.09%). While the group, "Unknown Ethnicity" (57.89%) had the lowest compliance rate, this group also had the lowest denominator with 19 members, reflecting only 8.56% of the total population (19/222). Given that the overall CBP compliance rate in San Diego County exceeded the goal, the DHCS MPL (61.31%), and that almost all reportable racial and ethnic groups also met the goal, addressing CBP performance in San Diego County was not identified as an opportunity for improvement. Blue Shield Promise will continue to monitor and stratify the CBP compliance rate among San Diego County members.

For Los Angeles County, the highest performing groups were Native Hawaiian or Other Pacific Islander (57.83%, n=83) and Asian members (50.30%, n=1,173). Even though these two groups with reportable populations demonstrated higher compliance compared to the other groups, both groups did not meet the goal, the DHCS MPL of 61.31%. Additionally, while Native Hawaiian or Other Pacific Islander (57.83%) showed the highest relative performance, the denominator accounts for 2.55% of the total population (83/3,259). On the other hand, members who identified as Asian account for 35.99% of the total population (1,173/3,259). The lowest scoring groups were White (46.74%) and Black or African Americans members (43.28%). These groups did not meet the goal of the DHCS MPL (61.31%) and performed lower than the highest performing reportable groups, Native Hawaiian or Other Pacific Islander (57.83%, n=83) and Asian members (50.30%, n=1,173). CBP compliance rates among members who identified a White or Black or African American may have driven overall performance because each group represents a considerable size of the overall denominator with White members reflecting 23.96% of the total membership (781/3,259) and Black Members reflecting 35.99% of the total membership (1,190/3,259). When

examining rates by ethnicity, although no group met the goal of 61.31%, the highest performing group were members who identified as Hispanic or Latino (56.82%). The lowest performing group were members who identified as Not Hispanic or Latino (47.23%) with a comparable denominator of 3,208 as those who identified a Hispanic or Latino with a denominator of 3,022. The largest group identified as “Unknown Ethnicity” (53.96%) with a denominator of 5,241, accounting for 44.63% of the total denominator. The category of “Unknown” is hard to discern and is not currently actionable. We have ongoing efforts to increase data collection of our membership and identify address disparities .

Section 1b. Medi-Cal Performance Data, HEDIS® by Race and Ethnicity: Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c poor control (>9.0%)

In 2024, scores for the HEDIS® measures were provided by Inovalon. Below is the breakdown of scores for the HEDIS® Measurement Year (MY) 2023 Hemoglobin A1c Control for Patients with Diabetes (HBD) - HbA1c poor control (>9.0%) measure for San Diego and Los Angeles County. In San Diego County, the tables reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

In MY 2023, the goal for Hemoglobin A1c Control for Patients with Diabetes (HBD) was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY 2023 DHCS MPL was 37.96%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories.
"Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".
"Asked But No Answer," is an option for members who decline to answer or provide a response.
"Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY 2023— Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c poor control (>9.0%) by Race:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
American Indian or Alaska Native	0	1	0%	37.96%	Yes	6	18	33.33%	37.96%	Yes
Asian	5	33	15.15%	37.96%	Yes	254	934	27.19%	37.96%	Yes
Black or African American	6	26	23.08%	37.96%	Yes	420	891	47.14%	37.96%	No
Native Hawaiian or Other Pacific Islander	2	5	40.00%	37.96%	No	17	66	25.76%	37.96%	Yes
Some Other Race	0	0	0%	N/A	N/A	7	16	43.75%	37.96%	No
Two Or More Races	0	0	0%	N/A	N/A	1	3	33.33%	37.96%	Yes
Asked But No Answer	0	0	0%	N/A	N/A	1	2	50.00%	37.96%	No
Unknown Race	0	0	0%	N/A	N/A	3	10	30.00%	37.96%	Yes
White	20	52	38.46%	37.96%	No	231	603	38.31%	37.96%	No
Total	**33**	**117**	**28.21%**	37.96%	Yes	**940**	**2,543**	36.96%	37.96%	**Yes**

N/A = Not applicable because there are no members in the numerator or denominator

Medi-Cal HEDIS® MY 2023— Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c poor control (>9.0%) by Ethnicity:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Hispanic or Latino	40	112	35.71%	37.96%	Yes	1,505	3,952	38.08%	37.96%	No
Not Hispanic or Latino	33	116	28.45%	37.96%	Yes	920	2,487	36.99%	37.96%	Yes
Asked But No Answer	0	0	0.00%	N/A	N/A	0	3	0.00%	37.96%	Yes
Unknown Ethnicity	9	17	52.94%	37.96%	No	2,579	6,197	41.62%	37.96%	No
Total	82	245	33.47%	37.96%	Yes	5,004	12,639	39.59%	37.96%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Quantitative Analysis:

The eligible population for the Hemoglobin A1c Control for Patients with Diabetes (HBD) measure are Blue Shield Promise members 18-75 years of age who had a diagnosis of diabetes (types 1 and 2). The measure assesses the percentage of the eligible population as controlled HbA1c as HbA1c less than 8.0%, and poorly controlled HbA1c as HbA1c greater than 9.0% during the measurement year. For the HBD measure, the focus will be on the poorly controlled HbA1c levels greater than 9.0% during the measurement year. Due to measure counting poorly controlled members, the lower the rate percentage, the better the performance. In San Diego County, the tables above reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

As the tables above show, overall, when examining HBD rates by race and ethnicity, the population in San Diego County exceeded goal, the DHCS MPL (37.96%). The total population, after stratifying by race, showed that 28.21% of members were diagnosed with diabetes had poorly controlled HbA1c levels, which was 9.75 percentage points lower than the MY 2023 DHCS MPL of 37.96%. Given that lower percentages for this measure translate to higher performance for this measure, overall San Diego exceeded the goal. The total population, after stratifying by ethnicity, showed that 33.47% of corresponding members demonstrated poorly controlled HbA1c levels, which was 4.49 percentage points lower than the MY 2023 DHCS MPL. Although the group "Unknown Ethnicity," did not meet the goal, the population size is not reportable and was not identified as an opportunity for improvement.

Similarly, when reviewing performance rates by race or ethnicity, the population in Los Angeles County, overall, met the DHCS MPL (37.96%). The total population, after stratifying by race, showed that 36.96% of members were diagnosed with diabetes had poorly controlled HbA1c levels, which was 1.0 percentage points lower than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that the 37.64% of corresponding members demonstrated poorly controlled HbA1c levels, which was 0.32 percentage points lower than the MY2023 DHCS MPL, except for members who identified as "Hispanic or Latino" and the group "Unknown Ethnicity".

For San Diego County, most racial groups had denominators less than 30, accentuating differences in HBD compliance between groups and are not actionable. Three groups performed better than the MY 2023 DHCS MPL, whereas at least two groups did not meet the goal of the MY 2023 DHCS MPL or no reported denominators. The lower the percentage rate is, the better the performance for this measure. For example, the highest performing groups in San Diego County were American Indian or Alaska Native, Asian, and Black or African American. American Indian or Alaska Native demonstrated 100% compliance but were only represented be denominator of 1. Asian members had a compliance rate of 15.15%, with a denominator of 33, which is above the reporting population requirement of 30. Black or African American had a compliance rate of 23.08%, with a denominator of 26. The lower performing groups were Native Hawaiian or Other Pacific Islander and White. Native Hawaiian or Other Pacific Islander members had a compliance rate of 40.00% (n=5) and White members had a compliance rate of 38.46% (n=52). When examining HBD rates by ethnicity, the highest performing groups are Hispanic or Latino (35.71%, n=112), and Not Hispanic or Latino (28.45%, n=116). The group "Unknown Ethnicity" had the lowest compliance rate (52.94%), but had a denominator of 17, which is below the reporting population requirement of 30. Additionally, the category is difficult to discern because the ethnicity is unknown for these members. Consequently, this category is not currently actionable. Blue Shield Promise will continue to monitor and stratify the HBD compliance rate among San Diego County members.

For Los Angeles County, most of the racial groups had denominators less than 30, accentuating differences in HBD compliance between groups. For example, the highest performing groups in Los Angeles County were American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander, "Two or More Races," and "Unknown Race".

Production Date: <Month Year>
Revision Date: <Month Year>

The lower the percentage rate is, the better the performance for this measure. The best performing group was Native Hawaiian or Alaska Native (25.76%) with a denominator of 66. The next best performing group was Asian (27.19%) with a denominator of 934. The next better performing groups were "Unknown Race" (30.00%, n=10), "Two or More Races" (33.33%, n=3), and American Indian or Alaska Native (33.33%, n=18), which are all less than the reporting population requirement of 30. Shortly following these groups, White members had a compliance rate of 38.31% (n=603) and did not meet the goal, suggesting an opportunity for improvement. The lowest performing groups were "Some Other Race" (43.75%), Black or African American (47.14%), and "Asked but No Answer" (50.00%). Black or African American group did not meet the goal, MY 2023 DHCS MPL, but had a denominator of 891, which is a larger total population compared to other racial groups and reflect an opportunity for improvement. The other lowest scoring groups had less than 30 denominators, making it difficult to act upon these opportunities. When examining HBD rates by ethnicity, one group met the goal of 37.96%, the MY 2023 DHCS MPL. The lower the percentage rate is, the better the performance for this measure. The highest performing group is Not Hispanic or Latino (36.99%) with a denominator of 2,487. The other lower performing groups are Hispanic or Latino (38.08%, n=3,952) and "Asked But No Answer" (0.00%, n=3). While "Unknown Ethnicity," is one of the largest categories and did not meet the goal of the DHCS MPL (37.96%), this group is not actionable because the ethnicity cannot be discerned.

