Quality Improvement and Health Equity Transformation Program Annual Evaluation

Medi-Cal Product

Report Year 2026

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Executive Summary

The Quality Improvement and Health Equity Transformation Program (QIHETP, or QIHET) Annual Evaluation Report Year (RY) 2026 documents the annual review and formal assessment of Blue Shield of California 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 2025 Quality Improvement and Health Equity Committee (QIHEC) Work Plan and conforms to the 2025 QIHET Program Description.

Blue Shield Promise's 2025 QIHET program goals and objectives support the QIHETP program principles that will seek to implement the Health Equity Office (HEO) milestones.

QIHET Program Goals and Objectives are built on the following 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, 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.

2025 QIHET Program Outcomes and Accomplishments:

- Blue Shield Promise received National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation with a score of 100%.
- Maintained Health Outcomes Accreditation with 100% of standards met.
- Achieved 100% compliance across health equity related contractual deliverables (150+ contractual requirements met), remained 100% audit ready.
- Operationalized the Diversity, Equity, and Inclusion (DEI) training program, reaching 90% readiness toward full launch.
- Launched internal *Advancing Health Equity* training with 100% completion and highest satisfaction rate.

- Successfully launched provider DEI training, with provider participation steadily increasing following April 2025 release.
- Implemented and advanced the Health Equity Integration Plan, reaching nearly 50% completion by Q3 with continued progress underway.
- Strengthened collection of Social Drivers of Health (SDOH) data, demonstrating measurable increases in member-level data capture.
- Demonstrated strong program impact through the HEART Advocate Program, with 97% of participants reporting value added to their role.
- Launched a student pipeline program to support workforce development and long-term health equity capacity.
- Sustained governance and transparency by publishing quarterly QIHEC updates and engaging committees in ongoing health equity oversight.
- Advanced a culture of equity across quality, compliance, and operations through data-driven monitoring and continuous improvement.

Based on 2025 outcomes and learnings, Blue Shield Promise will focus on further integrating health equity across functional areas with an emphasis on demonstrated outcomes such as improved care gap closure by race and ethnicity, increased coordination of care to address social drivers of health, and applied member feedback into program offerings.

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I. Overview

The Blue Shield of California Promise Health Plan (Blue Shield Promise, or Plan) is a managed care organization offering Medi-Cal in Los Angeles and San Diego counties. 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 and Health Equity Transformation Program (QIHETP), also known as the Health Equity Advancements Resulting in Transformation, or 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 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 Action Plan Goals and Objectives as outlined in the QIHET Program Description and table 1.

Table 1. QIHET Program Goals and Objectives

2025 QIHET Program Objectives	
Goal	**Objective**
Sound Infrastructure and Operations	Complete 100% of all Health Outcomes 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

Blue Shield Promise uses multiple reliable data sources, methodologies, techniques, and tools to conduct the annual evaluation. These 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 grievances (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 program, 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 meet professionally recognized standards of practice.

Quality improvement and health equity are 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 Promise uses multiple reliable data sources, methodologies, techniques, and tools to conduct the QIHETP annual evaluation. These 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 grievances (complaint) data: Cultural, linguistics, or discrimination related grievances (complaint) 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 2025.

3. Provider Advisory Committee (PAC), held in calendar year 2025.
4. Joint Operations Meetings (JOM), held in calendar year 2025.
5. Quality Improvement and Health Equity Committee (QIHEC), held in calendar year 2025.

III. Quality Improvement and Health Equity Transformation Program Activities

Blue Shield Promise 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. The Blue Shield Promise Health Equity Office (HEO) operationalized program activities to meet the four program goals and objectives. These goals focus on continually building a strong foundation of governance and organizational infrastructure necessary for centering health equity in operations and strategic planning.

Goal #1: Sound Infrastructure and Operations
Objective #1: Complete 100% of all Health Outcomes Accreditation activities as required by 12/31/2025.

NCQA Health Outcomes Accreditation

The Blue Shield Promise HEO works closely with the Blue Shield of California Health Operations Oversight Department to plan, develop, and implement NCQA Health Outcomes Accreditation (HOA) (previously known as the NCQA Health Equity Accreditation, or HEA) guidelines and activities meeting DHCS contract requirements to obtain formal accreditation.

In collaboration with Blue Shield of California Health Operations Oversight 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. As of January 2025, Blue Shield Promise received NCQA Health Outcomes Accreditation with a 100% score, in accordance with DHCS contractual requirements and reported on status to the QIHEC.

NCQA Health Outcomes Accreditation Reports

The HEO is tracking NCQA HOA 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.

At year end, in partnership with the Health Education and Cultural and Linguistics Department, the QIHEC tracked the Cultural and Linguistic Program Evaluation Report activities. The Cultural and Linguistic (CLAS) Evaluation Report examines all program activities annually to ensure members' needs and preferences are met in areas including race and ethnicity, language, sexual orientation, gender identity, cultural and linguistic grievances, and provider offerings. Insights from this evaluation inform the development of new interventions to address identified opportunities. Table 2 outlines a comprehensive review of health equity–related findings across provider networks, member and provider language access, grievances, and demographic data collection, along with targeted interventions and outcomes.

Table 2. 2024 Culturally and Linguistically Appropriate Services (CLAS) Report Findings, Interventions and Outcomes

Report	Finding	Intervention(s)	Outcomes	Status
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.	**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.	1, 2: Completed. A modification in logic was necessary to resolve this deficiency, affecting the data processes related to network analytics as well as the presentation of information in Blue Shield's provider directory. Our primary objective will be to evaluate the outcomes associated with these changes. Specifically, in 2025, Blue Shield enhanced its systems by setting English as the default language (in place of 'unknown'), thereby improving clarity for members searching for providers online. This adjustment is expected to better meet members' cultural needs and preferences through improved accuracy and system functionality. The Information Technology team has recently finalized the programming update, and the revised data will be incorporated in the forthcoming reporting cycle.	**Completed**
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.	**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.	1. Completed. Blue Shield Promise presented at the September 2024 Community Advisory Committee to gather input from members on various preferences on receiving health plan communications. Members shared they would strongly recommend continuing correspondence on programs/services provided by Blue Shield Promise.	**Completed**
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).	**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.	1. Completed. Blue Shield Promise presented at the September 2024 Community Advisory Committee to gather input from members on various preferences on receiving health plan communications. Members shared they would strongly recommend continuing correspondence on programs/services provided by Blue Shield Promise.	**Completed**

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.	**Member-Facing:** 2. Develop and disseminate a member notification on how to access language assistance services, including interpreter and translation information.	2. Completed. Member newsletter article went out in Q4 2024 on availability of translation services and interpreter services. The article expanded on the timeframes for scheduling face-to-face interpreters, including ASL.	**Completed**
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.	**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.	3. Completed. In 2025, there were two provider notifications regarding Blue Shield Promise language assistance services available to all providers. The annual mailing contains information on for providers on how to access interpreter services and language assistance information that is available to be used for their offices. Additionally, we shared information about the available provider training for them and office staff.	**Completed**
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.	**Administrative Facing:** 4. Set up 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.	4. Discontinued. Most grievances are related to issues with interpreter services and not translation of materials and our focus will be on improving experience and access to interpreter services.	**Discontinued**
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. NCQA requires health plans to 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.	**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.	1. The pilot program was discontinued as it yielded little provider engagement. As of May 2025, a total of 90 providers were onboarded of the targeted 5000 providers. Very little commitment was demonstrated; therefore, it was recommended to no longer proceed with this intervention.	**Discontinued**
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.	**Provider-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.	2. Sent 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.	**Completed**

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. Member self-reported race and ethnicity data captured: 95.5% Los Angeles; 82.8% San Diego 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.	**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. 4. Focus on data integration from external sources to increase the amount of self-reported member demographic data available to us	3. Completed. In 2025, Blue Shield Promise sent out written communication to all its Medi-Cal members to remind members of the importance of maintaining their information up to date. Members were reminded to leverage the member portal to self-identify race/ethnicity, preferred spoken and written languages, sexual orientation and ways that members can receive health plan communications. In 2025, while it did not achieve its goal of meeting the 20% goal of self-identified sexual orientation and gender identity, there was a slight increase in rates of self-identification. This modest improvement may be due to said reminders. In addition, this communication also includes reminders on the organization's importance of guarding personal and sensitive information which may have resonated with members' appeal to self-identify. 4. Completed initial assessment of data sources and inclusion of data. Assessing internal data streams and ability to integrate.	**Completed**
Member and Provider Race, Ethnicity, and Language Data Member Sexual Orientation and Gender Identity Data.	Blue Shield has low response rates (1%) for sexual orientation and gender identity data Blue Shield has low response rates (1%) for sexual orientation and gender identity data Blue Shield has low response rates (1%) for sexual orientation and gender identity data	1. Socialize process for updating member profile	The percentage of members who reported their gender identity and sexual orientation improved by 28.24% and 44.44%; however, the overall percentage of members who self-report this information remains very low (1%). Implement Community Advisory Committee feedback regarding availing members' concerns around use of their data and privacy when asking for members' demographic data.	**Completed**
Member and Provider Race, Ethnicity, and Language Data Member Sexual Orientation and Gender Identity Data.	Blue Shield has low response rates (1%) for sexual orientation and gender identity data	2. Training performed to improve staff comfort in broaching topic with members	The percentage of members who reported their gender identity and sexual orientation improved by 28.24% and 44.44%; however, the overall percentage of members who self-report this information remains very low (1%). Implement Community Advisory Committee feedback regarding availing members' concerns around use of their data and privacy when asking for members' demographic data.	**Completed**
Member and Provider Race, Ethnicity, and Language Data Member	Blue Shield has low response rates (1%) for sexual orientation and gender identity data	3. Focus group with Federally Qualified Health Centers to understand barriers for collection	Completed as of NCQA submission – November 2024. Results of focus groups indicate barriers for collection. Based on this, BSP HEO shared best practices toolkit for collecting SOGI from patients.	**Completed**

Sexual Orientation and Gender Identity Data.				
Member and Provider Race, Ethnicity, and Language Data Member Sexual Orientation and Gender Identity Data.	Blue Shield has low response rates (1%) for sexual orientation and gender identity data	4. Explore process for data sharing with Federally Quality Health Center	Discontinued exploring data sharing with FQHCs due to operational complexity and sensitivity around SOGI data. Resources will be redirected to alternative strategies to increase data capture of member SOGI data that still advance health equity.	**Discontinued**
CLAS Provider Training	Lack of current web system ability quantifies 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.	**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.	Discontinued. As part of the Department of Health Care Services requirement for all managed care plans and subcontractors are required to complete Diversity, Equity and Inclusion training as part of the Medi-Cal contract. This would require Blue Shield Promise to monitor providers' completion of this training. A 100% completion is required. To date, we are at a 10% completion.	**Discontinued**

Key findings included gaps in provider network language thresholds across certain specialties and regions, increased use and demand for interpreter and translation services, linguistically and culturally related grievances largely tied to interpreter experiences, and persistent challenges collecting race, ethnicity, language, sexual orientation, and gender identity data from members and providers. In response, Blue Shield Promise implemented a robust mix of administrative, member-facing, and provider-facing interventions—such as system logic updates to improve provider directory accuracy, community and provider outreach on language assistance services, governance and process reviews, enhanced training, and targeted communications to reinforce privacy protections and data use.

Most interventions were completed and resulted in improved data accuracy, near-universal fulfillment of translation requests, increased awareness of language services, modest gains in self-reported demographic data, strengthened governance, and improved transparency through reporting, while some initiatives were discontinued due to limited engagement or operational complexity. Overall, the actions demonstrate strong progress in addressing access, cultural responsiveness, and data infrastructure to support health equity goals, despite ongoing challenges in provider engagement and sensitive data collection.

Several interventions were discontinued after evaluation due to limited effectiveness, operational challenges, or shifts in strategic priorities; however, the underlying findings

continued to be addressed through alternative approaches. The Violet provider engagement pilot was discontinued due to low participation, and efforts were redirected to broader provider outreach and reminders to update demographic and language data. The grievance process review focused on translation was discontinued when findings showed interpreter services were the primary issue, prompting a shift toward improving interpreter access and member education. Exploration of SOGI data sharing with Federally Qualified Health Centers was halted due to operational complexity and data sensitivity concerns, with efforts instead focused on internal strategies such as member outreach, staff training, and incorporating community feedback to build trust and increase voluntary data reporting. Additionally, the planned enhancement to CLAS training tracking was discontinued due to new regulatory requirements mandating full provider completion of DEI training, shifting the focus to improving compliance rates. Overall, while specific interventions were discontinued, Blue Shield Promise redirected resources to more feasible and impactful strategies aligned with member needs and regulatory expectations.

The Health Education and Cultural and Linguistic Department conducted the 2025 Cultural and Linguistic Program Assessment Report, which includes an annual review of member and provider demographics across key domains such as race, ethnicity, language, sexual orientation, and gender identity. The findings indicate a high rate of self-reported race and ethnicity data, with 93.59% of members reporting this information—exceeding Blue Shield Promise's 80% goal. Of the total membership, 76.88% identify as Hispanic or Latino, followed by 7.35% reporting Some Other Race and 4.75% identifying as White.
In contrast, self-reporting of gender identity and sexual orientation remains limited. While 100% of members reported sex assigned at birth, only 1% reported gender identity, and fewer than 1% reported pronouns or sexual orientation. The assessment also evaluated threshold languages—defined as those spoken by 5% of the population or 1,000 members, whichever is fewer. Analysis of members' preferred language showed that Farsi met the threshold in Los Angeles County (n = 1,009; 0.27%).

Additionally, table 3 summarizes the 2025 Cultural and Linguistic Program Evaluation Report, highlighting Calendar Year (CY) 2024 findings, year-over-year trends, and identified CY 2025 opportunities that will continue to be tracked and monitored through CY 2026.

Table 3. Cultural and Linguistics Program Annual Evaluation Year-Over-Year Results

Category	2024 Findings	Year-over-Year	2025 Opportunity
Member and Provider Race, Ethnicity and Language Data	1. 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. 2. Blue Shield Promise did not meet the goal of having 1 Middle Eastern and North African practitioner for every 700 Middle Eastern and North African members, in either county. 3. Blue Shield Promise has not achieved 20% self-report on sexual orientation and gender identity data capture.	1. Some ratios improved while others didn't. Notably, cardiology ratios improved while gastroenterology ratios worsened. 2. Blue Shield Promise did not meet the goal of having 1 Middle Eastern and North African practitioner for every 700 Middle Eastern and North African members, in either county. 3. The percentage of members who reported their gender identity and sexual orientation improved by 28.24% and 44.44%; however, the overall percentage of members who self-report this information remains very low (1%).	1. Continue to work across teams to identify improvements in provider demographic data capture. 2. Work across teams identify new way to encourage providers to self-identify race, ethnicity and language. Clarify that language does not default to English, if field is left blank. 3. Implement Community Advisory Committee feedback regarding availing members' concerns around use of their data and privacy when asking for members' demographic data.
Grievances related to cultural and linguistic	1. Despite availability of language services (interpreter and translation), members and providers may be unaware these services exists or may not be aware on the timeframes needed to schedule face-to-face interpreters.	1. Despite education and promotion of language services, grievances persist specifically around face-to-face interpreter services.	1. Explore feasibility of implementing Community Advisory Committee feedback regarding developing a mailer or short video on availability of language services.
Member Experience	1. Low response rate for interpreter services member satisfaction survey	1. Response rate remains at similar rate as last year (5.6%) despite the implementation of member incentive for completion of the survey.	1. Implement a digital survey delivery system through email and the online survey platform, Qualtrics, as well as transition the survey cadence from annually to quarterly.

To ensure findings are addressed, the QIHEC will track the Cultural and Linguistic Program Evaluation Report activities as outlined in table 4 throughout CY 2026. Report findings and outcomes will be submitted to the QIHEC.