Given that Los Angeles County met the goal of the DHCS MPL, there was no opportunity identified for improvement after stratifying the rates by race. After stratifying by ethnicity, members who identified as Hispanic or Latino (38.08%, n=3,952) is an opportunity in Los Angeles because this category did not meet the goal of the DHCS MPL (37.96%), and this group reflects a large proportion of the denominator. The Hispanic or Latino group reflects 31% of the total population (3,952/12,639). Additionally, the larger prevalence of Diabetes reflected in the total population, necessitates a need to address this opportunity.

Section 1c. Medi-Cal Performance Data, HEDIS® by Race and Ethnicity: Prenatal and Postpartum Care (PPC)

In 2024, scores for the HEDIS® measures were provided by Inovalon. Below is the breakdown of scores for the HEDIS® Measurement Year (MY) 2023 Prenatal and Postpartum (PPC) measure in both Timeliness of Prenatal Care and Postpartum Care for San Diego and Los Angeles County. In San Diego County, the tables reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

In MY 2023, the goal for Prenatal and Postpartum (PPC) - Timeliness of Prenatal Care measure and Postpartum Care measure - was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY 2023 DHCS MPL for Timeliness of Prenatal Care was 84.23% and for Postpartum Care was 78.10%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories.
"Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".

"Asked But No Answer," is an option for members who decline to answer or provide a response.
"Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY 2023— Prenatal and Postpartum (PPC) – Timeliness of Prenatal Care by Race:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
American Indian or Alaska Native	2	2	100%	84.23%	Yes	4	5	80.00%	84.23%	No
Asian	4	4	100%	84.23%	Yes	56	85	65.88%	84.23%	No
Black or African American	4	6	66.67%	84.23%	No	200	291	68.73%	84.23%	No
Native Hawaiian or Other Pacific Islander	3	3	100%	84.23%	Yes	8	10	80.00%	84.23%	No
Some Other Race	1	2	50%	84.23%	No	10	10	100.00%	84.23%	Yes
Two Or More Races	0	0	N/A	N/A	N/A	0	1	0.00%	84.23%	No
Asked But No Answer	0	0	N/A	N/A	N/A	0	0	N/A	N/A	N/A
Unknown Race	2	2	100%	84.23%	Yes	9	10	90.00%	84.23%	Yes
White	23	25	92.00%	84.23%	Yes	87	111	78.38%	84.23%	No
Total	**39**	**44**	**88.63%**	84.23%	Yes	**374**	**523**	71.51%	84.23%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Medi-Cal HEDIS® MY 2023— Prenatal and Postpartum (PPC) - Timeliness of Prenatal Care by Ethnicity:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Hispanic or Latino	72	91	79.12%	84.23%	No	853	1,120	76.16%	84.23%	No
Not Hispanic or Latino	36	40	90.00%	84.23%	Yes	350	495	70.71%	84.23%	No
Asked But No Answer	0	0	0.00%	N/A	N/A	0	0	N/A	N/A	N/A
Unknown Ethnicity	13	16	81.25%	84.23%	No	1,361	1,770	76.89%	84.23%	No
Total	121	147	82.31%	84.23%	No	2,564	3,385	75.75%	84.23%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Medi-Cal HEDIS® MY 2023— Prenatal and Postpartum (PPC) – Postpartum Care by Race:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
American Indian or Alaska Native	2	2	100%	78.10%	Yes	1	5	20.00%	78.10%	No
Asian	3	4	75.00%	78.10%	No	70	85	82.35%	78.10%	Yes
Black or African American	5	6	83.33%	78.10%	Yes	174	291	59.79%	78.10%	No
Native Hawaiian or Other Pacific Islander	3	3	100%	78.10%	Yes	7	10	70.00%	78.10%	No
Some Other Race	2	2	100%	78.10%	Yes	7	10	70.00%	78.10%	No
Two Or More Races	0	0	N/A	N/A	N/A	1	1	100.00%	78.10%	Yes
Asked But No Answer	0	0	N/A	N/A	N/A	0	0	N/A	N/A	N/A
Unknown Race	2	2	100%	78.10%	Yes	6	10	60.00%	78.10%	No
White	21	25	84.00%	78.10%	Yes	73	111	65.77%	78.10%	No
Total	**38**	**44**	**86.36%**	78.10%	Yes	**339**	**523**	64.91%	78.10%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Medi-Cal HEDIS® MY 2023— Prenatal and Postpartum (PPC) – Postpartum Care by Ethnicity:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Hispanic or Latino	75	91	82.42%	78.10%	Yes	835	1,120	74.55%	78.10%	No
Not Hispanic or Latino	34	40	85.00%	78.10%	Yes	322	495	65.05%	78.10%	No
Asked But No Answer	0	0	N/A	N/A	N/A	0	0	N/A	N/A	N/A
Unknown Ethnicity	13	16	81.25%	78.10%	Yes	1,309	1,770	73.95%	78.10%	No
Total	122	147	82.99%	78.10%	Yes	2,466	3,385	72.85%	78.10%	**No**

N/A = Not applicable because there are no members in the numerator or denominator

Quantitative Analysis: Timeliness of Prenatal Care

The eligible population for the Prenatal and Postpartum (PPC) Timeliness of Prenatal Care measure are Blue Shield Promise members who had completed a prenatal care visit within the first trimester or within 42 days of enrollment with a primary care physician (PCP), an OB/GYN practitioner, or other prenatal care practitioner during the measurement year. The prenatal visit must include a note and date of prenatal visit, in addition to one of the following: basic physical obstetrical exam with fetal heart tone, pelvic exam, or measurement of fundus height; record of last menstrual period, estimated due date, or gestational age; a positive pregnancy result; documentation of gravidity and parity; completed obstetric history or prenatal risk assessment and counseling/education; evidence that a prenatal procedure was performed. In San Diego County, the tables above reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

As the tables above show, overall, when examining PPC Timeliness of Prenatal Care rates by race and ethnicity, the population in San Diego County exceeded goal, the DHCS MPL (84.23%). The total population, after stratifying by race, showed that 88.63% of members in the eligible population had prenatal visit within the first trimester or within 42 days of enrollment with a PCP, OB/GYN practitioner, or other prenatal practitioners, which was 4.4 percentage points higher than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that 82.31% of corresponding members completed a prenatal visit within the first trimester or within 42 days of enrollment with a PCP, OB/GYN practitioner, or other prenatal practitioners, which was 1.92 percentage lower than the MY 2023 DHCS MPL and did not meet goal.

When reviewing performance rates by race or ethnicity, the population in Los Angeles County, overall, did not meet goal, the DHCS MPL (84.23%). The total population, after stratifying by race, showed that 71.51% of members completed a prenatal visit within the first trimester or within 42 days of enrollment with a PCP, OB/GYN practitioner, or other prenatal practitioners, which was 13.08 percentage points lower than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that 75.75% of members had a prenatal visit within the first trimester or within 42 days of enrollment with a PCP, OB/GYN practitioner, or other prenatal practitioners, which did not meet goal, the MY 2023 DHCS MPL.

For San Diego County, all groups, when stratified by race, had a denominator less than 30, making this opportunity not actionable. Four groups achieved 100% compliance rate, which were American Indian or Alaska Native with a denominator of 2, Asian with a denominator of 4, Native Hawaiian or Other Pacific Island with a denominator of 3, and “Unknown Race” with a denominator of 2. The next highest performing group that achieved goal was White at 84.23% compliance rate with a denominator of 25, which also does not meet the minimum reporting population requirement of 30. The two lower performing groups are Black or African American (66.67%, n=6) and “Some Other Race” (50.00%, n=2), which did not meet goal and lower than the reporting population requirement of 30 for the denominator. The categories of “Two Or More Races” and “Asked but No Answer”, did not have any members reported to be counted towards the denominator. When examining PPC Timelines of Prenatal rates by ethnicity, all groups have smaller denominators less than 30. Given that all groups had denominators less than 30, this opportunity was not identified for improvement.

When examining timely prenatal care rates by ethnicity, San Diego County members who identified as Hispanic or Latino (79.12%) group accounted for a large proportion of the denominator with 91 members and did not meet the DHCS MPL (84.23%).

Similar to San Diego County, many groups in Los Angeles had smaller denominators. For Los Angeles County, there was one racial group that met goal, the DHCS MPL (84.23%). The highest performing group was “Some Other Race” with a 100.00% compliance rate and had a denominator of 10. The other groups did not meet goal, the DHCS MPL (84.23%). The groups American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander

achieved a compliance rate of 80.00%, with denominators 5 and 10, respectively. The next set of groups had a denominator greater than the reporting requirement of 30, which are: members who identified as White, had a compliance rate of 78.38% (n=111),members who identified as Black or African American had a compliance rate of 68.73% (n=291), and members who identified as Asian had a compliance rate of 65.88% (n=85). The other groups, "Two Or More Races", "Asked but No Answer", and "Unknown Race", had no members included in the denominator.