Table 4. 2025 Culturally and Linguistically Appropriate Services (CLAS) Report Findings, Interventions and Outcomes

Report	Finding	Intervention(s)	Outcomes	Status
Provider Race and Ethnicity – Middle Eastern and North African	Blue Shield Promise does not meet the goal of having 1 Middle Eastern and North African practitioner for every 700 Middle Eastern and North African members, in either county. Blue Shield Promise does not meet the goal of 1 other race practitioner for every 700 other race members in San Diego County.	Administrative facing: Blue Shield Promise is forming a cross departmental workgroup to examine provider data to determine the precise root cause and develop an action plan to ensure Middle Eastern and North African providers are adequately represented in the Blue Shield Promise network. Responsible: Provider Relations; Network Analytics; Provider Contracting	Will be included in 2026 CLAS report	Not Started
Provider Languages – Specialist	Blue Shield does not meet the 1:1200 ratio for the following specialty types in Los Angeles County: - Cardiology- Spanish - Gastroenterology- English, Spanish, Cantonese Blue Shield does not meet the 1:1200 ratio for the following specialty types in San Diego County: - Cardiology- English	Administrative facing: 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.	Will be included in 2026 CLAS report	Not Started Initial conversations have occurred with Provider Network. Meetings with a formal workgroup will be scheduled.

	- Gastroenterology- English, Spanish, Vietnamese and Tagalog			
Member Cultural and Linguistic Grievances	Blue Shield Promise does not currently maintain a formal target for member grievances; however, all grievances and identified gaps within the broader cultural and linguistic program are subject to thorough review and assessment.	Administrative facing intervention: A cross-department workgroup will be formed to review existing processes of categorizing grievances and identify ways to streamline the reporting process to internal teams. This will allow for better tracking and review of grievance	Will be included in 2026 CLAS report	In Progress
Member Cultural and Linguistic Grievances	Blue Shield Promise does not currently maintain a formal target for member grievances; however, all grievances and identified gaps within the broader cultural and linguistic program are subject to thorough review and assessment.	Member facing: 1. Explore the feasibility of a stand-along member flyer or short video on the availability of language services. 2. Transition interpreter satisfaction member survey from annual to quarterly.	Will be included in 2026 CLAS report	Not Started
Member Self-reported Gender Identification and Sexual Orientation	Blue Shield Promise has not achieved 20% self-report gender identity and sexual orientation data capture.	Administrative facing intervention: Explore opportunities for Customer Service to collect self-reported demographics from members when they call Blue Shield Promise.	Will be included in 2026 CLAS report	In Progress
Utilization of Language Assistance Services- Bilingual Services	Blue Shield Promise does not have a centralized system to track the number of employees who have been assessed for their bilingual skills.	Administrative facing intervention: Review current process with bilingual skills assessment vendor (Language Line) to explore the possibility of a reporting dashboard. Develop centralized tracking process whereby leaders of member-facing departments track bilingual assessments on a quarterly basis.	Will be included in 2026 CLAS report	In Progress
Member Experience with Interpreter Services During Healthcare Encounters and Health Plan Encounters	Blue Shield Promise has not achieved a 20% response rate for the interpreter member satisfaction surveys	Administrative facing intervention: Implement a digital survey delivery system through e-mail and an online survey platform. Transition the survey cadence from annually to quarterly.	Will be included in 2026 CLAS report	In Progress

Health Disparities Report

The Health Disparity Report analyzes race, ethnicity, language, sexual orientation, and gender identity data to identify inequities in Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures to identify and address disparities in healthcare outcomes among different population groups. Table 5 describes the Health Disparities report findings, interventions, and outcomes.

Table 5. 2024 Health Disparities Report Findings, Interventions and Outcomes

Category	Finding	Intervention(s)	Outcomes	Status
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%).	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.	Los Angeles County MY2024: 38.11%↑ (Goal not Met) Collaborated with Health Education to add a diabetes management series in Spanish there were a limited number of members attending the education classes, ranging from 8 to 12 in the August sessions (CRC- Wilmington), to 9 to 13 in the May 2025 series. Additionally, the intervention was not implemented as intended in January 2025 due to the wildfires in Los Angeles. The results from the April virtual and May in-person sessions highlighted the importance of documenting interest and intent to attend the course as it yielded higher attendance. Additionally, it may be beneficial to continue offering education and resources to members who are diagnosed with Diabetes and may have other chronic conditions or preventive care needs.	Completed
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.	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.	Los Angeles County MY2024: 56.97%↑ San Diego County MY2024: 54.17↑(Goal Met) Blue Shield Promise examined the clinic day completion rates from Q1-Q2 2025, by race. The completion rate for clinic days in Q1 – Q2 2025 ranged from the highest at 70.83% (n=72) among Asian members to the lowest at 25.53% (n=141) among Black or African American members. The completion rate among Native Hawaiian or Other Pacific Islander members was the second highest completion rate at 67.92% (n=53). Employing the heat maps to inform locations has been effective for Native Hawaiian or Other Pacific Islanders based on completion rates. Blue Shield Promise recognizes improvement may take more time. Blue Shield Promise will continue to monitor the rates by race and ethnicity and examine further at what step Black or African American members may not be attending the scheduled appointments (e.g., not scheduling, no-shows, etc.). Given the overall success of the partnership with the vendor on the WCV rates across all groups and counties, Blue Shield Promise will incorporate this strengthened partnership as part of its standard of operations and explore ways to expand the collaboration for different populations and health conditions.	Completed
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).	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	Los Angeles County MY2024: 56.97%↑ San Diego County MY2024: 54.17↑ (Goal Met) Incorporated this intervention as part of standard operations. Given the overall	Completed

	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.	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.	success of the partnership with the vendor on the WCV rates across all groups and counties, Blue Shield Promise will incorporate this strengthened partnership as part of its standard of operations and explore ways to expand the collaboration for different populations and health conditions.	

The findings summarize equity-focused performance for diabetes control and child and adolescent well-care visits, highlighting both progress and opportunities for improvement across race, ethnicity, and language groups. For diabetes care in Los Angeles County, overall and stratified performance met DHCS Minimum Performance Levels (MPL); however, Hispanic or Latino members slightly exceeded the HbA1c poor control threshold, prompting culturally tailored diabetes education interventions, including Spanish-language courses and community-based outreach, though attendance and outcomes were limited by external disruptions and engagement challenges. For well-care visits, targeted interventions such as vendor-supported well-child clinic days, language- and race-concordant outreach, heat mapping, and scheduling assistance resulted in significant improvements, with both Los Angeles and San Diego Counties meeting MPL goals. Completion rates varied by race and language, with stronger outcomes among Asian and Native Hawaiian or Other Pacific Islander members and lower rates among Black or African American members, indicating areas for continued monitoring and refinement. Overall, most interventions have been completed and incorporated into standard operations, reflecting meaningful progress while acknowledging that sustained, tailored efforts are needed to further reduce disparities and improve access and outcomes across all populations.

In 2025, Blue Shield Promise continued to identify opportunities to address the updated HEDIS® Glycemic Status Assessment for Patients with Diabetes >9% measure and analyzed HEDIS® measures for prenatal and postpartum care (by race/ethnicity), child and adolescent well-care visits (by language and gender), and CAHPS ratings (by race/ethnicity), prioritizing interventions for diabetes and maternal care disparities. Key findings indicate there are high rates of poor glycemic control (>9%) among Hispanic/Latino members in Los Angeles County (38.75%) and San Diego County (37.45%). Interventions will include Medically Tailored Meals and Wellvolution® resources. Wellvolution® is Blue Shield of California's digital health and wellness platform designed to support members in improving their overall physical, mental, and behavioral health. It offers access to a curated network of evidence-based lifestyle programs and tools that address key health needs such as nutrition, weight management, diabetes prevention and management, stress reduction, tobacco cessation, and emotional well-being. Through

personalized recommendations, online coaching, and interactive resources, Wellvolution® enables members to engage in self-guided or coach-supported programs tailored to their individual goals and risk factors. The platform emphasizes prevention and behavior change by connecting members to clinically validated programs at no additional cost (for eligible members), helping to improve health outcomes, increase self-management, and reduce the risk of chronic conditions. Prenatal and postpartum care rates fell below targets (PPC- Timeliness of Care: San Diego County: 82.36%; Los Angeles County: 82.70%; PPC-Postpartum Care: San Diego County: 80.00%; Los Angeles County: 78.89%). Strategies will focus on Black/African American members through early identification, maternity care management, and increased doula benefit utilization.

Blue Shield Promise will continue implementing and evaluating interventions, then re-analyze HEDIS® measures in Quarter 2, 2026 to assess improvement and benchmark achievement as outlined in table 6. Report findings will be submitted to the QIHEC.

Table 6. 2025 Health Disparities Report Findings, Interventions and Outcomes

Category	Finding	Intervention(s)	Outcomes	Status
HEDIS®: Glycemic Status Assessment for Patients with Diabetes >9%	We observed inequities by race/ethnicity for glycemic status assessment (>9%) for members in Los Angeles County, additionally target goals for San Diego were not achieved. Our intervention strategy will continue to focus on reducing inequities for Hispanic/Latino members in Los Angeles County and San Diego County as they accounted for a large proportion of the denominator (when stratifying rates by ethnicity) and had the highest number of members demonstrating glycemic status levels >9%.	Offering Medically Tailored Meals/Medically Supportive Meals (MTM/MSM) to members diagnosed with diabetes and demonstrating a glycemic index >9%.	Will be included in 2026 Health Disparities Report	Not Started
HEDIS®: Glycemic Status Assessment for Patients with Diabetes >9%	We observed inequities by race/ethnicity for glycemic status assessment (>9%) for members in Los Angeles County, additionally target goals for San Diego were not achieved. Our intervention strategy will continue to focus on reducing inequities for Hispanic/Latino members in Los Angeles County and San Diego County as they accounted for a large proportion of the denominator (when stratifying rates by ethnicity) and had the highest number of members demonstrating glycemic status levels >9%.	Modifying outreach approaches to promote relevant programs through the Wellvolution® platform.	Will be included in 2026 Health Disparities Report	Not Started
HEDIS®: Prenatal and Postpartum Care	We observed inequities by race/ethnicity for Postpartum care among Promise members in Los Angeles County. Target goals for Los Angeles County were not achieved when stratifying performance by race. Our intervention strategy will focus on reducing inequities for Black/African American, members as these groups	Promoting and increasing the utilization of the doula benefit among birthing members	Will be included in 2026 Health Disparities Report	Not Started

	showed the highest preventive care visit gaps among Promise members.			
HEDIS®: Prenatal and Postpartum Care	We observed inequities by race/ethnicity for Postpartum care among Promise members in Los Angeles County. Target goals for Los Angeles County were not achieved when stratifying performance by race. Our intervention strategy will focus on reducing inequities for Black/African American, members as these groups showed the highest preventive care visit gaps among Promise members.	Leveraging existing data tools to identify members earlier in their pregnancy, to offer maternity care-management, additional resources for the family, and provide support earlier in the birthing journey.	Will be included in 2026 Health Disparities Report	Not Started

Objective #2: 100% of health equity related contract deliverables will be compliant by 12/31/2025.

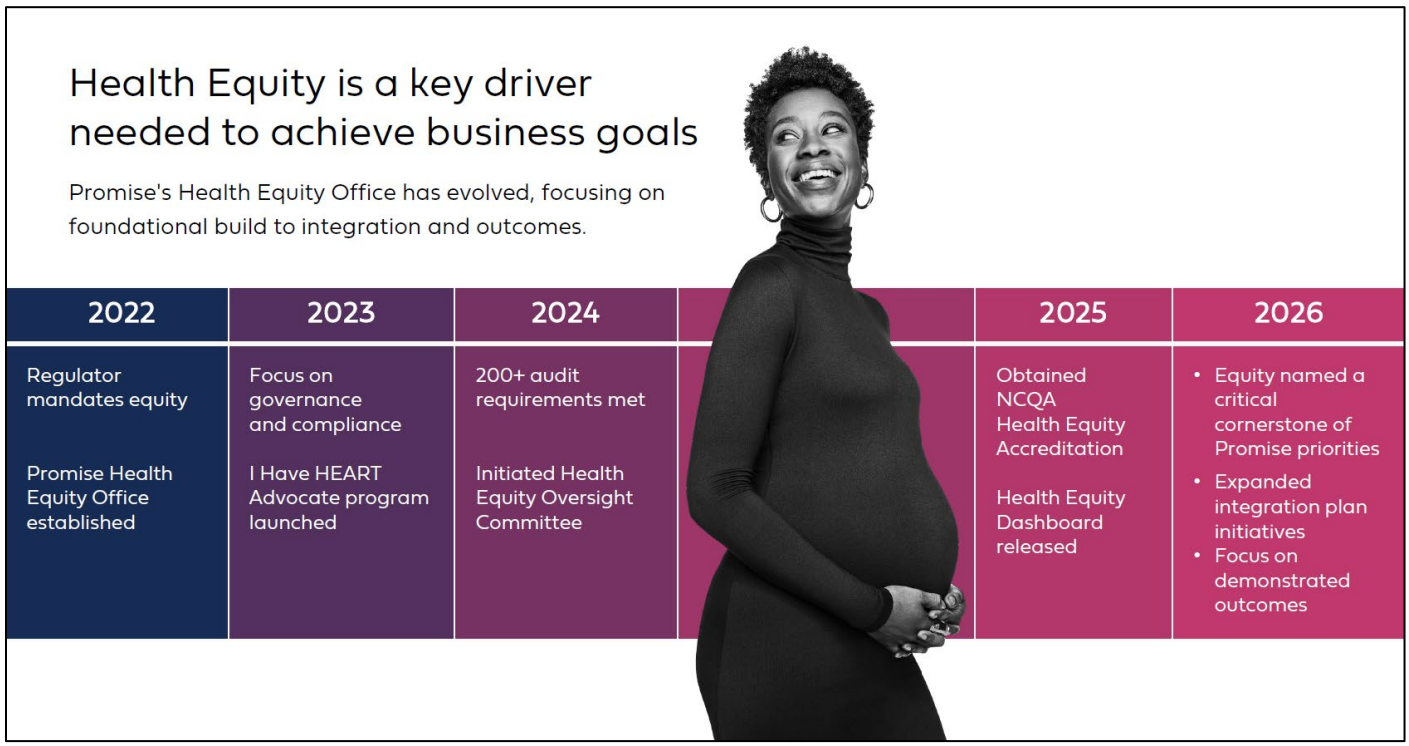
Since its launch in 2022, the Promise HEO has evolved from establishing foundational compliance and governance structures to advancing enterprise-wide integration and outcomes-focused reporting. During this period, the organization has successfully met more than 150 regulatory requirements, reflecting increasing maturity, accountability, and operational rigor. The DHCS issued an Additional Information Request (AIR), in response to findings from the Annual Quality Improvement and Health Equity Plan submission. This item regarding Population Health Management Liaison reports remained outstanding during the reporting period. However, in 2025, Blue Shield Promise achieved 100% compliance across all health equity–related contract deliverables, demonstrating strong performance and significant progress toward full compliance. This achievement reflects sustained organizational focus, effective implementation of interventions, and continued momentum toward meeting all requirements by the established target date.

This progress represents a multi-year transformation. In 2022, the HEO was established in response to regulatory mandates. In 2023, efforts centered on governance and compliance, including the launch of the *I Have HEART Advocate* program. By 2024, Promise had met more than 150 audit requirements and established a Health Equity Oversight Committee, further strengthening governance and accountability. In 2025, the organization earned NCQA Health Outcomes Accreditation and launched a Health Equity Dashboard, marking a shift toward greater transparency, standardized measurement, and outcomes accountability. Looking ahead to 2026, health equity is positioned as a critical enterprise priority, supported by expanded integration planning and a continued focus on demonstrable, measurable results.

This strategy closely aligns with state and federal regulatory direction and emphasizes improving quality outcomes, reducing disparities, strengthening infrastructure, and shaping organizational culture through training, data stratification, and shared accountability. Recent accomplishments include expanded integration planning across behavioral health and growth teams; alignment of program descriptions with the DHCS

Comprehensive Quality Strategy, with targeted focus on maternal, pediatric, and behavioral health priorities; refreshed equity training; and enhancements to the Health Equity Dashboard to better track outcomes for special populations. Together, these efforts position the organization for deeper analytics, more targeted interventions, and sustained impact moving forward (Reference Figure 1).

Figure 1. Promise HEO Business Goals (2022-2026)



California Advancing and Innovating Medi-Cal (CalAIM)

As part of DHCS contractual requirements, Managed Care Plans are required to implement California Advancing and Innovating Medi-Cal (CalAIM), a long-term initiative to transform and strengthen Medi-Cal by advancing a more equitable, coordinated, and person-centered approach to improving health and life outcomes for Californians. Led by DHCS, CalAIM advances a population-health model that prioritizes prevention and whole-person care. Its goal is to extend support and services beyond hospitals and traditional health care settings and into communities, meeting individuals where they are in life, addressing social drivers of health, and breaking down long-standing silos across systems of care. Through this transformation, CalAIM provides Medi-Cal enrollees with coordinated and equitable access to services that address physical, behavioral, developmental, dental, and long-term care needs across the life course, from birth through a dignified end of life (DHCS CalAIM, 2026).