When examining PPC Timelines in Prenatal care rates by ethnicity in Los Angeles County, the top performing group was "Unknown Ethnicity" with a compliance rate of 76.89% and a denominator of 1,770. However, because the ethnicity is unknown for this group of members, it is not an actionable opportunity. The next highest performing group was Hispanic or Latino with a compliance rate of 76.16% with the largest denominator of 1,120 across all groups. The next group is Not Hispanic or Latino with a compliance rate of 70.71% and a denominator of 495. The other two groups, "Asked but No Answer" had no members in the denominator.

Quantitative Analysis: Postpartum Care

The eligible population for the Prenatal and Postpartum (PPC) Postpartum Care measure are Blue Shield Promise members who had a postpartum visit or pap test on or between seven and eighty-four days after delivery during the measurement year. The postpartum care visit consists of a medical record including a note, date of postpartum visit, and one of the following services recorded. The services valid for the visit are: pelvic exam with weight, blood pressure, breasts, and abdomen and notation of breast feeding; notation of any key words "postpartum care", "PP check", "PP Care", or "6-week check"; screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders; glucose screening for women with gestational diabetes; documents of breastfeeding, intercourse or family planning, sleep/fatigue, physical activity, or healthy weight of guardian. In San Diego County, the tables above reflect results from hybrid data collection, whereas the results for Los Angeles County stratify results from administrative data collection.

As the tables above show, overall, when examining PPC Postpartum Care rates by race and ethnicity, the population in San Diego County exceeded goal, the DHCS MPL (78.10%). The total population, after stratifying by race, showed that 86.36% of members in the eligible population completed a postpartum visit, which was 8.26 percentage points higher than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that 82.99% of corresponding members demonstrated completion of a postpartum visit, which was 4.89 percentage points higher than the MY 2023 DHCS MPL and exceeding goal.

When reviewing performance rates by race or ethnicity, the population in Los Angeles County, overall, did not meet goal, the DHCS MPL (78.10%). The total population, after stratifying by race, showed that 64.91% of members completed a postpartum care visit, which was 13.19 percentage points lower than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that 72.85% of members had a postpartum care visit, which was 6.46 percentage points lower than the MY 2023 DHCS MPL.

For San Diego County, similar to timely prenatal care, all groups had denominators less than 30. Four groups – American Indian or Alasa Native, Native Hawaiian or Other Pacific Islander, "Some Other Race", and "Unknown Race" – achieved 100% compliance rate with denominators of 2, 3, 2, and 3 members, respectively. The next two highest performing groups that exceeded goal was White (84.00%, n=25), and Black or African American (93.33%, n=6), which are lower than the reporting population requirement of 30 in the denominator. The one group that did not meet goal was Asian (75.00%, n=4). The other groups, "Two Or More Races" and "Asked but No Answer", did not have compliance rates reported due to no members in the denominator.

When examining San Diego County PPC Postpartum Care rates by ethnicity, there were three groups that exceeded goal. The top performing group was Not Hispanic or Latino at 85.00% with a denominator of 40. The next best performing groups in order were Hispanic

or Latino (82.42%, n=91), and Unknown Ethnicity (81.25%, n=16). One group, "Asked but No Answer", did not have any members in the denominator so no compliance rate was reported for that group. Due to exceeding the goal of the DHCS MPL, groups in San Diego County were not identified as an opportunity for improvement. Blue Shield Promise will continue to monitor and stratify performance.

For Los Angeles County, most groups had denominators less than 30. Two groups exceeded goal, the DHCS MPL (78.10%), including members who identified as Asian achieved an 82.35% compliance rate with a denominator of 85. Additionally, members who identified as "Two or More Races," achieved a 100% compliance rate, with a denominator was 1. Out of the other groups that did not meet goal, Native Hawaiian or Other Pacific Islander and Some Other Race both had 70.00% compliance rate and both with a denominator of 10. The group White had a compliance rate of 65.77% (n=111) and Black or African American had a compliance rate of 59.79% (n=291) The group Alaska Indian or Alaska Native (20.022%) had a denominator of 5, which is less than the reporting population requirement of 30. The other groups, "Asked but No Answer" not have a rate reported due to no members in the denominator.

When examining PPC Postpartum Care rates by ethnicity, no groups in Los Angeles County achieved goal. The top performing group was Hispanic or Latino (74.55%) and had the greatest denominator count of 1,120. Next was "Unknown Ethnicity" (73.95%) with 1,770 members in the denominator. Because the member's ethnicity is unknown, no race information was obtained for these members to gather more information or tailor interventions, this category is not actionable at this time. The group Not Hispanic or Latino (65.05%) was the lowest performing group with the rest of the denominator of 495 from this breakdown. "Asked But No Answer", did not have any members in the denominator so no compliance rate was reported for that group.

Across counties and measures, there may be an opportunity to address timely prenatal and postpartum care among Hispanic or Latino members. In both counties, this group accounts for a considerable proportion of the denominator.

Section 1d. Medi-Cal Performance Data, HEDIS® by Race and Ethnicity: Child and Adolescent Well Care Visits (WCV)

In 2024, scores for the HEDIS® measures were provided by Inovalon. Below is the breakdown of scores for the HEDIS® Measurement Year (MY) 2023 Child and Adolescent Well Care Visits (WCV) measure for San Diego and Los Angeles County. In MY 2024, the goal for Child and Adolescent Well Care Visits (WCV) was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY 2023 DHCS MPL was 48.07%.

"Some other Race" is an option members can select if they don't self-identify with the other race categories.

"Two or More Races" is an option members can select if they identify with any combination of races, including "Some other Race".

"Asked But No Answer," is an option for members who decline to answer or provide a response.

"Unknown" represents those members whom the organization did not obtain race information and did not receive a declined response.

Medi-Cal HEDIS® MY 2023— Child and Adolescent Well Care Visits (WCV) by Race:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
American Indian or Alaska Native	17	48	35.42%	48.07%	No	33	79	41.77%	48.07%	No
Asian	480	925	51.89%	48.07%	Yes	2,153	4,396	48.98%	48.07%	Yes
Black or African American	605	1,248	48.48%	48.07%	Yes	3,995	10,268	38.91%	48.07%	No
Native Hawaiian or Other Pacific Islander	74	190	38.95%	48.07%	No	131	294	44.56%	48.07%	No
Some Other Race	12	19	63.16%	48.07%	Yes	42	70	60.00%	48.07%	Yes
Two Or More Races	4	13	30.77%	48.07%	No	13	18	72.22%	48.07%	Yes
Asked But No Answer	0	2	0.00%	48.07%	No	5	7	71.43%	48.07%	Yes
Unknown Race	10	19	52.63%	48.07%	Yes	42	91	46.15%	48.07%	No
White	1,361	3,016	45.13%	48.07%	No	2,112	4,809	43.92%	48.07%	No
Total	**2,563**	**5,480**	**46.77%**	48.07%	No	**8,526**	**20,032**	**42.56%**	48.07%	**No**

Medi-Cal HEDIS® MY 2023— Child and Adolescent Well Care Visits (WCV) by Ethnicity:

	San Diego County			MY 2023 Goal	Goal Met	Los Angeles County			MY 2023 Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Hispanic or Latino	7,191	12,991	55.35%	48.07%	Yes	15,262	27,439	55.62%	48.07%	Yes
Not Hispanic or Latino	2,525	5,410	46.67%	48.07%	No	8,376	19,753	42.40%	48.07%	No
Asked But No Answer	0	0	0.00%	N/A	N/A	2	5	40.00%	48.07%	No
Unknown Ethnicity	885	1,592	55.59%	48.07%	Yes	42,672	77,492	55.07%	48.07%	Yes
Total	10,601	19,993	53.02%	48.07%	Yes	66,312	124,689	53.18%	48.07%	**Yes**

N/A = Not applicable because there are no members in the numerator or denominator

Quantitative Analysis:

The eligible population for the Child and Adolescent Well Care Visits (WCV) measure are Blue Shield Promise members 3-21 years of age who had at least one comprehensive well-care visit with a primary care physician (PCP) or an OB/GYN practitioner during the measurement year. The well child visit consists of a health history, physical developmental history, mental developmental history, physical exam, and health education/anticipatory guidance.

As the tables above show, overall, when examining WCV rates by race, the population in San Diego County did not meet goal, the MY 2023 DHCS MPL (48.07%). The total population, after stratifying by race, showed that 46.77% of members in the eligible population had a comprehensive well-care visit with a PCP or OB/GYN practitioner, which was 1.3 percentage points lower than the MY 2023 DHCS MPL. When stratifying results by ethnicity, the total population showed that 53.02% of members completed at least one comprehensive well-care visits, which exceeded goal, the MY 2023 DHCS MPL (48.07%).

When reviewing performance rates by race, the population in Los Angeles County, overall, did not meet goal, the DHCS MPL (48.07%). The total population, after stratifying by race, showed that 42.56% of members completed at least one comprehensive well-care visit, which was 5.51 percentage points lower than the MY 2023 DHCS MPL. The total population, after stratifying by ethnicity, showed that 53.18% of members completed at least one comprehensive well-care visits, which exceeded goal, the MY 2023 DHCS MPL. Given that both Los Angeles and San Diego met the goal when WCV rates were stratified by ethnicity, addressing WCV performance by ethnicity was not identified as an opportunity for improvement Blue Shield Promise will continue to monitor performance.