Within this statewide transformation, Blue Shield Promise, through its HEO, played a critical role in advancing CalAIM by embedding health equity into the design, governance, and implementation of Medi-Cal transformation efforts. Blue Shield Promise HEO partnered with CalAIM leadership to operationalize the program's population-health and whole-person care goals through the Health Equity Advancements Resulting in Transformation (HEART) Program, the Plan's DHCS-required Quality Improvement and Health Equity Transformation Program. This work ensured that Enhanced Care Management (ECM) and Community Supports (CS) were implemented with a deliberate focus on populations experiencing the greatest inequities, including individuals experiencing homelessness and those involved in or transitioning out of the justice system.

Key activities included establishing equity-centered governance and performance-monitoring structures, developing and overseeing disparity-reduction metrics, and supporting the delivery of coordinated medical, behavioral, and social services—such as housing-related Community Supports—that extend beyond traditional clinical settings into communities. In addition, HEO actively participates in the Plan's Justice-Involved workgroup, applying an equity lens to policy and operational discussions and supporting implementation strategies for justice-involved and unhoused populations, particularly in facilitating care transitions, continuity of coverage, and community-based supports upon reentry or housing instability. The HEO also led mandatory *Advancing Health Equity* training for staff and network providers to meet CalAIM and managed care contract requirements, strengthening provider capacity to address social drivers of health and deliver culturally responsive, person-centered care. Collectively, these efforts advanced CalAIM's vision of a more equitable, coordinated, and prevention-oriented Medi-Cal delivery system that improves outcomes across the life course.

Health Equity Advancements Resulting in Transformation (HEART) Measure Set

Purpose and Overview

This section describes Blue Shield of California Promise Health Plan's Health Equity Advancements Resulting in Transformation (HEART) Measure Set, including the measurement framework, governance structure, departmental implementation, and use of stratified data to identify disparities and drive continuous quality improvement (CQI) in alignment with DHCS requirements.

Following the launch of the Health Equity Dashboard in Quarter 1, 2025, Blue Shield Promise sustained an enterprise-wide focus on integrating health equity across all functional areas. To support accountability and transparency, the Plan adopted the

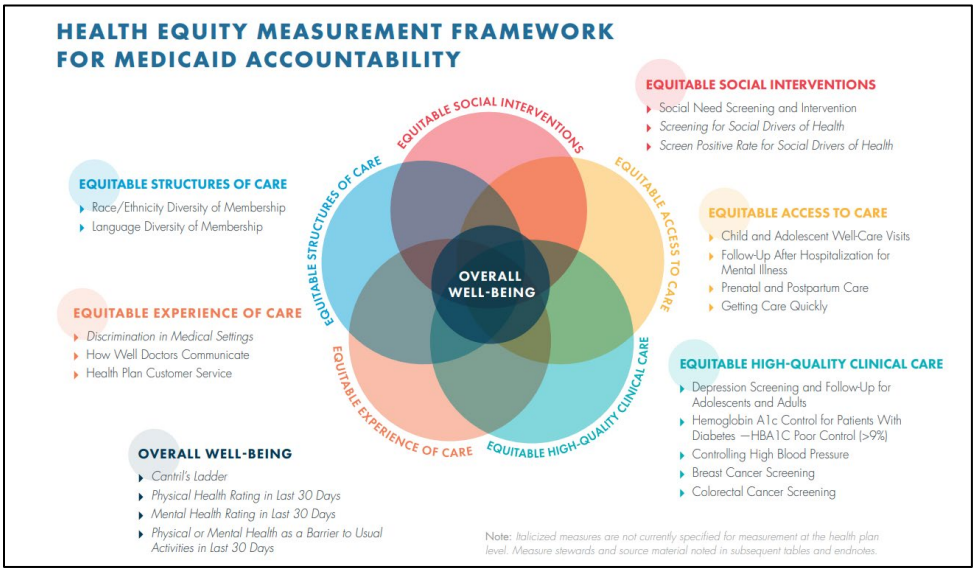
California Health Care Foundation (CHCF) and National Committee for Quality Assurance (NCQA) recommended health equity measurement framework for Medicaid. This framework supports a comprehensive, standardized, and data-driven approach to identifying inequities across clinical, operational, and member experience domains.

HEART Measurement Framework

The HEART framework consists of **six domains**, each representing a critical perspective on health equity and incorporating input from internal stakeholders and partners. The framework enables consensus-based measure selection and alignment with Blue Shield Promise's organizational Health Equity Strategic Plan.
Domains of the HEART Framework

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 2. Health Equity Measurement Framework for Medicaid Accountability Summarized



The domains are intentionally designed to recognize overlapping. For example, access to care influences clinical outcomes, while social drivers of health affect both access and overall well-being. Advancing equitable health outcomes requires coordinated progress across all domains.

Governance, Measure Selection, and Accountability

The HEART framework includes recommended quality metrics for each domain to support consistent evaluation of equity and inequity in health care delivery and outcomes. Measure selection is led by the HEO in collaboration with functional area leadership, using CHCF and NCQA guidance and incorporating additional metrics as necessary to meet DHCS regulatory requirements.

Consensus-building is a key component of this process. Blue Shield Promise conducted a health equity "roadshow" to engage departments, align priorities, and confirm measure relevance. Identified measures were mapped to the appropriate framework domains and incorporated into departmental dashboards.

Oversight of HEART Measure Set performance follows the Continuous Quality Improvement (CQI) model and is governed through the Quality Improvement and Health Equity Committee (QIHEC).

Enterprise-Wide Application of the HEART Measure Set

Health equity is integrated across the organization, recognizing that disparities transcend individual departments and require cross-functional accountability. Data and analytic sets extend beyond HEDIS® to include operational, experiential, and population health metrics. Select HEART measures are stratified, where applicable, by race, ethnicity, gender, age, and language (REGAL) to inform targeted health equity initiatives. The HEO collaborates with functional area leaders to select priority measures, develop dashboards, and monitor trends. This approach enables timely identification of disparities and supports targeted interventions, shared learning, and transparency across departments.
Priority functional areas applying the HEART Measure Set include:

- Quality HEDIS® measures
- Managed Care Accountability Set (MCAS) measures
- Grievances and Appeals
- Behavioral Health
- Provider Relations and Contracting
- Health Education
- Cultural and Linguistics
- CalAIM and subsidiary population health management functional area
- Customer Experience
- Clinical Access Programs
- Maternal Health
- Utilization Management

The HEART Measure Set incorporates regulatory reporting requirements and stretches Blue Shield Promise to consider health equity in oversight of metrics and outcomes. Blue Shield Promise understands that health equity integration goes beyond establishing a HEART Measure Set. Integration includes a responsibility to ensure covered services continue to meet the needs of the members served and are suitably integrated within the QIHETP. These were considered as the HEART Measure Set was developed. Functional areas refer to data in the HEART Measure Set to support continuous monitoring and support insights into understanding population needs and addressing disparities and inequities.

Below is a detailed list of the health equity measures set selection by department. Oversight of the HEART Measure Set outcomes and/or performance results follow the continuous quality improvement (CQI) process.

A. Customer Experience

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

- Call center metrics include 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 Customer Experience member-facing staff are representative of entire membership.
- Tracking and trending the total number of translated documents by language or alternative format requested by members.

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

B. Appeals and Grievances

Blue Shield Promise tracks and reports grievances to ensure that all services are equitable and free of discrimination. Blue Shield Promise' comprehensive Grievance and Appeal system facilitates 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 Blue Shield Promise' health equity infrastructure, 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 the HEO to support a broad approach to addressing these issues and improve 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:

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

- Overturned appeals stratified by race and ethnicity for all appeals received during the measurement period.

Over the past several years, the HEO and the Appeals and Grievances Department have partnered closely to review member feedback, analyze grievances with potential equity implications, and identify early signals of inequities in care or member experience. This collaboration enabled cross-departmental learning, improved understanding of systemic drivers of complaints, and informed several health-equity–focused quality initiatives.

Building on this foundation, the HEO and Appeals and Grievance Department planned and formally established the *Health Equity and Grievance Taskforce, or GRT* workgroup to strengthen the rigor, consistency, and visibility of this work. The GRT represents the natural evolution of prior informal collaboration into a structured, data-driven taskforce with dedicated governance and cross-functional membership.

Chaired by the Appeals and Grievance Director of Operations and supported by the HEO, the workgroup meets to review select discrimination, cultural, and linguistic grievances, conduct trend analyses across REGAL demographics, and identify indicators of inequity or bias within member interactions.

The GRT serves as a centralized forum to integrate qualitative member experiences with quantitative grievance trends, enabling more precise identification of root causes and opportunities for intervention. Insights generated through this process directly inform policies, corrective actions, cultural competency training, and future Integration Plan (IP) initiatives, ensuring that member feedback drives meaningful and measurable health equity improvements across the organization.

Through the GRT workgroup, Blue Shield Promise leverages grievance, demographic, and member experience data to identify patterns in culturally and linguistically related barriers, including disparities in language access, interpreter services, and preventive care engagement. These insights inform targeted interventions, such as, enhanced language access outreach, provider training, and process improvements resulting in improved data accuracy, increased awareness of services, and more responsive care delivery. Collectively, this approach demonstrates how data-driven equity efforts are strengthening access, improving quality, and enhancing the overall member experience, while highlighting priority areas for continued focus.

By evolving from an informal partnership to a formal taskforce with defined governance, escalation pathways, and reporting to the QIHEC, Blue Shield Promise

reinforces its commitment to elevating member voice, addressing inequities in care experiences, and embedding health equity into operational oversight.

C. CalAIM

California Advancing and Innovating Medi-Cal, or 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; all HEART Measure Set metrics apply to all Medi-Cal members served.

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 works collaboratively with the CalAIM functional area leaders including the Population Health Management Department, Quality Department, and Behavioral Health, to report and monitor all required metrics. 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 stratify the select health equity set by race, ethnicity, gender, age and language (REGAL) to identify any disparate populations within Blue Shield Promise' 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 Managed Care Accountability Set (MCAS) comprised of metrics assessing utilization, preventive care screening, and management of chronic health conditions. Quality and health equity intersect when disparities exist between reported MCAS results.

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.

Select MCAS measures include:

- **Perinatal Immunization Status – Influenza:**
  Percentage of deliveries in which members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date or had a documented adverse reaction to the influenza vaccine at any time during or before the measurement period.
- **Perinatal Immunization Status – Tdap:**
  Percentage of deliveries in which members received at least one Tdap vaccine during pregnancy (including the delivery date), or had a documented medical exclusion, including anaphylactic reaction to Tdap or Td vaccine or vaccine components, or encephalopathy due to Td or Tdap vaccination, at any time during or before the measurement period.
- **Pharmacotherapy for Opioid Use Disorder by REGAL:**
  Percentage of eligible members receiving pharmacotherapy for opioid use disorder during the measurement period, stratified by REGAL.
- **Follow-Up After ED Visits for Substance Use – 30 Days by REGAL:**
  Percentage of emergency department visits for substance use that were followed by a treatment visit within 30 days, stratified by REGAL.
- **Colorectal Cancer Screening by REGAL:**
  Percentage of adults ages 50–75 who received appropriate colorectal cancer screening using any approved test (e.g., annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every ten years, CT colonography every five years, or stool DNA test every three years), stratified by REGAL.
- **Hemoglobin A1c Control for Patients with Diabetes by REGAL:**
  Percentage of members ages 18–75 with type 1 or type 2 diabetes whose most recent HbA1c value was less than 9.0 percent during the measurement year, stratified by REGAL.
- **Controlling High Blood Pressure by REGAL:**
  Percentage of members ages 18–85 with diagnosed hypertension whose blood pressure was controlled at less than 140/90 mm Hg during the measurement year, stratified by REGAL.
- **Child and Adolescent Well-Care Visits by REGAL:**
  Percentage of members ages 3–21 who received at least one comprehensive well-care visit with a primary care provider or OB/GYN during the measurement period, stratified by REGAL.
- **Childhood Immunization Status by REGAL:**

Percentage of children who turned two years of age during the measurement period and completed the recommended vaccine series (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, rotavirus, and influenza) by their second birthday, stratified by REGAL.

- **Immunizations for Adolescents by REGAL:**
  Percentage of adolescents who turned 13 years of age during the measurement period and received a meningococcal vaccine, a Tdap vaccine, and completed the HPV vaccine series by their 13th birthday, with individual and combination rates reported, stratified by REGAL.
- **Prenatal and Postpartum Care – Postpartum Visit by REGAL:**
  Percentage of deliveries with a postpartum visit occurring between 7 and 84 days after delivery during the measurement period, stratified by REGAL.
- **Prenatal and Postpartum Care – Timeliness of Prenatal Care by REGAL:**
  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 during the measurement period, stratified by REGAL.
- **Well-Child Visits in the First 30 Months of Life by REGAL:**
  Percentage of children who turned 15 months of age during the measurement year and received at least six well-child visits with a primary care provider during their first 15 months of life, stratified by REGAL.
- **Follow-Up After ED Visit for Mental Illness – 30 Days by REGAL:**
  Percentage of emergency department visits for mental illness that were followed by a mental health visit within 30 days, stratified by REGAL.
- **Breast Cancer Screening by REGAL:**
  Percentage of women ages 40–74 who received a mammogram to screen for breast cancer within the past two years, stratified by REGAL.
- **Depression Screening and Follow-Up for Adolescents and Adults by REGAL:**
  Percentage of adolescents and adults who were screened for depression using a standardized tool and, if screening positive, received appropriate follow-up care during the measurement period, stratified by race, ethnicity, gender, age, language, and/or REGAL.

Additionally, the Quality Department tracks the CAHPS® Getting Needed Care and Getting Care Quickly measure by REGAL during the measurement period. The HEO collaborates with the Quality Department on the DHCS Bold Goals.

To support compliance with regulatory requirements, the Health Disparities Report undergo a standardized review and approval process through the QIHEC. Formal approval through QIHEC ensures consistent application of requirements, documented compliance, and ongoing regulatory readiness.

E. Behavioral Health

The scope of the QIHETP extends into the delivery of behavioral health services. The HEO and Behavioral Health Department monitor 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 helps Blue Shield Promise to identify any disparate populations within the prenatal/postpartum membership and identify any other populations that may be impacted by mental illness specifically among the most vulnerable populations including adolescents, homeless, and LGBTQ+ members for select measures.

The select metrics include the following:

- Positive maternal mental health screening results by REGAL during the measurement period
- **Perinatal Depression Screening**:
  Percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument during the measurement period
- **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.
- **Depression Screening and Follow-Up for Adolescents and Adults by REGAL:**
  Percentage of adolescents and adults who were screened for depression using a standardized tool and, if screening positive, received appropriate follow-up care during the measurement period, stratified by race, ethnicity, gender, age, language, and/or REGAL.

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 following metric:

- Provider Network by Threshold Language tracking **p**ercentage of providers that reflect the needs of the Medi-Cal population in the Contractor's Service Area, for example, percentage of provider that speak threshold languages per geographic area.

Furthermore, Blue Shield Promise ensures Network Providers complete cultural competency, sensitivity, health equity, and diversity training and provided for

employees and staff at key points of contact with members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C (Cultural and Linguistic Programs and Committees), and All Plan Letter (APL) 24-016: Diversity, Equity, and Inclusion Training Program Requirements.

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

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

Finally, the Provider Contracting and Relations Department works 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 disabled members. These select outcomes metrics allow Blue Shield Promise 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 cultural competency trainings completed
- track the utilization of interpreter services in partnership with Customer Experience.
- tracking the rate of bilingual member-facing health plan staff to ensure enough coverage is representative entire membership.
- tracking cultural and linguistic grievances filed by members.
- stratified Diabetes Prevention Program enrollment outcome metrics by REGAL.

To support compliance with regulatory requirements, CLAS-related documents including but not limited to policies and procedures, CLAS Program Description, CLAS Workplan, CLAS Assessment and Evaluation undergo a standardized review and approval process through the QIHEC. Formal approval through QIHEC ensures consistent application of CLAS requirements, documented compliance, and ongoing regulatory readiness.

H. Maternal Health

The Maternal, Infant, and Child Health Equity Department housed under the Office of the CMO supports the delivery of perinatal services. The HEO and Maternal, Infant, and Child Health Equity team monitor existing metrics to measure disparate populations including metrics that directly address the DHCS Bold Goals.

The Maternal, Infant, and Child Health Equity functional area tracks the following metric:

- C-section rates stratified by REGAL to identify any disparate trend within the population.

In partnership with the Behavioral Health Department, the Maternal, Infant, and Child Health Equity Department 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 Blue Shield Promise Black, African American, and Hispanic or Latino populations. Given its critical importance, this effort is intentionally aligned with the DHCS Comprehensive Quality Strategy and Bold Goals and has been established as a program goal for the year.

Additionally, the Maternal, Infant, and Child Health Equity team evaluates outcomes associated with doula-supported care, including comparative analysis of C-section rates among members who received doula support versus those who did not. These comparisons highlight meaningful differences in outcomes and help illustrate the potential impact of doula services on improving maternal health and reducing unnecessary interventions.

The team also tracks doula engagement and key birth outcomes through both claims and doula-reported data. In 2025, there were 83 births supported by doulas (verified through claims data) and 41 doula-reported birth outcome submissions, capturing eight core maternal and birth-related measures. These measures include indicators such as delivery type (vaginal vs. cesarean), preterm birth, birth complications, and member-reported experience measures, providing both clinical and experience-based insight into outcomes associated with doula support. In 2025, members who received doula support demonstrated a 6.41% lower C-section rate compared to their counterparts without doula engagement, indicating a measurable improvement in delivery outcomes.

Insights from these data, as reflected in the doula dashboard, demonstrate trends in outcomes such as increased rates of vaginal delivery, reductions in avoidable interventions, and patterns in maternal and infant outcomes, offering a more comprehensive view of program impact.

To support continuous monitoring and program improvement, the team developed a monthly refreshed doula dashboard that visualizes trends in utilization and outcomes over time. This tool enhances transparency, enables near real-time tracking of metrics (e.g., delivery outcomes, engagement levels by race and ethnicity, and reported experiences), and supports data-driven decision-making to further refine maternal health strategies and advance equitable outcomes.

I. Clinical Access Programs

The Clinical Access Programs Department supports the delivery of clinical programs including the Facility Site Review (FSR) program and Initial Health Appointments. The HEO and Clinical Access Programs selected specific metrics across various areas managed by the Department. The HEART measure set for this functional area supports identification of any health disparities among the provider network through the medical record review and facility site review audits.

The Clinical Access Programs functional area:

- track compliance rate for FSRs and ensuring providers are completing *Site personnel receive training on member rights* to ensure Blue Shield Promise' provider network is meeting minimally language assistance program requirements.
- track initial health appointment rate completion and stratify by REGAL to determine if there is a specific vulnerable population identified to be disparate and have a need for a targeted intervention.

In previous years, the HEO has worked together to develop the HEART measure set with several cross-functional departments. These individual exercises provided opportunities to leverage existing equity-related work and allowed the HEO to deepen partnership and collaboration efforts for future work. The HEO continues to meet with functional areas across the health plan to build upon the Blue Shield Promise Integrated Health Equity Measurement Set to ensure the measure set is encompassing and includes all impacted departments. The HEO optimizes the use of the Health Equity Measurement Framework to identify disparities and inequities occurring between populations.

Blue Shield Promise's commitment to continue to monitor health disparities, provide oversight of the health equity measure set outcomes and/or performance results following the continuous quality improvement (CQI) process. The HEO prepared its first disparity analysis, complete with statistical reviews, trend analysis, and collaboration from subject matter experts (SME) to establish a foundation for actionable insights; 3) Finalized a quarterly report template, incorporating key metrics from the HEART Dashboard, also featuring a structured format that includes sections for data summaries, analysis, and recommendations. The template has been distributed to respective teams for input and finalization; and 4) The Comprehensive Disparity Analysis report is complete and ready for review. The report features analysis of 52 metrics including data visualizations, key takeaways, and discussion on next steps.

HEART Measure Set Monitoring Data Report Results

A thorough disparity analysis of specific measures including a review of findings, results, and key takeaways for each metric were presented to the QIHEC Quarter 2 meeting. Disparity analysis included disaggregated data by race/ethnicity, age, and/or language for the following measures, reference Table 7 below.

Table 7. HEART Measure Set Disparity Analysis

Measure Description	Measure Definition	Measure Acronym	Findings	Results	Key Takeaways
1. Members Not Engaged in Ambulatory Care	Number of members with no ambulatory or preventive visit within a 12-month period.	PHM KPI 3	Los Angeles and San Diego counties Black /AA, Unknown, Other, American Indian, White, and Asian members are significantly behind other racial/ethnic groups in completing PHM KPI-3. Members aged 20-44 are significantly disparate in completing visits compared to all other age groups. Members whose preferred language is Korean have the lowest rate compared to all other languages. **Almost half of members (42%) do not access preventive care, with some REGAL groups having as low as 7 in 10 members with no visit within 12 months.**	Almost half, or 54.8%, of all members have not had a visit within the last 12 months.	Across most groups, a significant portion of adults (20-44Y), males, Black, American Indian, White, and Asian, and Korean-speaking populations are not engaged in ambulatory care or preventive care. DHCS refers to these members as "invisible ". Indication: potential for a systemic issue within disparate populations. Discussion: Why aren't most groups accessing care? Need for a utilization study and the impact on cost of healthcare.
2. Breast Cancer Screening	Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	BSC REGAL	Los Angeles and San Diego counties – Hispanic or Latino, Black /AA, Unknown, Other, American Indian or Alaska Native, White, Native Hawaiian or Other Pacific Islander, and Asian members are significantly behind other racial/ethnic groups in completing a breast cancer screening. Of note, there are no identified disparities between Age and Language. However, women ages 45-54 in both counties show lower BCS visits compared to women ages 55–64.	More than half, or 60.2%, of women had at least one mammogram to screen for breast cancer in the past two years.	All racial/ethnicity groups have a significant disparity when comparing all groups to one another. All groups are below the benchmark except for members whose preferred language is Farsi, Chinese, and Spanish. Promise's Quality team currently designing targeted interventions for Black/AA, Hispanic, and White populations to improve screening rates.
3. Prenatal Care	Percentage of deliveries with a prenatal visit in the first trimester or within 42 days of enrollment. This is also a Bold Goal metric - Close Maternity care disparity for Black and Native American persons by 50%.	PPC TIME REGAL	Los Angeles and San Diego's members completing a prenatal care visit. There are notable differences in completion rates across Age and Race/Ethnicity. Specifically, Hispanic or Latino, Unknown, Other, Asian, and **all Black or African American age ranges 15-44 have significantly less prenatal visit rates**. No significant disparities are present when assessing Age and Language.	82.9% of all members completed a prenatal visit in the first trimester. Notably, **50.0% of Black/AA members ages 15-19 years have not had a prenatal visit in their first trimester or within 42 days of enrollment**. Groups with lower, but not significant prenatal care visit rates, are observed among Korean, Arabic, and Tagalog speaking members.	The consistently low prenatal care completion rate among the 15-19 age group and the Black or African American population is a significant disparity. Early and consistent prenatal care is crucial for both maternal and infant health, making targeted interventions for this age group essential.

4. Postpartum Care	Percentage of deliveries with a postpartum visit between 7 and 84 days post-delivery.	PPC POST REGAL	Los Angeles and San Diego's Unknown, Other, Asian, and Black or African American members are significantly behind other racial/ethnic groups in completing a postpartum care visit. Upon further analysis, **Black/AA members ages 15-24 years have substantially lower completion rates (50.0%) compared to other age groups (25-34 years, 69.6%; 35-44 years, 79.3%).** There are no significant differences across Age and Language.	78.3% of members have completed the postpartum visit within 7 and 84 days post-delivery. Half, 50.0%, Black/AA members ages 15-24 years have not had a postpartum care visit. Groups with lower, but not significant prenatal care visit rates, are observed among Korean, Chinese, and Armenian speaking members.	Significant disparities are identified across the Black or African American population including all Black or African American age groups, confirming DHCS' focus as a Bold Goal priority population.
5. Child and Adolescent Well-Care Visits	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. This is also a Bold Goal metric - Close racial/ethnic disparities in well-child visits and immunizations by 50%.	WCV REGAL	Los Angeles and San Diego counties' **ALL racial/ethnic groups have a significant disparity in completing WCVs**. Members aged 15-21 have a significant disparity in completing well-care visits. Farsi-speaking members have the highest completion rate (58.3%) and Spanish speakers have higher rates (57%) compared to English speakers (43.7%)	Half, 49.8%, of all members ages 3-21, had at least one comprehensive well-care visit. Black or African American and American Indian, Native Hawaiian and White members AND members ages 20-21 and members whose preferred language is Vietnamese and Korean have the lowest rates.	All race/ethnicity groups are flagged as disparate, suggesting potential underutilization or barriers. The significant decline in rates for the 15-21 age group compared to younger age groups. This could indicate reduced engagement with healthcare services during adolescence, possibly due to factors like independence, lack of awareness, or access issues. Spanish speakers have higher rates (57%) compared to English speakers (43.7%), suggesting no disparity and possibly better support, outreach, or access for Spanish-speaking groups.
6. Hemoglobin A1c Control for Patients with Diabetes	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was poor control >9% during the measurement year.	HBD REGAL	Los Angeles and San Diego counties' **none of the Racial/Ethnic or Language groups have a significant disparity in completing diabetes control**. Members ages 18-19 (272 total members) do have a significant disparity in diabetes control. Arabic, Cambodian, Tagalog, Vietnamese, and Farsi-speaking members have the highest control rates, well above the Minimum Performance Level (MPL).	Just over half, 52.8%, of all members have Hemoglobin A1c control for diabetes. The only population falling below the MPL is members ages 18-19.	Race/ethnicity, language, and county show variations in control rates, but these are not flagged as significant disparities (no red bars), suggesting that these factors may not have a strong independent effect on outcomes after controlling for other variables. **Focus population should include the 272 members ages 18-19 with uncontrolled diabetes.**
7. Follow-Up After Emergency Department (ED) Visit for Mental Illness	The percentage of ED visits for members 6 years of age and older with a principal	FUM REGAL	**Disparities identified across Race/Ethnicity, Age, and Language.** Los Angeles and San Diego counties' race/ethnicity groups are all significantly lower, except for	Overall, 35% of all members receive follow-up after mental illness.	These disparities present across Race/Ethnicity, Age, and Language indicate a systemic issue such as coordination of care following an ED visit for mental illness.

	diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. This is also a Bold Goal metric - Improve follow up for mental health and substance use disorder by 50%.		the Middle Eastern/North African population. All age groups are noted as having a disparity. Additionally, all Language populations are significantly lower, except Chinese and Korean-speaking members.		

A disparity analysis of disparities among White members across key health measures in Los Angeles and San Diego counties throughout 2024 was provided. Quality metrics were assessed to identify significant disparities between the White population compared to all other Race and Ethnicities. Findings indicate that while health equity efforts often focus on addressing disparities among historically underserved populations, the data revealed measures where the White population presents with the lowest rates compared to all other Race/Ethnicity groups. Measures with lowest rates include: 1) Immunizations for Adolescents (IMA); 2) Initial Health Assessment (IHA); and 3) Breast Cancer Screening (BCS). Immunizations for Adolescents, or IMA, results showed the White population performance is consistently the lowest among the groups. This indicates underperformance in access or utilization for White members. Initial Health Assessment results, indicate the White population shows a steady decline from 21.5% in Q2 to 19.0% in Q4, now below the benchmark and further behind Asian and Latino members. Breast Cancer Screening rates demonstrate that the White population falls behind Asian and Latino groups, with all three quarters showing the lowest performance compared to all other races (from 40.8% in Q2 to 48.6% in Q4). Key takeaways specify that the White population is not always the population with the highest rates for utilization, preventive screening, and health outcomes (Reference Table 7).

Overall, key findings indicate the following, 1) the data reveals significant health equity disparities across racial/ethnic groups, age groups, and languages even when controlling for denominator variance; 2) the top rates observed across several Quality measures for Farsi, Chinese, Arabic, and Cambodian-speaking members; and 3) the lowest rates trending for members ages 15-24 and Black or African American members.

To address health disparities, Blue Shield Promise is dedicated to using a data-driven approach to improve our members' health outcomes. Targeted interventions such as

language support, enhanced outreach, age-specific programs, and addressing county-level differences are essential to improve screening rates, care engagement, and overall health equity. The HEO remains data-transparent and share data results with teams who can impact the rates; take a data-informed approach using the data to drive strategic planning and interventions; and expand the analysis to assess for trends across individual race/ethnicity, age, and language for all metrics within the HEART measure set.

Utilization Management Over- and Under- Utilization

Additional analysis conducted through the Utilization Management (UM) Health Equity Integration Plan identified significant patterns of over- and under-utilization of services, particularly in preventive and ambulatory care. Findings indicate that more than 40% of members were not engaged in preventive care, with notable disparities across race, age, and language. In response, Blue Shield Promise established a multidisciplinary workgroup to further assess barriers to care, evaluate utilization patterns, and develop targeted, equity-focused interventions to improve access and appropriate use of services.

Goal #2: Information in Action

Objective #1: Operationalize 100% of requirements to launch Diversity, Equity and Inclusion training program by 12/31/2025

In 2025, Blue Shield Promise continued to focus on successful implementation of the DHCS All Plan Letter (APL) 24-016: Diversity, Equity and Inclusion Training Program Requirements. Which requires Blue Shield Promise to maintain comprehensive oversight of a health equity training program spanning more than 10 functional areas, including training delivery, data systems, technical infrastructure, and cross-enterprise collaboration. In response, Blue Shield Promise developed, governed, and launched an annually required *Advancing Health Equity* training course for internal staff and external partners, formally approved by the DHCS and released in Quarter 1, 2025. A refresh training was released in Quarter 1, 2026 to incorporate the feedback received from members, providers, contractors, and regulators across key stakeholder committee meetings and post-training evaluation surveys gathered during calendar year 2025.

The organization implemented automated training and completion tracking for network providers through its learning management system, while overseeing and manually monitoring training compliance for vendors, subcontractors, and downstream partners. Technical enhancements include provider eligibility tracking, a robust health equity disparity dashboard drawing from over 12 data sources, continuous grievance monitoring, and a dedicated grievance review task force. Regionally, Blue Shield Promise also strengthened collaboration by executing a Memorandum of Understanding or MOU and

enabling secure bi-directional data sharing with partner health plans to improve visibility into provider training compliance.

The APL 24-016 has driven not only regulatory compliance but the development of a scalable, enterprise-wide model that integrates governance, technology, data, and partnerships to advance health equity, with early training completion rates reflecting recent launches and strong compliance among subcontractors and specialized training programs.

By the end of 2025, Blue Shield Promise reached 100% internal staff completion and 13% network provider completion rate. The table below provides an overview of Blue Shield Promise current compliance status with DHCS training program requirements under APL 24-016.

Table 8. California Department of Health Care Services (DHCS) Training Program Requirements Updates

APL Reference	Audience	Training Title	Latest Update	Status / Completion
APL 24-016	All Promise Staff	Advancing Health Equity Training to Support Member Interactions	2026 version released March 3, 2026	On track — 32% completion; 2026 deadline: May 2, 2026
	Network Providers	Advancing Health Equity Training	2026 version released March 3, 2026; ongoing coordination with local managed care plans and a system for training record sharing	On track — 15% completion
	Vendors, Subcontractors, Downstream Subcontractors (Member-facing staff)	Advancing Health Equity Training to Support Member Interactions	2026 version released March 3, 2026; ongoing collaboration with vendors, subcontractors, downstream subcontractors	On track — 95% cumulative completion
	Vendors, Subcontractors, Downstream Subcontractors (Licensed Providers)	Advancing Health Equity Training	2026 version released March 3, 2026; ongoing collaboration with vendors, subcontractors, downstream subcontractors	On track — cumulative 72% completion

Overall, Blue Shield Promise is meeting or exceeding DHCS requirements for internal staff and member-facing roles and are progressing on schedule for external providers and vendors, with established coordination and tracking processes in place.