For San Diego County, the two highest scoring groups were “Some Other Race” (63.16%) and “Unknown Race” (52.63%). However, these groups were only represented by denominators of 19. The next highest scoring groups that exceeded the goal of the DHCS MPL (48.07%) identified as Asian (51.89%, n=925) , or Black or African American (48.48%, n=1,248). The lower scoring groups that did not meet the goal of the DHCS MPL (48.07%) were White (45.13%, n=3,016), Native American or Other Pacific Islander (38.95%, n=190), and American Indian or Alaska Native (35.42%, n=48). Given that these lower scoring groups did not meet the DHCS MPL of 48.07% and performed lower than other racial groups indicate an opportunity for improvement for members who identify as White, Native American or Other Pacific Islander, or American Indian or Alaskan Native. When examining WCV rates by ethnicity, the highest scoring groups that exceeded the goal of the DHCS MPL (48.07%) were “Unknown” (55.59%, n=1,592), and Hispanic or Latino (55.35%, n=12,991). The lower performing group that did not meet goal is Not Hispanic or Latino (46.67%) with a denominator of 5,410. However, the group Hispanic or Latino had the greatest impact because they represent a much larger proportion of the overall denominator, highlighting the opportunity to address WCV compliance among lower scoring groups mentioned above, including White, Native American or Other Pacific Islander, or American Indian or Alaskan Native members.

For Los Angeles County, the two highest scoring groups that exceeded the goal of the DHCS MPL (48.07%) were” Two Or More Races” (72.22%, n=18) and “Asked But No Answer” (71.43%, n=7). Given these groups have denominators less than 30, results for these groups are not driving overall performance. The next highest scoring groups with denominators more than 30 and that exceeded goal included”Some Other Race” (60.00%) with denominator of 70 and Asian (48.98%) with denominator of 4,396. The lowest performing groups that did not meet goal are “Unknown Race” (46.15%, n=91), White (43.92%, n=4,809), Native Hawaiian or Other Pacific Islander (44.56%, n=294), American Indian or Alaska Native (41.77%, n=79), and Black or African American (38.91%, n=10,268). Compared to all the lowest performing groups that did not meet MPL, members who identified White or Black or African American reported the largest populations, highlighting potential opportunities for improvement.

When examining WCV rates by ethnicity, two groups met goal of 48.07%, the MY 2023 DHCS MPL. The highest scoring group was Hispanic or Latino (55.62%) with denominator of

27,439. The next highest performing group was “Unknown Ethnicity’ (55.07%) with the largest denominator group at 77,492. The lowest group that did not meet goal were Not Hispanic or Latino (42.40%) with denominator of 19,753. The group “Asked but No Answer” had a compliance rate of 40.00%, but the denominator was 5, which is lower than the reporting population requirement of 30. Similar to San Diego County observations, in Los Angeles, the group Hispanic or Latino had the greatest impact because they represent a much larger proportion of the overall denominator, highlighting the opportunity to address WCV compliance among lower scoring groups mentioned above, including White members and Black/African American members, and Native Hawaiian or Pacific Islander members.

Section 2. Medi-Cal Clinical Performance Data: HEDIS® measure by Preferred Language: Child and Adolescent Well Care Visits (WCV)

In 2024, scores for the HEDIS® measures were provided by Inovalon. Below is the breakdown of scores for the HEDIS® Measurement Year (MY) 2023 Child and Adolescent Well Care Visits (WCV) measure based on administrative data collection for San Diego County and Los Angeles County. The table below reflects members 3–21 years of age who should have had at least one comprehensive well-care visit with a Primary Care Physician or an Obstetrics/Gynecology practitioner during the measurement year (MY). The language categories in the tables display the results by the threshold languages for the respective counties.

In MY 2024, the goal for Child and Adolescent Well Care Visits (WCV) was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY 2023 DHCS MPL was 48.07%.

Medi-Cal HEDIS® MY 2023- Child and Adolescent Well Care Visits (WCV) by Preferred Language: San Diego County

Language	San Diego County			Benchmark	Goal Met
	Numerator	Denominator	% Rate		
Arabic	98	157	62.42%	48.07%	Yes
Chinese	4	6	66.67%	48.07%	Yes
English	7,226	14,356	50.33%	48.07%	Yes
Farsi	26	43	60.47%	48.07%	Yes
Other	47	85	55.29%	48.07%	Yes
Russian	51	93	54.84%	48.07%	Yes
Spanish	4,241	7,260	58.42%	48.07%	Yes
Tagalog	55	113	48.67%	48.07%	Yes
Unknown	2,564	4,859	52.77%	48.07%	Yes
Vietnamese	40	75	53.33%	48.07%	Yes
Grand total	14,352	27,047	53.06%	48.07%	Yes

Other represents languages outside of the respective county's threshold languages.

"Unknown" indicates members whose language was not provided or is unknown.

Medi-Cal HEDIS® MY 2023- Child and Adolescent Well Care Visits (WCV) by Preferred Language: Los Angeles County

Language	Los Angeles County			Benchmark	Goal Met
	Numerator	Denominator	% Rate		
Arabic	82	160	51.25%	48.07%	Yes
Armenian	222	418	53.11%	48.07%	Yes
Cambodian	2	4	50%	48.07%	Yes
Chinese	2	4	50%	48.07%	Yes

Language	Los Angeles County			Benchmark	Goal Met
	Numerator	Denominator	% Rate		
English	30,086	64,967	46.31%	48.07%	No
Farsi	1	2	50%	48.07%	Yes
Khmer	88	147	59.86%	48.07%	Yes
Korean	36	102	35.29%	48.07%	No
Other	79	139	56.83%	48.07%	Yes
Russian	109	255	42.75%	48.07%	No
Spanish	39,112	66,507	58.81%	48.07%	Yes
Tagalog	34	63	53.97%	48.07%	Yes
Unknown	6,020	11,463	52.52%	48.07%	Yes
Vietnamese	129	304	42.43%	48.07%	No
Grand Total	76,002	144,535	52.58%	48.07%	Yes

Other represents languages outside of the respective county's threshold languages.

"Not assigned" or "Not selected" indicates the members whose language was not provided or is unknown.

Quantitative Analysis:

Using the Department of Health Care Services (DHCS) Minimum Performance Level (MPL) as the goal, overall San Diego (53.06%) and Los Angeles (52.58%) met the goal of 48.07%. The language categories in the tables display the results by the threshold languages for the respective counties.

For San Diego County, all language groups met the goal of the DHCS MPL, 48.07%. The largest group were English-speaking members (14,356), reflecting 53% of the denominator (14,356/27,047). The compliance rate for English speaking members was 50.33%, which exceeded the goal of 48.07%. Because English-speaking members reflects over half of the denominator, English-speaking members are driving a large portion of the overall performance. The second largest language group were Spanish speaking members, with 7,260 members, representing 27% of the total denominator (7,260/27,047). The compliance rate for Spanish speaking members was 58.42%, which exceeded the goal of 48.07%. The third largest language group was "Unknown" reflecting members whose preferred language was not provided or is unknown. This group represented 18% of the overall denominator (4,859/27,047). Even though English-speaking members reflect over half the population, the highest scoring group with a denominator of more than 30 were Arabic speaking members with a compliance rate of 62.42% (n=157). The second highest scoring group were Farsi speaking members with a rate of 60.47% (n=43). Spanish speaking members were the third highest scoring group with 58.42% (n=7,260). Even though every language group met the DHCS MPL of 48.07%, the third lowest scoring groups were "Unknown" (52.77%, n=4,859), English speaking members (50.33%, n=14,356), and Tagalog speaking members (48.67%, n=113). Given all language groups and the overall county met the goal of the DHCS MPL, performance in San Diego County was not identified as an opportunity for improvement. Blue Shield Promise will continue to monitor and stratify the WCV compliance rate among San Diego County members.

For Los Angeles County, almost all language groups met the goal. The largest language group were Spanish-speaking members (66,507), reflecting 46% of the denominator (66,507/144,535). The compliance rate for Spanish speaking members was 58.81%, which met the goal of the DHCS MPL, 48.07%. The second largest group were English-speaking members reflecting 45% of the denominator (64,967/144,535). The compliance rate for English speaking members was 46.31%, which did not meet the goal of 48.07%. Because Spanish-speaking members reflect almost half of the denominator, Spanish-speaking members are also driving a large portion of the overall performance. However, the difference in WCV compliance between Spanish-speaking members (58.81%) and English-speaking members (46.31%) suggest an opportunity to improve the WCV rate among English-speaking members. Similar to San Diego, the third largest language group was "Unknown," reflecting 8% of the denominator (11,463/144,535). The highest scoring group in Los Angeles, were Khmer speaking members, with a compliance rate of 59.86% (n=147). The second highest scoring group driving performance was Spanish with a compliance rate of 58.81% (n=66,507). The third highest scoring group was "Other," reflecting members with language preferences outside of the Los Angeles County threshold languages. This group had a compliance rate of 56.83% (n=63). The lowest scoring groups that did not meet the goal of the DHCS MPL (48.07%) included English (46.31%, n=64,967), Russian (42.75%, n=255), Vietnamese (42.43%, n=304), and Korean (35.29%, n=102). For Los Angeles County there may be opportunities to address lower WCV compliance rates among members whose preferred language are English, Russian, Vietnamese, or Korean. The Clinical Quality Teams will continue to monitor compliance for Promise members.

Section 3. Medi-Cal Clinical Performance Data, HEDIS® by Gender: Child and Adolescent Well Care Visits (WCV)

In 2024, scores for the HEDIS® measures were provided by Inovalon. Below is the breakdown of scores for the HEDIS® Measurement Year (MY) 2023 Child and Adolescent Well Care Visits (WCV) measure based on administrative data collection for San Diego and Los Angeles County. The table below reflects members 3–21 years of age who should have had at least one comprehensive well-care visit with a Primary Care Physician or an Obstetrics/Gynecology practitioner during the measurement year.

In MY 2024, the goal for Child and Adolescent Well Care Visits (WCV) was the Department of Healthcare Services (DHCS) established Minimum Performance Level (MPL). The MPL is the quality standard that Managed Care Plans (MCPs) contracting with DHCS are required to meet or exceed. For this report, we have decided to use the MPL as the benchmark to compare our sub-population results. The MY 2023 DHCS MPL was 48.07%.

Medi-Cal HEDIS® MY 2023 Child and Adolescent Well Care Visits (WCV) by Gender

Gender	San Diego County			Goal	Goal Met	Los Angeles County			Goal	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Female	7,022	13,176	53.29%	48.07%	Yes	38,003	70,941	53.57%	48.07%	Yes
Male	7,329	13,870	52.84%	48.07%	Yes	37,999	73,594	51.63%	48.07%	Yes
Unknown	1	1	100.00%	48.07%	Yes	0	0	N/A	N/A	N/A
Total	14,352	27,047	53.06%	48.07%	Yes	76,002	144,535	52.58%	48.07%	Yes

Quantitative Analysis

In MY2023, the overall rate for Child and Adolescent Well Care Visits (WCV) was 53.06% for San Diego County, and 52.58% for Los Angeles County. Both counties met the goal of the DHCS MPL, 48.07%.

For San Diego County, although both groups met the goal of the DHCS MPL, the highest scoring group were female, with 53.29% (n=13,176). However, the difference in compliance between males and females was minimal, with WCV compliance for males at 52.84% (n=13,870), which is 0.45 percentage points lower than the WCV compliance for females (53.29%).

Similarly in Los Angeles County, both groups met the goal of the DHCS MPL, and the highest scoring group were female. The compliance rate among males was 51.63% (n=73,594), which was 1.94 percentage points lower than the compliance rate among females (53.57%, n=70,941).

Given that all groups in each county met the goal of the DHCS MPL, there was no identified opportunity for improvement. Blue Shield Promise will continue to monitor and stratify the WCV compliance rate among San Diego and Los Angeles County members.

Section 4. Medi-Cal Individual Experience Data: CAHPS Measures from Press Ganey Analytics Stratified by Race and Ethnicity: Rating of Health Care (8+9+10)

In 2023, scores for the following measures were provided by Press Ganey Analytics for Medi-Cal Promise members in San Diego and Los Angeles counties. Below is a breakdown of scores for the following measure:

- **Rating of Health Care (8+9+10)**

In 2023, the goal for the Rating of Health Care (8+9+10) was improvement from the prior year, the 2022 rate. Given that the goal was directional improvement, the goal for San Diego County was 67.8%, and the goal for Los Angeles County was 74.7%.

Medi-Cal Overall Composite Scores – San Diego County Adult

CAHPS Measures	2021	2022	2023	2023 Quality Compass Percentile*	Improvement Goal Met (Yes/No)
Rating of Health Care (8+9+10)	71.2%	67.8%	70.6%	10th	Yes

*For RY2023, the benchmarks for Quality Compass for Rating of Healthcare were 10th:69.41%; 33rd:73.05%; 66th: 76.5%; 90th: 79.85%

Medi-Cal Overall Composite Scores – Los Angeles County Adult

CAHPS Measures	2021	2022	2023	2023 Quality Compass*	Improvement Goal Met (Yes/No?)
Rating of Health Care (8+9+10)	70.4%	74.7%	67.2%	Less than 10th	No

*For RY2023, the benchmarks for Quality Compass for Rating of Healthcare were 10th:69.41%; 33rd:73.05%; 66th: 76.5%; 90th: 79.85%

Medi-Cal CAHPS Reporting Year (RY) 2023 Rating of Health Care (8+9+10) Adult - Scores by Race

Race	San Diego County			Improvement Goal*	Goal Met	Los Angeles County			Improvement Goal*	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
White	100	142	70.4	71.7%	No	55	75	73.3%	74.5%	No
Black or African American	17	21	81.0%	64.3%	Yes	7	13	53.8%	53.8%	No
Asian	22	29	75.9%	64.0%	Yes	10	18	55.6%	56.5%	No
Native Hawaiian or Other Pacific Islander	1	2	50%	66.7%	No	1	2	50%	100%	No
American Indian or Alaska Native	5	7	71.4%	55.6%	Yes	3	4	75%	80%	No
Other	50	63	79.4%	68.3%	Yes	38	56	67.9%	80.4%	No

*Improvement goal is based on the prior year performance rate, Reporting Year (RY) 2022 rate for each sub-population.

"Other" is an option members can select if they identify with another race category.

Medi-Cal CAHPS Reporting Year (RY) 2023 Rating of Health Care (8+9+10) Adult - Scores by Ethnicity

Race	San Diego County			Improvement Goal*	Goal Met	Los Angeles County			Improvement Goal*	Goal Met
	Numerator	Denominator	% Rate			Numerator	Denominator	% Rate		
Hispanic	99	126	78.6%	69.0%	Yes	90	127	70.9%	83.7%	No
Not Hispanic	93	135	68.9%	69.7%	No	31	53	58.5%	60.0%	No

*Improvement goal is based on the prior year performance rate, Reporting Year (RY) 2022 rate for each sub-population.

Quantitative Analysis

As the tables above show, San Diego scores on the Rating of Health Care for the top box rating (8, 9, and 10) increased from 2022 (67.8%) to 2023 (70.6%) ultimately achieving the goal of directional improvement. Conversely, Los Angeles observed a decline from 2022 (74.7%) to 2023 (67.2%), and did not meet its directional goal of improvement.

When examining race and/or ethnicity in relation to the San Diego population, almost all groups had denominators less than 30, including respondents who identified as Black or African American (21), Asian (29), Native Hawaiian or Other Pacific Islander (2), or American Indian or Alaskan Native (7). The low denominators for most of these groups result in accentuated differences between groups making it difficult to assess for directional improvement between 2022 and 2023. Among the groups with reportable populations, respondents who identified as "Other," demonstrated the highest rating at 79.4% (50/63) for rating of health care. Compared to the group's rating in 2022 at 68.3%, this group achieved its goal of directional improvement and is not identified as an area for improvement. Although the group with the second highest reportable rating for rating of health care were respondents who identified as White with 70.4% (100/142) as the 2023 rating, the group did not exceed its 2022 rating (71.7%) and did not achieve directional improvement. When examining the rating of health care by ethnicity, the highest performing group were respondents who identified as Hispanic, with a rating of 78.6% (99/126). This group met its respective goal of directional improvement (69.0%). The second group, respondents who identified as not Hispanic had a rating of 68.9% (93/135) in 2023, which did not exceed its prior rate of 69.7% and did not meet the goal of directional improvement by 0.8 percentage points. Given the small population sizes when examining the scores by race, these categories are not actionable at this time. Blue Shield Promise is working on increasing survey responses to help accurately evaluate our membership and identify opportunities.

Los Angeles County observed similar trends when examining rating of health care by race and/or ethnicity as almost all race groups had denominators less than 30, including respondents who identified as Black or African American (13), Asian (18), Native Hawaiian or Other Pacific Islander (2), or American Indian or Alaskan Native (4). The low denominators for most of these groups resulted in accentuated differences between groups making it difficult to assess directional improvement between 2022 and 2023. Different from the San Diego population, among the groups with reportable populations, respondents who identified as White demonstrated the highest rating at 73.3% (55/75) for rating of health care. Compared to the group's rating in 2022 at 74.5%, this group did not achieve the goal of directional improvement. Respondents who identified as "Other" did not rate their health care as high with 67.9% (38/56) as the 2023 rating. The group did not exceed its 2022 rating (80.4%) and did not achieve the goal of directional improvement. When examining the rating of health care by ethnicity, no groups achieved their respective goals of directional improvement. The highest performing group were respondents who identified as Hispanic, with a rating of 70.9% (90/127). This group did not meet its respective goal of directional improvement (83.7%). The second group, respondents who identified as not Hispanic had a lower rating of 58.5% (31/53) in 2023, which did not exceed its prior rate of 60% and did not meet the goal of directional improvement by 1.5 percentage points.

Given the low denominator sizes for most race/ethnic groups and categories, the reasons for observing decreases among groups are unclear and not actionable. Therefore, no opportunity for improvement was identified. Blue Shield Promise will continue to monitor and stratify the summary rates. The clinical quality team will actively work with the Member Experience teams to investigate potential reasons for these decreases in 2024 and identify ways to increase response rates and scores on this question going forward.

Production Date: <Month Year>
Revision Date: <Month Year>

Section 5. Identifying and Prioritizing Opportunities for Improvement and Interventions

Identified Barriers and Prioritizing Opportunities for Improvement

Blue Shield Promise initially identified all performance areas that did not meet the goal and identified barriers to achieving the goal. The table below outlines, by county, and performance area, the quality measures that did not meet the goal.