Objective #2: At least 30% of network providers complete Diversity, Equity, and Inclusion training by 12/31/2025.

Blue Shield Promise launched the external, provider-facing *Advancing Health Equity* training on April 28, 2025, through the Blue Shield of California Provider Learning Center platform, providing standardized access to required content for the network. As of the reporting period, provider training completion reached 15%, reflecting early uptake following the initial release.

To accelerate progress toward the 30% completion target, Blue Shield Promise implemented a multi-pronged outreach and monitoring strategy, including automated eligibility and completion tracking through the learning management system, monthly reminder communications, and targeted follow-up with high-volume and member-facing

provider groups. Completion data is routinely reviewed to identify gaps by region, provider type, and specialty, enabling focused technical assistance and tailored engagement.

Additionally, Blue Shield Promise strengthened cross-plan collaboration by operationalizing secure, bi-directional data sharing with regional partner health plans to validate completion records and improve visibility into provider compliance across overlapping networks. These efforts support data-driven decision-making, enhance accountability, and promote consistent application of APL 24-016 requirements.

With foundational infrastructure in place and early completion trends tracking with expected post-launch adoption curves, Blue Shield Promise is positioned to continue increasing provider participation throughout calendar year 2026 while reinforcing the integration of health equity principles into routine provider operations and care delivery.

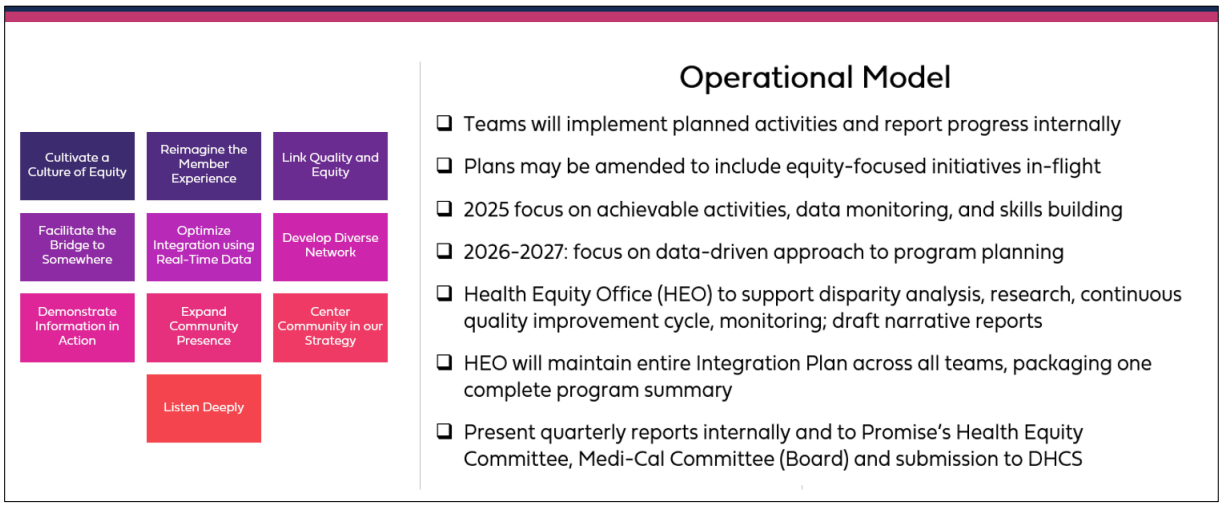
Goal #3: Equity embedded in everything we do
Objective #1: 90% of finalized Health Equity Integration Plan activities will be completed by 12/31/2025.

To embed equity into every aspect of our work, Blue Shield Promise HEO continued to strengthen and expand our partnerships and collaboration efforts. This work began in 2023, when we partnered with multiple cross-functional departments to develop the HEART measure set. In 2025, these efforts were fully implemented across all areas, reinforcing equity as a shared organizational priority.

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, 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 (Reference Figure 3).

Figure 3. Health Equity Integration Plan Operational Model



The health equity integration plans included formal assessments, frameworks, and recommendation reports by department. Beginning in 2025, activities were implemented across the functional areas and progress was reported quarterly. Integration plan activities span across the health plan and align with Health Equity program tenets. To highlight a few key operations, the HEO supported disparity analysis, research, continuous quality improvement cycle, monitoring, and draft narrative reports.

Emphasis was placed on completing regulatory staff training, provider network access, provider engagement, maternal health equity, community engagement, and preventative care. New intersectionality between teams was identified to partner on initiatives, enabling departments to work together more effectively through aligned goals, shared resources, and collaborative planning.

The HEO maintained an 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. Each functional area leader was accountable for monitoring their respective workstreams and is responsible for presenting comprehensive updates, key accomplishments, and outcome metrics during the internal Performance Operations Driver's meeting. These presentations occurred on a quarterly basis and served as a forum to evaluate progress, promote cross departmental collaboration, and ensure that all operational efforts remain on track to meet established goals.

Blue Shield Promise HEO prepared and successfully finalized 8 health equity integration plans which included 38 activities in calendar year 2025. Across the 8 integration plans, 97% (37/38) of activities were completed. This work will continue to focus on interventions

and identifying opportunities. These are the activities reflected in each integration plan that aligns with the contract requirements.

Integration plan activities spanned across the health plan in alignment with the Health Equity program tenets (Reference Figure 4). Emphasis was placed on completing regulatory staff training, provider network access, provider engagement, maternal health equity, community engagement, and preventative care. New intersectionality between teams has been identified to partner on initiatives, enabling departments to work together more effectively through aligned goals, shared resources, and collaborative planning.

Figure 4. Health Equity Integration Plan Activities

Cultivate a culture of equity	*Reimagine the member experience*	*Link Quality and Equity*	*Facilitate the Bridge to Somewhere*	*Optimize integration using real-time data*	*Develop diverse network*	*Demonstrate information in action*	*Expand community presence*	*Center community in our strategy*	*Listen deeply*
Staff training- Advancing Health Equity Expand provider training to include health equity topics Diversified Talent Acquisition Toolkit training	Add availability of ASL interpretation to health education materials Translate updated health education referral letter into threshold languages	Host well-child visits in Los Angeles and San Diego in areas with highest need Host mobile mammography events	Include SDOH assessments in Quality Health Partners visits Diabetes Management Health Education classes	Offer health education classes in multiple languages leveraging member data Include C-section disparities between Black and White birthing people in over/under utilization analysis Stratify overturned appeals by REGAL during measurement period Outreach calls for identified care gap closures	Well-child visits health disparity Performance Improvement Project Pilot Skilled Nursing Facility preferred placement Obtain data on member and provider ethnic and racial background to evaluate network needs LGBTQ+ network enhancements to expand services	Partner with LA County Doula Hub and community partners supporting Doula Hub implementation Implement staff training on Writing in Plain Language and Readability Assessment Review of Grievance and Appeals member letters for equity lens	Implement health education classes at CBO's and faith-based sites in San Diego County Marketing Plan integrates health equity focus to identify events and communities in need	Community Advisory Committee feature health equity approach to inclusion and program planning	Host listening sessions to inform member and family engagement strategy

The figure below summarizes the Health Equity Integration Plan activities completed during the year, highlighting each department's contributions, progress to date, and key outcomes realized as of the close of 2025. Key outcomes resulted from identified opportunities and strategic actions taken.

Figure 5. Health Equity Integration Plan Activities Completed

Health Equity Integration Plan

- Full plan 97% complete, with 37/38 activities completed as of Q4 close.
- Progress for Network to add Gender Affirming Care to the directory was impacted by federal policy uncertainty related to DEI, resulting in a temporary pause; remaining provider validation and service confirmation activities will be completed in 2026.

Department	Activities Completed	Progress	Key Outcomes
Quality	6/6	100%	Tailored events to promote well-child clinics and mobile mammograms.
Health Education	8/8	100%	Piloted support group for Chinese members.
Utilization Management	2/2	100%	Attended Health Equity Office Training.
Population Health Management	6/6	100%	Engaged Hispanic members with Children's Service programs.
Medical Services – CMO Office	3/3	100%	Updated policies to include Health Equity statement.
Community Engagement/ Marketing	5/5	100%	Hosted member listening sessions.
Network	4/5	80%	Pilot preferred placement into skilled nursing facilities.
Grievance & Appeals	3/3	100%	Launched taskforce for deep-dive review of member complaints.

A more detailed analysis for each initiaitve is simmarized below:

1. Quality

In-Person Diabetes Management Education- Los Angeles County

This activity focused on delivering diabetes education to members with identified care gaps through both virtual and in-person classes offered in English and Spanish. While Quarter1 efforts were disrupted due to the Los Angeles fires, outreach resumed through collaboration with Community Engagement and the Healthcare Effectiveness Data and Information Set (HEDIS) outreach team to promote spring sessions. By Quarter 3, 472 members with care gaps were identified, with 39 expressing interest and smaller groups attending both virtual and in-person sessions. This initiative addressed disparities by targeting high-risk individuals, reducing language barriers through bilingual education, and connecting members to additional supports such as medically tailored meals and wellness programs, thereby improving both access and chronic disease management.

Staff Training (Health Equity Foundations)

This activity ensured staff completed a Health Equity Foundations training course to strengthen organizational capacity to address disparities. Completion rates improved significantly from 33% in Quarter 1 to 100% in Q2. By equipping all staff with foundational knowledge in health equity, the initiative addressed disparities indirectly by promoting culturally competent care, increasing awareness of inequities, and standardizing equitable practices across teams and programs.

Host Well-Child Visits in Los Angeles & San Diego

This activity expanded access to pediatric preventive care by hosting clinic days across both regions. There was a notable increase in both scheduled and completed visits over time, growing from 253 completed visits in Quarter 1 to hundreds more in subsequent quarters, supported by a significant increase in clinic days. This effort addressed disparities by reducing barriers such as limited appointment availability, transportation challenges, and scheduling constraints, particularly benefiting underserved populations and helping close preventive care gaps among children.

Inclusion of Social Determinants of Health (SDOH) Assessments in Quality Health Partner's Visits

This activity integrated Social Drivers of Health (SDOH) screenings into routine care for consenting members. Building on prior large-scale screening efforts, assessments continued consistently through 2025. By capturing non-medical needs such as food insecurity, housing instability, and transportation barriers, this initiative addressed disparities by enabling providers to connect members with appropriate community resources and support services, ultimately promoting more comprehensive and equitable care.

Mobile Mammography Events in Los Angeles & San Diego

This activity brought breast cancer screening services directly into communities through mobile clinics. Across the reporting period, multiple clinic days were conducted, resulting in hundreds of scheduled and completed screenings. By delivering care in community settings, the initiative reduced geographic and transportation barriers and improved access for populations with historically lower screening rates, helping to address disparities in preventive cancer care and early detection.

W30 Health Disparity Performance Improvement Project (PIP)

This activity focused on advancing structured interventions to reduce health disparities through ongoing program implementation and refinement. Efforts included continuing existing interventions, training health navigators to better support members, and completing a formal submission to Department of Health Care Services (DHCS). The strategy shifted toward strengthening current initiatives to maximize impact. This project addressed disparities by providing targeted, coordinated support to vulnerable populations, improving care navigation, and aligning efforts with broader quality and regulatory frameworks to sustain long-term equity improvements.

2. Community Engagement/Marketing

Finalize 2025 Marketing Plan with Health Equity Considerations

This activity focused on developing and completing a 2025 marketing plan that embedded health equity principles, including diverse partnerships and a member-centric approach to outreach, events, and engagement. The plan was completed in Quarter 1 and reviewed by the Chief Health Equity Officer, with implementation beginning thereafter. By ensuring that outreach strategies intentionally prioritize diverse and underserved populations, this effort addressed disparities by promoting more inclusive communication, improving awareness of services, and increasing equitable access to programs among communities that are often underrepresented or harder to reach.

Community Programs Staff Diversity Equity & Inclusion Training Completion

This activity ensured that all Community Programs staff completed Diversity, Equity, and Inclusion (DEI) training by June 30, 2025. Training was assigned in Quarter 1 and fully completed in Quarter 2, achieving 100% participation. This initiative addressed disparities by strengthening staff awareness, cultural competency, and ability to engage effectively with diverse populations. By reinforcing a culture grounded in equity and inclusion, staff are better equipped to design and deliver programs that meet the needs of marginalized communities and reduce inequities in engagement and care access.

Full Compliance with Department Health Care Services (DHCS) Community Advisory Committee (CAC) Requirements

This activity ensured full compliance with DHCS requirements for the Community Advisory Committee, including implementing all required components and maintaining a checklist to monitor ongoing compliance. All requirements were completed, and the organization was recognized as one of four plans selected to present best practices at a statewide meeting. This effort addressed disparities by elevating community voice and engagement in decision-making processes. By incorporating feedback and guidance from diverse community representatives, programs and policies can better reflect the needs of underserved populations, leading to more equitable outcomes.

Implementation of Approved Marketing Plan Focused on Diverse and Marginalized Communities

This activity centered on executing the approved marketing plan across Los Angeles and San Diego counties, with a specific focus on increasing enrollment and retention among diverse and marginalized populations. The plan was developed and submitted for regulatory approval in Quarter 1 and implemented in Quarter 2, remaining on track. This initiative addressed disparities by targeting outreach and engagement efforts toward populations that historically face barriers to enrollment and continuous coverage, thereby improving access to care and reducing gaps in utilization.

Incorporation of Feedback from Listening Sessions, Focus Groups, and Co-Design Efforts

This activity aimed to gather and incorporate feedback from at least six listening sessions with members, providers, and community partners to inform 2026 programming focused on member experience, quality improvement, and health equity. In Quarter 1, partnerships were established with key community organizations to plan sessions, and in Quarter 2, listening sessions, focus groups, and co-design sessions were conducted, including targeted discussions on improving well-child visits, prenatal care, and postpartum care. This effort addressed disparities by directly engaging communities in program design, ensuring that interventions are informed by lived experiences and specific barriers faced by underserved populations. Incorporating this feedback helps create more responsive, culturally appropriate, and equitable programs.

3. Health Education

Staff Training – "Health Equity Foundations"

This activity focused on ensuring staff completed foundational training in health equity principles. Completion increased from 3 out of 7 staff in Quarter 1 to full participation by Quarter 2. By equipping all staff with a shared understanding of health equity, this initiative addressed disparities by strengthening internal capacity to recognize inequities, improve culturally responsive communication, and design education efforts that better meet the needs of diverse populations.

Add ASL Interpretation Availability to Health Education Referral Follow-Up Letter

This activity updated member communication materials to include information about the availability of American Sign Language (ASL) interpretation services. The update was approved and implemented, and the revised letter is now in use. This addressed disparities by improving accessibility for individuals who are deaf or hard of hearing, ensuring that communication about health education services is inclusive and that these members are better able to access and benefit from available resources.

Translate Updated Health Education Referral Letter into All Threshold Languages

This activity focused on expanding language access by translating referral letters into threshold languages. Following approval, letters were translated into Spanish and Chinese, with additional languages available on demand. This effort addressed disparities by reducing language barriers that can prevent members with limited English proficiency from understanding and accessing health education services, thereby improving equitable access to care and information.

Implement Health Education Classes at Community Based Organizations (CBO)'s and Faith-Based Sites in San Diego County

This activity delivered in-person health education classes in community-based organizations (CBOs) and faith-based settings. Sessions covered topics such as stress management, healthy eating, diabetes management, and family nutrition, with participation ranging from small to moderate group sizes (e.g., over 50 participants in diabetes education sessions). Although no sessions occurred in Quarter 3, future classes were scheduled. This initiative addressed disparities by bringing culturally relevant education directly into trusted community settings, reducing barriers such as transportation and trust, and engaging populations that may be less likely to access traditional clinical environments.

Staff Training on Writing in Plain Language and Readability Assessment

This activity aimed to improve the clarity and accessibility of written communications by training staff in plain language and readability best practices. Training was scheduled and conducted with strong participation (e.g., 96 participants in Quarter 2), with additional sessions planned. This addressed disparities by ensuring health education materials are easier to understand for individuals with varying levels of health literacy, thereby improving comprehension, engagement, and the ability to act on health information.

Implement Health Education Classes in Mandarin

This activity expanded language-specific education by offering classes in Mandarin, both in-person and virtually, covering topics such as hypertension, diabetes management, mental health, and nutrition. Participation varied across sessions, with both small group and series-based classes delivered across multiple quarters. This effort addressed disparities by providing culturally and linguistically appropriate education to a population that may face language barriers in accessing traditional health education, thereby improving engagement and health literacy among Mandarin-speaking members.