Performance Metrics That Did Not Meet Goal, by County

Performance Area	Stratification	County	Barriers
Controlling High Blood Pressure	Race/Ethnicity – Asian, Black or African American, Native Hawaiian or Other Pacific Islander, Hispanic or Latino	Los Angeles	• Behavioral factors such as diet, weight, and medication adherence and SDoH such as education, income, and neighborhood resources contribute to Black– White disparities in hypertension. Lower healthcare utilization compared to non-Hispanic White adults. Additionally, awareness of hypertension, treatment and control were lower in Hispanic adults compared to non-Hispanic white adults. (Colvin, Kalejaiye, Ogedegbe, Commodore-Mensah, 2022). • A larger proportion of Hispanic and Black adults lacked a personal health care provider compared the proportion White population that lacked a personal health care provider (Javed, Haisum Maqsood, Yahya, Amin, Acquah… & Nasir, 2022). • Implicit provider attitudes could also influence patient care. For example, health care professionals may have implicit feelings about medication use/adherence in certain racial/ethnic groups, which may affect quality of delivered care, including screening, prescribing, monitoring, etc. (Javed, Haisum Maqsood, Yahya, Amin, Acquah… & Nasir, 2022). • A 2023 qualitative study examining facilitators and barriers to hypertension management among Native Hawaiian or Alaskan Native populations highlighted barriers to hypertension management emphasized neighborhood level factors, such as historical loss of land and culture. This underlying issue influenced how Native Hawaiian perceived and experienced their neighborhood. Within the social environment, barriers included a lack of social cohesion and activities, influencing this populations motivation to be physically active, adopt a healthy diet, and lower stress (Ing, Park, Vegas, Haumea, Kaholokula). • Among Asian members, limited English proficiency may be a better to utilizing care even though insurance coverage is present. Additionally, diet may be another barrier as the

Performance Area	Stratification	County	Barriers
			article noted reduction in sodium intake is critical for East Asian countries including China, Korea, and Japan (Abrahamowicz, Ebinger, Whelton, Commodore-Mensah, & Yang, 2023).
Hemoglobin A1c Control for Patients with Diabetes (HBD) - HbA1c poor control (>9.0%)	Race/Ethnicity – Black or African American, White, Hispanic or Latino	Los Angeles	• Among Hispanic/Latino members, a lack of knowledge is a barrier to successful diabetes self-management. Other studies had noted a lack of awareness of resources available (Ramal, Petersen, Ingram, & Champlin, 2012). • Among Black or African American, White, and Hispanic/Latino populations, a 2019 systematic review noted diet as a barrier to diabetes management. Difficulty in healthy cooking and cultural influence in dietary habits were also reported as barriers. Additionally, long working hours responding to the high cost of living was another barrier to diabetes management (Alloh, Hemingway, Turner-Wilson, 2019). • Among Black or African American populations, late diagnosis and lack of awareness were also barriers to proper diabetes management because lifestyle changes are key to successful diabetes management (Alloh, Hemingway, Turner-Wilson, 2019). • Competing demands in prioritizing bills over purchasing more expensive foods (Rendle, May, Uy, Tietbohl, Mangione, & Frosch, 2013). • Diabetes self-management is influenced by immediate and extended family (Ramal, Petersen, Ingram, & Champlin 2012).
Timeliness of Prenatal Care	Race/Ethnicity – Asian, Black or African American, White, Hispanic or Latino	Los Angeles	• A 2021 scoping review examined several articles aimed at capturing all the articles that depicted qualitative experiences of racial and ethnic minority patients who are low income with the worst perinatal outcomes. Minority was defined as black, Hispanic, Native American, or other racial or ethnic persons who self-identified as being a minority (Wishart, Cruz Alvarez, Ward, Danner, O'Brian). • The results from the journal article highlighted distrust in the healthcare system as a driver to not seeking or adhering to clinical care recommendations. Conversely, building a relationship with the clinician has been shown to increase a patient's willingness to follow clinical guidelines (Wishart, Cruz Alvarez, Ward, Danner, O'Brian, 2021). • Care coordination and communication styles are additional drivers to patient satisfaction and comfort with a patient's obstetric care ((Wishart, Cruz Alvarez, Ward, Danner, O'Brian, 2021).
Timeliness of Prenatal Care	Race/Ethnicity – Hispanic or Latino	San Diego	

Performance Area	Stratification	County	Barriers
Postpartum Care	Race/Ethnicity - Black or African American, White, Hispanic or Latino	Los Angeles	• A 2021 systematic review of the literature on postpartum attendance in marginalized populations in the United States noted barriers reported included transportation and unstable housing (Wouk, Morgan, Johnson, Tucker, Carlson, Berry, & Stuebe, 2021). The article defined people of color as under resourced groups, including Black and Indigenous mothers, Hispanic and Asian mothers. • The same systematic review reported that provider-level factors included being treated poorly during the intrapartum stay due to the race, ethnicity, language, culture, insurance status, or difference of opinion with the provider. Additionally, patients who had difficulty understanding their provider were also less likely to return for postpartum care (Wouk, Morgan, Johnson, Tucker, Carlson, Berry, & Stuebe, 2021). • Conversely, peer supporters, community health workers, and doulas who share culture and language with mothers could support increasing postpartum healthcare use and improve quality of care (Wouk, Morgan, Johnson, Tucker, Carlson, Berry, & Stuebe, 2021).
Child and Adolescent Well Care Visits	Race/Ethnicity - American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, White	San Diego	• Qualitative interviews with Black/African American and Hispanic/Latinx caregivers and patients highlighted transportation, language, and scheduling as key barriers to well-child visits (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler,...& Alper, 2022). • Among Native Hawaiian and Other Pacific Islanders, this group lacks a usual source of care when they are sick or need health advice. Additionally, immigration status may also impact this group's inclination to access government benefits (A Child Is a Child: Native Hawaiian and Pacific Islander Children's Health, 2024). • Transportation, language, and scheduling as key barriers to well-child visits (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler,...& Alper, 2022). • Unique barriers for American Indian/Alaskan Native children include a long-standing mistrust of governmental agencies, discrimination in clinical settings, and the "cumulative burden of generations of unresolved traumas and racism" (Bell, Deen, Fuentes, Moore, & Committee on Native American Children Health, 2021).
Child and Adolescent Well Care Visits	Race/Ethnicity - American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, White	Los Angeles	
Child and Adolescent Well Care Visits	Language – English, Korean, Russian, Vietnamese	Los Angeles	• Due to cultural reasons for individuals who speak Russian there is a lack of awareness of what health insurance is and may experience challenges accessing care (Kostareva, Albright, Berens, Levin-Zamir, Aringazina, Lopatina,... & Sentell, 2020).

Performance Area	Stratification	County	Barriers
			• The same study noted immigrants may not be familiar with the significance of preventive services, noting limited language proficiency as a barrier. (Kostareva, Albright, Berens, Levin-Zamir, Aringazina, Lopatina,... & Sentell, 2020). • Among Vietnamese members, a barrier to visits is not having a usual place of care (A Look at Health in Orange a Look at Health in Orange County's Vietnamese Community County's Vietnamese Community, n.d). Another study noted this group was more likely to have had no contact with a health professional within the past 12 months than non-Hispanic White children (Yu, Huang, & Singh, 2010).
Rating of Health Care (8+9+10)	Race/Ethnicity – White, Hispanic or Latino	Los Angeles	• A 2011 study of Hispanic patients enrolled in Medicare or Medicaid managed care found that potential drivers of satisfaction include sharing the patient's preferred language for Spanish (especially among patients who are not bilingual) and the patient's health literacy levels (O'Brien & Shea, 2011).

Prioritizing Opportunities for Improvement

Opportunities and barriers were identified based on the prior analysis by race/ethnicity, language, and gender, literature, applicable member feedback, and existing Blue Shield Promise resources and programs. Opportunities for improvement were prioritized based on the prevalence of the condition based on the group's demographic size, and the positive impact of addressing the condition or clinical area. Blue Shield Promise will continue to monitor all opportunities among groups with low denominator sizes or not reportable populations. Because of the prevalence of diabetes among Hispanic or Latino members, the consequences from uncontrolled diabetes, and the significance of supporting childhood development, we selected the opportunities around Hemoglobin A1c Control for Patients with Diabetes (HBD) and Child and Adolescent Well Care Visits (WCV) for improvement.

Undiagnosed and untreated diabetes can result in increased risk of morbidity and mortality. To mitigate the consequences of untreated diabetes, it is critical to ensure members are managing their condition, evidenced by controlled Hemoglobin (HbA1c) levels. Almost 4,000 members in Los Angeles County who identify as Hispanic or Latino are diagnosed with Diabetes, with almost 40% of members demonstrating poor blood sugar control levels (HbA1c levels >9%). As shown in the tables below, barriers for Hemoglobin A1c Control for Patients with Diabetes (HBD) were identified as lack of knowledge around the importance of controlling A1c levels, external factors such as food insecurity or access to care, and social support impacting management of diabetes. The focus of improvement was on culturally tailored education for managing diabetes, including treatment options, diet, and other resources members can utilize through Blue Shield Promise in managing diabetes.