Increase Availability of Health Education Materials in Threshold Languages (Diabetes, Hypertension, Nutrition)

This activity focused on identifying and translating key health education materials into threshold languages. Comprehensive diabetes materials were identified and translated, with additional work ongoing for hypertension materials. This addressed disparities by expanding access to critical health information for members with limited English proficiency, ensuring they can better understand, manage, and prevent chronic conditions.

4. Medical Services- Office of the Chief Medical Officer

Staff Training – "Foundations of Diversity, Equity and Inclusion"

This activity ensured that all Promise CMO staff completed training on diversity, equity, and inclusion, reaching 100% completion by March 2025. By building a strong, shared foundation in DEI principles, this effort strengthened the organization's ability to recognize and address inequities in care delivery. It addressed disparities by improving cultural competency, increasing awareness of systemic barriers, and equipping staff to implement more equitable and inclusive practices across programs and patient interactions.

Medical Services Policy Updates

This activity involved updating medical services policies to formally include a health equity statement. The updates were completed in Quarter 3, embedding equity considerations into organizational policy. By institutionalizing health equity within policy frameworks, this effort addressed disparities by ensuring that equitable care delivery is not only encouraged but required in decision-making, program design, and clinical practices, helping to sustain long-term, system-level change.

Support Los Angeles County Doula Hub with $250K Funding (FY 2025)

This activity provided financial and operational support to the LA County Doula Hub, including executing a community investment agreement, coordinating procurement, disbursing funds, and engaging in ongoing collaboration with the doula network. Key milestones included funding approval, disbursement, participation in community events, and receipt of an initial grant report. This initiative addressed disparities by investing in maternal health supports that are particularly impactful for underserved populations. Doula services are known to improve birth outcomes and patient experience, especially for communities that face higher rates of maternal morbidity and mortality. By supporting workforce development, education, and community-based care through the Doula Hub, this effort helps reduce disparities in maternal and postpartum health outcomes.

5. Population Health Management (PHM)

100% of PHM Staff Complete 2025 Advancing Health Equity Training

This activity focused on ensuring all Population Health Management (PHM) staff completed the Advancing Health Equity training by May 2025. Completion rates increased from 34% in Quarter1 to 97% in Quarter 2, reaching 100% by Quarter 3. This initiative addressed disparities by strengthening staff knowledge and competencies in identifying and addressing inequities within care management. By ensuring all staff are trained, PHM is better positioned to deliver culturally responsive services, recognize systemic barriers, and design interventions that more effectively meet the needs of diverse member populations.

Increase Engagement in Children's Service Programs for Hispanic Members

This activity aimed to increase engagement among Hispanic members in Children's Service Programs. Engagement grew steadily from 96 members in Quarter 1 to 125 in Quarter 2 and 201 by Quarter 3, exceeding the original target. This effort addressed disparities by focusing on a population that often experiences gaps in access and utilization of pediatric services. By increasing outreach and engagement, PHM improved access to preventive and supportive services, helping reduce disparities in health outcomes among Hispanic children and families.

Train PHM Leaders in the Diversified Talent Acquisition Toolkit

This activity provided training for PHM leaders on the Diversified Talent Acquisition Toolkit, completed in Quarter 3. The toolkit supports inclusive hiring practices and workforce diversification. This initiative addressed disparities by promoting a more diverse and representative workforce, which is critical to delivering culturally competent care. A workforce that better reflects the communities served can enhance trust, improve communication, and reduce inequities in care delivery.

PHM Social Services Individual Contributors Complete Health Equity Learning and Promote Training

This activity required PHM Social Services staff to complete at least one health equity learning opportunity per quarter and encouraged leaders to promote additional training opportunities. Staff remained on track throughout the year, with all employees completing required trainings by Quarter 4. This effort addressed disparities by embedding continuous learning into staff expectations and performance, ensuring that equity remains a core component of daily practice. Ongoing education reinforces the ability to identify disparities and implement targeted interventions in care management.

Operationalize PHM Social Services Health Equity Dashboard

This activity focused on developing and implementing a Health Equity Dashboard to accurately capture and display disparities data with a target accuracy rate of 95%. Training was provided to managers, and the dashboard was built, tested, and expanded in scope before completion, with plans for continued refinement. This initiative addressed disparities by improving data visibility and enabling teams to identify, monitor, and act on inequities in real time. Enhanced data tracking supports more informed decision-making and targeted interventions to close gaps in care.

Revise Desk Level Procedures (DLPs) to Include SDOH and Health Equity Focus

This activity involved updating Desk Level Procedures to incorporate Social Determinants of Health (SDOH) and a health equity focus, ensuring care managers consistently document these factors in member cases. Progress included identifying, reviewing, and

ultimately updating all procedures with equity-focused language. This effort addressed disparities by embedding equity considerations into standard workflows, ensuring that social and structural barriers are consistently recognized and addressed in care planning. This leads to more personalized, effective interventions and improved outcomes for members facing disproportionate challenges.

6. Network

Staff Training – "Advancing Health Equity"

This activity focused on identifying, implementing, and tracking completion of training to ensure staff were equipped with health equity knowledge. Trainings were identified in Quarter 1, staff were informed and tracking mechanisms were developed in Quarter 2, and by Quarter 3 all staff had completed the training. This effort addressed disparities by strengthening provider network staff awareness of health equity principles, enabling more equitable decision-making, improved cultural competency, and better alignment of services with the needs of diverse member populations.

Pilot Skilled Nursing Facility (SNF) Preferred Placement

This activity aimed to improve skilled nursing facility (SNF) placement processes by analyzing trends and identifying barriers to timely long-term care (LTC) placement. The team conducted research in Quarter 1, collected admission data and identified drivers of delays in Quarter 2, and in Quarter 3 refined reporting processes and began implementing interventions to improve transitions from hospital to long term care settings. This effort addressed disparities by identifying and reducing systemic barriers that may disproportionately impact vulnerable members—such as delays in care transitions, thereby improving access to appropriate post-acute care and supporting more equitable health outcomes.

Identify Opportunities to Build a Diverse Provider Network

This activity focused on analyzing member and provider demographic data to identify opportunities to diversify the provider network. The team leveraged the National Committee for Quality Assurance (NCQA) Health Equity Dashboard in Quarter 1, analyzed trends in language, race/ethnicity, and geographic data in Quarter 2, and identified gaps in provider data in Quarter 3 while developing strategies to address them. This effort addressed disparities by working toward a provider network that better reflects the cultural and linguistic diversity of the population served, which can improve access, communication, trust, and overall quality of care for underserved communities.

Expand Provider Training to Include Health Equity Topics

This activity integrated health equity content into provider training requirements. Cultural awareness and linguistics were included in training modules, requirements were clarified,

and by Quarter 3 health equity content was incorporated into Medi-Cal IPA Joint Operational Meetings (JOMs). This effort addressed disparities by ensuring providers are educated on equity-related topics, improving their ability to deliver culturally responsive care, recognize inequities, and better serve diverse populations across the network.

Expand Gender Affirming Services

This activity focused on expanding access to gender-affirming care through contracted provider networks and improved visibility of providers. Partnerships were established with key health systems (e.g., LA County and San Diego networks), providers were made searchable and accessible in directories, and systems were enhanced to validate and identify gender-affirming care practitioners. This effort addressed disparities by improving access to specialized, affirming care for populations that often face significant barriers, ensuring greater visibility of services and facilitating more equitable access to appropriate care.

7. Grievance and Appeals

Staff Training – "Health Equity Foundations"

This activity focused on ensuring staff completed foundational training in health equity principles. In Quarter 1, 54 staff members completed the training, achieving full completion early in the year. This effort addressed disparities by strengthening staff awareness and understanding of health equity, enabling more equitable handling of appeals and grievances. By building this foundation, staff are better equipped to recognize patterns of inequity and provide more consistent, fair, and culturally responsive resolution processes for all members.

Work with Health Equity Office (HEO) to Review Discrimination Grievances on a Quarterly Basis

This activity involved collaborating with the Health Equity Office (HEO) to review discrimination-related grievances and improve related processes. Initial efforts began as pending in Quarter 1, followed by structured reviews of grievance letter templates in Quarter 2 and continued collaboration in Quarter 3 to incorporate equity-focused feedback and implementation planning. This initiative addressed disparities by ensuring that grievance processes are evaluated through a health equity lens, improving how discrimination concerns are documented, communicated, and resolved. These enhancements help ensure that members experiencing inequities have their concerns addressed more effectively and transparently.

Create a Workgroup to Review Data to Track and Trend Discrimination Grievances

This activity focused on establishing a dedicated workgroup to analyze and monitor trends in discrimination grievances. Planning began in Quarter 3, with the taskforce officially

launching in Quarter 4 and continuing into 2026. This effort addressed disparities by creating a structured mechanism to identify systemic patterns of inequity within grievance data. By tracking trends over time, the organization can proactively identify areas of concern, implement targeted improvements, and ensure accountability in addressing disparities in member experience.

8. Utilization Management

Staff Training – "Advancing Health Equity"

This activity focused on ensuring all Utilization Management (UM) staff completed Advancing Health Equity training. In Quarter 1, all staff were enrolled and notified of the expectation to complete the training, and by Quarter 3, 100% of staff had successfully completed the training. This effort addressed disparities by strengthening staff knowledge and awareness of health equity principles, enabling more consistent, equitable decision-making in utilization management processes. With full staff participation, the team is better equipped to recognize potential biases, consider social determinants of health, and ensure fair and appropriate care determinations for diverse member populations.

Health Equity Office Training for Utilization Management Leaders – Diversified Talent Acquisition Toolkit

This activity focused on partnering with the Health Equity Office to train UM leaders on the Diversified Talent Acquisition Toolkit. Training logistics were coordinated in Quarter 2 and completed in Quarter 3 as scheduled. This initiative addressed disparities by promoting more inclusive hiring practices and supporting workforce diversity, which is critical to delivering culturally competent care. By strengthening leadership capabilities in equitable talent acquisition, the organization can better align its workforce with the diverse communities it serves, ultimately improving member experience and reducing disparities in care delivery.

Starting in 2026, the Health Equity Office took a significant step toward a more comprehensive integrated approach by expanding the HEIP to include Behavioral Health as a designated functional area under Medical Services. Behavioral Health will maintain its own integration plan with initiatives focusing on addressing behavioral health services, care, and outcomes. This expansion acknowledges the critical role behavioral health plays in overall wellness and creates pathways for more seamless support for patients. By adding Behavioral Health, this aims to improve outcomes, reduce barriers to care, and ensure that health equity principles are applied consistently across the health plan.

Objective #2: HEART advocate program survey yields >90% participant report of value added upon program completion.

The HEART Advocate Program was developed and championed by Blue Shield Promise's CHEO in response to two key dynamics: a lean health equity support team and a growing interest in equity-focused work among staff. Recognizing an opportunity to expand equity capacity beyond formal roles, the CHEO designed the program to cultivate a group of volunteer Advocates who could actively support health equity in both their professional and personal lives. A cohort of engaged employees with a demonstrated interest in equitable solutions was assembled, and a structured forum was created for learning, reflection, and the sharing of lived experiences.

Grounded in Blue Shield Promise's HEART Program goals and its five equity tenets to transform, build, heal, partner, and champion, the HEART Advocate Program was intentionally designed to advance organizational culture and practice. The program supports listening deeply, centering community voices in strategy, cultivating a culture of equity, aligning multidisciplinary initiatives, reimagining the member experience, expanding community presence, and advancing the organization's mission to eliminate health disparities.

The *I Have HEART Advocate Program* is a strategic initiative that directly supports Blue Shield Promise's QIHETP goals and objectives. Central to the program is the commitment to "Cultivate a Culture of Equity" by empowering staff, known as I Have HEART Advocates, to serve as equity champions within their departments. The second cohort launched in March 2025 and concluded in August 2025, engaging 62 participants in a six-month curriculum that included monthly meetings, volunteer opportunities, and professional development activities focused on health equity, cultural humility, and social drivers of health.

Throughout the program, Advocates participated in a wide range of activities designed to deepen understanding of systemic inequities and promote inclusive practices. These included one-on-one sessions with the CHEO, peer discussions, leadership coffee chats, educational workshops, guest speakers, and community engagement opportunities such as volunteering at food banks and Well Child Clinics. Advocates were also invited to attend a QIHEC meeting and provided safe spaces for reflection on current events impacting equity and community well-being. Interactive learning experiences included the "Cost of Poverty" simulation and documentary screenings to reinforce real-world application.

In addition to skill-building and education, HEART Advocates contributed meaningfully to internal equity initiatives. Participants supported the Promise Health Equity Committee and helped develop practical tools, including the *Advancing Health Equity: A Guide for*

Navigating Challenging Conversations job aid, which was led and presented by HEART Advocate Maira Torre, Health Education Cultural & Linguistic Specialist. Advocates were encouraged to apply program learnings within their teams and departments, and feedback was collected after each session to assess impact and continuously improve the program.

Feedback from participants was overwhelmingly positive, with survey results demonstrating increased confidence and knowledge related to health equity concepts. One hundred percent (100%) of respondents indicated they plan to use the job aid in their work. Overall, the program strengthened internal capacity for equity advocacy, supported organizational culture change, and reinforced Blue Shield Promise's commitment to embedding equity into daily practice.

Looking ahead, the HEART Advocate Program presents a strong opportunity for scalability and broader impact. The program should be evaluated for expansion to include all Blue Shield of California staff. Additionally, this model offers a promising pathway for external application within the provider network. Promise's CHEO is exploring options to pilot a similarly structured program for Federally Qualified Health Centers (FQHCs) interested in developing or strengthening their own health equity initiatives, further extending the program's influence and advancing system-level change.

Goal #4: Interventions that Matter
Objective #1: Member social drivers of health data collection increases by 5% by 12/31/2025

To increase member social drivers of health (SDOH) data collection by 5% by December 31, 2025, Blue Shield Promise implemented a multi-faceted strategy focused on integrating data collection into routine operations, strengthening partnerships, and improving data systems. Standardized SDOH screening questions were embedded into existing care management, case management, and member outreach workflows to ensure consistent and systematic data collection. These efforts reduced reliance on one-time or standalone screenings and aligned data collection practices with applicable state and regulatory requirements while maintaining consistency across programs.

Blue Shield Promise also prioritized Providers network partners engagement to expand data collection opportunities beyond internal teams. Providers and network partners were supported in collecting and submitting SDOH information during routine clinical and non-clinical encounters, with technical guidance provided to improve accurate documentation and reporting. At the same time, collaborations with community-based organizations, contractors, and downstream partners enabled SDOH data to be captured during service delivery and referral processes, further enriching member records where allowed.

To support sustainability and data quality, Blue Shield Promise enhanced internal systems to improve the capture, tracking, and reporting of SDOH data, established baseline measurements, and created ongoing monitoring processes to track progress toward the 5% increase target. Training and guidance were provided to staff and partners to reinforce the importance of SDOH data collection and its direct role in informing care planning and referrals. Importantly, collected SDOH data is actively used to connect members to targeted interventions addressing needs such as housing instability, food insecurity, transportation barriers, and financial strain, ensuring that data collection efforts translate into meaningful action and improved member outcomes.

IV. Key Findings

The following list highlights key findings the HEO has identified throughout the calendar year 2025.

- **Enterprise alignment and oversight:** The HEO continued active participation in the Health Equity Oversight Committee (HEOC) in partnership with Blue Shield of California and Blue Shield of California Life & Health Insurance Company, promoting enterprise-wide alignment, shared accountability, and coordination of health equity strategies across lines of business.
- **NCQA Health Outcomes Accreditation:** Blue Shield Promise successfully achieved and maintained NCQA Health Outcomes Accreditation with 100% of standards met, with progress, monitoring activities, and required reports consistently presented to the QIHEC on a quarterly basis.
- **DEI Training Program implementation:** The Plan fully operationalized the DHCS-approved Advancing Health Equity DEI Training Program in accordance with APL 24-016, achieving 100% completion among internal staff and launching provider training in April 2025, with early but steadily increasing network provider completion rates. Governance, tracking, attestation, and regional data-sharing processes were established to support continued progress.
- **Health equity data maturity:** Continued monitoring of the HEART Measure Set identified meaningful disparities across race, ethnicity, age, and language while also revealing limitations related to denominator size and data completeness for certain measures. These findings underscored the importance of longitudinal trend analysis rather than one-time comparisons.
- **Analytics and dashboard enhancements:** The HEO partnered with IT and Data Analytics to enhance the Health Equity Dashboard, improving stratified reporting, trend visibility, and usability for operational teams to support data-driven decision-making.

- **Disparity reporting and transparency:** Provider Profile reports, disparity analyses, and standardized quarterly reporting templates were developed and refined in collaboration with internal and external stakeholders to strengthen transparency, comparability, and actionability of equity data.
- **Member demographic data collection:** While member self-reported race and ethnicity data exceeded internal targets, persistent challenges remain in collecting SOGI data. Pilot approaches that demonstrated limited engagement were discontinued, and alternative strategies emphasizing member trust, privacy, staff training, and workflow integration continue to be explored.
- **SDOH**: Expanded integration of SDOH screening into care management and outreach workflows resulted in measurable increases in data capture, highlighting both progress and the ongoing need to further normalize SDOH collection and utilization across programs.
- **HEART Advocate Program**: The HEART Advocate Program demonstrated strong impact and sustainability, with Cohort 2 completing the program in 2025 and achieving participant satisfaction rates well above the 90% target, supporting internal culture change and equity capacity building.
- **Health Equity Integration Plan**: Implementation of the Health Equity Integration Plan progressed across multiple functional areas, with activities advancing on schedule and reinforcing the integration of health equity into quality, operations, population health, provider engagement, and member experience.
- **Member and Family Engagement** requirements further demonstrated the organization's ability to translate member feedback into actionable program improvements.
- **Utilization disparities:** Analysis of preventive care utilization identified that over 40% of members were not engaged in routine care, with disparities across REGAL factors, leading to targeted intervention planning through the UM Health Equity Integration Plan.

V. Action Plan

In 2026, 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.

Table 9. 2026 QIHET Program Goals and Objectives

2026 QIHET Program Goals and Objectives	
Goal	**Objective**
Sound Infrastructure and Operations ***Maintain NCQA Health Outcomes Accreditation (formerly HEA)***	Complete 100% of all Health Outcomes Accreditation activities as required by 12/31/2026
Sound Infrastructure and Operations ***Ensure contract compliance***	100% of health equity related contract deliverables will be compliant by 12/31/2026
	For Well Child Visits HEDIS® measure, the compliance rate among Black/African American members and Asian members will meet or exceed the minimum performance level or achieve improvement equivalent to at least 6 points (based on the DHCS Quality Withold and Incentive Program).
	For Post-Partum Care HEDIS® measures, Black/African American members will meet or exceed the minimum performance level or demonstrate a statistically significant increase in directional improvement
	At least 30% of network providers complete Diversity Equity and Inclusion training by 12/31/2025
Equity embedded in everything we do ***Build and Integrate a Culture of Equity***	90% of finalized Health Equity Integration Plan activities will be completed by 12/31/2026
	Member social drivers of health data collection increases by 5% by 12/31/2026
	85% of members with 1+ social driver will be addressed by 12/31/2026

Furthermore, the QIHETP Action Plan lists all actions and milestones needed to formally build and implement the Blue Shield Promise QIHETP. The Action Plan is managed by the HEO (Reference Appendix 1. 2025 QIHET Program Description).

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 QIHEC, Medi-Cal Committee, Health Equity Oversight Committee (HEOC), Community Advisory Committee (CAC), Provider Advisory Committee (PAC) and Joint Operations Meetings (JOM) are engaged and provide valuable feedback from internal and external partner engagement, for example, from a member, provider, community-based organization, etc. and their perspective to impact Blue Shield Promise's QIHETP, or HEART program.

a. Quality Improvement and Health Equity Committee

In 2025, the Blue Shield Promise HEO hosted four (4) quarterly QIHEC meetings. The QIHEC continues to serve as a key feedback and engagement mechanism for providers and stakeholders, ensuring that quality improvement efforts are informed by frontline experience and equity-focused perspectives.

The QIHEC facilitated regular opportunities for provider and stakeholder input through structured meetings, discussions, and review of performance data. Providers and community stakeholders were engaged to share feedback on access to care, quality outcomes, member experience, and identified health equity challenges impacting diverse populations.

Committee activities included reviewing quality metrics, monitoring health equity initiatives, and discussing disparities identified through data analysis and provider insights. Provider feedback was used to inform quality improvement strategies, address barriers to care, and refine interventions aimed at improving health outcomes for underserved populations.

QIHEC also served as a forum to communicate updates on quality programs, regulatory requirements, and health equity priorities, allowing for bidirectional communication between leadership and providers. Feedback gathered through the committee was documented, elevated as appropriate, and incorporated into ongoing quality improvement and health equity action plans.

Overall, QIHEC strengthened provider stakeholder engagement by promoting collaboration, transparency, and shared accountability, ensuring that quality improvement activities and health equity initiatives remained responsive to provider input and community needs throughout 2025.

b. Medi-Cal Committee

In 2025, the Medi-Cal Committee of the Board provided governance-level oversight of the QIHETP, or HEART program, with a focus on quality improvement, health equity, regulatory compliance, and member and provider experience. The committee served as a key forum for elevating feedback from internal teams, providers, and community stakeholders to the Board level.

The committee regularly reviewed Medi-Cal performance metrics, quality and access indicators, health equity data, and compliance updates, including emerging regulatory and policy requirements. Feedback and insights gathered through operational committees, including QIHEC and provider engagement efforts, were synthesized and presented to the Medi-Cal Committee to inform strategic oversight and decision-making. Through structured discussions, the Medi-Cal Committee assessed progress on quality improvement initiatives, monitored disparities affecting Medi-Cal members, and provided guidance on interventions aimed at improving outcomes for underserved populations. Committee members offer direction on priorities, resource allocation, and accountability to ensure alignment with state requirements and organizational goals.

The Medi-Cal Committee of the Board strengthened stakeholder engagement by promoting transparency, elevating provider and community feedback, and ensuring that health equity and quality improvement remained central to Medi-Cal program strategy throughout 2025.

c. Health Equity Oversight Committee

In 2025, the Blue Shield Promise HEO continued its participation in the Health Equity Oversight Committee (HEOC) in partnership with Blue Shield of California and Blue Shield of California Life & Health Insurance Company. The HEOC provides enterprise-wide oversight of health equity–related activities across all Blue Shield of California lines of business, including Commercial HMO and PPO, Exchange HMO and PPO, Medicare HMO and PPO, Medi-Cal, and Life & Health insurance products.

The HEOC serves as the organization's primary accountability body for advancing health equity strategies and identifying opportunities to expand and scale effective practices across lines of business. The committee is co-chaired by the Blue Shield of California and Blue Shield Promise CHEOs, or other designated personnel on an ad hoc basis.

Through focused governance and oversight, the HEOC ensured alignment of health equity efforts with regulatory requirements, organizational priorities, and community needs. The committee functioned as a dedicated forum for monitoring disparities, evaluating equity-

focused initiatives, and guiding actions to promote equitable access, quality, and outcomes for Medi-Cal members.

The committee regularly reviewed disaggregated data by race, ethnicity, language, geography, and other key demographic factors to identify inequities in care, utilization, and member experience. These findings informed assessments of progress, supported the development of targeted equity interventions, and helped prioritize populations and geographic areas requiring focused action.

In addition, the HEOC reviewed updates on health equity initiatives, community engagement efforts, and quality improvement strategies, including recommendations elevated from the QIHEC and other stakeholder engagement activities. Input from providers, community-based organizations, and members was incorporated to ensure equity strategies were grounded in lived experience and community voice.
Through ongoing monitoring, discussion, and strategic guidance, the HEOC strengthened organizational accountability for health equity, ensured transparency in reporting, and supported continuous improvement efforts throughout 2025.

d. Community Advisory Committee

Blue Shield Promise continuously engages the Community Advisory Committee (CAC) as a critical mechanism for gathering community input on health plan activities that may impact the QIHETP. Blue Shield Promise regularly provided health equity program updates to the CAC, solicited feedback, discussed opportunities for improvement, and reviewed progress toward QIHETP goals and objectives.

The CAC remains an essential forum for incorporating community perspectives into health equity initiatives. Blue Shield Promise shared relevant updates, including QIHEC-related activities, findings, recommendations, and actions, and invited CAC members to provide input to inform program development, refinement, and enhancement.
Feedback on *Advancing Health Equity* training

In 2025, the Blue Shield Promise HEO brought forward the newly developed *Advancing Health Equity* training to meet APL 24-016 DEI training program requirements and an opportunity to solicit feedback from CAC members and external partners. Committee members emphasized that cultural background could create barriers to care and underscored the need for greater cultural awareness to support effective provider–patient relationships.

Members highlighted communication as a cornerstone of quality care, noting that understanding cultural nuances enables staff and providers to anticipate potential

misunderstandings, build trust, and reduce frustration for both patients and providers. In response, the training was enhanced to reinforce the importance of culturally responsive communication and now includes updated references to Health Literacy resources. These resources are designed to help providers convey information in clear, accessible ways, ensuring members feel supported, informed, and understood. These enhancements aim to bridge cultural gaps, improve patient satisfaction, and promote equitable treatment across culturally diverse populations by helping providers better understand how cultural context influences expectations, decision-making, and health outcomes.

Incorporating Traditional Health Practices

CAC members from Los Angeles County and San Diego County emphasized the need for expanded training content related to traditional home remedies and cultural healing practices. Members shared that many individuals incorporate herbal medicines, vitamins, folk remedies, spiritual healing practices, or traditional systems such as Traditional Chinese Medicine (TCM) into their health routines practices that may not always be disclosed or understood in clinical settings.

To address this feedback, the training was enhanced to include detailed examples of traditional remedies, explanations of their cultural significance, descriptions of the roles of community healers (such as Curanderas), and commonly used herbal or supplement practices. The training also encourages providers to foster open, nonjudgmental dialogue that supports voluntary disclosure of these practices. This approach enables providers to offer guidance that respects cultural values while helping to identify potential safety concerns, such as interactions with prescribed medications. These updates promote more holistic, culturally responsive care, strengthen trust, and support improved health outcomes.

CAC members from San Diego County highlighted the need for expanded training on gender-affirming care, including clearer information on what such care entails, the types of services that may be involved, and how members can access appropriate care. Members also emphasized the importance of active listening and respectful communication with transgender, gender-diverse, and intersex (TGI) patients.

In response, the *Advancing Health Equity* training now directs learners to the Shield Learns course *Improving the Healthcare Experience for the Transgender, Gender Diverse, and Intersex Community*. This training provides real-world scenarios, community-informed insights, and evidence-based practices that support the delivery of affirming care. The course addresses common barriers faced by TGI patients, offers guidance on initiating respectful and supportive conversations, and outlines appropriate referral pathways. Additionally, outdated job aids were removed from provider training materials to ensure

accuracy and prevent confusion. Collectively, these updates strengthen providers' ability to deliver respectful, affirming, and equitable care to all members.

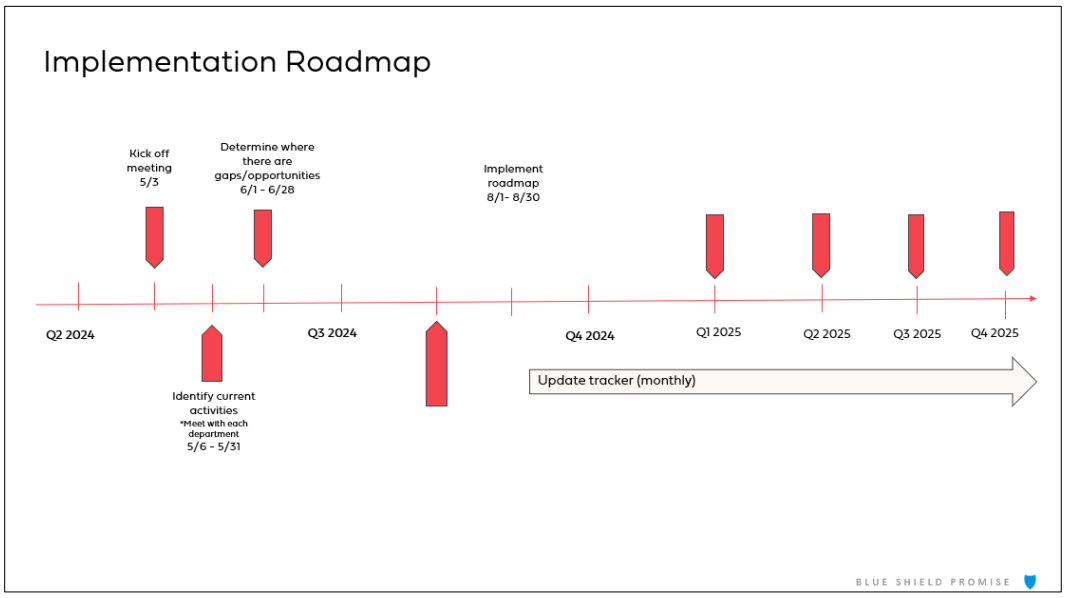
Member and Family Engagement

Additional details regarding Blue Shield Promise's Member and Family Engagement approach, including Community Advisory Committee (CAC) engagement, listening sessions, surveys, and the incorporation of member feedback into program design and decision-making—demonstrates how member voice is systematically integrated into policy development, program refinement, and organizational decision-making.

Blue Shield of California Promise Health Plan demonstrates its commitment to Member- and family-focused care through a structured, ongoing engagement strategy that involves Members, families, caregivers, and community partners as active contributors to the design, delivery, evaluation, and improvement of covered services.

A structured implementation roadmap was established in 2024, progressing from assessment and gap identification to phased rollout. The Community Programs department operationalized the Member and Family Engagement policy through a defined engagement strategy, with ongoing program management supported by regular tracking, stakeholder engagement, and continuous improvement to align with organizational goals and member needs.

Figure 6. Implementation Roadmap

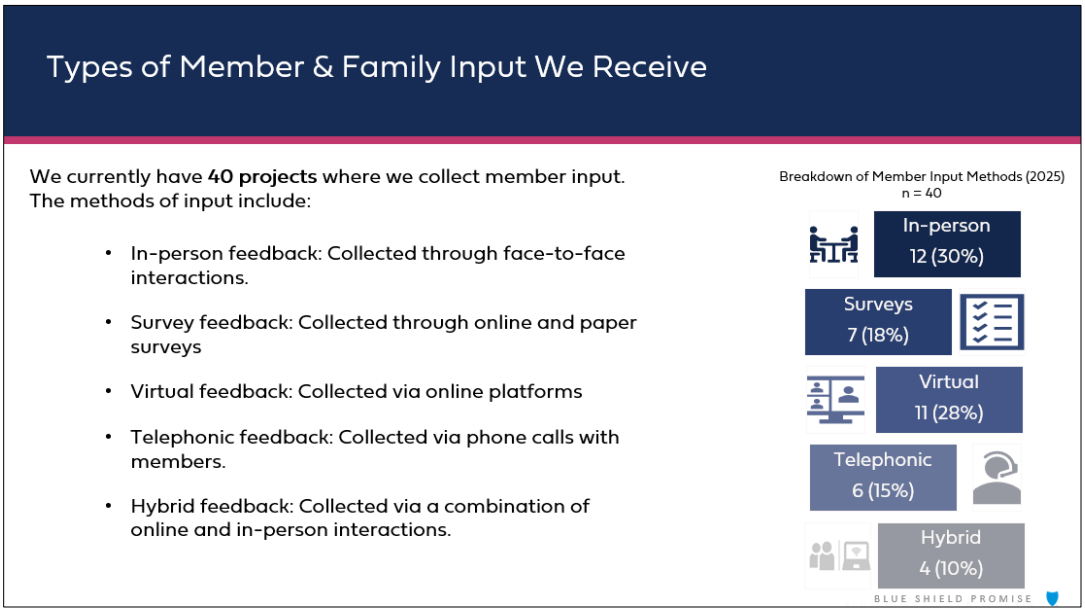


Consistent with its Member and Family Engagement policy, Blue Shield Promise seeks input through multiple channels, including the Community Advisory Committee (CAC), Public Policy Committee (PPC), annual Consumer Assessment of Healthcare Providers and

Systems (CAHPS) surveys, monthly Net Promoter Score (NPS) surveys, Population Needs Assessment-related activities, focus groups, listening sessions, interviews, town halls, and community conversations conducted in partnership with trusted community-based organizations. This engagement approach is designed to ensure that Member and family perspectives are incorporated into policies, programs, services, and organizational decision-making on an ongoing basis.