Using the similar method of prioritization, considering the most expansive impact of currently available resources and sizable population of the measure, Child and Adolescent Well Care Visits (WCV) was also selected as an opportunity for improvement. Inequities can begin in childhood based on the social conditions in which children are raised. These inequities could potentially persist in adulthood and become intergenerational (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler,...& Alper, 2022). Acting on this opportunity enables Blue Shield Promise to make the most impact long-term by ensuring children receive the quality care necessary to supporting a healthy development. As shown below, the barriers identified for WCV pertain to lacking a usual source of care and other social drivers of health (e.g., transportation, parents cannot take time off from work, etc.). These barriers are actionable given Blue Shield Promise hosts in-person clinic events within the member's community and offers walk-in visits. Considering manageable efforts, we refined this intervention through increased frequency of hosting clinic days and contracted with a new vendor to enhance member outreach, and access to care. We recognized that providers have barriers with getting well care visits due to the guardian's lack of knowledge around age guidelines, language barriers, transportation, and timing of scheduled appointments during weekday working hours (Wolf, et al. 2020). The benefit of having an in-person clinic days is that the available hours are extended beyond a normal 9-5 workday and open on select Saturdays. The clinic day events give an opportunity for the child to receive all the checkpoint health services needed by age range, and educate the guardian on the next age health visit and other Blue Shield services that may serve as barriers to family members getting services they need.

1. HEDIS® Hemoglobin A1c Control for Patients With Diabetes (HBD): HbA1c Poor Control (>9.0%) measure by Race and Ethnicity

The data showed that there was an opportunity in Los Angeles County among members who identified as Hispanic or Latino because they accounted for a large proportion of the overall denominator and did not meet the goal of the DHCS MPL. In San Diego County, most groups had denominators less than thirty and are not actionable at this time. Therefore, we began a barrier analysis to identify the drivers of performance for members in Los Angeles County. A group of Quality Improvement staff completed the initial barrier analysis and brainstormed the following potential barriers and opportunities for improvement.

HEDIS® Hemoglobin A1c Control for Patients With Diabetes (HBD): HbA1c Poor Control (>9.0%) measure by Race and Ethnicity		
Item	Category Type	Identified Barrier
1	Member-Facing for Hispanic or Latino members	• Lack of knowledge on diabetes and diabetes self-management, including a lack of culturally tailored education that considers a patients' background, culture, and lifestyle. • Respondents from a 2013 qualitative study of 20 patients with type 2 diabetes also stated that diabetes self-care is considered overwhelming because of the time and knowledge it takes to both prepare and select healthy food (Rendle, May, Uy, Tietbohl, Mangione, & Frosch, 2013). • A meta-analysis of literature exploring the lived experience among Hispanic individuals diagnosed with type 2 diabetes living in San Bernadino California also noted the lack of awareness of resources available to them, impacted their ability to self-manage their condition (Ramal, Petersen, Ingram, & Champlin, 2012). • There is an opportunity to provide culturally tailored education that accounts for patients' background, beliefs, culture, and lifestyle, and increase awareness of the resources available by promoting the Blue Shield Promise Diabetes Management course.

		• The United States Preventive Service Task Force (USPSTF) highlighted the benefits of culturally targeted and tailored lifestyle and self-management interventions to help mitigate health inequities (2021). Another study highlighted the benefits of employ culturally and linguistically appropriate health information (Rawlins, Toscano-Garand, & Graham, 2017).
2	Member-Facing for Hispanic or Latino members	• Social drivers of health including food insecurity, and access to care (transportation, scheduling appointments, taking time off work, cost of care). • A 2013 qualitative study of 20 patients with type 2 diabetes receiving care at safety-net clinics in Southern California reinforced the findings, emphasizing competing demands in prioritizing bills over purchasing more expensive foods (Rendle, May, Uy, Tietbohl, Mangione, & Frosch, 2013). • There is an opportunity to promote Blue Shield Promise's services including transportation and Community Support services at Community Resource Centers (CRC). CRC's offer services for the community, including a food pantry, or Wi-Fi, for telehealth visits. Members can visit a visit for health plan member services and offer childcare while a member may take one of the classes. Consequently, this barrier can also be addressed by promoting the in-person Health Education Diabetes Management courses. Members can learn about Blue Shield Promise services as they visit the Community Resource Center to attend the Diabetes Management Course.
3	Member-Facing for Hispanic or Latino members	• Lack of family or social support. Family members or caregivers may not have the knowledge or resources to support member with diabetes self-management. • A qualitative study of Hispanic individuals diagnosed with diabetes living in San Bernardino indicated dietary changes were more difficult because of its impact on the immediate and extended family (Ramal, Petersen, Ingram, & Champlin 2012). • The same study participants mentioned another challenge was lack of buy-in from family members. The family could limit or enhance an individual's motivation and self-efficacy to implement lifestyle changes. • These barriers suggest the need to increase family involvement to support diabetes self-management, or the need to increase knowledge and awareness of how to support a loved one diagnosed with diabetes. • Currently Blue Shield Promise members can bring family members or caregivers to the Diabetes Management course. We will collaborate with the Health Education team to explore the feasibility of developing additional educational guides for families and/or a family-based diabetes management education class.

2. HEDIS® Child and Adolescent Well Care Visits (WCV) measure by Race and Ethnicity, and Language

For Child and Adolescent Well Care Visits, the barriers are combined as there is overlap in the impact by race, ethnicity, and language. Even though the barriers are combined, separate strategies may be developed to address barriers related to race or ethnicity and barriers related to language. The data showed there were opportunities for improvement, in both counties, among members who identified as Black or African American, Native Hawaiian or Other Pacific Islander, or White. These

are opportunities for improvement because they did not meet the goal of the DHCS MPL, and their population sizes account for a large proportion of the denominator. For Los Angeles, the data showed there were opportunities for language groups, English, Russian, Vietnamese, and Korean.

HEDIS® Child and Adolescent Well Care Visits (WCV) by Race and Ethnicity, and Language			
Item	Category Type	Stratification	Identified Barrier
1	Member-Facing	Race/ethnicity - Black/African American members, White members	• Social drivers of health including food insecurity, and access to care (transportation, scheduling appointments, taking time off work, cost of care). • Qualitative interviews with Black/African American and Hispanic/Latinx caregivers and patients highlighted transportation, language, and scheduling as key barriers to well-child visits (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler,...& Alper, 2022). • Member feedback from prior Blue Shield Promise hosted well child clinic days emphasized competing priorities with their health, including pursuing education (receiving their GED). • Literature highlighted one strategy for improvement was to offer well-child visits at different appointments to help patients avoid making multiple trips (Garg, Wilkie, LeBlanc, Lyu, Scornavacca, Fowler, ... & Alper, 2022). Therefore, offering different ways and appropriate options to for members to complete the well-care visit can address this barrier. • Liljenquist & Coker (2021) emphasize the need to engage members by building the capacity of community-based programs and reducing the burden on primary care providers and enhancing access to appropriate services for families.
2	Member Facing	Race/ethnicity – Native Hawaiian or Other Pacific Islander	• A UCLA Center for Health Policy Research on Native Hawaiian or Other Pacific Islander children noted that this group lacks a usual source of care when they are sick or need health advice (*A Child Is a Child: Native Hawaiian and Pacific Islander Children's Health*, 2024). Therefore, increasing access to a source of care, and connecting children to their primary care provider is critical to establish a source of care for children.
3	Member Facing	Race/ethnicity – Native Hawaiian or Other Pacific Islander	• The same publication also noted that Native Hawaiian or Other Pacific Islander individuals may avoid accessing government benefits like Medi-Cal due to immigration, or public charge concerns. This is relevant because the UCLA Center for Health Policy Research on Native Hawaiian or Other Pacific Islander children noted that 1 in 3 Native Hawaiian or Other Pacific Island children live in immigrant families, with at least one parent or guardian who was born outside of the United States (*A Child Is a Child: Native Hawaiian and Pacific Islander Children's Health*, 2024). • Partnering with an organization or trusted provider can help address this barrier and mitigate this group's concerns for accessing their Medi-Cal benefits so their children can receive preventive care.

4	Member Facing	Race/ethnicity – American Indian or Alaskan Native	• American Indian/Alaskan Native youth experience "conventional" barriers including lack of transportation, difficulty finding childcare, inability to miss work, caring for elders, and other family and work obligations (Bell, Deen, Fuentes, Moore, & Committee on Native American Children Health, 2021). • Additionally, unique barriers include a long-standing mistrust of governmental agencies, discrimination in clinical settings, and the "cumulative burden of generations of unresolved traumas and racism" (Bell, Deen, Fuentes, Moore, & Committee on Native American Children Health, 2021).
5	Member Facing	Language – Russian	• There are cultural differences in engaging with the healthcare system. A 2020 study noted that a growing number of international immigrants are from the former Soviet Union and typically speak Russian. The Soviet healthcare system was the same across all Soviet republics and different from the Western healthcare delivery model. Compared to the prior concepts of universal coverage, coming to America, immigrants were not familiar the concept of health insurance and may experience challenges accessing care (Kostareva, Albright, Berens, Levin-Zamir, Aringazina, Lopatina,… & Sentell, 2020). • The same study also noted that immigrants may not be familiar with the importance and utilization of preventive services such as screenings and regular checkups. They also may have difficulty with referrals and navigating among and between providers. Additionally, immigrants with limited language proficiency may experience difficulty in communicating or explaining their health needs.
6	Member-Facing	Language – Vietnamese, Korean	• According to a study of the Vietnamese Community in Orange County, Vietnamese individuals or families may not have a usual source of care for when they are sick or need health advice. The study cited that the main reason for not having a usual place of care is because the largest proportion of respondents stated that they seldom or never get sick or do not know where to go for care (*A Look at Health in Orange a Look at Health in Orange County's Vietnamese Community County's Vietnamese Community*, n.d). • Another study of health status and health services access and utilization among Chinese, Filipino, Japanese, Korean, South Asian, and Vietnamese Children in California, found that Korean and Vietnamese children were more likely to be without a usual place for health care and to have had no contact with a health professional within the past 12 months than were non-Hispanic White children (Yu, Huang, & Singh, 2010).