The following information was presented to the Quality Improvement and Health Equity Committee in September 2025.

Figure 7. Types of Member and Family Engagement Input



Blue Shield Promise routinely reviews CAC findings and other Member feedback to identify barriers, preferences, and opportunities for improvement. As described in the policy, the CAC and PPC are standing committees that provide direct input on policies, programs, Member materials, service delivery, and organizational priorities. Committee members have weighed in on a wide range of topics, including the Marketing Plan, newsletter content, health plan information videos, member incentives, website updates, maternal health, appeals and grievances, and preventive screening initiatives. That input has informed tangible actions such as updates to welcome materials, improvements to Member ID cards, additional incentive options, and enhanced outreach support to help Members schedule appointments and navigate services. Blue Shield Promise also surveys committee participants and uses those results to assess whether engagement is meaningful and to identify additional topics of interest for future reviews.

Blue Shield Promise also gathers ongoing feedback through CAHPS and NPS surveys to monitor Member experience and identify trends requiring action. The plan receives

approximately 300 NPS responses each month and has used this ongoing feedback to reinforce continuous improvement efforts. In addition to standing committees and surveys, Blue Shield Promise conducts targeted listening sessions and focus groups to better understand the experiences of specific Member populations. Examples include listening sessions at the Metro LA Community Resource Center; quality focus groups with Medi-Cal members to identify barriers to well-child visits, vaccinations, and postpartum care; and the first ever community-driven quality co-design sessions with approximately 10 local community organizations focused on improving prenatal and postpartum care and promoting child wellness visits. Blue Shield Promise has also collaborated with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) partners and local community organizations to identify emerging Member needs and support timely outreach, resource navigation, and community education during periods of disruption affecting food assistance access.

Blue Shield Promise also uses these findings to shape future interventions and monitor accountability for acting on Member and community input. Insights from committee discussions, surveys, focus groups, and listening sessions are used to tailor outreach materials, improve cultural and linguistic appropriateness, strengthen communication strategies, identify opportunities for provider education, and develop community-informed solutions to improve access and reduce disparities.

The following graphic illustrates three Member and Family Engagement initiatives implemented in 2025, detailing their objectives, key activities, and outcomes to show how member feedback is driving meaningful program enhancements.

Figure 8. Implementation Initiatives

Through this continuous feedback loop, Blue Shield Promise demonstrates not only that it engages Members and families as partners, but also that it uses the information gathered from these engagements to guide policy development, program refinement, and decision-making in a manner responsive to the needs of the communities it serves.

Documentation, Transparency, and Continuous Improvement

Feedback gathered through CAC meetings and discussions was systematically reviewed and incorporated into training updates and program enhancements. Written summaries of QIHEC activities, findings, recommendations, and actions are prepared following meetings and are made publicly available on the Blue Shield Promise website at https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/health-equity on at least a quarterly basis, in alignment with Medi-Cal contractual requirements.

Throughout 2025, the Blue Shield Promise HEO continued to publish QIHETP and QIHEC updates on the website available at https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/health-equity and bring forward relevant health equity topics to CAC meetings. This ongoing engagement supports transparency, accountability, and continuous improvement of health plan programs informed by community voice.

e. Provider Advisory Committee

Blue Shield Promise ensures contracted health care providers, practitioners, and allied health care personnel receive pertinent information regarding the QIHETP. The Blue Shield Promise HEO engaged contracted providers through Quarter 1, 2025 Provider Advisory Committee (PAC) meetings in Los Angeles and San Diego Counties to share updates and solicit feedback on the QIHETP, including the newly developed *Advancing Health Equity* training.

Feedback reflected a range of perspectives. Some providers expressed concern about potential conflicts between DHCS-mandated training requirements and federal Executive Orders, particularly regarding DEI-related content and the risk of federal sanctions. One federally funded provider organization reported scaling back internal DEI efforts and raised concerns about the inclusion of gender-affirming care topics. Conversely, multiple stakeholders emphasized that cultural competency training is required under state regulations, that state law often parallels or exceeds federal guidance, and that advancing health equity remains critical to meeting community needs. Several participants underscored the importance of continuing gender-affirming care services and equity-focused practices. At the same time, concerns were raised regarding the cumulative administrative burden of training and regulatory requirements, with suggestions that the current year may not be optimal for implementing the new required APL 24-016.

This feedback was shared with the DHCS for consideration. Blue Shield Promise HEO will continue documenting QIHEC activities and publishing updates at least quarterly to remain compliant with Medi-Cal contractual requirements, while continuing to engage providers to inform program development and implementation.

f. Joint Operations Meeting

The Blue Shield Promise HEO also participated in 2025 Joint Operations Meetings (JOMs) and engaged with several Independent Practice Associations (IPAs) and medical groups throughout the year. The HEO presented on DHCS APL 24-016 at approximately 50 JOM meetings over the calendar year.

Through Joint Operations Meetings and sustained outreach with IPAs and medical groups—initiated in March 2025 and continuing monthly—Blue Shield Promise gathered critical external partner feedback on DEI and TGI training requirements, operational feasibility, and implementation challenges. These engagements directly informed pilot planning, enabled iterative refinement of training approaches, and supported continued progress toward meeting APL 24-016 implementation timelines.

During these meetings, the HEO provided IPAs and medical groups with regular updates on revised APL 24-016 requirements, which supersede APL 23-025, including implementation timelines and key program developments. Presentations detailed the phased approach to training development; cross-collaboration with regional Managed Care Plans (MCPs); development, submission, and regulatory approval of the DEI training program; and the pilot rollout and completion tracking process. The HEO also reiterated that, effective January 1, 2026, all Blue Shield Promise internal staff, subcontractors, downstream subcontractors, and network providers are required to complete the DEI Training Program, Advancing Health Equity, which covers sensitivity, diversity, cultural competency, cultural humility, and health equity topics.

JOM participants provided constructive initial feedback on the training and implementation approach. One IPA requested additional clarification regarding expectations for IPAs and medical groups, including how they would obtain visibility into completion status if network providers were required to self-attest. The IPA expressed a preference to attest on behalf of all providers within its network, submitting a detailed list of training completions to the MCP, and thereby alleviating administrative burden for individual providers. This feedback was taken into consideration as Blue Shield Promise continued to refine the attestation process. Additional clarification was requested regarding training cadence—specifically whether completion is required annually or only at hire, credentialing, and recredentialing milestones. The HEO confirmed that the cadence

aligns with requirements outlined in the APL. The IPA also expressed interest in participating in regional workgroup discussions.

The HEO documented this feedback and collaborated with the Provider Education team to finalize the attestation process ahead of training implementation planned for April 28, 2025. Blue Shield Promise accepts both individual self-attestations and group attestations submitted via a standardized spreadsheet available on the Provider website. Completed spreadsheets may be returned to the MCP via posted instructions. Blue Shield Promise then imports the data into the Provider Learning Center to reflect completion status and shares completion data with regional MCP partners.

g. Other Stakeholder Engagement

Internal Stakeholder Engagement

Employee Resource Group

In 2025, the Blue Shield Promise CHEO served as co-chair of the ¡Unidos! Employee Resource Group (ERG), strengthening leadership-level engagement in enterprise-wide health equity efforts. In this role, the CHEO helped guide strategic planning and influenced the design and implementation of equity-focused initiatives across departments. ERG activities emphasized advancing culturally responsive practices, elevating employee perspectives, and aligning internal efforts with Blue Shield Promise's broader health equity goals.

Key areas of focus included workforce pipeline development, inclusive employee engagement, poverty simulation training, and the elevation of preventive health education topics that disproportionately impact underserved communities. A central pipeline strategy was engagement with the Cristo Rey Student Work Program, which is widely recognized as a best-in-class, equity-centered workforce development model. By integrating rigorous academics with paid professional work experience and mentorship, the program helps address systemic barriers to opportunity while preparing students for college completion and meaningful careers.

For organizations like Blue Shield Promise, participation in the Cristo Rey program aligns strongly with health equity, community investment, and future workforce development priorities. Collectively, these ERG-led efforts strengthened partnerships, reinforced internal accountability, and created shared value for employees, students, and the communities most impacted by health inequities.

In 2026, the ERG will continue to serve as a cornerstone of internal stakeholder engagement, with a strong focus on equity-related initiatives and workforce pipeline development. Priority efforts include deepening partnerships that support Cristo Rey

Student Associates, providing meaningful early-career exposure and paid work experience aligned with long-term career pathways. In parallel, the Blue Shield Promise HEO will lead to the expansion of internship opportunities across undergraduate, graduate, and doctoral levels, strengthening talent development and succession planning while ensuring access for individuals from historically underrepresented backgrounds. Together, these efforts reinforce the organization's commitment to building a diverse, inclusive, and future-ready workforce through sustained internal collaboration and investment.

External Stakeholder Engagement

Throughout 2025, Blue Shield Promise sustained robust external engagement to advance health equity, strengthen cross-sector collaboration, and support compliance with evolving state requirements. Engagement efforts spanned Los Angeles and San Diego Counties and emphasized co-designing solutions with providers, community partners, peer health plans, and regulators, while reducing administrative burden and improving equitable care delivery for Medi-Cal members.

Regional APL 24-016 Training Collaborative Workgroups (Los Angeles and San Diego Counties)

Blue Shield Promise actively participated in ongoing, multi-plan DEI Training Collaborative Workgroups to align implementation of DHCS DEI Training Program requirements (APL 24-016). Initiated in June 2023 and continuing through 2025, these monthly forums focused on reducing duplicative provider training and administrative burden across managed care plans. Key outcomes included development of a co-branded letter with peer MCPs (LA Care, Anthem, and Blue Shield Promise), alignment on curriculum standards, confirmation of shared databases and systems for data exchange, and coordination of individual MCP curriculum submissions.

Targeted Provider Capacity-Building and Training

The HEO delivered tailored health equity training to external partners to build provider capacity and embed a health equity lens into daily workflows. Notably, in October 2025, Blue Shield Promise conducted a health equity training for the Health Navigator Program in San Diego County, supporting medical groups—including Vista Community Clinic—in applying equity principles to care gap outreach, appointment navigation, and identification of social drivers of health such as interpreter and transportation needs. The training received positive feedback and reinforced Blue Shield Promise's leadership in advancing equitable service delivery, with requests for expanded training to broaden reach.

Community and Regional Health Equity Collaboration

Blue Shield Promise engaged in regional health equity collaboration through participation in the Healthy San Diego Health Equity Workgroup. These efforts focused on advocating for cross-plan collaboration among Medi-Cal CHEOs and elevating shared implementation challenges. Planning activities are underway to formalize collaborative efforts, including a pending letter to DHCS to support alignment and coordinated policy approaches.

Direct Regulator and Statewide Engagement

Blue Shield Promise actively participated in Quarterly DHCS–Quality and Population Health Management (QPHM) Joint CMO/CHEO Meetings in June 2025. These forums supported cross-plan and regulatory dialogue on DEI and TGI training implementation, primary care access, network adequacy, engagement of underutilizing members, and oversight of delegates and IPAs. In addition, Blue Shield Promise participated in the 2025 Medi-Cal Managed Care Quality Conference in November 2025, where health equity was a central theme across discussions on Children's Preventive Care, Behavioral Health Integration, and Maternity Outcomes and Birth Equity.

Los Angeles Care Health Plan Engagement

As Blue Shield Promise's regulator, Los Angeles (LA) Care Health Plan plays a central role in regional oversight, coordination, and alignment on Medi-Cal health equity priorities. The Blue Shield Promise HEO actively participates in LA Care-led external engagement activities to support compliance with contractual obligations and consistency across Los Angeles County Medi-Cal managed care plans.

Through ongoing collaboration with LA Care, the HEO engages in regulatory meetings, workgroups, and forums including the LA Care Health Plan QIHEC meetings and standing APL 24-016 implementation workgroups involving all Los Angeles County MCPs. These engagements focus on advancing health equity, cultural competency, and quality improvement strategies within the Medi-Cal managed care environment.

LA Care-facilitated convenings provide a structured venue to share updates on DHCS policies, including health equity and training requirements; exchange best practices among peer MCPs; and coordinate regional implementation approaches. The HEO also leverages these forums to elevate provider and community feedback, identify operational and compliance challenges, and promote alignment across plans—particularly related to training cadence, attestation processes, and minimizing administrative burden on providers.

Participation in LA Care external engagement activities supports Blue Shield Promise's regulatory compliance while strengthening cross-plan collaboration, fostering shared accountability, and reinforcing a collective commitment to advancing equitable, high-quality care for Medi-Cal members across Los Angeles County.

Leading the Way Awards – Community Recognition

Blue Shield Promise's Leading the Way Awards is an annual community recognition initiative that honors individuals and organizations demonstrating sustained leadership in advancing health equity, improving access to care, and delivering high-quality, compassionate services to Medi-Cal members and underserved populations. The awards are designed to elevate partners whose work addresses both clinical and non-clinical drivers of health, aligns with Blue Shield Promise's mission, and contributes to measurable improvements in community well-being.

Through this program, Blue Shield Promise recognizes a diverse group of honorees, including healthcare providers, community-based organizations, advocates, and civic leaders whose efforts strengthen the healthcare delivery system and expand equitable access to care. Awardees reflect a broad range of disciplines and service areas, such as primary and specialty care, behavioral health, public health, social services, youth engagement, and community resilience. Together, they exemplify innovative and collaborative approaches to serving populations disproportionately impacted by health disparities.

The Leading the Way Awards are presented annually at a community convening that brings together healthcare leaders, community partners, public officials, and Blue Shield Promise leadership. These gatherings serve not only as a recognition event, but also as an opportunity to highlight best practices, foster cross-sector collaboration, and reinforce shared accountability for advancing equity in Medi-Cal managed care. Award categories vary by year and commonly include areas such as Distinguished Service, Wellness and Empowerment, Youth Engagement and Resiliency, Equitable Health Access, Quality Health Care, and Visionary Leadership, with the latter recognizing long-standing and transformational contributions to community health.

The program supports Blue Shield Promise's broader community engagement strategy by strengthening relationships with trusted local partners and elevating proven, community-driven solutions that address social determinants of health. By formally recognizing exemplary leadership and impact, the Leading the Way Awards help reinforce values of equity, inclusion, cultural humility, and partnership across the healthcare ecosystem. The initiative underscores Blue Shield Promise's commitment to working

alongside providers and community organizations to improve health outcomes and ensure that Medi-Cal members receive care that is accessible, culturally responsive, and centered on community needs.

Outcomes and Impact

Collectively, these external engagement activities strengthened cross-sector partnerships, informed continuous improvement of Blue Shield Promise's health equity initiatives, and supported compliance with DHCS and DMHC requirements. They also reinforced Blue Shield Promise's role as a collaborative leader in advancing equitable, community-centered Medi-Cal delivery across Los Angeles and San Diego Counties.

VII. Annual Evaluation Reporting and Oversight

Results and key findings of the QIHETP Annual Evaluation will be presented to QIHEC in Quarter 2, 2026. The Health Equity Principal Program Manager will manage the 2026 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 2026, as applicable. The QIHETP Annual Evaluation will be posted on the Plan's public website available at https://www.blueshieldca.com/en/bsp/about-blue-shield-promise-health-plan/health-equity. Notification of the website and program updates will be transmitted via the member newsletter, Member Handbook (Evidence of Coverage), and Provider Manual.

VIII. References

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2. Blue Shield of California Promise Health Plan Quality Improvement and Health Equity Committee Charter.
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4. Blue Shield of California Promise Health Plan Quality Improvement and Health Equity Committee Policy.
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15. National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation Standards retrieved from https://www.ncqa.org/programs/health-equity-accreditation/.

IX. Appendices

Appendix 1. 2025 QIHET Program Description

Appendix 2. 2025 QIHEC Work Plan

Appendix 3. Annual Culturally and Linguistically Appropriate Services (CLAS) Program Assessment Report

Appendix 4. Annual Culturally and Linguistically Appropriate Services (CLAS) Program Evaluation Report

Appendix 5. Medi-Cal Annual Health Disparities Report