Interventions:

Below we prioritize interventions that are not only available to our Blue Shield Promise members but could also be adapted or tailored to address our priority populations.

Priority	Opportunity for Improvement	Measure	Intervention	Date of Implementation	Rationale for Choosing Intervention	Status
1	Increase the number and percentage of members diagnosed with Diabetes who have controlled HbA1c levels (by decreasing the number of members with poor controlled HbA1c levels) to improve the health of our members, with an emphasis on members who identified as Hispanic or Latino in Los Angeles County	HEDIS®: Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c >9%	Employing tailored and culturally appropriate Diabetes management courses, offering a parallel Spanish speaking course. Offering the courses in person at Blue Shield Promise Community Resource Centers. Using heat maps to identify Hispanic or Latino members who reside in Los Angeles County to encourage attendance through mailed letters. Among Hispanic or Latino members who are assigned to a provider group with Health Navigators, encourage attendance through live calls.	July 2024	The Diabetes management course, tailored and taught in Spanish considers our member's background, culture, and lifestyle. Offering the course in-person at the Blue Shield Community Resource Center also allows members to learn about other Blue Shield services that can help the social drivers of health (e.g., transportation, food insecurity, etc.) Members can also bring family members or caregivers to increase family involvement.	In Process
2	Increase overall performance for child and adolescent well care visits, with an emphasis on Black or African American, Native Hawaiian or Other	HEDIS®: Child and Adolescent Well Care Visits	Well Child Clinic Days: Partnering with vendor to increase access to timely well-child visits through live calls to members who have not yet had a well-care visit, offering scheduling assistance, and hosting well child clinic days. We will also employ heat maps to identify areas/regions where a large	January 2024	Partnering with an organization with appropriate clinical staff increases access to care by connecting members to a usual source of care. Hosting well child clinic days where our members live and on weekends and that invites families to attend addresses social drivers of health, like transportation, or scheduling, which makes it difficult to complete these preventive visits. In addition,	In Process

Priority	Opportunity for Improvement	Measure	Intervention	Date of Implementation	Rationale for Choosing Intervention	Status
	Pacific Islander members.		volume of Black or African, and Native Hawaiian or Other Pacific Islander members and families live to identify new community sites for well child clinic days that are familiar to and trusted by our target population. We will also partner with our vendor to match the practitioner's race/ethnicity to our target group's race/ethnicity. In addition to completing the visit during the well child clinic day, the vendor will also help members complete a social driver of health (SDOH) assessment to address social needs.		we work with trusted community partners to ensure the locations where the well child clinic days are hosted consider the cultural needs of our target population. The clinic days also enable members to identify a source of care as the exam results are sent to the member's assigned primary care provider. Additionally, given that the vendor administers SDOH assessments, the vendor can also help address social needs. The clinic days also offer appointments, walk-in options, and some clinic days offer extended hours to accommodate a member's schedule. This flexibility helps address barriers commonly found among our priority populations, including finding childcare or taking off work.	
3	Increase overall performance for child and adolescent well care visits, with an emphasis on members whose preferred language includes	HEDIS®: Child and Adolescent Well Care Visits	Well Child Clinic Days: Partnering with a vendor to conduct tailored outreach to members who speak Vietnamese, Korean, and Spanish, helping members with limited English proficiency get appointments scheduled. Intervention includes matching members with these language preferences to	November 2024	Matching members with language preferences to representatives that speak their language helps address the member's potential limited English language proficiency. This addresses the barrier of communicating or explaining the member's health needs. Overcoming this barrier is essential to building rapport and encouraging the member to accept scheduling assistance or attending one of the clinic days.	Not Started

Priority	Opportunity for Improvement	Measure	Intervention	Date of Implementation	Rationale for Choosing Intervention	Status
	Vietnamese, Russian, or Korean.		customer service representatives who speak the corresponding languages. The customer service representatives will contact the member in their preferred language to help offer scheduling assistance and book appointments during the clinic days.		Similar to above, the clinic days also enable members to identify a source of care as the exam results are sent to the member's assigned primary care provider. Additionally, given that the vendor administers SDOH assessments, the vendor can also help address social needs.	

Plan for Evaluation of Interventions:

This is the first year we have conducted this report, and it will serve as a baseline report. In 2025, we will conduct our first evaluation of the effectiveness of the 2024 interventions to reduce inequity.

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Annual Medi-Cal Disparities Report Contributors Roster				
Name	**Title**	**Qualifications**	**Specialty**	**Clinical and/or Non-Clinical**

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 CalAIM, 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 CalAIM, 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 CalAIM, 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 CalAIM, 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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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 CalAIM, NCQA	Equitable High Quality Clinical Care	Quality CalAIM	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	Disnerollment by REGAL	Voluntary disenrollment by REGAL during the measurement period	DISENR REGAL
19	Redetermination Rate by REGAL	Redetermination rate of members reinstated by REGAL during the measurement period	REDET REGAL
20	Interpreter service utilization	Number of Language line interpreter service requests by language during the measurement period	INT SVC UTIL
21	Translated documents	Number of translated documents by language or alternative format during the measurement period	TRNSLTD DOCS
22	Physical Accessibility	Percent of providers passing Physical Accessibility Review Survey with score >90% during the measurement period	PARS
23	IHA Completion	IHA completion rate stratified by REGAL during the measurement period	IHA
24	DPP Enrollment by REGAL	DPP enrollment by REGAL during the measurement period	DPP REGAL
25	Getting Needed Care	Getting Needed Care by REGAL during the measurement period	GNC REGAL
26	Getting Care Quickly by (REGAL)	Getting Care Quickly by REGAL during the measurement period	GCQ REGAL
Equitable Social Interventions			
Measure Description		**Measure Definition**	**Measure Acronym**
27	Care Management for High-Risk Members after Discharge	The total number of transitions for high-risk members during the Intake Period within a 12-month period.	PHM KPI 5
28	SDOH reporting	Rate of network providers reporting SDOH codes	SDOH
29	SDOH reporting by REGAL	Total number of members screened for SDOH by REGAL during the measurement period	SDOH REGAL
30	Populations of Focus	Percent of members stratified into each populations of focus	POF
31	Community Support utilization	Community support utilization by category	CS UTIL
Equitable High-Quality Clinical Care			
Measure Description		**Measure Definition**	**Measure Acronym**
32	Overturned appeals stratified by race and ethnicity	Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period	APP-RE
33	Follow-Up After ED Visit for Mental Illness – 30 days by REGAL	Percentage of Follow-Up After ED Visit for Mental Illness – 30 days by (REGAL) during the measurement period	FUM REGAL
34	Pharmacotherapy for Opioid Use Disorder by REGAL	Percentage of Pharmacotherapy for Opioid Use Disorder by (REGAL) during the measurement period	POD REGAL
35	Follow-Up after ED Visits for Substance Use – 30 day by REGAL	Percentage of Follow-Up after ED Visits for Substance Use – 30 days by (REGAL) during the measurement period	FUA REGAL
36	Well-Child Visits in the First 30 Months of Life by REGAL	Percentage of children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life stratified by REGAL	W30 REGAL
37	Breast Cancer Screening by REGAL	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years stratified by REGAL	BCS REGAL

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

2024-2025 Quality Improvement Health Equity Transformation Program Action Plan

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

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

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

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

				Social Services Management Community Engagement	
Update global policies and procedures with health equity lens	Need to review all policies and procedures with a health equity lens. Need to connect with Sylvona Boler for P&P operational process as presented in April 2023 MPOD meeting	Yes	12/31/2023	HEO Compliance Medi-Cal Growth Office	Closed
QIHETP Annual Evaluation Report	Need to draft QIHETP Annual Evaluation Report	Yes	4/30/2024	HEO	Closed
Review Marketing Plan and identify HE activities	CHEO to review Marketing Plan and identify HE activities in collaboration with Community Engagement Department	Yes	3/14/2025	Community Engagement HEO	Closed
Population Needs Assessment and Population Health Management Strategy	Support draft and use findings to guide program activities None	Yes	TBD	BSC- Health Transformation Lab HEO	Open
BSP Population Needs Assessment	Support draft and use findings to guide program activities None	Yes	6/30/2023	HE/CL HEO	Closed
BSP Population Health Management Strategy	support draft and use findings to guide program activities	Yes	3/31/2024	PHM HEO	Closed
Provider Health Equity training	No known training. Need to develop content and implement. Systems to track provider compliance unknown.	Yes	12/31/2025	HEO Provider Relations HE/CL	Open
Assess health equity pilots	Need to assess current health equity pilots, projects, programs – part of 5-year strategic planning and maturation model.	Yes	12/31/2024	HEO A&G BH CalAim PHM Customer Experience Clinical Services (FSR) HE/CL Maternal Health Provider Contracting Quality Corporate Citizenship and Reputation Social Services Management Community Engagement	Closed
Committee involvement (QIHEC, MAC, PAC, PPC)	CHEO representation in committee involvement. Co-chairing QIHEC with CMO	Yes	12/31/2024	HEO Community Engagement	Closed

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